[2]GETHER NHS FOUNDATION TRUST

BOARD MEETING

THURSDAY 24 NOVEMBER 2016 AT 10.00AM

KINDLE CENTRE, HEREFORD

AGENDA

10.00	1	**Apologies**	
	2	**Declaration of Members Interests**	
10.05	3	**Minutes of the Board meeting held on 29 September 2016**	**PAPER A**
	4	**Action Points and Matters Arising**	
10.10	5	**Questions from the Public**	
IMPROVING QUALITY			
10.15	6	**Patient Story Item – Psychological Therapies**	**PRESENTATION**
10.45	7	**Performance Dashboard Report**	**PAPER B**
10.55	8	**Quality Report Quarter 2**	**PAPER C**
11.05	9	**Service Experience Report Quarter 2**	**PAPER D**
11.15	10	**National Patient Survey Report**	**VERBAL**
11.25	11	**Non-Executive Director Audit of Complaints**	**PAPER E**
BREAK – 11.35AM			
IMPROVING ENGAGEMENT			
11.45	12	**Chief Executive's Report**	**PAPER F**
IMPROVING SUSTAINABILITY			
11.55	13	**Summary Financial Report**	**PAPER G**
12.00	14	**Board Assurance Map Report**	**PAPER H**
12.10	15	**Risk Management Framework**	**PAPER I**
12.20	16	**Board Committee Summaries** • Audit Committee – November • Delivery – September, October and November (Verbal) • Governance – September, October and November (Verbal) • MHLS Committee – November (Verbal) • Charitable Funds Committee - November	 **PAPER J1** **PAPER J2** **PAPER J3** **VERBAL** **PAPER J4**
INFORMATION SHARING (TO NOTE ONLY)			
12.35	17 18 19	**Chair's Report** **Council of Governor Minutes – September 2016** **Use of the Trust Seal**	**PAPER K** **PAPER L** **PAPER M**
12.40	20	**Any Other Business**	
12.45	21	**Date of Next Meeting** Thursday 26 January 2017 at Trust HQ, Rikenel, Gloucester	

QUESTIONS FROM THE PUBLIC

Written questions for the Board Meeting

People who live or work in the county or are affected by the work of the Trust may ask:

- the Chairperson of the Trust Board;
- the Chief Executive of the Trust;
- a Director of the Trust with responsibility; or
- a chairperson of any other Trust Board committee, whose remit covers the subject matter in question;

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

Notice of questions

A question under this procedural standing order may be asked in writing to the Chief Executive by 10 a.m. 4 clear working days before the date of the meeting.

Response

A written answer will be provided to a written question and will be given to the questioner and to members of the Trust Board before being read out at the meeting by the Chairperson or other Trust Board member to whom it was addressed.

Additional Questions or Oral Questions without Notice

A member of the public who has put a written question may, with the consent of the Chairperson, ask an additional oral question on the same subject. The Chairperson may also permit an oral question to be asked at a meeting of the Trust Board without notice having been given.

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

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

Unless the Chairperson decides otherwise there will not be discussion on any public question.

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

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

For further information, please contact the Assistant Trust Secretary on 01452 894165

[2]GETHER NHS FOUNDATION TRUST

BOARD MEETING
TRUST HQ, RIKENEL
29 SEPTEMBER 2016

PRESENT

Ruth FitzJohn, Trust Chair
Andrew Lee, Director of Finance and Commerce
Shaun Clee, Chief Executive
Marie Crofts, Director of Quality
Dr Chris Fear, Medical Director
Martin Freeman, Non-Executive Director
Marcia Gallagher, Non-Executive Director
Duncan Sutherland, Non-Executive Director
Jane Melton, Director of Engagement and Integration
Colin Merker, Director of Service Delivery
Quinton Quayle, Non-Executive Director
Nikki Richardson, Non-Executive Director
Carol Sparks, Director of Organisational Development
Jonathan Vickers, Non-Executive Director

IN ATTENDANCE

Ian Stead, Herefordshire Healthwatch
Frances Martin, Director of Transformation
John McIlveen, Trust Secretary
Andrew Smart, Head of Communications
Rob Blagden, Trust Governor
Rhian Edwards, Sunovion Pharmaceuticals
Philippa Moore, Joint Director of Infection Control (Item 11)

1. WELCOMES, APOLOGIES AND INTRODUCTIONS

1.1 Apologies were received from Charlotte Hitchings and David Farnsworth.

2. DECLARATIONS OF INTERESTS

2.1 There were no new declarations of interests.

3. MINUTES OF THE MEETING HELD ON 28 JULY 2016

3.1 The minutes of the meeting held on 28 July were agreed as a correct record.

4. MATTERS ARISING AND ACTION POINTS

4.1 The Board reviewed the action points, noting that these were now complete or progressing to plan.

4.2 Jonathan Vickers asked whether the issue of prospective changes to Deprivation of Liberty Safeguards (DoLS) had been added to the Trust's Risk Register. The Director of Service Delivery informed the Board that since the meeting of the Mental Health Legislation Scrutiny Committee where this matter had been discussed, the Trust had obtained legal advice which indicated that the current DoLS framework would remain in place until such time as the legislation was changed, and thus the risk that a new scheme would not be available for use in mental health hospitals had now receded.

5. QUESTIONS FROM THE PUBLIC

5.1 There were no questions received from members of the public.

6. PATIENT STORY PRESENTATION

6.1 The Board welcomed Genevieve to the meeting who gave a very honest and articulate account of her experience as a young person receiving mental health services, and of the issues surrounding transition to adult services.

6.2 Genevieve is 19 years old, and identifies as a member of the LGBT community. She has been receiving mental health services since the age of 12, when she was initially referred for an eating disorder. Following a referral from her GP, Genevieve had received care from the Stroud Children and Young People's Service until the age of 18. Genevieve had attempted to take her own life at the age of 17, which resulted in her being admitted to an inpatient facility in London. Genevieve had been in adult mental health services since 2015.

6.3 Genevieve commented that mental health staff were predominantly caring and supportive, and mentioned one healthcare professional whom Genevieve found particularly supportive. However Genevieve felt that the well-meaning language used by healthcare professionals could sometimes be misinterpreted by young people as not being taken seriously, and could lead young people to turn to destructive behaviours in order to receive the treatment they felt was necessary. Genevieve felt that in Young People's Services the potential to defer to parents' views could also contribute to young people feeling deprived of their autonomy and their concerns being downplayed.

6.4 Genevieve described her experience of inpatient services in London, while recognizing that inpatient services were not provided by 2gether. She commented that going to an out of county placement was an issue for young people as it could be far from home, and that the numbers of temporary staff employed in these units can lead to patients feeling that care plans were not being followed. Genevieve said that she felt her inpatient stay had not helped her recovery, and she had taken an overdose six months after her discharge from the unit. Genevieve said that she would have found contact from the mental health team in her home area valuable, especially leading up to her discharge.

6.5 Genevieve spoke about the transition from young people's services to adult services. She felt the former offered much support but that this could lead to a perceived lack of autonomy for the young person. On the other hand, it felt to her that in adult services the onus was too much on the patient taking responsibility for engaging in treatment, and she felt unprepared for the change in approach which the transition presented. Genevieve also said she felt there was a significant link between mental ill health and members of the LGBT community, who often felt a sense on not belonging.

6.6 Quinton Quayle thanked Genevieve for a confident presentation, and asked whether her perceived lack of autonomy for patients in Young People's Services affected self-esteem and anxiety levels. Genevieve replied that it may be difficult for a young person to articulate how they feel, especially if they are struggling with something they don't understand. The well-meaning words of the clinician may then be mistaken for not being taken seriously, and the young person may then be inadvertently incventivised to escalate issues and destructive behaviour in order to feel they are being listened to.

6.7 The Director of Quality asked whether more intensive treatment in the community might be preferable to an inpatient stay. Genevieve replied that sometimes the underlying issue for a young person is the home environment, and they feel they need to be taken out of that environment. However long term patients could feel trapped in an inpatient unit, and some form of half-way house offering respite from the home environment for a few days, alongside intensive treatment, could be more beneficial.

6.8 Ruth FitzJohn asked Genevieve what the Trust could have done better when she returned from the inpatient unit. Genevieve replied that she would have found some contact from her mental health worker a week or so before discharge very helpful, in order to talk about her treatment plan when she returned home. Phone calls and home visits by Trust staff would also be helpful on the occasions when patients can't visit Trust premises for appointments, especially in the first couple of months. Genevieve felt that these measures would have helped her to reintegrate into the community.

6.9 The Board thanked Genevieve for coming and talking so openly about her experiences.

7. PERFORMANCE DASHBOARD

7.1 The Board received the performance dashboard report which set out the performance of the Trust for the period to the end of July 2016 against Monitor, Department of Health, Contractual and CQUIN key performance indicators. Of the 141 contractual measures, 85 were reportable for July with 74 being compliant and 11 non-compliant at the end of the reporting period. 1 indicator (5.18 CYP-IAPT Dataset) was Under Review. The information team was working with operational colleagues to build and implement reporting solutions to report on this indicator which would be included in future reporting. The Board noted that this report had been received and scrutinised in detail at the August Delivery Committee meeting.

7.2 Where non-compliance had highlighted issues within a service, Service Directors were taking the lead to address issues, with a particular focus continuing to be on IAPT services which accounted for 7 of the 11 non-compliant indicators. Work was ongoing to further understand the service issues and to develop plans to improve performance in relation to these indicators. The Board noted that in relation to the measure regarding bed occupancy for Gloucestershire patients, performance had been temporarily distorted due to certain beds at Charlton lane being closed for upgrade.

7.3 The Director of Service Delivery asked the Board to note that with regard to the two non-compliant indicators concerning percentage of service users asked if they have a carer, and percentage of carers offered a carer's assessment, these were new measures and the Trust has an action plan in place and is on trajectory to meet the threshold. An increase in performance was expected next month, and should this not materialize, the Delivery Committee would require specific service focus reports to be provided so as to be assured about progress. The Board was assured that non-compliance in these two indicators related to recording the relevant information on clinical systems rather than to poor practice on the ground.

7.4 The Board was assured that IAPT performance had been discussed in depth at the Delivery Committee, which was closely monitoring the service improvement plan which had been put in place, and that progress was being made. The Board noted that the maximum wait by the end of October was expected to be 18 weeks in both Herefordshire and Gloucestershire, however the numbers of patients not attending appointments had had an impact on the recovery plan and a plan was in place to reengage with those patients. The Trust intended to invite the Intensive Support Team back in to validate the October position, and the Board welcomed this approach. The Trust would also maintain its proactive reporting of progress to NHS Improvement.

7.5 The Board noted that there was one admission of an under-18 patient to an adult ward in Herefordshire in July. There had previously been four under-18 admissions during the year, 1 in Gloucestershire and 3 in Herefordshire. The Board was assured that where an under-

18 patient was admitted to an adult ward, this was done only where no safer and more clinically appropriate alternative was available, and such admissions were carefully considered, fully risk assessed and widely consulted with the patient and their family. A bespoke and exclusive package of care was put in place to ensure the safety and dignity of the young person while an inpatient.

7.6 The Board noted the dashboard report and the assurance that this provided.

8. QUALITY REPORT – QUARTER 1

8.1 The Director of Quality reported that this was the first review of the Quality Report priorities for 2016/17 and this quarterly report was in the format of the annual Quality Report.

8.2 The report showed the progress being made towards achieving targets, objectives and initiatives identified in the Annual Quality Report. The Board noted that the report had been scrutinized in detail by the Governance Committee.

8.3 The Board was disappointed to note that the report offered limited assurance that the majority of targets will be met. 3 of the 11 targets are currently being achieved with a further 3 being rated 'amber' and 5 not achieved. The Board felt strongly that while 3 of the safety targets (suicide minimization, Absence Without Leave, and prone restraint) are to an extent dependent on the clinical presentation of service users and may therefore be challenging to meet, it is right that the Trust should set itself these challenging targets, and delivering improvements in these areas should always be a strong focus of the Trust's work.

8.4 The Board noted that it is within the gift of services to improve individual team responses, performance and correct recording in relation to discharge planning, joint Care Programme Approach reviews for young people transitioning to adult services, improved service user experience and 48 hour follow up, where practice and data quality issues had impacted on performance in relation to some indicators. The Governance Committee had referred the poor performance set out in the Quality Report to Locality Delivery Committees for action.

8.5 The Board noted that a new sub-committee of the Governance Committee had been established with the intention of reducing the incidence of restrictive intervention such as prone restraint. The Chief Executive said the Trust needed to understand its own data regarding prone restraint, which appeared to show that [2]gether had a higher use of the technique than the national average, and a high level of incident reporting though with a low reported level of violence. He felt that a clinical view should be taken to determine whether the use of prone restraint was ever acceptable. The Board asked the Chief Executive to raise the matter at the Executive Committee and to report back on the outcome of that discussion.

ACTION: Executive Committee to discuss the use of prone restraint.

8.6 Jonathan Vickers asked whether the Trust understood the causes for the increase in patients absent without leave (AWOL) compared to last year. The Director of Quality said that 2gether was currently trying to learn from other Trusts through the patient safety programme, but further analysis of the data was necessary in order to fully understand the figures.

8.7 The Chief Executive noted that the indicator relating to personalised discharge care planning contained seven components, of which four related to safety with the remaining

three being administrative. The Board stressed the need for the Trust to be assured that the four safety elements of this indicator are always completed before discharge.

8.8 The Board noted the progress to date and actions set out in the Quality Report, and agreed that the report be shared with partner organisations, commissioners and Governors.

8.8 The Board noted the progress made to date and supported the recommendation that the Quarter 1 Quality Report update be shared with partner organisations, commissioners and governors.

9. SERVICE EXPERIENCE REPORT – QUARTER 1

9.1 The Director of Engagement and Integration presented the Service Experience Report for Quarter 1 2016/17. The Board noted that the report had been scrutinized by the Governance Committee in September 2016.

9.2 The Board noted that there was significant assurance that the organisation had listened to, heard and understood patient and carer experience of [2]gether's services. This is offered from a triangulation of feedback including complaints, concerns, comments and compliments. Survey information had also been used to understand service experience.

9.3 The report offered full assurance that complaints have been acknowledged within the required timescale, with 100% of the 27 complaints received in Q1 being acknowledged within 3 days. The report also offered significant assurance that all complainants receive regular updates on any potential delays to the provision of a response. However, there was limited assurance that all complainants receive a letter detailing the outcome of the complaint investigation within the initially agreed timescale, with 74% of complaints during the quarter being closed within the timescale agreed with the complainant. The Board noted that this figure had not previously been reported but performance against this measure would be included in Service Experience reports henceforth.

9.4 The report offered significant assurance that service users value the service being offered by the Trust, and would recommend it to others. The Boards noted that during quarter 1, 94% of people completing the Friends and Family Test said they would recommend 2gether''s services. This is a small improvement (1 percentage point) from the previous quarter, and is a higher percentage than that achieved by other Trust's nationally.

9.5 The Board noted that there was limited assurance that people are participating in the local survey of quality in sufficient numbers. Further work is underway to raise the profile of the local survey amongst staff and also to find other ways of collecting the required information. The establishment of a Task and Finish working group to review how people are involved in planning their care and treatment would also raise the profile of this source of feedback amongst staff.

9.6 Between 1st April and 30th June 2016, we received 27 complaints, 57 concerns were expressed through PALS and 533 people told us they were pleased with our service by giving us a compliment. 59 people took part in a survey about their experience (Gloucestershire 48; Herefordshire 11) and 94% said that they would recommend our service.

9.7 Some of the key themes and areas of feedback received included:

- Service users have raised concerns about exercising their right to record their clinical consultations.

- Service users have also raised concerns about the consistency with which information about them is shared with other organisations
- Risk management plans must be regularly completed, recorded and reviewed in conjunction with and in relation to other relevant individuals

10. SAFE STAFFING 6 MONTHLY UPDATE

10.1 The Board is mandated to receive a 6 monthly report outlining the requirements of the NHS National Quality Board (NQB) guidance on safe staffing levels. The Board noted that the Governance Committee continues to receive a monthly report detailing staffing levels across all inpatient sites.

10.2 The Director of Quality advised that this report provided significant assurance in relation to actual staffing levels against planned and significant assurance regarding delivery against the 10 national expectations set out in the NQB guidance. The last six months (March-August 2016 inclusive) has seen continued high compliance against planned staffing levels.

10.3 In summary for August 2016:

- No staffing issues were escalated to the Director of Quality or the Deputy Director
- Where staffing levels dipped below the planned fill rates of 100% for qualified nurses this was usually offset by increasing staffing numbers of unqualified nurses based on ward acuity and dependency and the professional judgement of the nurse in charge of the shift
- 96.7% of the hours exactly complied with the planned staffing levels
- 2.7% of the hours during August 2016 had a different staff skill mix than planned staffing however overall the staffing numbers were compliant and the needs of patients were met
- 0.6% of the hours during August had a lower number of staff on duty than the planned levels.
- There was 1 shift where it has been reported that the skill-mix of staff was non-compliant and the needs of patients were not met.

10.4 The National Quality Board (NQB) was currently reviewing the safer staffing guidance for all specialties. The mental health work-stream guidance is due to be published in late September/early October 2016. This will inform future staffing across inpatient and community teams

10.5 From November 2015 the Trust has been mandated to report to Monitor (now NHS Improvement) on agency nursing levels across the organisation (qualified only). The Trust was now completing weekly returns to NHSI in relation to agency costs, the number of agency shifts used and the use of any agencies not on the nationally agreed framework of providers. The Trust has received an agency expenditure control total from NHS Improvement, and has been mandated to reduce agency expenditure by over £2m to £3.404m in 2016/17. This represents a reduction of c.38% on 2015/16 agency expenditure. The Board noted that a Project Board had been set up to ensure effective monitoring of the position, feeding in to the Executive Committee. The Project Board, chaired by the Director of Quality and with representation from both the Director of Finance and the Director of Organisational Development, was focusing on four work streams including bank staff, recruitment and e-rostering. Significant progress had been made regarding agency use for inpatient nurses, and the next focus would be on medical staff and Allied Health Professionals.

10.6 The Board noted the content of the Safe Staffing report and the assurance it offered regarding staffing within inpatient units.

11. INFECTION CONTROL ANNUAL REPORT 2015/16

11.1 Philippa Moore presented the Annual Infection Prevention and Control report 2015/16 to the Board. She reported that the Trust remained compliant with the Health and Social Care Act: Code of Practice for Health and Adult Social Care on the prevention and control of infections and related guidance (The Hygiene Code). Risks for healthcare associated infection remained low in the Trust.

11.2 The Board was assured that the Trust was committed to providing high standards of infection control across all its services. Evidence was provided of infection control related activity, monitoring and governance during 2015/16.

11.3 The Board noted the following for 2015/16:

- There had been no MRSA bacteraemias detected in patients from Gloucestershire or Herefordshire
- There had been no reportable cases of c. difficile in either Herefordshire or Gloucestershire
- There had been no flu outbreaks
- There had been an improvement in antibiotic prescribing compliance in Herefordshire both and particularly in Gloucestershire

11.4 During 2015/16 there had been some concerns regarding the contract with the Wye Valley Infection Control Team due to staffing issues. However, all area audits had been completed, with feedback being provided to audited areas and action plans implemented where necessary.

11.5 Inpatient audit results for Gloucestershire provided significant assurance with all areas being scored 85% or above. Outpatient results provided a lower level of assurance with 4 out of the 8 areas audited scoring below the required 85%. The Board noted that many of the environmental issues affecting outpatient sites in Gloucestershire would be resolved once the new team base at Pullman Place came into use. Audit coverage for Herefordshire had increased in 2015/16, however three areas scored below the required 85% and the Board noted that action plans were in place.

11.6 Infection control training compliance scores provided limited assurance in both Gloucestershire and Herefordshire, with overall compliance rates standing at 66% at the end of February. These areas were being addressed by the provision of additional face to face training sessions to complement e-learning. An annual infection control study day had taken place on 14th May 2015 and had been attended by both Herefordshire and Gloucestershire staff.

11.7 In relation to hand hygiene compliance it was pleasing to note that during 2015/16, overall compliance was maintained at 96% against a target of 90%.

11.8 Marcia Gallagher asked about progress on Oak House in Herefordshire, where poor cleaning results had been reported during the year, and poor facilities scores had been reported for the past 4 years. The Board noted that while NHS Estates owned the building and was responsible for maintenance, the Trust was responsible for the care provided at the building. The Director of Finance and Commerce replied that work was ongoing with NHS Estates to complete improvement works following the Trust's recent CQC inspection.

However these works would improve but not fully resolve the issues associated with this property. The Board asked the Director of Finance and Commerce to provide an update on Oak House at the next meeting.

ACTION: Director of Finance to provide an update on Oak House at the next Board meeting

11.8 The Board noted the Annual Infection Prevention and Control report and continued to support the infection prevention and control programme to minimise the risks of healthcare associated infection, as required by the Health and Social Care Act.

12. MEDICAL APPRAISAL ANNUAL REPORT

12.1 The Board received the Annual Medical Appraisal Report, noting that the appraisal process had continued to be instituted within 2gether aligned with national policy. Investment in SARD JV and the transfer to that system was supporting effective monitoring, recording and review of the quantity, quality and uptake of appraisal. The Medical Appraisal Committee has instituted a work plan that will further deliver assurance annually and sustain quality.

12.2 The Board was assured that recruitment processes provided appropriate safety and quality checks aligned with national policy and best practice, and the use of locum practitioners was being monitored and used to sustain service commitments and activity appropriately.

12.3 In July 2015 the Trust's appraisal and revalidation systems were scrutinised by an NHS England Independent Verification Review Team. Overall the Trust was highly commended and scored at least 5 out of 6 (equating to 'Excellence') in all of the core standards. No required actions were recommended and many areas of good practice were noted. The Trust was subsequently invited to present at the SW Region Responsible Officers network as an example of good practice.

12.4 The Board noted that at the end of March 2016 90.9% of doctors had a valid appraisal. Of those Doctors who were non-compliant, 6.5% was due to exclusion criteria such as being on long term sick leave. 2.6% of Doctors were classed at the end of March as non-engaged. The Medical Director assured the Board that a further review of those cases suggested they are accounted for by short term delays and that all those doctors had since completed an appraisal. The Board noted the processes in place to remind doctors to engage with the appraisal process.

12.5 The Board noted that the use of locum doctors remains necessary for the safe provision of services, but that this is monitored appropriately.

12.6 The Board agreed the recommendations in the Medical Appraisal Annual Report and noted the significant assurance that this report provided. The Board agreed to submit the appropriate Statement of Compliance to NHS England.

13. ENGAGEMENT, ACTIVITY AND PHYSICAL HEALTH REPORT

13.1 The Board received a verbal report from the Director of Quality on the work of the Engagement, Activity and Physical Health (EAP) team.

13.2 EAP is collaborative and needs-led service provided at Greyfriars Ward Psychiatric Intensive Care Unit (PICU), designed to help patients make the transition back to acute inpatient services. The service, comprising members of staff from various disciplines (OT,

Health and Exercise, nurses, HCAs) who work together to support service users, had developed as a result of a small team from the ward together with a service user attending the Board in January 2016 to share their story. The service user had commented about the decrease in activity support that was experienced when transitioning from the PICU back to mainstream acute inpatient support.

13.3 The Board noted that the EAP service is designed to ensure that for PICU patients, interest in everyday activities is triggered and that confidence is built in preparation for the next step in the person's recovery journey. The EAP model matches the intensity of the PICU environment where there is a greater acuity and complexity of need, and the Matron at the PICU had commended the therapy team for their collaboration and high level of teamwork with nursing colleagues. The Board heard that there is emerging evidence of a direct correlation between the provision of higher level therapy on adult wards and a reduced length of stay.

13.4 The Board welcomed and supported the continued delivery of this model of care .

14. WORKFORCE RACE EQUALITY STANDARD REPORT

14.1 The Board received a report on the Trust's performance against the Workforce Race Equality Standard (WRES). The WRES was introduced as a mandatory report in April 2015, and is designed to highlight where staff from a Black and Minority Ethnic (BME) background have a different experience of working in the NHS to White colleagues. The WRES will form part of the Care Quality Commission's inspection schedule from 2016.

14.2 WRES data are drawn from the previous year's Staff Survey. This year's WRES therefore relies on responses to the 2015 Staff Survey and re-analyses the data the survey provides.

14.3 The Board noted that results from 2016 were broadly similar to those of 2015. However, the Board noted the disappointing outcome in respect of one indicator (Indicator 5 – percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public) where the Trust was an outlier when compared with results nationally, with a large percentage of the 19 BME staff responding to the 2014 survey describing a significantly worse experience of work than their white colleagues. The Board noted that the reasons for this result were not understood at the moment, and that the response rate from the 2015 survey had been too low to enable results to be published, meaning that the Trust could not assess progress against indicator 5.

14.4 The Board noted that a number of actions had been agreed by the Executive Committee in order to understand the data and improve further the Trust's performance against the WRES. Alongside this action plan, a Freedom to Speak Up Guardian had been appointed. Dignity at Work Co-ordinators were in place, and the Speak in Confidence facility was available on the staff intranet. The Board noted that all staff (rather than just a sample of staff as had been the case in previous years) would be invited to complete the 2016 staff survey, which should increase uptake, provide more robust data and enable any issues to be identified and addressed.

14.5 The Board noted that the Trust was part of a network and would seek to share learning from members of that network about the WRES. Ruth FitzJohn asked the Director of Organisational Development to undertake further analysis to determine which staff groups were most affected, and to develop actions to address this.

ACTION: Further analysis to be undertaken to determine which staff groups are most affected by issues raised in the WRES report, and develop appropriate actions

14.6 The Board noted the significant assurance provided around timely submission of the WRES, subsequent scrutiny of the national comparative results, and the development of an action plan reflecting the Trust's own comparison of its 2015 and 2016 results. The Board noted the limited assurance available that the underpinning data which inform the WRES are sufficiently to fully understand the experience of BME staff employed by the Trust.

15. CHIEF EXECUTIVE'S REPORT

15.1 The Chief Executive presented his report to the Board which provided an update on key national communications via the NHS England NHS News and a summary of key progress against organisational major projects.

15.2 The Board noted the extensive engagement activities that had taken place during the past month, and the importance of these activities in order to inform strategic thinking, raise awareness of mental health, build relationships and influence the strategic thinking of others. The Chief Executive advised that this report offered the Board significant assurance that the Executive Team was undertaking wide engagement; however, it only offered limited assurance on the effectiveness of that engagement.

15.3 The Board noted the Chief Executive's report

16. SUMMARY FINANCIAL REPORT

16.1 The Board received the Finance Report that provided information up to the end of August 2016. The month 5 position was a deficit of £211k compared to the planned deficit of £207k. The budgets had been revised to include the £650k Sustainability and Transformation Fund monies that have been allocated to the Trust. One quarter of this fund had previously been included in the month 3 position. The Trust was allocated £650k from the Sustainability and Transformation Fund (STF) by NHS Improvement. The Trust also had its 2016/17 control total of a surplus of £4k adjusted upward by £650k to a revised 2016/17 revenue control total of £654k surplus. The month 5 forecast outturn is a £654k surplus, excluding impairments, as per the revised revenue control total and Trust budgets. The Trust is anticipating it will receive the full allocation from the STF.

16.2 The Board noted that the Trust has a Financial Sustainability Risk Rating of 4, the highest rating achievable, rather than the rating of 3 as set out in the report.

16.3 The Trust has a revised forecast agency spend of £3.903m at month 5. This is above the £3.404m control total, but £1.6m below expenditure in 2015/16, and takes account of the impact of a considerable number of actions taken by the Trust to reduce agency spend. The current figure equates to achievement of 76% of NHS I's required reduction in agency spending in 2016/17, and the Trust projects that it will meet the run rate to fully deliver the target reduction in 2017/18.

16.4 The Board noted that the Trust was ahead of its capital programme due to the purchase of the Gloucester Hub at Pullman Place. The Board also noted that the Trust faced a cost pressure of £500k from an increase in the forecast of Public Dividend Capital in 2016/17.

16.5 The Board noted that the Trust has completed a mid-year financial review including revenue budgets, capital expenditure, savings schemes, balance sheet provisions and risks and

opportunities. In response to a question from Marcia Gallagher, the Board was assured that the mid-year review demonstrated that the Trust's cash flow position remained sustainable over the 5 year period covered by its strategic plan.

16.6 The Board noted the Trust's Public Sector Payment Policy performance for the year to date, and asked that future reports also include the target performance for this measure.

ACTION: Public Sector Payment Policy target to be included in future finance reports

16.7 The Board noted the summary Finance Report for the period ending 31st August 2016.

17. AUDIT COMMITTEE ANNUAL REPORT

17.1 Marcia Gallagher presented the annual report of the Audit Committee which provided an overview of the Committee's work during 2015/16. The report was structured in sections reflecting each of the headings in the Committee's Terms of Reference, and set out the Committee's activities in overseeing the internal control mechanisms in the Trust in support of the Annual Governance Statement.

17.2 Marcia Gallagher pointed out to the Board that while there had been no meeting with the internal or external auditors during the year, this was due to changes in the chairmanship of the Committee. Marcia had met with both sets of auditors immediately after her appointment as Audit Committee chair. Neither the internal auditor nor the external auditor had raised any concerns at that meeting.

17.3 Marcia Gallagher drew the Board's attention to the annual review of the Audit Committee's effectiveness. This had been a largely positive self-assessment. Some areas for improvement had been identified and an action plan was in place to address these.

17.4 The Board noted the Audit Committee annual report.

18. BOARD COMMITTEE REPORT – AUDIT COMMITTEE

18.1 Marcia Gallagher presented the summary report from the Audit Committee meeting held on 3 August 2016 and noted the key points raised during the meeting and the assurance received by the Committee.

18.2 The Committee received an update on the Board Assurance Framework and trialled a new format based on assurance mapping. The Committee had found this new format useful and agreed to receive only the new format and covering report in future.

18.3 The Committee had reviewed its terms of reference and made some minor changes which were presented to the Board for approval. Jonathan Vickers suggested some further changes regarding attendance, and the Board asked Jonathan Vickers and Marcia Gallagher to agree a suitable form of words for this section of the terms of reference. The Board approved the revised terms of reference subject to these changes being agreed and incorporated.

ACTION: Jonathan Vickers and Marcia Gallagher to agree changes to the 'In Attendance' section of the Audit Committee's terms of reference

18.4 Marcia Gallagher provided an update on progress in appointing an external auditor, which was a responsibility of the Council of Governors. A panel comprising Governors, the Deputy

Director of Finance and the Audit Committee Chair had recently received presentations from bidding firms, and a recommendation on a preferred candidate would go from the panel to the November Council of Governors.

19. BOARD COMMITTEE REPORTS – DELIVERY COMMITTEE

19.1 The Board received the summary reports from the Delivery Committee meetings held on 27 July 2016 and 24 August and noted the key points raised during these meetings and the assurance received by the Committee.

19.2 Martin Freeman provided a verbal report from the Delivery Committee meeting held on 27 September. A full written report would be presented at the next Board meeting. Key items received and discussed at the meeting included:

- The Committee received significant assurance about the Trust's trajectory for its CQUIN targets for the year.
- Inpatient services continued to overspend, partly due to the impact of national directives on these services.
- Statutory and mandatory training compliance has decreased across the Trust. Sickness absence rates varied across the Trust and more work was required to understand why this is
- The Committee received an update on progress with the Children and Young People's Service waiting list
- Significant assurance had been received about the Trust's Winter Plan. There was partial compliance with Emergency Planning core standards, but a clear plan was in place to improve this
- The new training system had gone live but data quality issues had become apparent during the transition to the new system. Work was underway with the software provider to understand and address this but currently assurance remains limited until these issues are resolved.
- The Committee had received a Procurement Shared Services annual report which provided limited assurance that the service had achieved its anticipated savings target for the year. Actions had been suggested by the Committee to address the issues raised.

20. BOARD COMMITTEE REPORTS – GOVERNANCE COMMITTEE

20.1 Martin Freeman presented the summary report from the Governance Committee meetings that had taken place on 15 July and 19 August 2016, and the Board noted the key points raised during these meetings and the assurance received by the Committee.

20.2 Martin Freeman presented a verbal report from the Governance Committee meeting on 16 September. A full written report would be presented at the next Board meeting. Key items received and discussed at the meeting included:

- Implementation of the new Datix incident reporting system was going well but data quality issues had surfaced during the process, and a lack of consistency in categories (particularly Health and Safety) within the system made trend analysis difficult. The Committee therefore took only limited assurance on Health and Safety reporting within Datix
- There had been an incident of fingers being trapped in a door at a Learning Disability inpatients unit. The Committee had asked for further detail to understand whether any common factors existed between this and other ostensibly similar incidents.

- Safeguarding training rates remained below target, and intensive work was underway to improve compliance.
- Significant assurance had been received on research governance.
- Significant assurance had been received on professional regulation. Significant assurance was provided regarding supervision, but in respect specifically of nursing and therapy assurance was limited and improvement work was requested by the Committee.
- The Committee had received an annual whistleblowing report. 8 'Speak in Confidence' conversations had taken place up to March 2016, with a further 10 since. No whistleblowing policy issues had been raised.
- A library service report had indicated that the service in Herefordshire was not meeting the needs of staff, and an action plan had been put in place.

21. BOARD COMMITTEE REPORTS – MH LEGISLATION SCRUTINY COMMITTEE

21.1 Martin Freeman provided a verbal report from the Mental Health Legislation Scrutiny Committee meeting held on 7 September. A full written report would be presented at the next Board meeting. Key items received and discussed at the meeting included:

- Three visits had been undertaken by the CQC since the Committee's last report. A number of issues had been raised regarding recording of information. This provided limited assurance, and an action plan was in place to address the issues raised. The plan provided significant assurance that actions were being taken to address the findings. A new tracking process had been put in place to manage inspection findings.
- A report on key performance indicators under the Mental Health Act Code of Practice provided significant assurance that the Code of Practice is being used appropriately and that patients are exercising their rights of appeal.
- The Committee received a draft policy on photographing detained patients for use in the event that they later absconded. The Committee asked for further work to be done in order to ensure compliance with the Mental Health Act Code of Practice.

22. INFORMATION SHARING REPORTS

22.1 The Board received and noted the following reports for information:
- Chair's Report
- Council of Governors Minutes – July 2016

21.2 The Board noted the full assurance regarding engagement activities provided by the Chair's report

23. ANY OTHER BUSINESS

23.1 There was no other business.

24. DATE OF THE NEXT MEETING

24.1 The next Board meeting would take place on Thursday 24 November 2016 at The Kindle Centre, Hereford.

Signed: …….. **Date: …….**
Ruth FitzJohn, Chair

BOARD MEETING
ACTION POINTS

Date of Mtg	Item ref	Action	Lead	Date due	Status/Progress
29 Sept 2016	8.5	Executive Committee to discuss the use of prone restraint.	Shaun Clee	November	**Complete** Discussed at Exec Committee on 14 November. There is a good understanding of when prone restraint is used and high confidence in the data. The Trust is looking at a change in practice to promote the use of alternative measures such as rapid tranquilisation.
	11.8	Director of Finance to provide an update on Oak House at the next Board meeting	Andrew Lee	October	**Complete** Included in the report
	14.5	Further analysis to be undertaken to determine which staff groups are most affected by issues raised in the WRES report, and develop appropriate actions	Carol Sparks	November	Further work has been done and medical staffing identified as the staff group most affected. Further discussions will be held with the Medical Director prior to a report being presented to the Executive Committee
	16.6	Public Sector Payment Policy target to be included in future finance reports	Andrew Lee	October	**Complete** Included in the report
	18.3	Jonathan Vickers and Marcia Gallagher to agree changes to the 'In Attendance' section of the Audit Committee's terms of reference	Jonathan Vickers/Marcia Gallagher	October	**Complete** Wording agreed and incorporated into TOR.

Agenda item 7 **Enclosure Paper B**

Report to:	2gether Trust Board Meeting – 24th November 2016
Author:	Chris Woon, Head of Information Management and Clinical Systems/Colin Merker Director of Service Delivery
Presented by:	Colin Merker Director of Service Delivery
SUBJECT:	**Performance Dashboard Report for the period to the end of September 2016**

This Report is provided for:

Decision	Endorsement	**Assurance**	**To Note**

EXECUTIVE SUMMARY:

Overview

This month's report sets out the performance of the Trust for the period to the end of September 2016 against our NHSI, Department of Health, Herefordshire and Gloucestershire CCG Contractual and CQUIN key performance indicators.

Of the 144 performance indicators, 96 are reportable in September with 79 being compliant and 17 non-compliant at the end of the reporting period.

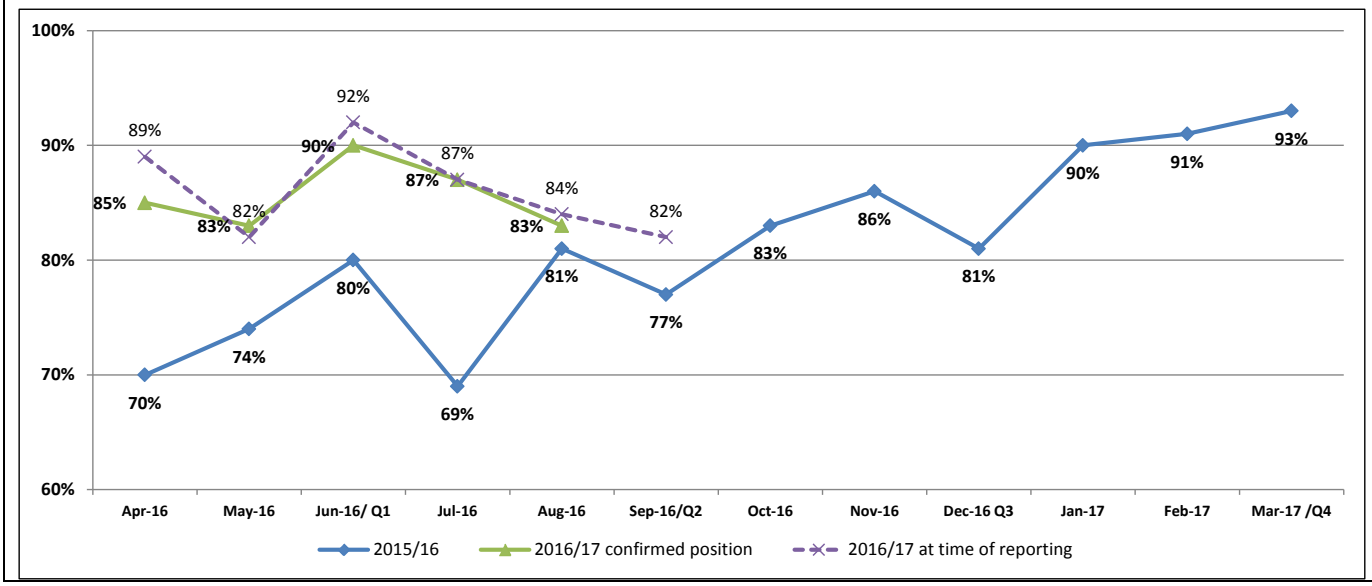
Where performance is not compliant, Service Directors are taking the lead to address issues with a particular focus continuing to be on IAPT services which account for 7 of the 17 non-compliant indicators (1.09, 1.10, 3.18, 3.19, 3.30, 5.08 and 5.09). Work is ongoing in accordance with our agreed Service Delivery Improvement Plans to address the underlying issues affecting this performance.

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

The following table summarises our performance position as at the end of September 2016 for each of the KPIs within each of the reporting categories.

Indicators Reported in Month and Levels of Compliance							
Indicator Type	Total Measures	Reported in Month	Compliant	Non Compliant	% non-compliance	Not Yet Required	NYA / UR
NHSi Requirements	13	13	8	5	38	0	0
Never Events	17	17	17	0	0	0	0
Department of Health	10	8	6	2	25	2	0
Gloucestershire CCG Contract	56	26	22	4	15	28	2
Social Care	15	12	10	2	17	3	0
Herefordshire CCG Contract	22	20	16	4	20	2	0
CQUINS	11	0	0	0	0	0	11
Overall	144	96	79	17	18	35	13

The following graph shows our percentage compliance by month and the previous year's compliance for comparison. The line "2016/17 confirmed position" has been added to show the confirmed position of our performance. This is reported a month in arrears to enable late data entry/late data validation to be taken into account.



Summary Exception Reporting

The following 17 key performance thresholds were not met for September 2016:

NHS Improvement Requirements

- 1.02 – Number of C Diff cases
- 1.03 – Care Programme Approach – follow-up contact within 7 days of discharge
- 1.07 – New psychosis (EI) cases as per contract
- 1.09 – IAPT: Waiting times - Referral to Treatment within 6 weeks
- 1.10 – IAPT: Waiting times - Referral to Treatment within 18 weeks

Department of Health Requirements

- 2.21 – No children under 18 admitted to adult in-patient wards
- 2.26 – Interim report for all SIs received within 5 working days of identification

Gloucestershire CCG Contract Measures

- 3.18 – IAPT Recovery rate : Access to psychological therapies should be improved
- 3.19 – IAPT Access rate : Access to psychological therapies should be improved
- 3.27 – CYPS Level 2 & 3: Referral to treatment within 8 weeks
- 3.30 – IAPT Integrated service: 14 days from referral to screening assessment.

Social Care –Gloucestershire CCG Contract Measures

- 4.06 – Percentage of service users asked if they have a carer
- 4.07 – Percentage who have a carer who has been offered a carer's assessment

Herefordshire CCG Contract Measures

- 5.08 – IAPT Recovery rate – those who have completed treatment and have "caseness"
- 5.09 – IAPT maintain 15% of patients entering the service against prevalence
- 5.12 – Emergency referrals to CRHT seen within 4 hours of referral (8am-6pm)
- 5.19 – All admitted patients 65+ must have a completed MUST assessment

RECOMMENDATIONS

The Board are asked to:

- Note the Performance Dashboard Report for September 2016.
- Accept the report as a significant level of assurance that our contract and regulator performance measures are be met or that appropriate action plans are in place to address areas requiring improvement.
- Be assured that there is ongoing work to review all of the indicators not meeting the required performance threshold. This includes a review of the measurement and data quality processes as well as clinical delivery and clinical practice issues.

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

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

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

Reviewed by:		
Colin Merker	Date	November 2016

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

What consultation has there been?		
Not applicable.	Date	

Explanation of acronyms used:	
	AOT Assertive Outreach Team AKI Acute kidney injury ASCOF Adult Social Care Outcomes Framework CAMHS Child and Adolescent Mental health Services C-Diff Clostridium difficile CIRG Clinical Information Reference Group CPA Care Programme Approach CPDG Contract Performance and Development Group CQUIN Commissioning for Quality and Innovation CRHT Crisis Home Treatment CYPS Children and Young People's Services DASH Drug and Alcohol Service Herefordshire ED Emergency Department EI Early Intervention EWS Early warning score HoNoS Health of the Nation Outcome Scale IAPT Improving Access to Psychological Therapies IST Intensive Support Team (National IAPT Team) KPI Key Performance Indicator LD Learning Disabilities MHICT Mental Health Intermediate Care Team MHL Mental Health Liaison MRSA Methicillin-resistant Staphylococcus aureus MUST Malnutrition Universal Screening Tool NHSI NHS Improvement NICE National Institute for Health and Care Excellence SI Serious Incident SUS Secondary Uses Service VTE Venous thromboembolism YOS Youth Offender's Service

1. CONTEXT

This report sets out the performance Dashboard for the Trust for the period to the end of September 2016, month six of the 2016/17 contract period.

1.1 The following sections of the report include:

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

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

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

2.1 The following tables outline the performance in each of the performance categories within the Dashboard as at the end of September 2016. Where indicators have not been met during the reporting period, an explanation is provided relating to the non-achievement of the Performance Threshold and the action being taken to rectify the position.

2.2 Where stated, 'Cumulative Compliance' refers to compliance recorded from the start of this contractual year April 2016 to the current reporting month, as a whole.

2.3 Indicator IDs has been colour coded in the tables to indicate whether a performance measure is a national or local requirement. Blue indicates the performance measure is national, while lilac means the measure is local.

	=	**Target not met**
	=	**Target met**
NYA	=	**Not Yet Available from Systems**
NYR	=	**Not Yet Required by Contract**
UR	=	**Under Review**
N/A	=	**Not Applicable**
Baseline	=	**2016/17 data reporting to inform 2017/18**

DASHBOARD CATEGORY - NHSI REQUIREMENTS

NHS Improvement Requirements				
	In month Compliance			Cumulative Compliance
	Jul	Aug	Sep	
Total Measures	13	13	13	13
🔴	2	4	5	3
🟢	11	9	8	10
NYA	0	0	0	0
NYR	0	0	0	0
UR	0	0	0	0
N/A	0	0	0	0

Performance Thresholds not being achieved in Month

(Reference number relates to the number of the indicator within the scorecard):

1.02: Number of C Diff cases

There was one case in Herefordshire during September on Cantilupe ward. A review to ascertain the cause has yet to be held. The result of this review will determine whether the case is reported as avoidable or unavoidable. For transparency it is assumed to be avoidable until confirmed as otherwise.

1.03: Care Programme Approach – follow-up contact within 7 days of discharge

Non-compliance is reported for Herefordshire and Trustwide. There were 2 cases in Herefordshire not followed up within 7 days during September. Both cases are being investigated to determine the reasons and to check the accuracy of recording.

1.07: New psychosis (EI) cases as per contract

For September, Gloucestershire have reported 5 new cases against an expected threshold of 6 and Herefordshire one new case against an expected number of 2 new cases.

As cases do not present evenly across the months, compliance fluctuates between months. Work continues to understand what an accurate threshold looks like for both the Gloucestershire and Herefordshire counties. The Committee will be updated once work in this area has been completed.

Services that the Trust can offer are continuing to be promoted with external agencies.

This indicator has been red flagged as it requires further analysis to fully understand the issues and identify the actions required.

1.09: IAPT: Waiting times - Referral to Treatment within 6 weeks
This service is subject to an agreed Service Development Improvement Plan which is under specific monthly review by the Delivery Committee.

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

Cumulative Performance Thresholds Not being Met

1.02: Number of C Diff cases
As above

1.09: IAPT: Waiting times - Referral to Treatment within 6 weeks
As above

1.10: IAPT: Waiting times - Referral to Treatment within 18 weeks
As above

Changes to Previously Reported Figures

1.02: Number of C Diff cases
A review has shown that there was one avoidable case in Herefordshire on Jenny Lind ward in August. The review of the case identified a number of non contributory issues relating to cleaning standards within the ward which have now been addressed.

Early Warnings / Notes

1.07: New psychosis (EI) cases – Gloucestershire
The NHSI threshold for cases is 95% of expected contract and has previously been shown as whole integers per month, which when totalled exceed the actual expected number. It is proposed, therefore, to avoid confusion that both the threshold and performance are shown as year to date cumulative totals.

This indicator has been red flagged as it requires further analysis to fully understand the issues and identify the actions required.

NHS Improvement Requirements

ID	Performance Measure (PM)		2015/16 Outturn	July-2016	August-2016	September-2016	Cumulative Compliance
1							
1.01	Number of MRSA Bacteraemias	PM	0	0	0	0	0
		Gloucestershire	0	0	0	0	0
		Herefordshire	0	0	0	0	0
		Combined Actual	0	0	0	0	0
1.02	Number of C Diff cases (day of admission plus 2 days = 72hrs)	PM	0	0	0	0	0
		Gloucestershire	0	0	0	0	0
		Herefordshire	0	0	1	1	2
		Combined Actual	0	0	1	1	2
1.03	Care Programme Approach follow up contact within 7 days of discharge	PM	95%	95%	95%	95%	95%
		Gloucestershire	95%	99%	96%	95%	98%
		Herefordshire	96%	100%	100%	94%	97%
		Combined Actual	96%	99%	98%	94%	97%
1.04	Care Programme Approach - formal review within12 months	PM	95%	95%	95%	95%	95%
		Gloucestershire	99%	99%	99%	95%	99%
		Herefordshire	98%	99%	99%	98%	99%
		Combined Actual	99%	99%	99%	96%	99%
1.05	Delayed Discharges (Including Non Health)	PM	7.5%	7.5%	7.5%	7.5%	7.5%
		Gloucestershire	1.0%	1.0%	1.4%	2.5%	1.8%
		Herefordshire	1.2%	0.8%	0.0%	0.0%	1.8%
		Combined Actual	1.0%	0.9%	1.1%	1.9%	1.8%
1.06	Admissions to Adult inpatient services had access to Crisis Resolution Home Treatment Teams	PM	95%	95%	95%	95%	95%
		Gloucestershire	99%	100%	98%	98%	99%
		Herefordshire	100%	100%	100%	100%	100%
		Combined Actual	99%	100%	98%	98%	99%
1.07	New psychosis (EI) cases as per contract	PM	72	6	6	6	34.2
		Gloucestershire	76	8	4	5	32
		PM	24	2	2	2	11.4
		Herefordshire	41	3	0	1	14
		PM	92	8	8	8	45.6
		Combined Actual	117	11	4	6	46
1.08	New psychosis (EI) cases treated within 2 weeks of referral	PM	50%	50%	50%	50%	50%
		Gloucestershire	66%	88%	75%	80%	69%
		Herefordshire	61%	100%	N/A	100%	71%
		Combined Actual	64%	91%	75%	83%	70%

NHS Improvement Requirements

ID	Performance Measure		2015/16 Outturn	July-2016	August-2016	September-2016	Cumulative Compliance
1.09	IAPT - Waiting times: Referral to Treatment within 6 weeks (based on discharges)	PM	75%	75%	75%	75%	75%
		Gloucestershire	87%	33%	29%	31%	33%
		Herefordshire	95%	55%	47%	40%	52%
		Combined Actual	89%	38%	34%	33%	38%
1.10	IAPT - Waiting times: Referral to Treatment within 18 weeks (based on discharges)	PM	95%	95%	95%	95%	95%
		Gloucestershire	99%	88%	77%	82%	86%
		Herefordshire	99%	83%	83%	83%	89%
		Combined Actual	99%	87%	79%	83%	87%
1.11	**MENTAL HEALTH SERVICES DATA SET PART 1 DATA COMPLETENESS: OVERALL**	PM	97%	97%	97%	97%	97%
		Gloucestershire	99.6%	99.9%	99.9%	99.9%	99.9%
		Herefordshire	99.9%	99.9%	99.9%	99.9%	99.9%
		Combined Actual	99.6%	99.9%	99.9%	99.9%	99.9%
1.11a	Mental Health Services Data Set Part 1 Data completeness: DOB	PM	97%	97%	97%	97%	97%
		Gloucestershire	100.0%	100.0%	100.0%	100.0%	100.0%
		Herefordshire	100.0%	100.0%	100.0%	100.0%	100.0%
		Combined Actual	100.0%	100.0%	100.0%	100.0%	100.0%
1.11b	Mental Health Services Data Set Part 1 Data completeness: Gender	PM	97%	97%	97%	97%	97%
		Gloucestershire	99.9%	99.9%	99.9%	99.9%	99.9%
		Herefordshire	100.0%	99.9%	99.9%	99.9%	99.9%
		Combined Actual	99.9%	99.9%	99.9%	99.9%	99.9%
1.11c	Mental Health Services Data Set Part 1 Data completeness: NHS Number	PM	97%	97%	97%	97%	97%
		Gloucestershire	99.9%	99.9%	99.9%	99.9%	99.9%
		Herefordshire	99.9%	99.9%	99.9%	99.9%	99.9%
		Combined Actual	99.9%	99.9%	99.9%	99.9%	99.9%
1.11d	Mental Health Services Data Set Part 1 Data completeness: Organisation code of commissioner	PM	97%	97%	97%	97%	97%
		Gloucestershire	98.8%	100.0%	100.0%	100.0%	100.0%
		Herefordshire	99.9%	100.0%	100.0%	100.0%	100.0%
		Combined Actual	99.1%	100.0%	100.0%	100.0%	100.0%
1.11e	Mental Health Services Data Set Part 1 Data completeness: Postcode	PM	97%	97%	97%	97%	97%
		Gloucestershire	99.5%	99.8%	99.9%	99.9%	99.8%
		Herefordshire	99.6%	99.8%	99.8%	99.8%	99.8%
		Combined Actual	99.5%	99.8%	99.8%	99.8%	99.8%
1.11f	Mental Health Services Data Set Part 1 Data completeness: GP Practice	PM	97%	97%	97%	97%	97%
		Gloucestershire	99.1%	99.4%	99.4%	99.4%	99.4%
		Herefordshire	99.5%	99.7%	99.7%	99.7%	99.7%
		Combined Actual	99.2%	99.5%	99.5%	99.5%	99.4%

NHS Improvement Requirements

ID	Performance Measure		2015/16 Outturn	July-2016	August-2016	September-2016	Cumulative Compliance
1.12	MENTAL HEALTH SERVICES DATA SET PART 2 DATA COMPLETENESS : OVERALL	PM	50%	50%	50%	50%	50%
		Gloucestershire	97.9%	97.7%	97.7%	97.5%	97.6%
		Herefordshire	95.3%	93.8%	93.7%	93.5%	94.0%
		Combined Actual	97.4%	97.0%	97.0%	96.8%	97.0%
1.12a	Mental Health Services Data Set Part 2 Data completeness: CPA Employment status last 12 months	PM	50%	50%	50%	50%	50%
		Gloucestershire	97.2%	96.7%	96.7%	96.5%	96.6%
		Herefordshire	93.7%	91.9%	91.2%	91.0%	91.8%
		Combined Actual	96.4%	95.8%	95.8%	95.5%	95.7%
1.12b	Mental Health Services Data Set Part 2 Data completeness: CPA Accommodation Status in last 12 months	PM	50%	50%	50%	50%	50%
		Gloucestershire	97.1%	96.9%	96.9%	96.7%	96.8%
		Herefordshire	93.8%	91.9%	91.9%	91.8%	92.3%
		Combined Actual	96.5%	96.0%	96.0%	95.8%	96.0%
1.12c	Mental Health Services Data Set Part 2 Data completeness: CPA HoNOS assessment in last 12 months	PM	50%	50%	50%	50%	50%
		Gloucestershire	99.6%	99.5%	99.4%	99.3%	99.4%
		Herefordshire	98.5%	97.8%	97.8%	97.8%	98.0%
		Combined Actual	99.4%	99.2%	99.1%	99.0%	99.2%
1.13	Learning Disability Services: 6 indicators: identification of people with a LD, provision of information, support to family carers, training for staff, representation of people with LD; audit of practice and publication of findings	PM	6	6	6	6	6
		Gloucestershire	6	6	6	6	6
		Herefordshire	6	6	6	6	6
		Combined Actual	6	6	6	6	6

DASHBOARD CATEGORY – DEPARTMENT OF HEALTH PERFORMANCE

DoH Performance				
	In month Compliance			Cumulative Compliance
	Jul	Aug	Sep	
Total Measures	27	27	27	27
🔴	1	1	2	2
🟢	25	24	23	24
NYA	0	0	0	0
NYR	0	1	1	0
UR	0	0	0	0
N/A	1	1	1	1

Performance Thresholds not being achieved in Month

2.21: No children under 18 admitted to adult inpatient wards
There was 1 under 18 admission in September in Gloucestershire. The patient, aged 16, was placed on section 136 by police after absconding from a care home in Worcestershire. The patient was then admitted under Section 2 until a suitable bed could be sourced.

2.26: Interim report for all SIs received within 5 working days of identification
1 initial report for Herefordshire was submitted late in September. The processes surrounding submission have been investigated and amendments made to ensure future compliance.

Cumulative Performance Thresholds Not being Met

2.21: No children under 18 admitted to adult inpatient wards
Including the admission in September there have been 8 admissions to date, 4 admissions in Gloucestershire and 4 in Herefordshire.

2.26: Interim report for all SIs received within 5 working days of identification
There have been 3 late submissions year to date, 2 in May for Gloucestershire and 1 in Herefordshire in September.

Changes to Previously Reported Figures
None

Early Warnings
None

DOH Never Events

ID	Performance Measure		2015/16 Outturn	July-2016	August-2016	September-2016	Cumulative Compliance
2							
2.01	Wrongly prepared high risk injectable medications	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.02	Maladministration of potassium containing solutions	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.03	Wrong route administration of oral/enteral treatment	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.04	Intravenous administration of epidural medication	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.05	Maladministration of insulin	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.06	Overdose of midazolam during conscious sedation	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.07	Opioid overdose in opioid naive patient	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.08	Inappropriate administration of daily oral methotrexate	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.09	Suicide using non collapsible rails	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.10	Falls from unrestricted windows	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.11	Entrapment in bedrails	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.12	Misplaced naso - or oro-gastric tubes	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.13	Wrong gas administered	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.14	Failure to monitor and respond to oxygen saturation - conscious sedation	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.15	Air embolism	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.16	Severe scalding from water for washing/bathing	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.17	Mis-identification of patients	PM	0	0	0	0	0
		Actual	0	0	0	0	0

DOH Requirements

ID	Performance Measure		2015/16 Outturn	July-2016	August-2016	September-2016	Cumulative Compliance
2.18	Mixed Sex Accommodation - Sleeping Accommodation Breaches	PM	0	0	0	0	0
		Gloucestershire	0	0	0	0	0
		Herefordshire	0	0	0	0	0
		Combined	0	0	0	0	0
2.19	Mixed Sex Accommodation - Bathrooms	Gloucestershire	Yes	Yes	Yes	Yes	Yes
		Herefordshire	Yes	Yes	Yes	Yes	Yes
		Combined	Yes	Yes	Yes	Yes	Yes
2.20	Mixed Sex Accommodation - Women Only Day areas	Gloucestershire	Yes	Yes	Yes	Yes	Yes
		Herefordshire	Yes	Yes	Yes	Yes	Yes
		Combined	Yes	Yes	Yes	Yes	Yes
2.21	No children under 18 admitted to adult in-patient wards	PM	0	0	0	0	0
		Gloucestershire	11	0	2	1	4
		Herefordshire	4	1	0	0	4
		Combined	15	1	2	1	8
2.22	Failure to publish Declaration of Compliance or Non Compliance pursuant to Clause 4.26 (Same Sex accommodation)	Gloucestershire	Yes	Yes	Yes	Yes	Yes
		Herefordshire	Yes	Yes	Yes	Yes	Yes
		Combined	Yes	Yes	Yes	Yes	Yes
2.23	Publishing a Declaration of Non Compliance pursuant to Clause 4.26 (Same Sex accommodation)	Gloucestershire	Yes	Yes	Yes	Yes	Yes
		Herefordshire	Yes	Yes	Yes	Yes	Yes

DOH Requirements

ID	Performance Measure		2015/16 Outturn	July-2016	August-2016	September-2016	Cumulative Compliance
2.24	Serious Incident Reporting (SI)	Glos	32	0	3	2	18
		Hereford	11	1	1	1	5
2.25	All SIs reported within 2 working days of identification	PM	100%	100%	100%	100%	100%
		Gloucestershire	100%	100%	100%	100%	100%
		Herefordshire	100%	100%	100%	100%	100%
2.26	Interim report for all SIs received within 5 working days of identification (unless extension granted by CCG)	PM		100%	100%	100%	100%
		Gloucestershire		N/A	100%	100%	89%
		Herefordshire		100%	100%	0%	80%
2.27	SI Report Levels 1 & 2 to CCG within 60 working days	PM		100%	100%	100%	100%
		Gloucestershire		100%	NYR	NYR	100%
		Herefordshire		NYR	NYR	NYR	100%
2.28	SI Report Level 3 - Independent investigations - 6 months from investigation commissioned date	PM		100%	100%	100%	100%
		Gloucestershire		N/A	N/A	N/A	N/A
		Herefordshire		N/A	N/A	N/A	N/A
2.29	SI Final Reports outstanding but not due	Gloucestershire	3	0	3	2	5
		Herefordshire	0	1	1	1	3

DASHBOARD CATEGORY – GLOUCESTERSHIRE CCG CONTRACTUAL REQUIREMENTS

Gloucestershire Contract				
	In month compliance			Cumulative Compliance
	Jul	Aug	Sep	
Total Measures	56	56	56	56
	4	3	4	4
	12	13	22	23
NYA	0	0	2	3
NYR	39	39	26	24
UR	0	0	0	0
N/A	1	1	2	2

Performance Thresholds not being achieved in Month

3.18: IAPT Recovery rate: Access to psychological therapies should be improved
This service is subject to an agreed Service Development Improvement Plan which is under specific monthly review by the Delivery Committee.

3.19: IAPT Access rate: Access to psychological therapies should be improved
This service is subject to an agreed Service Development Improvement Plan which is under specific monthly review by the Delivery Committee.

3.27: CYPS Level 2 & 3: Referral to treatment within 8 weeks
For Quarter 2 performance is 4% below the expected performance threshold of 80%. The total number of attendances in the 2nd quarter is low due to school holidays and the total number of non-compliant cases is high as an increased number of long waiters are seen during the month of September. This is mainly due to requests for delays in appointments until young people are back at school.

Expected compliance: Low performance in September for the reasons detailed above have meant lower than expected compliance for quarter 2. As the indicator is predicted to be compliant for both October and November it is anticipated that it will be compliant when reported in Quarter 3.

3.30: Adult Mental Health Intermediate Care Teams (New Integrated Service): Wait times from referral to screening assessment within 14 days of receiving referral

This indicator relates to one of the performance thresholds within the IAPT care pathway which combined IAPT and Nursing data. This has been reviewed as part of the NHSI IST review and is under review.

This indicator has been red flagged as it requires further analysis to fully understand the issues and identify the actions required.

Expected compliance: The new MHICT Service Specification is currently under review. Once confirmed and a contract variation is finalised this indicator will change to report on Nursing activity only. This indicator is unlikely to be compliant until that piece of work is complete. Reporting on the new indicator is expected in Quarter three.

Cumulative Performance Thresholds Not being Met

3.18: IAPT Recovery rate: Access to psychological therapies should be improved
As above

3.19: IAPT Access rate: Access to psychological therapies should be improved
As above

3.27: CYPS Level 2 & 3: Referral to treatment within 8 weeks
As above

3.30: Adults Mental Health Intermediate Care Teams (New Integrated Service): Wait times from referral to screening assessment within 14 days of receiving referral
As above

Changes to Previously Reported Figure

None

Early Warnings

None

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2015/16 outturn	July-2016	August-2016	September-2016 / Quarter 2	Cumulative Compliance
	B. NATIONAL QUALITY REQUIREMENT						
3.01	Zero tolerance MRSA	PM	0	0	0	0	0
		Unavoidable	0	0	0	0	0
3.02	Minimise rates of Clostridium difficile	PM	0	0	0	0	0
		Unavoidable	0	0	0	0	0
3.03	Duty of candour	PM	Report	Report	Report	Report	Report
		Actual	Compliant	Compliant	Compliant	Compliant	Compliant
3.04	Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS,	PM	99%	99%	99%	99%	99%
		Actual	100%	99%	99%	99%	99%
3.05	Completion of Mental Health Services Data Set ethnicity coding for all detained and informal Service Users	PM	90%	90%	90%	90%	90%
		Actual	97%	98%	99%	94%	98%
3.06	Completion of IAPT Minimum Data Set outcome data for all appropriate Service Users	PM	90%	90%	90%	90%	90%
		Actual	85%	99%	99%	99%	99%
	C. Local Quality Requirements						
	Domain 1: Preventing People dying prematurely						
3.07	Increased focus on suicide prevention and reduction in the number of reported suicides in the community and inpatient units	PM	Report				Annual
		Actual	Complete				NYR
3.08	To reduce the numbers of detained patients absconding from inpatient units where leave has not been granted	PM	N/A			<36	<36
		Actual	55			NYA	21
3.09	Compliance with NICE Technology appraisals within 90 days of their publication and ability to demonstrate compliance through completion of implementation plans and costing templates.	PM					PM
		Actual					NYA
3.10	Minimum of 5% increase in uptake of flu vaccination (15/16 55.3%)	PM					Annual
		Actual					NYR

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2015/16 outturn	July-2016	August-2016	September-2016 / Quarter 2	Cumulative Compliance
	Domain 2: Enhancing the quality of life of people with long-term conditions						
3.11	2G bed occupancy for Gloucestershire CCG patients	PM	N/A	>91%	>91%	>91%	>91%
		Actual	92%	90%	92%	91%	92%
3.12	Care Programme Approach: 95% of CPAs should have a record of the mental health worker who is responsible for their care	PM	95%	95%	95%	95%	95%
		Actual	100%	100%	100%	100%	100%
3.13	CPA Review - 95% of those on CPA to be reviewed within 1 month (Review within 13 months)	PM	95%	95%	95%	95%	95%
		Actual	99%	99%	98%	99%	99%
3.14	Assessment of risk: % of those 2g service users on CPA to have a documented risk assessment	PM	85%			95%	95%
		Actual	99%			98%	99%
3.15	Assessment of risk: All 2g service users (excluding those on CPA) to have a documented risk assessment	PM				85%	85%
		Actual				94%	94%
3.16	Dementia should be diagnosed as early in the illness as possible: People within the memory assessment service with a working diagnosis of dementia to have a care plan within 4 weeks of diagnosis	PM	85%	85%	85%	85%	85%
		Actual	89%	100%	94%	88%	95%
3.17	AKI (previous CQUIN 1516) 95% of pts to have EWS score within 12 hours	PM				95%	95%
						100%	100%
	Domain 3: Helping people to recover from episodes of ill-health or following injury						
3.18	IAPT recovery rate: Access to psychological therapies for adults should be improved	PM	50%	50%	50%	50%	50%
		Actual	35%	47%	42%	41%	48%
3.19	IAPT access rate: Access to psychological therapies for adults should be improved	PM		5.00%	6.25%	7.50%	7.50%
		Actual		2.31%	2.88%	3.72%	3.72%
3.20	IAPT reliable improvement rate: Access to psychological therapies for adults should be improved	PM	N/A	50%	50%	50%	50%
		Actual	55%	74%	79%	75%	75%
3.21	Care Programme Approach (CPA): The percentage of people with **learning disabilities** in inpatient care on CPA who were followed up within 7 days of discharge	PM	95%	95%	95%	95%	95%
		Actual	100%	N/A	N/A	N/A	N/A
3.22	To send :Inpatient and day case discharge summaries electronically, within 24 hours to GP	PM				Report	Report
		Actual				NYA	NYA

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2015/16 outturn	July-2016	August-2016	September-2016 / Quarter 2	Cumulative Compliance
	Domain 4: Ensuring that people have a positive experience of care						
3.23	To demonstrate improvements in staff experience following any national and local surveys	PM	Annual				Annual
		Actual	Compliant				NYR
	CYPS						
3.24	Number of children that received support within 24 hours of referral, for crisis home treatment (CYPS)	PM	95%			95%	95%
		Actual	97%			N/A	N/A
3.25	Children and young people who enter a treatment programme to have a care coordinator - (Level 3 Services) (CYPS)	PM	98%	98%	98%	98%	98%
		Actual	99%	99%	100%	99%	99%
3.26	95% accepted referrals receiving initial appointment within 4 weeks (excludes YOS, substance misuse, inpatient and crisis/home treatment and complex engagement) (CYPS)	PM	95%			95%	95%
		Actual	98%			98%	99%
3.27	Level 2 and 3 – Referral to treatment within 8 weeks , excludes LD, YOS, inpatient and crisis/home treatment) (CYPS)	PM	80%			80%	80%
		Actual	65%			76%	77%
3.28	Level 2 and 3 – Referral to treatment within 10 weeks (excludes LD, YOS, inpatient and crisis/home treatment) (CYPS)	PM	95%			90%	90%
		Actual	78%			93%	92%
3.29	Adults of working age - 100% of MDT assessments to have been completed within 4 weeks (or in the case of a comprehensive assessment commenced within 4 weeks)	PM	85%	85%	85%	85%	85%
		Actual	94%	94%	94%	95%	95%
3.30	Adults Mental Health Intermediate Care Teams (New Integrated service) Wait times from referral to screening assessment within 14 days of receiving referral	PM	85%	85%	85%	85%	85%
		Actual	70%	64%	61%	61%	63%

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2015/16 outturn	July-2016	August-2016	September-2016 / Quarter 2	Cumulative Compliance
	Vocational Service (Individual Placement and Support)						
3.31	100% of Service Users in vocational services will be supported to formulate their vocational goals through individual plans (IPS)	PM	98%			98%	98%
		Actual	100%			100%	100%
3.32	The number of people finding paid employment or self-employment (measured as a percentage against accepted referrals into the (IPS) Excluding those in employment at time of referral - Annual	PM	50%				50%
		Actual	45%				NYR
3.33	The number of people retaining employment at 3/6/9/12+ months (measured as a percentage of individuals placed into employment retaining employment) (IPS)	PM	50%			50%	50%
		Actual	65%			67%	67%
3.34	The number of people supported to retain employment at 3/6/9/12+ months	PM	50%			50%	50%
		Actual	73%			82%	82%
3.35	Fidelity to the IPS model	PM	Annual				90%
		Actual	NYA				NYR
	General Quality Requirements						
3.36	GP practices will have an individual annual (MH) ICT service meeting to review delivery and identify priorities for future.	PM	Annual				Annual
		Actual	NYA				NYR
3.37	Care plan audit to show : All dependent Children and YP <18 living with adults know to Recovery, MAHRS, Eating Disorder and Assertive Outreach Services. Recorded evidence in care plans of impact of the mental health disorder on those under 18s plus steps put in place to support.(Think family)	PM				Report	Report
		Actual				Compliant	Compliant
	New KPIs for 2016/17						
3.38	Transition- Joint discharge/CPA review meeting to be held within 4 weeks of acceptance into adult MH services during which a working diagnosis to be agreed, adult MH care coordinator allocated and care cluster and risk levels agreed as well as CYPS discharge date. The meeting will be recorded on RIO.	PM					100%
		Actual					NYA
3.39	Number and % of crisis assessments undertaken by the MHARS team on CYP age 16-25 within agreed timescales of 4 hours	PM					90%
		Actual					NYR
3.40	MHARS wait time to assessment (4 hours)	PM					TBC
		Actual					NYR

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2015/16 outturn	July-2016	August-2016	September-2016 / Quarter 2	Cumulative Compliance
	New KPIs for 2016/17 LD						
3.41	To define LD clearly and the route into specialist LD service	PM					Annual
		Actual					NYR
3.42	LD: To implement Pathways for work within specialist service with easy read supporting information	PM					Annual
		Actual					NYR
3.43	The CLDT will ask when an annual health check is due and will notify GP where one is needed, and offer support regarding reasonable adjustments.	PM					80%
		Actual					NYR
3.44	LD: All clients referred will have a risk assessment completed when core assessment is completed	PM					80%
		Actual					NYR
3.45	LD:All clients referred for difficulties they are expressing through their behaviour will have an assessment and formulation completed within 56 days of case being opened by the relevant clinician	PM					80%
		Actual					NYR
3.46	LD: All clients referred for difficulties they are expressing through their behaviour will have single support plan, containing (as appropriate) changes within the person, changes external to the person (systems), and reactive interventions completed within 56 days of case being opened by the relevant clinician	PM					80%
		Actual					NYR
3.47	LD: All new patients have a risk assessment completed within 48 hours of admission	PM					80%
		Actual					NYR
3.48	LD: All new patients have a psychological assessment and formulation of behaviours and emotions completed within 28 days of admission.	PM					80%
		Actual					NYR
3.49	LD: All new patients have a single support plan to support their behavioural and emotional presentation completed within 28 days of admission. This will contain, as appropriate, goals targeting changes within the person, changes external to the person, and reactive interventions.	PM					80%
		Actual					NYR

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2015/16 outturn	July-2016	August-2016	September-2016 / Quarter 2	Cumulative Compliance
3.50	LD: All new patients receive a health check within 48 hours of admission.	PM					95%
		Actual					NYR
3.51	LD: All new patients have a Health Action Plan completed within 3 days of admission	PM					95%
		Actual					NYR
3.52	LD: All new patients requiring a health screening are supported to access screenings where appropriate.	PM					95%
		Actual					NYR
3.53	LD: All clients referred for challenging behaviour will have a risk assessment completed within five days of case being allocated to clinician	PM					80%
		Actual					NYR
3.54	LD: All clients have a functional assessment / formulation of behaviours completed within 28 days on completion of assessment	PM					80%
		Actual					NYR
3.55	LD: All clients referred for challenging behaviours will have a single plan describing how their behaviour will be supported positively. It will contain primary, secondary and reactive interventions. Goals for the person and the wider system will be clear. The plan will be completed within 30 days of case being opened by the clinician.	PM					80%
		Actual					NYR
3.56	LD: All clients being admitted for challenging behaviour to Learning Disability Assessment and Treatment services will have a blue light meeting where feasible. This will be notified to Commissioners for Commissioners or their designee to Chair	PM					80%
		Actual					NYR

Schedule 4 Specific Measures that are reported Nationally

Performance Thresholds not being achieved in Month

NHS Improvement

1.09 IAPT Waiting times: Referral to Treatment within 6 weeks (based on discharges)
This service is subject to an agreed Service Development Improvement Plan which is under specific monthly review by the Delivery Committee.

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

Department of Health

2.21 No children under 18 admitted to adult in-patient wards
There was 1 under 18 admission in September in Gloucestershire. The patient, aged 16, was placed on section 136 by police after absconding from a care home in Worcestershire. The patient was admitted under Section 2 until a suitable bed could be sourced.

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

ID	Performance Measure		2015/16 outturn	July-2016	August-2016	September-2016 / Quarter 2	Cumulative Compliance
NHSI 1.01	Number of MRSA Bacteraemias avoidable	PM	0	0	0	0	0
		Actual	0	0	0	0	0
NHSI 1.02	Number of C Diff cases (day of admission plus 2 days = 72hrs) - avoidable	PM	0	0	0	0	0
		Actual	0	0	0	0	0
NHSI 1.03	Care Programme Approach follow up contact within 7 days of discharge	PM	95%	95%	95%	95%	95%
		Actual	95%	99%	96%	95%	98%
NHSI 1.05	Delayed Discharges (Including Non Health)	PM	7.5%	7.5%	7.5%	7.5%	7.5%
		Actual	1.0%	1.0%	1.4%	2.5%	1.8%
NHSI 1.06	Admissions to Adult inpatient services had access to Crisis Resolution Home Treatment Teams	PM	95%	95%	95%	95%	95%
		Actual	99%	100%	98%	98%	99%
NHSI 1.08	New psychosis (EI) cases treated within 2 weeks of referral	PM	50%	50%	50%	50%	50%
		Actual	66%	88%	75%	80%	69%
NHSI 1.09	IAPT - Waiting times: Referral to Treatment within 6 weeks (based on discharges)	PM	75%	75%	75%	75%	75%
		Actual	87%	33%	29%	31%	33%
NHSI 1.10	IAPT - Waiting times: Referral to Treatment within 18 weeks (based on discharges)	PM	95%	95%	95%	95%	95%
		Actual	99%	88%	77%	82%	86%
DoH 2.18	Mixed Sex Accommodation Breach	PM	0	0	0	0	0
		Actual	0	0	0	0	0
DoH 2.21	No children under 18 admitted to adult in-patient wards	PM	0	0	0	0	0
		Actual	11	0	2	1	4
DoH 2.25	All SIs reported within 2 working days of identification	PM	100%	100%	100%	100%	100%
		Actual	100%	100%	100%	100%	100%
DoH 2.26	Interim report for all SIs received within 5 working days of identification (unless extension granted by CCG)	PM		100%	100%	100%	100%
		Actual		N/A	100%	100%	89%
DoH 2.27	SI Report Levels 1 & 2 to CCG within 60 working days	PM		100%	100%	100%	100%
		Actual		100%	NYR	NYR	100%

DASHBOARD CATEGORY – GLOUCESTERSHIRE SOCIAL CARE

Gloucestershire Social Care				
	In month compliance			Cumulative Compliance
	Jul	Aug	Sep	
Total Measures	15	15	15	14
🔴	2	3	2	2
🟢	10	9	10	10
NYA	0	0	0	0
NYR	1	1	1	1
UR	0	0	0	0
N/A	2	2	2	2

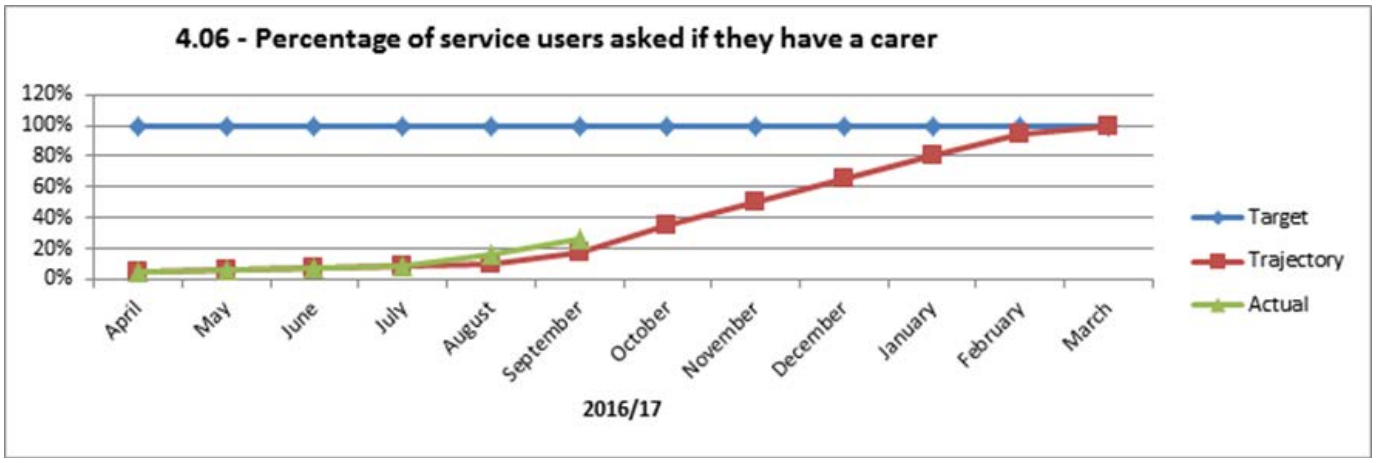
Performance Thresholds not being achieved in Month

4.06 – Percentage of service users asked if they have a carer

This is the third month this indicator has been reported. The new data collection form went "live" in RiO a few months ago and work is on-going to inform staff about the new way to record carer information.

This indicator has been red flagged as it requires further analysis to fully understand the issues and identify the actions required.

Expected compliance: The trajectory below shows we are slightly ahead of our planned improvement trajectory. A further push with staff is being planned in the Autumn in an attempt to bring compliance forward from the current trajectory.

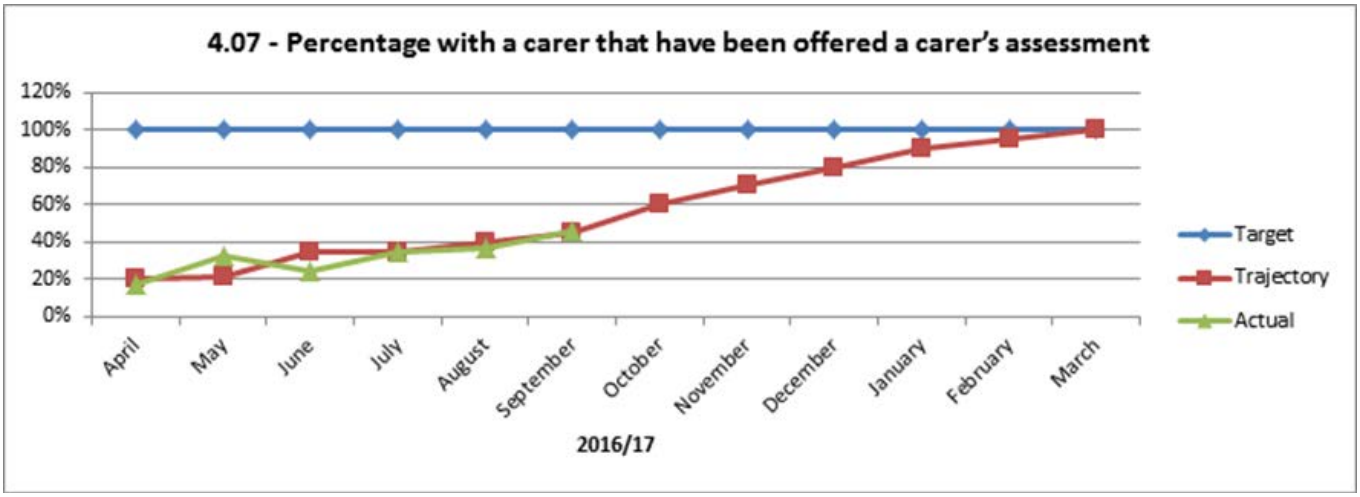


4.07– Percentage with a carer that have been offered a carer's assessment

This is the third month this indicator has been reported. The new data collection form went "live" in RiO a few months ago and work is needed to ensure all staff are aware that it is available and that information is collected at the right time in the pathway.

This indicator has been red flagged as it requires further analysis to fully understand the issues and identify the actions required.

Expected compliance: The trajectory below shows we are in line with our planned improvement trajectory. . A further push with staff is being planned in the Autumn in an attempt to bring compliance forward from the current trajectory.



Cumulative Performance Thresholds Not being Met

4.06 – Percentage of service users asked if they have a carer

As above

4.07– Percentage with a carer that have been offered a carer's assessment

As above

Changes to Previously Reported Figures

None

Early Warnings

None

Gloucestershire Social Care

ID	Performance Measure		2015/16 outturn	July-2016	August-2016	September-2016 / Quarter 2	Cumulative Compliance
4.01	The percentage of people who have a Cluster recorded on their record	PM	TBC	90%	90%	90%	90%
		Actual	96%	97%	96%	96%	97%
4.02	Percentage of people getting long term services, in a residential or community care reviewed/re-assessed in last year	PM	95%	95%	95%	95%	95%
		Actual	96%	96%	92%	94%	95%
4.03	Ensure that reviews of new packages take place within 12 weeks of commencement	PM	95%				95%
		Actual	96%				NYR
4.04	Current placements aged 18-64 to residential and nursing care homes per 100,000 population	PM	TBC	13	13	13	13
		Actual	13.01	12.90	12.90	12.90	12.75
4.05	Current placements aged 65+ to residential and nursing care homes per 100,000 population	PM	TBC	22	22	22	22
		Actual	21.21	16.34	16.34	16.34	16.81
4.06	% of WA & OP service users on caseload asked if they have a carer	PM		100%	100%	100%	100%
				9%	17%	26%	15%
4.07	% of WA & OP service users on the caseload who have a carer, who have been offered a carer's assessment	PM		100%	100%	100%	100%
		Actual		37%	36%	45%	46%
4.08a	% of WA & OP service users/carers on caseload who accepted a carers assessment	PM	TBC	TBC	TBC	TBC	TBC
		Actual	NYA	53%	51%	53%	54%
4.08b	Number of WA & OP service users/carers on caseload who accepted a carers assessment	PM	TBC	TBC	TBC	TBC	TBC
		Actual	NYA	16	28	58	28
4.09	% of eligible service users with Personal budgets	PM	80%	80%	80%	80%	80%
		Actual	97%	100%	100%	100%	100%

Gloucestershire Social Care

ID	Performance Measure		2015/16 outturn	July-2016	August-2016	September-2016 / Quarter 2	Cumulative Compliance
4.10	% of eligible service users with Personal Budget receiving Direct Payments (ASCOF 1C pt2)	PM	15%	15%	15%	15%	15%
		Actual	19%	19%	17%	20%	19%
4.11	Adults subject to CPA in contact with secondary mental health services in settled accommodation (ASCOF 1H)	PM	80%	80%	80%	80%	80%
		Actual	86%	87%	87%	87%	87%
4.12	Adults not subject to CPA in contact with secondary mental health service in settled accommodation	PM	TBC	90%	90%	90%	90%
		Actual	91%	96%	96%	96%	96%
4.13	Adults subject to CPA receiving secondary mental health service in employment (ASCOF 1F)	PM	13%	13%	13%	13%	13%
		Actual	14%	14%	15%	15%	14%
4.14	Adults not subject to CPA receiving secondary mental health service in employment	PM	TBC	20%	20%	20%	20%
		Actual	23%	24%	24%	24%	24%

DASHBOARD CATEGORY – HEREFORDSHIRE CCG CONTRACTUAL REQUIREMENTS

Herefordshire Contract				
	In month Compliance			Cumulative Compliance
	Jul	Aug	Sep	
Total Measures	22	22	22	22
🔴	2	3	4	3
🟢	18	17	16	17
NYA	0	0	0	0
NYR	0	0	0	0
UR	0	0	0	0
N/A	2	2	2	2

Performance Thresholds not being achieved in Month

🚩 **5.08: IAPT Recovery rate – those who have completed treatment and have "caseness"**
This service is subject to an agreed Service Development Improvement Plan which is under specific monthly review by the Delivery Committee.

🚩 **5.09: IAPT achieve 15% of patients entering the service against prevalence**
This service is subject to an agreed Service Development Improvement Plan which is under specific monthly review by the Delivery Committee.

5.12: Emergency referrals to CRHT seen within 4 hours of referral (8am-6pm)
There is one case reported in September as not having been seen within 4 hours of referral. Initial findings are that this may be a data recording error which the service is currently investigating.

5.19: All admitted patients 65+ must have a completed MUST assessment
There were 2 admissions in September that do not have a MUST assessment recorded. The ward manager is currently investigating whether the assessments have not been carried out or have not been recorded.

Cumulative Performance Thresholds Not being

5.08: IAPT Recovery rate – those who have completed treatment and have "caseness"
As above

5.09: IAPT achieve 15% of patients entering the service against prevalence
As above

5.19: All admitted patients 65+ must have a completed MUST assessment
As above

Changes to Previously Reported Figures

None

Early Warnings / Notes

5.21: Attendances at ED for self-harm receive a mental health assessment
This indicator is still being reviewed with the service to look at whether all relevant data is being captured**.**

Herefordshire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2015/16 Outturn	July-2016	August-2016	September-2016 / Quarter 2	Cumulative Compliance
5.01	Duty of candour	Plan	Report	Report	Report	Report	Report
		Actual	Compliant	Compliant	Compliant	Compliant	Compliant
5.02	Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS	Plan	99%	99%	99%	99%	99%
		Actual	100%	99%	99%	99%	99%
5.03	Completion of Mental Health Services Data Set ethnicity coding for all detained and informal Service Users	Plan	90%	90%	90%	90%	90%
		Actual	100%	100%	100%	97%	99%
5.04	Completion of IAPT Minimum Data Set outcome data for all appropriate Service Users	Plan	90%	90%	90%	90%	90%
		Actual	96%	100%	99%	100%	99%
5.05	Zero tolerance MRSA	Plan	0	0	0	0	0
		Unavoidable	0	0	0	0	0
5.06	Minimise rates of Clostridium difficile	Plan	0	0	0	0	0
		Unavoidable	0	0	0	0	0
5.07	VTE risk assessment: all inpatient service users to undergo risk assessment for VTE	Plan	95%	95%	95%	95%	95%
		Actual	99%	100%	100%	100%	100%
5.08	IAPT Recovery Rate - The number of people who are "moving to recovery" (those who have completed IAPT treatment and have "caseness" at the final session did not)	Plan	50%	50%	50%	50%	50%
		Actual	33%	49%	34%	48%	43%
5.09	IAPT Roll-out (Access Rate) - IAPT maintain 15% of patient entering the service against prevalence	Plan	2,178	726	908	1089	1089
		Actual	2,005	495	627	712	712
5.10	IAPT waiting times and completed treatments - Number of ended referrals in the reporting period that received a course of treatment against the number of ended referrals that received a single treatment appt	Plan	N/A	TBC	TBC	TBC	TBC
		Actual		46%	43%	52%	48%
5.11	IAPT High Intensity - Number of discharged patients that received step 3 treatment	Plan	350	29	29	29	175
		Actual	356	32	41	58	211

Herefordshire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2015/16 Outturn	July-2016	August-2016	September-2016 / Quarter 2		Cumulative Compliance
5.12	Emergency referrals to Crisis Resolution Home Treatment Team seen within 4 hours of referral (8am-6pm)	Plan	98%	95%	95%	95%		95%
		Actual	99%	100%	100%	83%		98%
5.13a	Dementia Service - number of new patients aged 65 years and over receiving an assessment	Plan		45	45	45		270
		Actual		48	35	53		278
5.13b	Dementia Service - total number of new patients receiving an assessment	Plan						
		Actual		51	37	63		301
5.14	Waiting times - Specialist Memory Service: All patients are offered a first appointment within 4 weeks of referral	Plan	100%	95%	95%	95%		95%
		Actual	97%	100%	100%	98%		99%
5.15	Reduce those people readmitted to inpatient care within 30 days following discharge.	Plan	<8%	<8%	<8%	<8%		<8%
		Actual	6%	6%	0%	7%		4%
5.16	Number of service users on the caseload who have been seen (face to face) within the previous 90 days (Recovery Service). Excludes service users with a medic as Lead HCP.	Plan	100%	98%	98%	98%		98%
		Actual		98%	98%	99%		99%
5.17	Patients are to be discharged from local rehab within 2 years of admission (Oak House). Based on patients on ward at end of month.	Plan	80%	80%	80%	80%		80%
		Actual	86%	100%	100%	100%		100%
5.18	CYPS IAPTOutcomes - Consistent with the data specification for CYP-IAPT CAMHS V2 (Dec 2012).(Caseload at month end for CYPS IAPT trained staff with a CYPS IAPT outcome recorded).	Plan		40%	40%	40%		40%
		Actual		84%	85%	84%		84%
5.19	All admitted patients aged 65 years of age and over must have a completed MUST assessment	Plan		95%	95%	95%		95%
		Actual		100%	100%	67%		91%
5.20	Any attendances at ED with mental health needs should have rapid access to mental health assessment within 2 hours of the MHL team being notified.	Plan		50%	50%	50%		50%
		Actual		75%	75%	72%		73%
5.21	Attendances at ED for self-harm receive a mental health assessment	Plan		55%	55%	55%		55%
		Actual		100%	100%	100%		100%

Schedule 4 Specific Measures that are reported Nationally

Performance Thresholds not being achieved in Month

NHS Improvement

1.02: Number of C Diff cases

There was one case in Herefordshire during September on Cantilupe ward. A review to ascertain the cause has yet to be held. The result of this review will determine whether the case is reported as avoidable or unavoidable. For transparency it is assumed to be avoidable until confirmed as otherwise.

1.03: Care Programme Approach – follow-up contact within 7 days of discharge

Herefordshire is non-compliant at 94%. There were 2 cases in Herefordshire not followed up within 7 days. . Both cases are being investigated to determine the reasons and check the accuracy of recording.

.

1.09 IAPT Waiting times: Referral to Treatment within 6 weeks (based on discharges)

This service is subject to an agreed Service Development Improvement Plan which is under specific monthly review by the Delivery Committee.

1.10 IAPT Waiting times: Referral to Treatment within 18 weeks (based on discharges)

This service is subject to an agreed Service Development Improvement Plan which is under specific monthly review by the Delivery Committee.

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

ID	Performance Measure		2015/16 outturn	July-2016	August-2016	September-2016 / Quarter 2	Cumulative Compliance
NHSI 1.01	Number of MRSA Bacteraemias avoidable	PM	0	0	0	0	0
		Actual	0	0	0	0	0
NHSI 1.02	Number of C Diff cases (day of admission plus 2 days = 72hrs) - avoidable	PM	0	0	0	0	0
		Actual	0	0	1	1	2
NHSI 1.03	Care Programme Approach follow up contact within 7 days of discharge	PM	95%	95%	95%	95%	95%
		Actual	96%	100%	100%	94%	97%
NHSI 1.04	Care Programme Approach - formal review within12 months	PM	95%	95%	95%	95%	95%
		Actual	98%	99%	99%	98%	99%
NHSI 1.05	Delayed Discharges (Including Non Health)	PM	7.5%	7.5%	7.5%	7.5%	7.5%
		Actual	1.2%	0.8%	0.0%	0.0%	1.8%
NHSI 1.08	New psychosis (EI) cases treated within 2 weeks of referral	PM	50%	50%	50%	50%	50%
		Actual	61%	100%	N/A	100%	71%
NHSI 1.09	IAPT - Waiting times: Referral to Treatment within 6 weeks (based on discharges)	PM	75%	75%	75%	75%	75%
		Actual	95%	55%	47%	40%	52%
NHSI 1.10	IAPT - Waiting times: Referral to Treatment within 18 weeks (based on discharges)	PM	95%	95%	95%	95%	95%
		Actual	99%	83%	83%	83%	89%
DoH 2.18	Mixed Sex Accommodation Breach	PM	0	0	0	0	0
		Actual	0	0	0	0	0
DoH 2.21	No children under 18 admitted to adult in-patient wards	PM	0	0	0	0	0
		Actual	4	1	0	0	4

DASHBOARD CATEGORY – GLOUCESTERSHIRE CQUINS

Gloucestershire CQUINS				
	In month Compliance			Cumulative Compliance
	Jul	Aug	Sep	
Total Measures	2	2	2	2
	0	0	0	0
	0	0	0	2
NYA	0	0	2	0
NYR	2	2	0	0
UR	0	0	0	0
N/A	0	0	0	0

Performance Thresholds not being achieved in Month
None

Cumulative Performance Thresholds Not being Met
None

Changes to Previously Reported Figures
None

Early Warnings
None

Gloucestershire CQUINS

ID	Performance Measure		2015/16 Outturn		Quarter 2			Cumulative Compliance
	Local CQUINs							
	CQUIN 1							
7.01	Transition from Young People's Service to Adult Mental Health Services	PM	Qtr 4		Report			Qtr 1
		Actual	Compliant		NYA	NYA		Awarded
	CQUIN 2							
7.02	Perinatal Mental Health	PM	Qtr 4		Report			Qtr 1
		Actual	Compliant		NYA	NYA		Awarded

DASHBOARD CATEGORY – LOW SECURE CQUINS

Low Secure CQUINS				
	In month Compliance			Cumulative Compliance
	Jul	Aug	Sep	
Total Measures	1	1	1	1
	0	0	0	0
	0	0	0	1
NYA	0	0	1	0
NYR	1	1	0	0
UR	0	0	0	0
N/A	0	0	0	0

Performance Thresholds not being achieved in Month
None

Cumulative Performance Thresholds Not being Met
None

Changes to Previously Reported Figures
None

Early Warnings
None

Low Secure CQUINS

ID	Performance Measure		2015/16 Outturn		Quarter 2			Cumulative Compliance
	Local CQUINs							
	CQUIN 1							
8.01	Reducing the length of stay in specialised MH services	PM			Report			Qtr 1
		Actual			NYA	NYA		Awarded

DASHBOARD CATEGORY – HEREFORDSHIRE CQUINS

Herefordshire CQUINS				
	In month Compliance			Cumulative Compliance
	Jul	Aug	Sep	
Total Measures	8	8	8	8
🔴	0	0	0	0
🟢	0	0	0	8
NYA	0	0	8	0
NYR	8	8	0	0
UR	0	0	0	0
N/A	0	0	0	0

Performance Thresholds not being achieved in Month

None

Cumulative Performance Thresholds Not being Met

None

Changes to Previously Reported Figures

Herefordshire CQUINS for 2016/17 have been confirmed and changes to the report are as follows:

CQUINs not previously included:
9.01a: (b) Introduction of Health and Wellbeing Initiatives
9.01b: Healthy food for NHS Staff, Visitors and Patients
9.01c: Improving the update of Flu vaccinations for Front Line Clinical Staff
9.02: Personalised relapse prevention plans for adults

CQUIN removed:
Urgent and Emergency Care: Development of an adult personalised discharge care plan

Early Warnings

None

Herefordshire CQUINS

ID	Performance Measure		2015/16 Outturn		Quarter 2		Cumulative Compliance
	National CQUINs						
	CQUIN 1						
9.01a	(b) Introduction of Health and Wellbeing Initiatives	PM			Report		Qtr 1
		Actual			NYA	NYA	Awarded
9.01b	Healthy food for NHS Staff, Visitors and Patients	PM			Report		Qtr 1
		Actual			NYA	NYA	Awarded
9.01c	Improving the uptake of Flu vaccinations for Front Line Clinical Staff	PM			Report		Qtr 1
		Actual			NYA	NYA	Awarded
9.02a	Improving physical healthcare: Cardio Metabolic Assessment for patients with psychoses	PM	Qtr 4		Report		Qtr 1
		Actual	Compliant		NYA	NYA	Awarded
9.02b	Improving physical healthcare: Communication with GPs	PM	Qtr 2		Report		Report
		Actual	Awarded		NYA	NYA	NYA
	Local CQUINs						
	CQUIN 2						
9.02	Personalised relapse prevention plans for adults accessing and using 2G Mental Health Services	PM			Report		Qtr 1
		Actual			NYA	NYA	Awarded
	CQUIN 3						
9.03	Personalised relapse prevention plans for children and young people accessing and using MH services				Report		Qtr 1
					NYA	NYA	Awarded
	CQUIN 4						
9.04	Appropriate care and management for frequent attenders to WVT A&E dept				Report		Qtr 1
					NYA	NYA	Awarded

Agenda item 8 **PAPER C**

Report to: Trust Board – 24 November 2016
Author: Gordon Benson, Assistant Director of Governance & Compliance
Presented by: Marie Crofts, Director of Quality

SUBJECT: **Quality Report: Report for 2nd Quarter 2016/17**

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

EXECUTIVE SUMMARY

This is the second review of the Quality Report priorities for 2016/17. The quarterly report is in the format of the annual Quality Report format.

Assurance

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

- Overall, there are 2 confirmed targets which will not be met by year end:

    1. 1.3 – Joint CPA reviews for young people transitioning to adult services
    2. 3.2 – Reduction in the number of detained patients who are AWOL

- There is limited assurance that target 3.1 – Reduction in the numbers of reported deaths by suspected suicide, and target 3.3 – 5% reduction in the number of prone restraints on adult wards/PICU will be met.

- These targets will continue to receive considerable focus through operational management systems, wider work streams such as the Patient Safety Improvement Programme, and sub-committees such as the Positive & Safe Sub-Committee.

Improvements

- The data within relates to Quarter 2 and will, therefore, be subject to change throughout the year as the supportive evidence base grows.

- There have been sustained improvements across all User Experience targets, 48hr follow up and Personalised Discharge Care Planning which demonstrate that measures put in place to improve performance in these areas by Service Directors have been effective. These will continue to receive focus throughout the year.

RECOMMENDATIONS
The Board is asked to: • Note the progress made to date and actions in place to improve/sustain performance where possible;

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

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

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

Reviewed by:		
Marie Crofts, Director of Quality	Date	10 August 2016

Where in the Trust has this been discussed before?		
Governance Committee	Date	18 November 2016

What consultation has there been?		
	Date	

Explanation of acronyms used:	

1. CONTEXT

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

Quality Report 2016/17

Quarter 2

CONTENTS

Part 1: Statement on Quality from the Chief Executive

Introduction

This will be completed at year end.

Part 2a: Looking ahead to 2017/18

Quality Priorities for Improvement 2017/18

This will be completed at year end.

Effectiveness

These will be developed during Quarter 4

User Experience

These will be developed during Quarter 4

Safety

These will be developed during Quarter 4

Part 2b: Statements relating to the Quality of NHS Services Provided

This will be completed at year end.

Participation in Clinical Audits and National Confidential Enquiries

This will be completed at year end.

Participation in Clinical Research

This will be completed at year end.

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

A proportion of [2]gether NHS Foundation Trust's income in 2016/17 was conditional on achieving quality improvement and innovation goals agreed between [2]gether NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed CQUIN goals for 2016/17 are available electronically at *http://www.2gether.nhs.uk/cquin*

2016/17 CQUIN Goals

Gloucestershire

Gloucestershire Goal Name	*Description*	*Goal weighting*	*Expected value*	*Quality Domain*
Young Peoples Transitions	This CQUIN will improve outcomes in young people transitioning from [2]gether Young People's Services to Adult Mental Health Services.	.80	£564256	Effectiveness
Perinatal Mental Health	This CQUIN will focus on quality improvement across the perinatal mental health pathway to promote integration, knowledge and skills of staff and improve outcomes for women and families.	1.7	£1199044	Effectiveness

Herefordshire

Herefordshire Goal Name	*Description*	*Goal weighting*	*Expected value*	*Quality Domain*
1a (b) National CQUIN – Staff health and wellbeing	The introduction of health and wellbeing initiatives covering physical activity, mental health and improving access to physiotherapy for people with MSK issues	.25	£41100	Effectiveness
1b National CQUIN – Staff health and wellbeing	Healthy food for NHS staff, visitors and patients	.25	£41100	Effectiveness
1c National CQUIN - Staff health and wellbeing	Improving the uptake of flu vaccinations for front line staff	.25	£41100	Safety
Improving Physical Healthcare	The purpose of this CQUIN is twofold. Firstly, to improve the physical health of service users who	.25	£41100	Effectiveness
Local CQUIN personalised relapse prevention plans for adults	Personalised relapse prevention plans for adults accessing services, specifically Assertive Outreach Team and Early Intervention Service	0.52	£85488	Safety
Local CQUIN personalised relapse prevention plans for Children and Young People	Personalised relapse prevention plans for adults accessing services, specifically children and young people accessing and using CAMHS services	0.52	£85488	Safety
Local CQUIN 3 – Frequent attenders	Care and management for frequent attenders to WVT Accident and Emergency	0.46	£75624	Safety

Low Secure Services

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

The total potential value of the income conditional on reaching the targets within the CQUINs during 2016/16 is £2,219,300 of which we anticipate £2,219,300 will be achieved.

In 2015/16, the total potential value of the income conditional on reaching the targets within the CQUINs was £2,107,995 of which £2,107,153 was achieved.

2017/18 CQUIN Goals

These will be developed during Quarter 4.

Statements from the Care Quality Commission

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

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

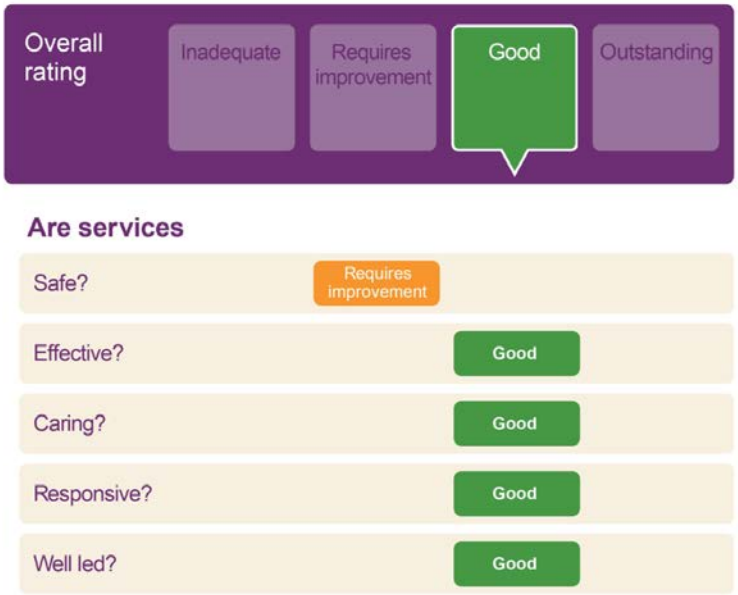
- Assessment or medical treatment to persons detained under the Mental Health act 1983;
- Diagnostic and screening procedures;
- Treatment of disease, disorder or injury.

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

The CQC has not taken enforcement action against [2]gether NHS Foundation during 2016/17 or the previous year 2015/16.

CQC Inspections of our services

[2]gether NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2015/16. The Care Quality Commission undertook a planned comprehensive inspection of the Trust week commencing 26 October 2015 and published its findings on 28 January 2016. The CQC rated our services as GOOD, rating **2** of the **10** core services as "outstanding" overall and **6** "good" overall.



The inspection found that there were some aspects of care and treatment in some services that needed improvements to be made to ensure patients were kept safe. However, the vast majority of services were delivering effective care and treatment.

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

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

[2]gether NHS Foundation Trust intends to take the following action to address the conclusions or requirements reported by the CQC:

- The Trust has developed an action plan in response to the **15** "must do" recommendations, and the **58** "should do" recommendations identified by the inspection.

[2]gether NHS Foundation Trust has made the following progress by 30th June 2016 in taking such action:

- Setting up a Project Group to manage all actions through to their conclusion;
- Progressing and monitoring the associated actions with reporting to both the CQC and local CCGs

Changes in service registration with Care Quality Commission for 2016/17

There have been no requests to change our registration with the CQC this year.

Quality of Data

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

This will be completed at year end.

Information Governance Toolkit

This will be completed at year end.

Clinical Coding Error Rate

This will be completed at year end.

Part 3: Looking Back: A Review of Quality during 2016/17

Introduction

The 2016/17 quality priorities were agreed in May 2016.

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

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

Summary Report on Quality Measures for 2016/2017

		2015 - 2016	Quarter 2 2016 - 2017
Effectiveness			
1.1	To increase the number of service users (all inpatients and all SMI/CPA service users in the community, inclusive of Early Intervention Service, Assertive Outreach and Recovery) with a LESTER tool intervention (a specialist cardio metabolic assessment tool) alongside increased access to physical health treatment**.**	**Achieved**	**Achieved**
1.2	To improve personalised discharge care planning in: a) Adult inpatient wards and; b) Older people's wards.	**Achieved**	**Achieved**
1.3	To ensure that joint Care Programme Approach reviews occur for **all** service users who make the transition from children's to adult services.	**-**	**Not achieved**
User Experience			
2.1	Were you involved as much as you wanted to be in agreeing what care you will receive? **> 78%**	**78%**	**86%**
2.2	Were you involved as much as you wanted to be in decisions about which medicines to take? **> 73%**	**73%**	**79%**
2.3	Do you know who to contact out of office hours if you have a crisis? **>71%**	**71%**	**80%**
2.4	Has someone given you advice about taking part in activities that are important to you? **> 48%**	**48%**	**75%**
Safety			
3.1	Reduce the numbers of deaths by suspected suicide (pending inquest) of people in contact with services when comparing data from previous years.	**24**	**17**
3.2	Reduce the number of detained patients who are absent without leave (AWOL) when comparing data from previous years. Reported against 3 categories of AWOL as follows: 1. Absconded from an escort 2. Did not return from leave 3. Absconded from a ward	**13** **23** **78** **114 total**	**14** **28** **80** **122 total**
3.3	To reduce the number of prone restraints by 5% year on year (on all adult wards & PICU) based on 2015/16 data.	**120**	**102**
3.4	**95%** of adults will be followed up by our services within 48 hours of discharge from psychiatric inpatient care.	**90%**	**97%**

Effectiveness

In 2016/17 we remained committed to ensure that our services are as effective as possible for the people that we support. We set ourselves 3 targets against the goals of:

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

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

There is a long established association between physical comorbidity (the presence of multiple illnesses) and mental ill health. People with severe and enduring mental health conditions experience reduced life expectancy compared to the general population. People with Schizophrenia and Bipolar disorder die on average, 20 to 25 years earlier than the general population, largely because of physical health problems. These include coronary heart disease, diabetes, respiratory disease, greater levels of obesity and metabolic syndrome.

In 2014/15 the Trust introduced the LESTER screening tool within the inpatient services, as part of the National Physical Health Commissioning for Quality and Innovation (CQUIN) payment framework. The LESTER tool is a way of identifying service users at risk of cardiovascular disease and to implement interventions to reduce any risk factors identified. Specific areas covered in the tool are, diabetes, high cholesterol, high blood pressure, increased body mass index, smoking, diet and exercise levels, and substance and alcohol misuse.

In 2015/16 the National Physical Health CQUIN was repeated within the inpatient services and was extended to include the Early Intervention teams within Herefordshire and Gloucestershire. We successfully achieved full compliance with this CQUIN and using the same methodology for both the inpatients and community teams, the Trust achieved overall 93% compliance (see Figure 1)

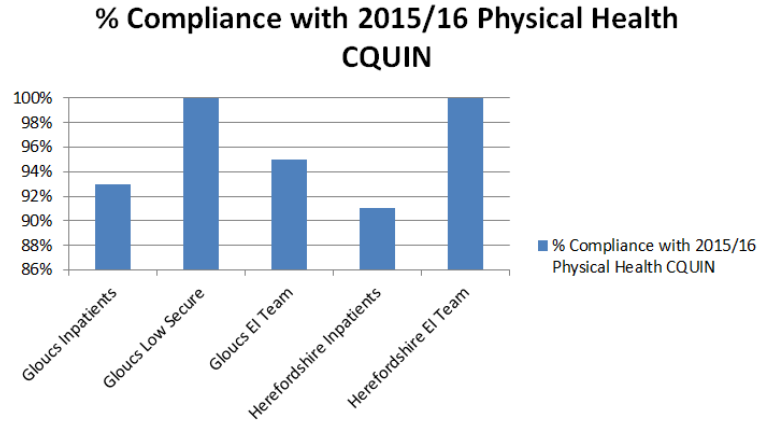


Figure 1

This year 2016/17 the Physical Health CQUIN has been adapted slightly to continue to build on the good work already in place. The sample group has now been extended to include both inpatients and patients from all community mental health teams who have a diagnosis of psychosis and are on CPA. (This year the CQUIN only relates to Herefordshire, however internal audits continue within Gloucestershire to ensure standards are maintained trust wide).

In order to support this work a substantial Lester Tool training programme for both inpatient areas and community mental health teams has been undertaken by the Physical Health Facilitator. The training department have also facilitated a one day Physical Health Awareness course, designed to complement the Lester tool training and increase staff awareness of coronary heart disease, chronic obstructive pulmonary disease and diabetes. All teams currently working with the Lester tool have an allocated 'lead' professional who receives regular feedback regarding progress in implementing and completing the Lester tool.

Within quarter two, the Trust has reviewed and updated the established pathways which are currently in place for both Inpatients and the Early Intervention teams. For example; the Department of Health's Alcohol Guidelines Review published in January 2016 suggested that the level of recommended units of alcohol for men and women to be lowered to14 units a week, this change has been highlighted to staff and the new figures changed on documentation. For the Recovery and Assertive Outreach Teams, for whom this was a new initiative, extra training was put in place to ensure that staff were aware of the various pathways available to patients, if identified whilst using the Lester Tool.

The medical doctor's induction programme includes a section on the Lester tool. This training focuses on the role of the medical teams to support the Lester tool as well as an overview of the need for increased physical health screening for patients with serious mental illnesses.

The roll out of the screening programme within the community teams highlighted the need for a standardisation of physical health equipment needed as a minimum to undertake the screening. A set stock list is now available for community teams to access and the training team have offered a clinical skills training package for staff that are unfamiliar with how to use the equipment. Lack of staff trained in venepuncture skills again was highlighted as a potential barrier to completing the Lester tool and a group of staff have now received this training and are competent to take the blood samples needed.

A "Physical Health Clinic" has been established at the community base in Hereford to enable staff to complete the Lester tool in a suitable environment; however staff are also able to screen patients at home if they are unable to attend the clinic.

Documentation has been highlighted as an issue nationwide, in that physical health information (screening details and interventions offered) are currently documented in multiple locations within the Electronic Patient Record RiO. The Trust received access to 'open RiO' in May 2015 which enabled the Trust to make changes to the Electronic Patient Record. Work has taken place to streamline where Physical Health information is recorded within the Electronic Patient Record RiO system. This will improve the way in which information can be audited and fed back to the clinicians. This system has now gone live and staff are now familiar with the new pages within RiO. Feedback from staff so far has been positive and appears to reduce the need for duplication of data.

Work continues to revise and update the Physical Health information pages within the Trust intranet. It is hoped to be a central point for obtaining information regarding the Lester tool, along with general physical health information, updates, audits and quality improvement projects.

Following the success of the Physical Health Day for staff and patients at Wotton Lawn hospital in January 2016, a second similar event is planned for February 2017. External providers invited to attend include; The Independence Trust, Stop Smoking Service, Slimming World, Sexual Health clinic and Dental Access Centres. The Trust's Working Well team, dietician and health and exercise practitioners will also be represented.

The Trust is continuing with its plans to achieve "Smoke Free" status in spring next year, and ground work is being undertaken by a small team to ensure this transition takes place smoothly. The annual Flu vaccination programme is currently being rolled out across the Trust and it is hoped to increase the number of staff and patients immunised this year.

We are currently meeting this target.

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

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

This year identical criteria are being used in the services across both counties as follows:

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

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

Results from the Quarter 2 audit against these standards are seen below.

Gloucestershire Services

Criterion	Compliance Quarter 4 (2015/16)	Compliance Quarter 1 (2016/17)	Compliance Quarter 2 (2016/17)
Overall Average Compliance (Gloucestershire)	**75% (712/950)**	**73%**	**77%**
Chestnut Ward	84% (62/74)	83%	88%
Mulberry Ward	75% (83/110)	77%	86%
Willow Ward	59% (37/63)	66%	68%
Abbey Ward	72% (113/158)	73%	75%
Dean Ward	79% (169/215)	73%	76%
Greyfriars PICU	50% (13/26)	64%	71%
Kingsholm Ward	75% (55/73)	72%	72%
Priory Ward	80% (173/217)	77%	81%
Montpellier Unit	50% (7/14)	42%	50%
Honeybourne	N/A	68%	78%
Laurel House	N/A	56%	67%

* Data for Honeybourne and Laurel House (Recovery Units) was not collected in 2015/16 – only hospital wards were audited to reflect comparable data across both Gloucestershire and Herefordshire.

Overall compliance in Gloucester with these standards has increased during Quarter 2; there will be an increased focus on this important work during Quarter 3.

Herefordshire Services

Criterion	Compliance Quarter 4 (2015/16)	Compliance Quarter 1 2016/17)	Compliance Quarter 2 (2016/17)
Overall Average Compliance (Herefordshire)	**N/A**	**73%**	**74%**
Cantilupe Ward	**N/A**	77%	85%
Jenny Lind Ward	**N/A**	65%	76%
Mortimer Ward	**N/A**	72%	70%
Oak House	**N/A**	67%	78%

There is no 2015/16 data for Herefordshire. This is due to the audit criteria changing from the original set of questions which were influenced by the West Midlands Quality Review which agreed a differing set of standards within Herefordshire. As the audit widened to the whole Trust across two counties, the criteria within the audit changed to reflect the standards outlined within the clinical system in relation to discharge care planning. It is seen that overall compliance has improved during Quarter 2.

Of the seven individual criteria assessed, overall compliance has improved in both counties in all areas except in the following:

1. Has the Pre-Discharge Planning Form been completed?
2. Have the inpatient care plans been closed within 7 days of discharge?

Services will, therefore, be focusing on these elements to promote improvement.

We are currently meeting this target.

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

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

Gloucestershire Services

During Quarter 1, there were 7 young people who transitioned into adult services, of these 7, 6 (86%) had a joint CPA review. All young people received input from the relevant services but this is not clearly documented within RiO.

During Quarter 2, 5 young people were transitioned from CYPS to adult services. All of these (100%) had a joint CPA review with CYPS and adult services staff present.

Criterion	Compliance Quarter 1 2016/17)	Compliance Quarter 2 (2016/17)
Joint CPA Review	86%	100%

Compliance improved during Quarter 2 and now needs to be maintained at 100%.

Herefordshire Services

During Quarter 1, there were 3 young people who transitioned into adult services, of these 3, 1 (33%) had a joint CPA review. All young people received input from the relevant services but this is not clearly documented within RiO.

During Quarter 2, there were 2 young people who transitioned into adult services, of these 1 (50%) had a joint CPA review. The one young person who did not receive a joint CPA review was having their care coordinated by a new member of staff who was unfamiliar with process.

Criterion	Compliance Quarter 1 2016/17)	Compliance Quarter 2 (2016/17)
Joint CPA Review	33%	50%

To improve our practice and documentation in relation to this target a number of measures have been developed as follows:

- Transition will be included as standard agenda item for teams, to provide the opportunity to discuss transition cases;
- Transition will be included as a standard agenda item in caseload management to identify emerging cases;
- Teams are encouraged to contact adult mental health services to discuss potential referrals;
- There is a data base which identifies cases for transition;
- SharePoint report identifies 17.5 years open to CYPS. Team Managers will monitor those who are coming up to transition and discuss in supervision.

We have not met this target.

User Experience

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

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

Local surveys using the same questions have been implemented in our community and inpatient settings using a paper based survey method. This has been across the Trust in both Gloucestershire and Herefordshire, and below are the cumulative responses to the returned service user questionnaires at year end. A combined total percentage for both counties is provided for these questions to mirror the methodology used by the CQC Community Mental Health Survey, as this does not differentiate by county.

Target 2.1 Were you involved as much as you wanted to be in agreeing what care you will receive? > 78%

Questions	**Treatment Setting**	Sample Size **Glos**	Number 'yes' **Glos**	Sample size **Hereford**	Number 'yes' **Hereford**	**Total %** giving 'yes' answer
Question 1 Were you involved as much as you wanted to be in agreeing what care you will receive? > 78%	Inpatient	7	6	12	10	**86%**
	Community	63	52	30	28	
	Total Responses	70	58	42	38	

This target has been met.

Target 2.2 Were you involved as much as you wanted to be in decisions about which medicines to take? > 73%

Questions	**Treatment Setting**	Sample Size **Glos**	Number 'yes' **Glos**	Sample size **Hereford**	Number 'yes' **Hereford**	**Total %** giving 'yes' answer
Question 2 Were you involved as much as you wanted to be in decisions about which medicines to take? **> 73%**	Inpatient	7	6	12	9	**79%**
	Community	52	43	26	19	
	Total Responses	59	49	38	28	

This target has been met.

Target 2.3 Do you know who to contact out of office hours if you have a crisis? >71%

Questions	Treatment Setting	Sample Size Glos	Number 'yes' Glos	Sample size Hereford	Number 'yes' Hereford	Total % giving 'yes' answer
Question 3 Do you know who to contact out of office hours if you have a crisis? **>71%**	Inpatient	7	6	12	8	**80%**
	Community	59	45	29	27	
	Total Responses	66	51	41	35	

This target has been met.

Target 2.4 Has someone given you advice about taking part in activities that are important to you? > 48%

Questions	Treatment Setting	Sample Size Glos	Number 'yes' Glos	Sample size Hereford	Number 'yes' Hereford	Total % giving 'yes' answer
Question 4 Has someone given you advice about taking part in activities that are important to you? **> 48%**	Inpatient	7	7	12	9	**75%**
	Community	61	38	29	28	
	Total Responses	68	45	41	37	

This target has been met.

Friends and Family Test (FFT)

FFT responses and scores for Quarter 2

Service users are asked "How likely are you to recommend our service to your friends and family if they needed similar care or treatment?", and have six options from which to choose:

1. Extremely likely
2. Likely
3. Neither likely nor unlikely
4. Unlikely
5. Extremely unlikely
6. Don't know

The table below details the number of responses received each month; the FFT score is the percentage of people who chose either option 1 or 2 – they would be extremely likely/likely to recommend our services.

	Number of responses	FFT Score (%)
July 2016	242	93%
August 2016	382	86%
September 2016	430	92%
Total	**1,087 (Q1 = 643)**	**90% (Q1 = 94%)**

Table 1

Friends and Family Test Scores for [2]gether Trust for the past year

The following graph shows the FFT Scores for the past rolling year, including this quarter. The Trust receives consistently positive feedback.

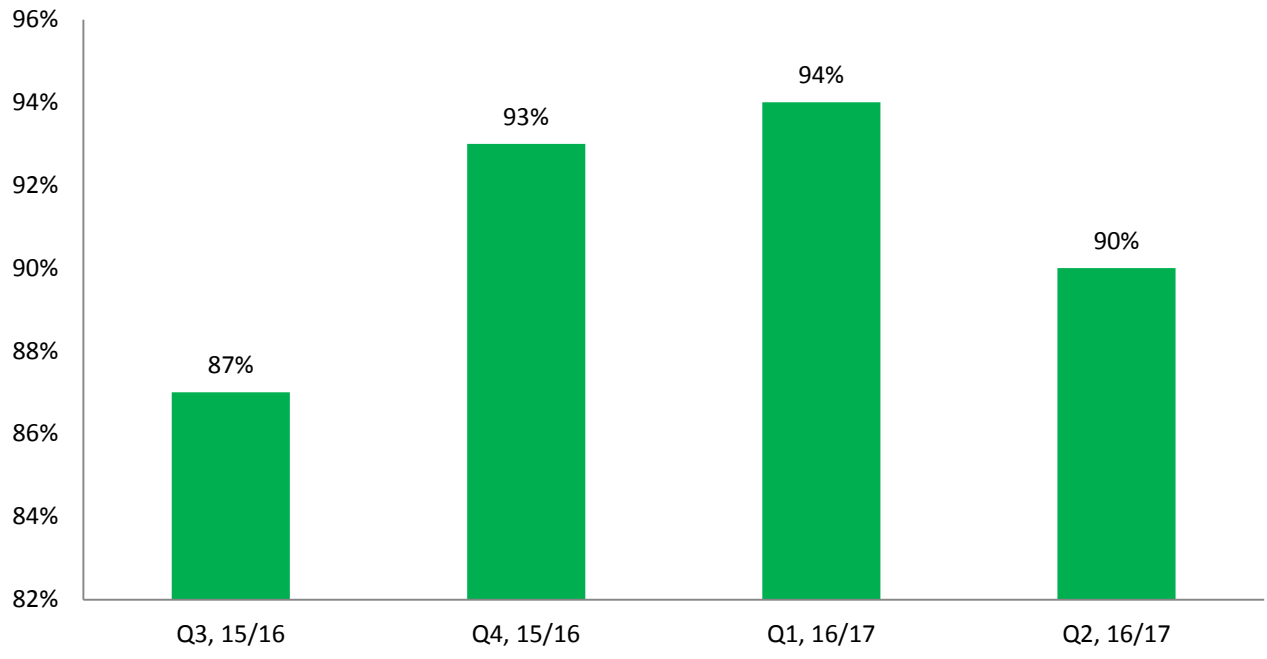


Figure 2

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

The following graph shows the FFT Scores for the past six months, including this quarter. The Trust receives a consistently high percentage of recommendation scores (*September 2016 data for England is not yet available*)

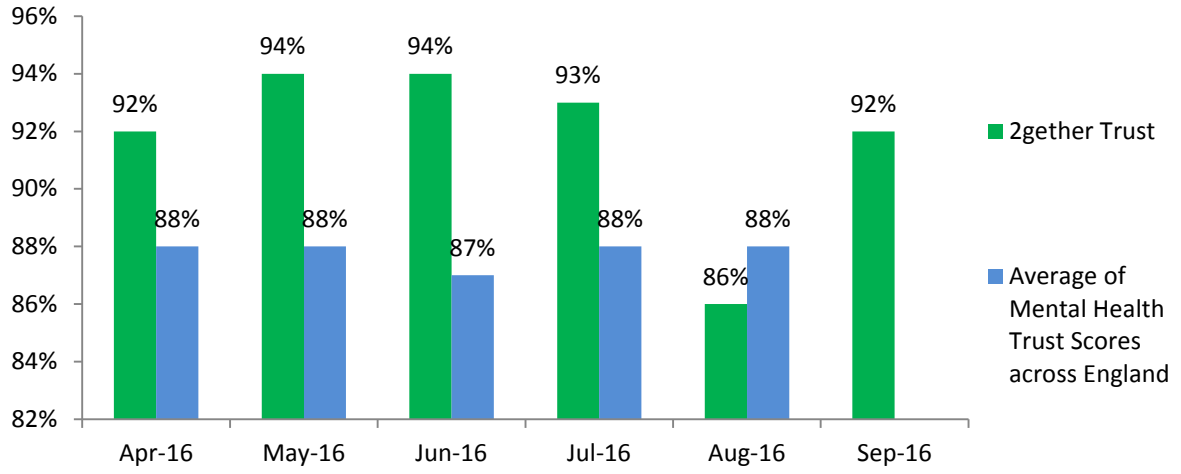


Figure 3

Friends and Family Test Scores – comparison between 2gether Trust and other Mental Health Trusts in the NHSE South Central Region

The following graph shows the FFT Scores for June, July and August 2016 (the most recent data available). The Trust receives a consistently high percentage of feedback. (*September 2016 data for the region is not yet available*)

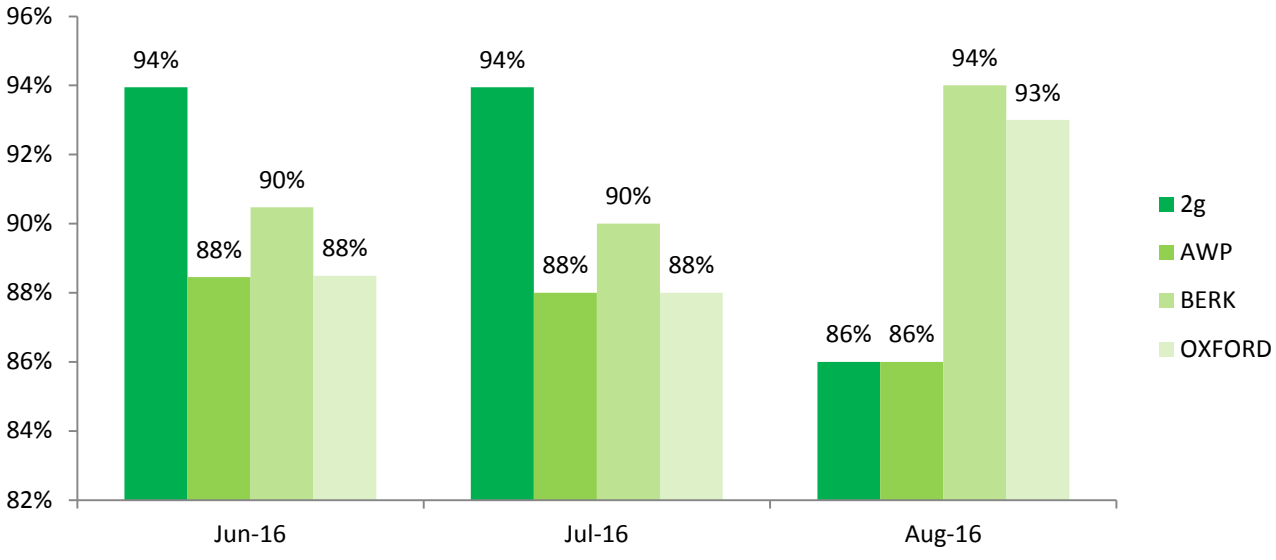


Figure 4

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

Complaints

This will be completed at year end.

Safety

Protecting service users from further harm whilst they are in our care is a fundamental requirement. We seek to ensure we assess the safety of those who use our services as well as providing a safe environment for service users, staff and everyone else that comes into contact with us. In this domain, we have set ourselves 4 goals to:

- Minimise the risk of suicide of people who use our services;
- Ensure the safety of people detained under the Mental Health Act;
- Reduce the number of prone restraints used in our adult inpatient services:
- Ensure we follow people up when they leave our inpatient units within 48 hours to reduce risk of harm.

There are 4 associated targets.

Target 3.1 Reduce the numbers of deaths relating to identified risk factors of people in contact with services when compared data from previous years.

We aim to minimise the risk of suicide amongst those with mental disorders through systematic implementation of sound risk management principles. In 2013/14 we set ourselves a specific quality target for there to be fewer deaths by suicide of patients in contact with teams and we have continued with this important target each year. Last year we reported **24** suspected suicides, **4** more than last year, therefore we did not meet the target. This year has seen a marked rise in these tragic incidents during Quarter 1 and at the end of Quarter 2 we have reported **17** suspected suicides.

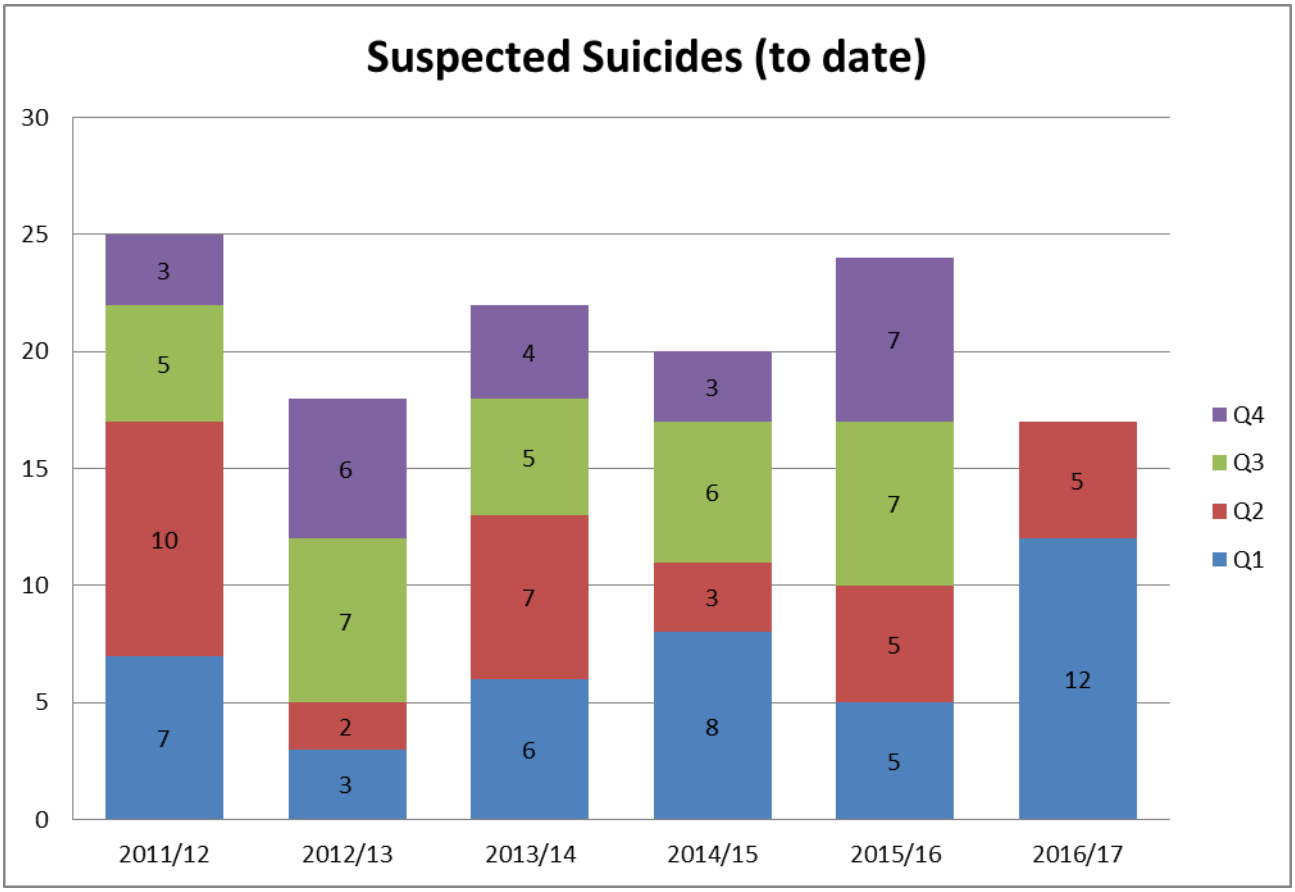


Figure 5

This information is provided below in Figures 6 & 7 for both Gloucestershire and Herefordshire services separately. It is seen that greater numbers of suspected suicides are reported in Gloucestershire services. There is no clear indication of why the difference between the two counties is so marked, but it is noted that the population of people in contact with mental health services in Gloucestershire is greater, and the services in each county are configured differently to reflect individual commissioning requirements.

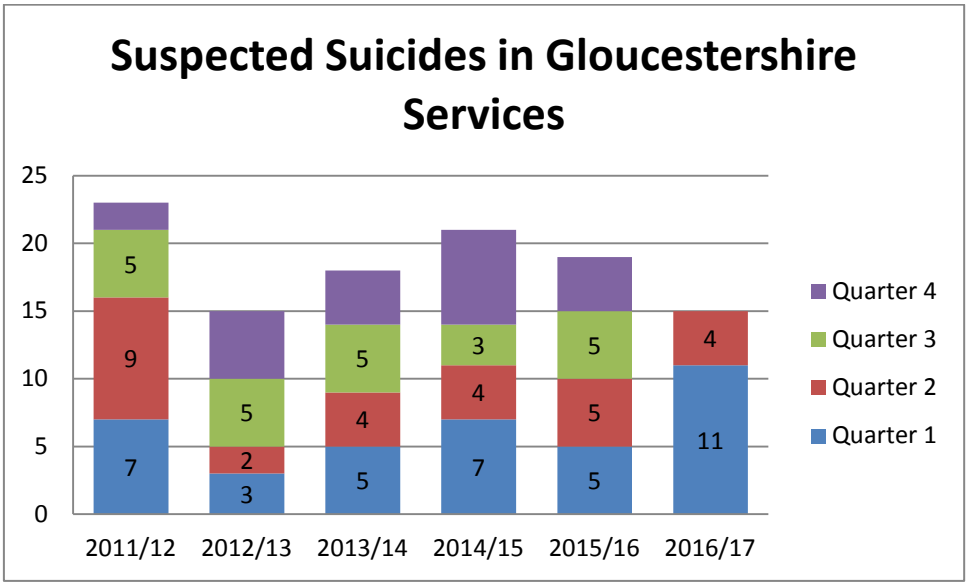


Figure 6

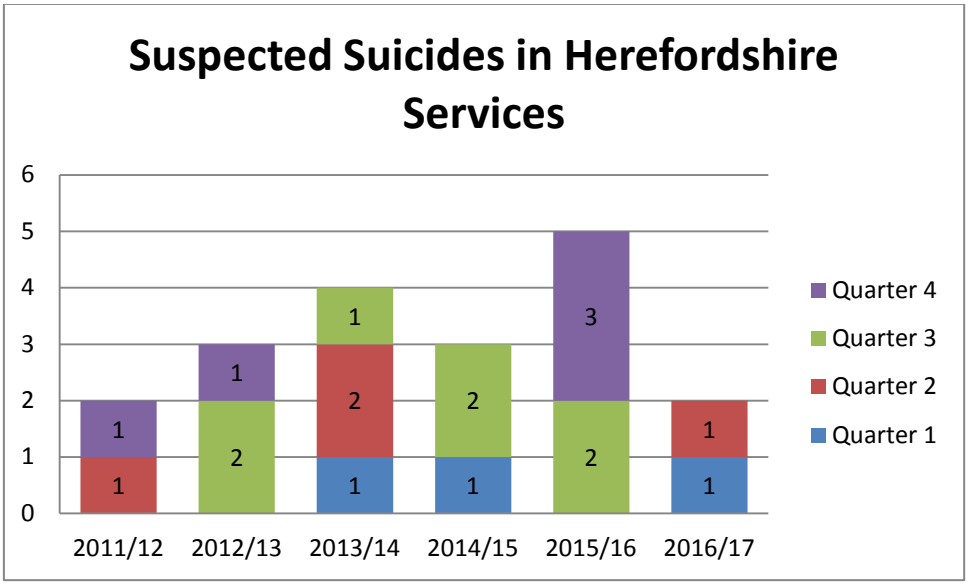


Figure 7

Whilst we report all deaths which appear to be as a consequence of self-harm as suspected suicide, ultimately it is the coroner who determines how a person came by their death. Figure 8 provides the number of suicide, open and narrative conclusions following an inquest being heard for the same cohort of service users. The outcome of inquests for each county is subsequently provided in Figures 9 & 10.

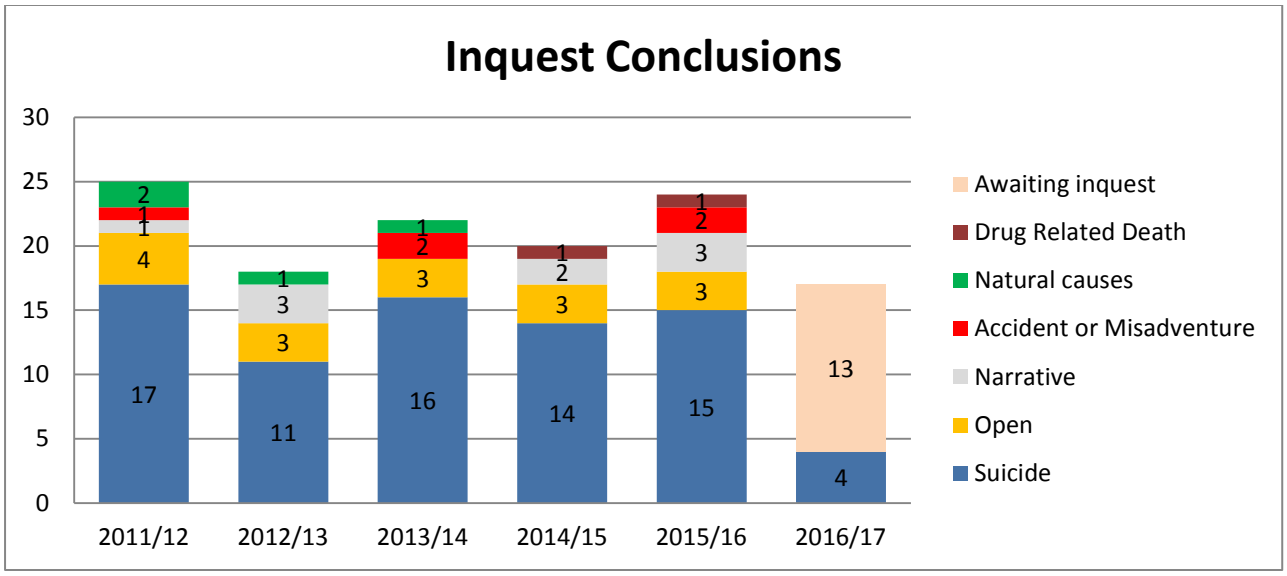


Figure 8

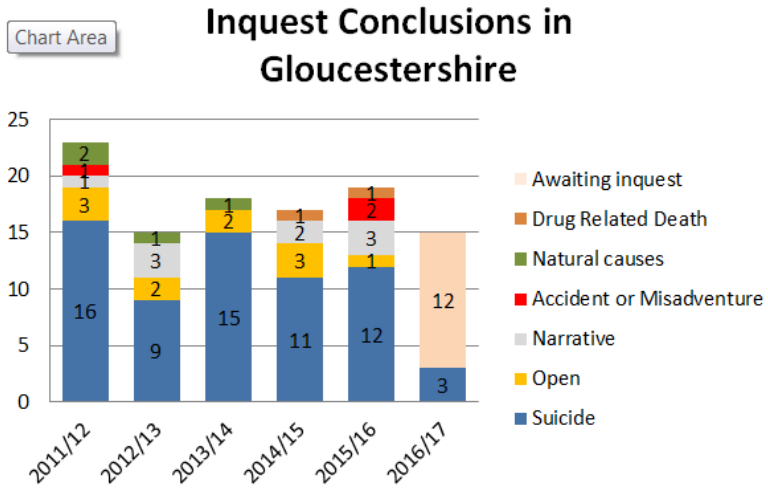


Figure 7

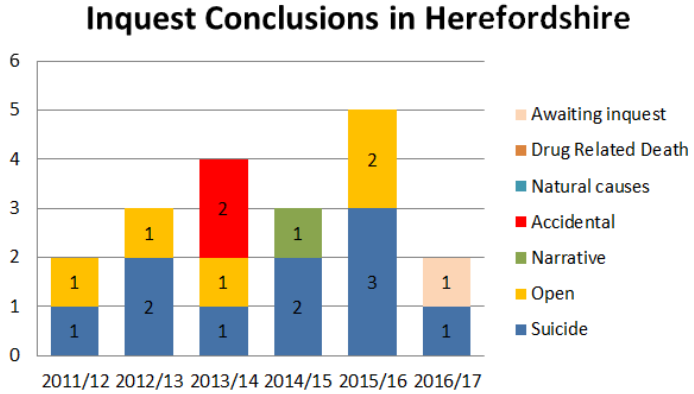


Figure 8

The Trust is an active member of the Gloucestershire Suicide Prevention Partnership Forum (GSPPF). This Forum brings together key stakeholders in the county to develop and deliver a countywide suicide prevention strategy and action plan and contribute to reducing the stigma around suicide and self-harm.

We are currently meeting this target as the total number remains below 24; however we have reported more suspected suicides in Quarters 1 & 2 this year than in the previous 4 years and there is a high risk that this target will not be met.

Target 3.2 Reduce the number of people who are absent without leave from inpatient units who are formally detained.

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

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

During 2015/16 **114** episodes of AWOL were been reported with the overall target being met, but there was an increase of **9** incidents where service users absconded from a ward. Therefore, we want to continue with this indicator as a quality priority during 2016/17. A breakdown of the 3 categories of AWOL for each county showing the year-end figures for 2015/16 and the Quarter 1 figures for 2016/17 are seen below.

Herefordshire

	Total 2015/16	Quarter 1 2016/17	Quarter 2 2016/17	Quarter 3 2016/17	Quarter 4 2016/17
Absconded from a ward	23	15	9		
Did not return from leave	4	2	1		
Absconded from an escort	4	2	0		
Totals for year	**31**	**29**			

Gloucestershire

	Total 2015/16	Quarter 1 2016/17	Quarter 2 2016/17	Quarter 3 2016/17	Quarter 4 2016/17
Absconded from a ward	55	20	36		
Did not return from leave	19	9	16		
Absconded from an escort	9	3	9		
Totals for year	**83**	**93**			

A total of **122** episodes of AWOL for Quarters 1 & 2 which now exceeds the total number of AWOL for the year 2015/16.

For the category “Did not return from leave” the team on Mortimer Ward at the Stonebow Unit in Hereford have tested out, and now use “Leave Cards”. These are cards given to patients, along with a conversation on what the expectations of returning from leave are as agreed. For example, planned leave arrangements can be documented on the back of the credit card sized “leave card”, explicitly showing the time due to return and a prompt to contact the ward team if unable to return by the agreed time. The hospital/ward contact numbers are provided on the other side of the cards also.

This piece of work is part of the greater understanding around AWOLS that has developed through measurement and focus. Levels of harm from AWOLS have reduced over time although reported numbers of AWOLs have generally increased. From Quarter 3 we will start reporting on the levels of harm to detained patients as a consequence of their absconding.

There will be a continued focus on positive engagement within our inpatient services to try to reduce the number of occasions where detained patients abscond from the ward environment.

We have not met this target.

Target 3.3 To reduce the number of prone restraints by 5% year on year (on all adult wards & PICU)

This is a new target for 2016/17. During 2015/16, the Trust developed an action plan to reduce the use of restrictive interventions, in line with the 2 year strategy – Positive & Safe: developed from the guidance Positive and Proactive Care: reducing the need for restrictive interventions. This strategy offered clarity on what models and practice need to be undertaken to support sustainable reduction in harm and restrictive approaches, with guidance and leadership by the Trust Board and a nominated lead.

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

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

As use of prone restraint (face down) is sometimes necessary to manage and contain escalating violent behaviour, it is also the response most likely to cause harm to an individual. Therefore, we want to minimise the use of this wherever possible through effective engagement and occupation in the inpatient environment. All instances of prone restraint are recorded and this information was used to establish a baseline in 2015/16. Overall, there were **121** occasions when prone restraint was used in our acute adult wards and PICU and the breakdown of this information by month is shown in Figure 9 below.

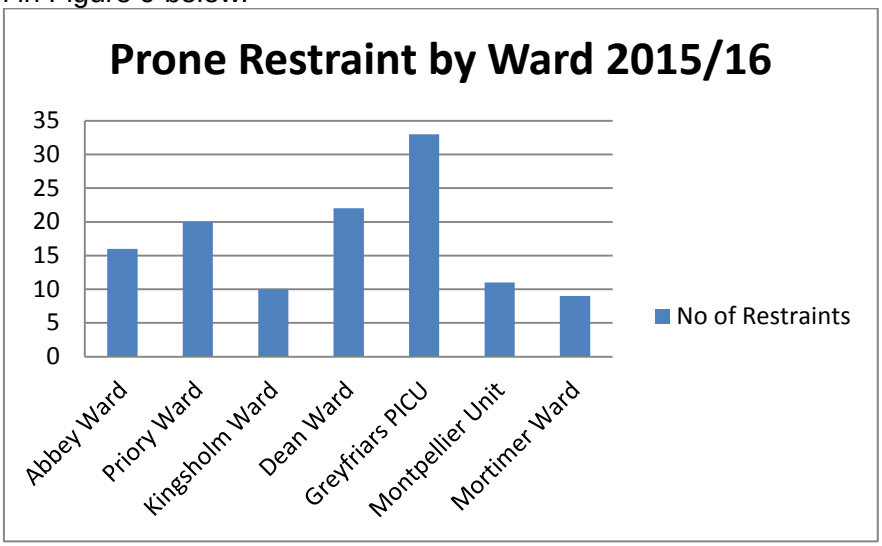


Figure 9

At the end of Quarter 2, **102** instances of prone restraint were used as seen in Figure 10 which is a significant increase.

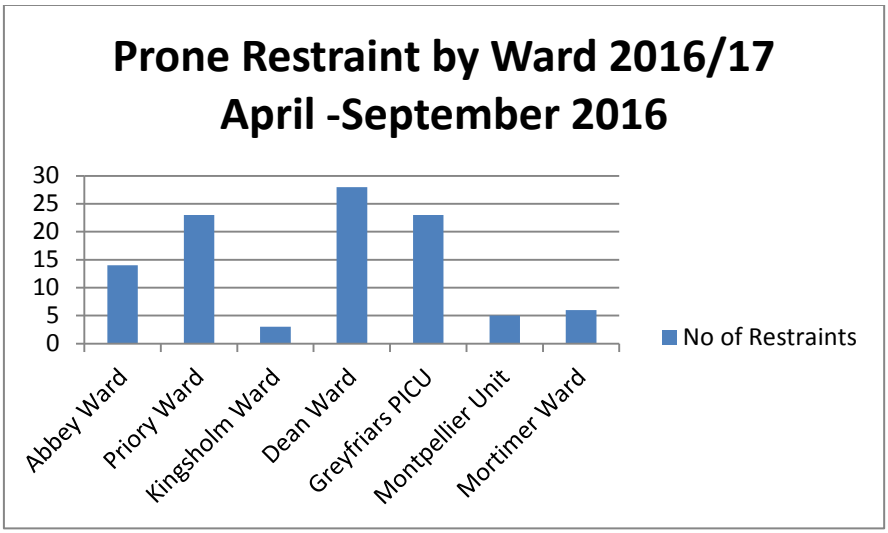


Figure 10

Analysis of the data has identified that not all of these incidents are, in fact, episodes of prone restraint, rather the application of precautionary holds for individuals who place themselves face down whilst holding items being used for the purpose of self-harm. These precautionary holds are fleeting and the person is released as soon as the item has been safely removed. A new category of "Precautionary/Non-Standard Hold" has, therefore, been added to DATIX and the wards advised of this. These episodes will be reviewed in detail and re-categorised where appropriate, so it is anticipated that these figures will change when next reported in Quarter 3.

In terms of further developments to minimise the use of prone restraint, injection sites for the purpose of rapid tranquillisation have been reviewed. Currently staff are trained to provide rapid tranquillisation intramuscularly via the gluteal muscles, this necessitates the patient being placed into the prone restraint position if they are resistant to the intervention. New training is in the process of being rolled out to all inpatient nursing and medical staff to be able to inject via the quadriceps muscles. This requires the patient to be placed in the supine position which poses less risk. When the workforce is in a position to implement this change, it is anticipated that we will see a corresponding reduction in the use of prone restraint.

Each year, the Trust engages in the NHS Mental Health Benchmarking exercise, which all English NHS Trusts who are providers of secondary mental health services participate in. This enables individual organisations to compare trends and benchmark themselves against the national data. Figure 11 below shows that the Trust reports incidences of prone restraint slightly above the national average.

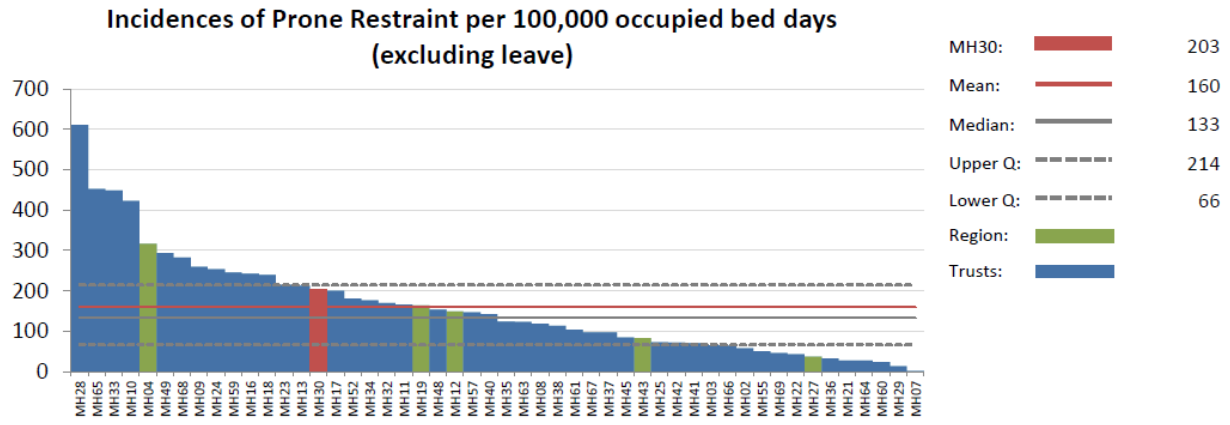


Figure 11

We are currently meeting this target as the total number remains below 121; however there is a high risk that the 5% reduction target may not be met at year end.

Target 3.4 95% of adults will be followed up by our services within 48 hours of discharge from psychiatric inpatient care

This is a local target and one which we first established as a quality target in 2012/13. The national target is that 95% of CPA service users receive follow up within 7 days[1].

Discharge from inpatient units to community settings can pose a time of increased risk of self-harm for service users. The National Confidential Inquiry into Suicides and Homicides[2] recommended that *'All discharged service users who have severe mental illness or a recent (less than three months) history of self-harm should be followed up within one week'*

One of the particular requirements for preventing suicide among people suffering severe mental illness is to ensure that follow up of those discharged from inpatient care is treated as a priority and that care plans include follow up on discharge. Although the national target for following up service users on CPA is within 7 days, in recognition that people may be at their most vulnerable within the first 48 hours, we aim to follow up 95% of people within these 2 days. This has been an organisational target for two years, and the cumulative figures for each year end are seen in the table below.

During 2015/16 we took the opportunity to review our practices and policies associated with both our 7 day and 48 hour follow up of patients discharged from our inpatient services. Whilst the adjustments we have undertaken have strengthened the patient safety aspects of our follow up contacts, introducing these changes have led to an impact on our in year performance, in comparison to our previous year's performance against these performance standards. In the case of our 48 hour local stretch target, our 2015/16 organisational performance fell to **90% (**Herefordshire services followed up **91%** (**25** breaches) of people discharged from inpatient care and Gloucestershire services have followed up **90%** (**83** breaches) which is below our stretch target.

We are confident that the practice changes we introduced have strengthened the patient safety aspects of this measure and that our performance in both our 7 day and 48 hour follow ups will ultimately return to being well above the national performance requirement and our local stretch target.

At the end of Quarter 2, Herefordshire services followed up **98%** (**2** breaches) of people discharged from inpatient care and Gloucestershire services followed up **96%** (**8** breaches). This gives an overall organisational compliance of **97%.** Each of these breaches will be reviewed to establish if there are any themes and trends, and the learning from this review will be used to promote practice.

	Target	2012-13	2013-14	2014-15	2015-16	2016-17 Q2
Gloucestershire Services	>95%	89%	95%	95%	90%	96%
Herefordshire Services	>95%	70%	95%	92%	91%	98%

We are currently meeting this target.

[1] Detailed requirements for quality reports 2014/15: Monitor, February 2015
[2] Five year report of National Confidential Inquiry into Suicide and Homicide by people with mental illness Department of Health – 2001

Serious Incidents reported during 2016/17

At the end of Quarter 2 2016/17, **22** serious incidents were reported by the Trust, and the types of incidents reported are seen in Figure 12.

Figure 13 overleaf shows a 6 year comparison of reported serious incidents. The most frequently reported serious incidents are “suspected suicide” and attempted suicide which is why we will continue into 2016/17 with a target to reduce suicide of people in contact with services. All serious incidents are investigated by a senior member of staff who has been trained in root cause analysis techniques. Wherever possible, we include service users and their families/carers in this process to ensure their perspective is taken into account, and we provide feedback to them on conclusion of an investigation. We also share copies of our trust investigation reports regarding “suspected suicides” with the Coroners in both Herefordshire and Gloucestershire to assist with the Coronial investigations.

There have been no Department of Health defined “Never Events” within the Trust during 2016/17. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

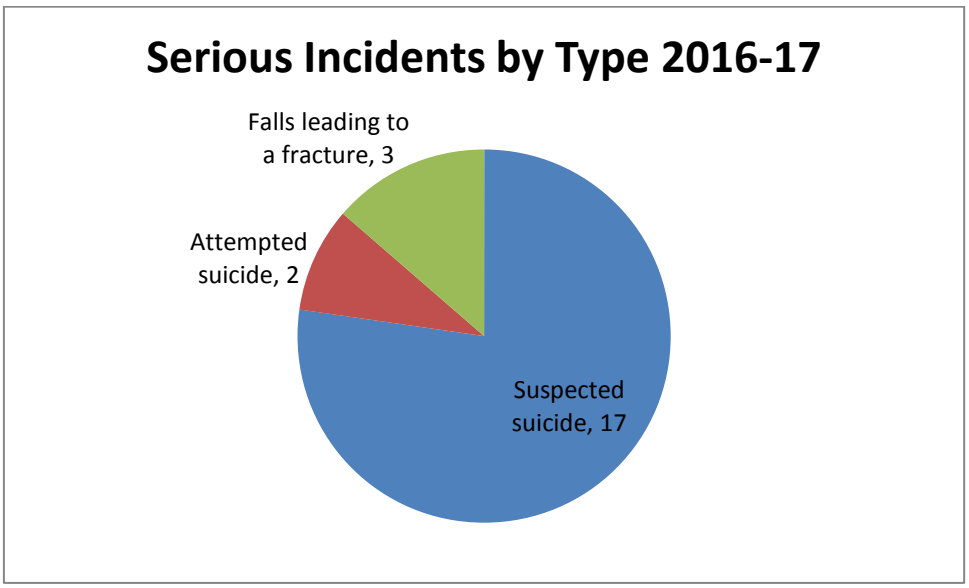


Figure 12

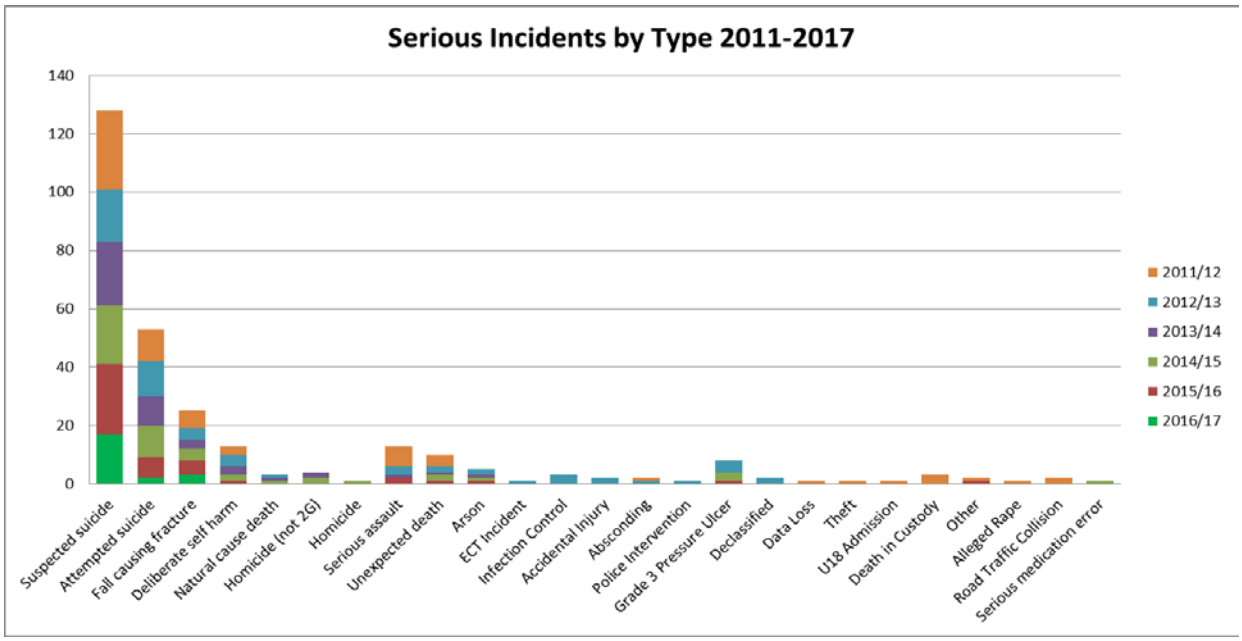


Figure 13

Duty of Candour

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

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

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

During the CQC comprehensive inspection of our services, they reviewed how the Duty of Candour was being implemented in across the Trust and provided the following comments in their report dated 27 January 2016.

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

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

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

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

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

Indicators & Thresholds for 2016/2017

The following table shows the 10 metrics that were monitored during 2016/17. These are the indicators and thresholds from NHS Improvement (NHSI) and follow the standard Department of Health national definitions. Note that some are also the Trust Quality targets, and some may have more stretching targets than Monitor require as a threshold.

		2013-2014 Actual	2014-2015 Actual	2015-2016 Actual	National Threshold	2016-2017 YTD
1	Clostridium Difficile objective	1	3	0	0	**2**
2	MRSA bacteraemia objective	0	0	0	0	**0**
3	7 day CPA follow-up after discharge	99.1%	97.73%	95.63%	95%	**97.32%**
4	CPA formal review within 12 months	96.4%	97.1%	99.35%	95%	**99.03%**
5	Delayed transfer of care	0.12%	0.06%	1.02%	≤7.5%	**1.80%**
6	Admissions gate kept by Crisis resolution/home treatment services	99.1%	99.57%	99.74%	95%	**99.30%**
7	Serving new psychosis cases by early intervention teams	100%	100%	63.56%	50%	**69.57%**
8	MHMDS data completeness: identifiers	99.7%	99.71%	99.57%	97%	**99.85%**
9	MHMDS data completeness: CPA outcomes	80.6%	97.06%	97.42%	50%	**97.60%**
10	Learning Disability – six criteria	6	6	6	6	**6**

Mandated Quality Indicators 2016 -2017

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

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

	Quarter 1 2015-16	Quarter 2 2015-16	Quarter 3 2015-16	Quarter 4 2015-16	Quarter 1* 2015-16

[2]gether NHS Foundation Trust	98.4%	97%	97.2%	98.10%	97.1%
National Average	97%	96.8%	96.9%	97.2%	96.2%
Lowest Trust	88.8%	83.4%	50%	80%	28.6%
Highest Trust	100%	100%	100%	100%	100%

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

- During 2015/16 we have taken the opportunity to review our practices and policies associated with both our 7 day and 48 hour follow up of patients discharged from our inpatient services. Whilst the adjustments we have undertaken have strengthened the patient safety aspects of our follow up contacts, introducing these changes have led to an impact on our in year performance, in comparison to our previous year's performance against these performance standards. Our 7 day performance has fallen to just over 95% in Gloucestershire and just over 96% in Herefordshire which are lower than our previous year's performance, but still above the national performance requirement of 95 %. We are confident that the practice changes we have introduced have strengthened the patient safety aspects of this measure and that our future years performance in both our 7 day and 48 hour follow ups will return to being well above the national performance requirement and our local stretch target as in previous years.

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

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

* Activity published on NHS England website via the NHS IC Portal is revised throughout the year following data quality checks. Activity shown for Quarter 1 2016/17 has not yet been revised and may change, Quarter 2 2016/17 activity is not yet available.

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

	Quarter 1 2015-16	Quarter 2 2015-16	Quarter 3 2015-16	Quarter 4 2015-16	Quarter 1* 2016-17
[2]gether NHS Foundation Trust	99.5%	98.6%	100%	98.4%	98.9%
National Average	96.3%	97%	97.5%	98.2%	98.1%
Lowest Trust	18.3%	48.5%	61.9%	84.3%	78.9%
Highest Trust	100%	100%	100%	100%	100%

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

- Staff respond to individual service user need and help to support them at home wherever possible unless admission is clearly indicated;
- During 2015/16, crisis teams also gate kept admissions to older people's services beds within Gloucestershire.

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

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

* Activity published on NHS England website via the NHS IC Portal is revised throughout the year following data quality checks. Activity shown for Quarter 1 2016/17 has not yet been revised and may change, Quarter 2 2016/17 activity is not yet available.

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

	Quarter 2 2015-16	Quarter 3 2015-16	Quarter 4 2015-16	Quarter 1 2016-17	Quarter 2 2016-17
[2]gether NHS Foundation Trust 0-15	0%	0%	0%	0%	0%
[2]gether NHS Foundation Trust 16 +	7%	10%	6%	7%	6%
National Average	Not available	Not available	Not available	Not available	Not available
Lowest Trust	Not available	Not available	Not available	Not available	Not available
Highest Trust	Not available	Not available	Not available	Not available	Not available

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

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

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

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

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

	NHS Staff Survey 2012	NHS Staff Survey 2013	NHS Staff Survey 2014	NHS Staff Survey 2015
[2]gether NHS Foundation Trust Score	3.19	3.46	3.61	3.75
National Median Score	3.54	3.55	3.57	3.63
Lowest Trust Score	3.06	3.01	3.01	3.11
Highest Trust Score	4.06	4.04	4.15	4.04

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

- The National Staff Survey does not report directly on this question but does report on 'Staff recommendation of the trust as a place to work or receive treatment'. This key finding is derived from the responses to three linked questions relating to care of patients, recommending the organization as a place to work and being happy with the standard of care provided by the organisation. The response to the component questions was more positive in 2015 than in the previous three surveys indicating increasing satisfaction with the trust as a place to receive treatment and to work as perceived by staff. The 2015 survey also shows the trust score continues to move ahead of the median score for other like-type trusts;
- The National Staff Survey results continues to be complemented by the introduction of the Staff Friends and Family Test that has now been in operation since April 2014 giving staff the opportunity to voice their opinion on the trust as an employer and provider of care, confidentially in three questionnaires during the year. In the most recent survey held in March 2016, 85% of respondents said they would be likely or extremely likely to recommend the trust to friends and family as a place to receive care or treatment;
- The staff survey showed an increase in the percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver;
- Staff have reported an increase in the level of motivation at work. Whilst the improved level of staff satisfaction is encouraging, the trust is very careful to also take note of feedback from colleagues who are less satisfied and where possible to address these concerns.

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

- Administering the National Staff Survey entirely online in 2015 in response to staff feedback;
- Publicizing the Staff Friends and Family Test results widely in each quarter (excluding Quarter 3 which corresponds with the National Staff Survey). This has continued to prove to be a popular medium for staff to feedback how they perceive the trust as an employer and provider of care. Close monitoring of feedback from these regular surveys highlight areas where not only improvements can be made but also to celebrate success;
- Using the Trust's intranet, known as [2]getherNet to provide a more accessible resource for staff. This is the main method of communication throughout the Trust and development continues with feedback from staff. Work is continuing to ensure easy access to information relating to support available for the health and wellbeing of staff and of a range of benefits available locally for colleagues;
- Increasing the visibility of senior managers including a regular programme of site visits by Executive and Non-Executive Directors.

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

	NHS Community Mental Health Survey 2012	NHS Community Mental Health Survey 2013	NHS Community Mental Health Survey 2014	NHS Community Mental Health Survey 2015
[2]gether NHS Foundation Trust Score	8.4	8.7	8.2	7.9
National Average Score	Not available	Not available	Not available	Not available
Lowest Score	8.2	8.0	7.3	6.8
Highest Score	9.1	9.0	8.4	8.2

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

- The survey results for this set of questions are broadly similar to the previous three years when compared with the national scores. In fact, in relation to previous years, [2]gether's scores are nearer the higher scores nationally. There is still work to do to enhance service experience and some of the actions being taken are reflected in the points below.

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

- Ensuring that people are involved in the development and review of their plan of care including decisions about their medication
- Understanding people's individual interests and circumstances beyond health care.
- Signposting and supporting individuals to other agencies for social engagement
- Ensuring that service users are provided with information about who can be contacted out of office hours should they need support in a crisis.
- Providing information about getting support from people who have experience of similar mental health needs.

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

	1 April 2015 – 30 September 2015				1 October 2015 – 31 March 2016			
	Number	Rate*	Severe	Death	Number	Rate*	Severe	Death
[2]gether NHS Foundation Trust	1,464	39.61	1	6	1,371	39.01	1	5
National	144,850	-	492	992	146,325	-	501	1167
Lowest Trust	8	6.46	0	0	25	14.01	0	0
Highest Trust	6,723	83.72	74	95	5,572	85.06	51	91

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

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

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

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

- Re-auditing its Incident Reporting Systems (DATIX) to improve the processes in place for the timely review, approval of, and response to reported patient safety incidents.
- Appointing a Datix Systems Manager, upgrading the Trust's DATIX system and making the Incident Reporting Form more "user friendly";
- Setting up a DATIX User Group.

Community Survey 2016

This will be added following publication of the survey.

Staff Survey 2015

This will be added following publication of the results.

Annex 1: Statements from our partners on the Quality Report

These will be provided at year end.

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

This will be completed at year end.

Annex 3: Glossary

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

	Parliament.
MRSA	Methicillin-resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans. It is also called multidrug-resistant
NHS	The National Health Service refers to one or more of the four publicly funded healthcare systems within the United Kingdom. The systems are primarily funded through general taxation rather than requiring private insurance payments. The services provide a comprehensive range of health services, the vast majority of which are free at the point of use for residents of the United Kingdom.
NICE	The National Institute for Health and Care Excellence (previously National Institute for Health and Clinical Excellence) is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health.
NIHR	The National Institute for Health Research supports a health research system in which the NHS supports outstanding individuals, working in world class facilities, conducting leading edge research focused on the needs of patients and the public.
NPSA	The National Patient Safety Agency is a body that leads and contributes to improved, safe patient care by informing, supporting and influencing the health sector.
PBM	Positive Behaviour Management
PHSO	Parliamentary Health Service Ombudsman
PICU	Psychiatric Intensive Care Unit
PLACE	Patient-Led Assessments of the Care Environment
PROM	Patient Reported Outcome Measures (PROMs) assess the quality of care delivered to NHS patients from the patient perspective.
PMVA	Prevention and Management of Violence and Aggression
RiO	This is the name of the electronic system for recording service user care notes and related information within ^{2}gether NHS Foundation Trust.
ROMs	Routine Outcome Monitoring (ROMs)
SIRI	Serious Incident Requiring Investigation, previously known as a “Serious Untoward Incident”. A serious incident is essentially an incident that occurred resulting in serious harm, avoidable death, abuse or serious damage to the reputation of the trust or NHS. In the context of the Quality Report, we use the standard definition of a Serious Incident given by the NPSA
SMI	Serious mental illness
VTE	Venous thromboembolism is a potentially fatal condition caused when a

blood clot (thrombus) forms in a vein. In certain circumstances it is known as Deep Vein Thrombosis.

Annex 4: How to Contact Us

About this report

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

Mr Shaun Clee
Chief Executive Officer
2gether NHS Foundation Trust
Rikenel
Montpellier
Gloucester
GL1 1LY

Or email him at: shaun.clee@nhs.net

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

Other Comments, Concerns, Complaints and Compliments

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

You can give us feedback about our services by:

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

Alternative Formats

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

Agenda item **9** **Enclosure** **Paper D**

Report to: Trust Board, 24 November 2016
Author: Angie Fletcher, Interim Service Experience Clinical Manager
Presented by: Jane Melton, Director of Engagement and Integration

SUBJECT: **SERVICE EXPERIENCE REPORT – Quarter 2**

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

EXECUTIVE SUMMARY

(1) Assurance

This Service Experience Report provides a high level overview of feedback received from service users and carers in Quarter 2 2016/2017. Learning from people's experiences is the key purpose of this paper which provides assurance that service experience information has been reviewed, scrutinised for themes and considered for both individual team and general learning across the organisation.

Significant assurance that the organisation has listened to, heard and understood Service User and carer experience of 2gether's services.

This assurance is offered from a triangulation of information gathered across all domains of feedback including complaints, concerns, comments and compliments. Survey information has also been triangulated to understand service experience.

Significant assurance that service users value the service being offered and would recommend it to others.

During quarter 2, 90% of people who completed the Friends and Family Test said that they would recommend 2gether's services. The Trust continues to maintain a high percentage of people who would recommend our services.

Limited assurance that people are participating in the local survey of quality in sufficient numbers.

A review is in process to raise the profile of the Local Survey amongst staff. The review will explore additional ways of presenting, distributing and collecting this information.

Limited assurance that services are consistently reporting details of compliments they have received.

The Service Experience Department are working with services to raise the profile of compliment reporting throughout the trust. A dedicated email address has now been set up in order to ease the process for staff to report compliments that they have received.

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

Full Assurance that complaints have been acknowledged in required timescale
During quarter 2 100% of complaints received were acknowledged within 3 days.

Limited assurance that all people who complain have their complaint dealt with by the initially agreed timescale.

41% of complaints were closed within timescales agreed with the complainant. The contributory factors to this delay have been identified. The Service Experience Department are working with Service Directors to create systems to ensure investigations are completed within the agreed timescales.

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

(2) Learning and Improvement recommended

The Trust continues to seek feedback about service experience from multiple sources on a continuous basis.

This quarter there have been concerns raised by Service Users regarding the informal submission of documents by our staff to legal proceedings. A Trust policy is being developed to guide staff and this will be cascaded throughout the organisation once ratified.

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

- We must communicate clearly with carers and families. We should write down what we talk about with them.
- People are unhappy that we did not do the things we said we would do. We should keep our promises or explain why we can't.

An update on Parliamentary and Health Service Ombudsman activity is included within this report.

RECOMMENDATIONS

The Board is asked to note the contents of this report.

Corporate Considerations	
Quality implications:	Patient and carer experience is a key component of the delivery of best quality of care. The report aims to outline what is known about service experience of 2gether's services in Q2 2016/17 and to make key recommendations for action to enhance quality.
Resource implications:	A service experience report offers assurance to the Trust that resources are being used to support best service experience.
Equalities implications:	The Service Experience Report offers assurance that the Trust is attending to its responsibilities regarding equalities for service users and carers.
Risk implications:	Feedback from service experience offers an insight into how services are received. The information provides a mechanism for identifying performance, reputational and clinical risks.

WHICH TRUST VALUESIVES DOES THIS PAPER PROGRESS OR CHALLENGE?			
Supporting clinical care	P	Skilled workforce	P
Getting the basics right	P	Using better information	P
Social inclusion	P	Financial efficiency	P
Seeking involvement	P	Legislation	P

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

Reviewed by:		
Director of Engagement and Integration	Date	16 November 2016

Where in the Trust has this been discussed before?		
Governance Committee	Date	18 November 2016

What consultation has there been?		
Service Experience Committee members	Date	October 2016

Explanation of acronyms used:	NHS – National Health Service HW – Healthwatch PALS – Patient Advise and Liaison Service GP – General Practitioner MP – Member of Parliament OPS – Older Peoples Service LD – Learning Disabilities CYPS – Children and Young People's Service GRIP – Gloucestershire Recovery in Psychosis Team MHA- Mental Health Act GHNHSFT – Gloucestershire Hospitals NHS Foundation Trust CCG – Clinical Commissioning Group BME – Black and Minority Ethnic Groups

	IAPT – Improving Access to Psychological Therapies PHSO – Parliamentary Health Services Ombudsman CAMHS – Child and Adolescent Mental Health Service CRHTT – Crisis Resolution and Home Treatment Team

2gether
Making life better

2gether
NHS Foundation Trust

Service Experience Report

Quarter 2

1st July 2016 – 30th September 2016

"Thank you ever so much for clearing my clouded head. I know what I need to do to be able to look the people who I care about most in the world."

Dean Ward, Wotton Lawn, Gloucestershire

"The Stonebow Unit was vastly different and soon put the plan into action, which is where you came in. Your enthusiasm and genuine efforts to help me establish a comfortable home have made me feel that someone thinks I'm worth the effort and all thoughts of suicide have gone."

Stonebow, Herefordshire

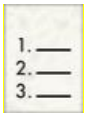
Contents

Key

NHS	National Health Service
HW	HealthWatch
PALS	Patient Advice and Liaison Service
GP	General Practitioner
MP	Member of Parliament
OPS	Older People's Service
LD	Learning Disabilities
CYPS	Children and Young People Service
GRIP	Gloucestershire Recovery in Psychosis
HR	Human Resources
CDW	Community Development Worker
CEO	Chief Executive Officer
BME	Black and Minority Ethnic Groups
IAPT	Improving access to psychological therapies
PHSO	Parliamentary and Health Service Ombudsman
CBT	Cognitive Behavioural Therapy
DMHOP	Department of Mental Health for Older People
CAMHS	Child and Adolescent Mental Health Service
CRHTT	Crisis Resolution and Home Treatment Team
MHA	Mental Health Act
MCA	Mental Capacity Act
CCG	Clinical Commissioning Group
GHNHSFT	Gloucestershire Hospitals NHS Foundation Trust
Q1	Quarter 1 (previous quarter)
FFT	Friends and Family Test (survey)

Service Experience Report – Quarter 2

1st July 2016 – 30th September 2016

Complaints 	**28** complaints (194 separate issues) were made this quarter. This is nearly the same as last time (n=27).	↔
Concerns 	**48** concerns were raised through PALS. This is less than last time (n=57). We encourage people to tell us about any concerns about their care. This means we can make it better.	↓
Compliment 	**389** people told us they were pleased with our service. This is a lower number than last time (n=533). We will ask teams to tell us about every compliment they get.	↓
FFT 	**90%** people said they would recommend our service to their family or friends. This is nearly the same as last time (94%).	↔
Local Survey 	Gloucestershire: **79 people told us what they thought** Herefordshire: **42 people told us what they thought** Lots more people told us what they thought compared to last time. We still need to ask more people to tell us what they think.	↑
We must listen 	We must communicate clearly with carers and families. We should write down what we talk about with them.	
We must listen 	People are unhappy that we did not do the things we said we would do. We should keep our promises or explain why we can't.	

Key

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

Section 1 – Introduction

1.1 Overview of the paper

1.1.1 This paper provides an overview of people's reported experience of ²gether NHS Foundation Trust's services between **1st July 2016 and 30th September 2016**. It provides examples of the learning that has been achieved through service experience reporting, and an update on activity to enhance service experience.

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

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

- A synthesis of service experience reported to ²gether NHS Trust (complaints, concerns, comments, compliments)
- Patient Advice and Liaison Service (PALS)
- Narrative reports made by members of the Service Experience Committee
- Meetings with stakeholders
- ²gether meetings with patients in the ward environment
- ²gether local patient surveys
- National Friends and Family Test (FFT) responses
- ²gether Carer focus groups
- HealthWatch Gloucestershire reports and engagement events
- HealthWatch Herefordshire reports and engagement events

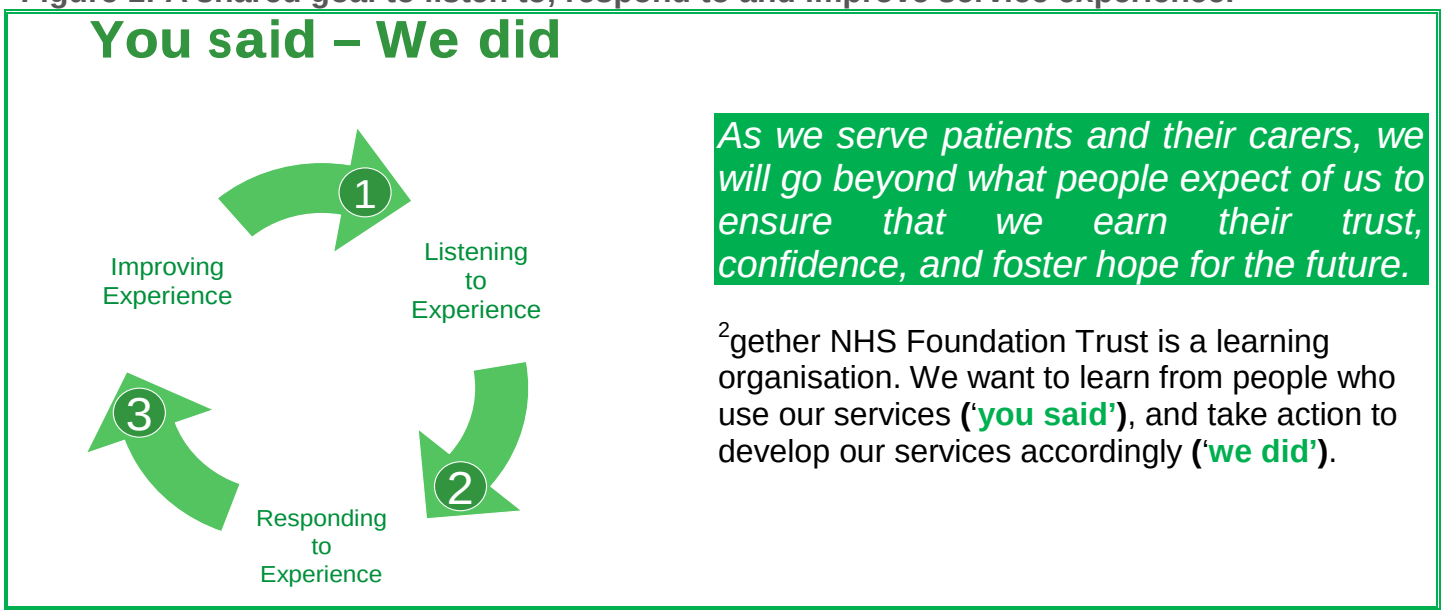
1.1.4 **Section 3** provides examples of the learning that has been gleaned through service experience reporting and subsequent action planning.

1.2 Strategic Context

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

1.2.2 [2]gether NHS Trust's Service User Charter, Carer Charter and Staff Charter outline the commitment to delivering our values and this is supported by active implementation of [2]gether's Service Experience Strategy (2013). The Service Experience Strategy will be reviewed and updated during 2016/17 in collaboration with our stakeholders.

Figure 1: A shared goal to listen to, respond to and improve service experience.



1.2.3 **The overarching vision for service experience is that:**

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

Through a continuous cycle of learning from experience we will provide the best quality service experience and care.

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

Section 2 – Emerging Themes about Service Experience

2.1 Complaints

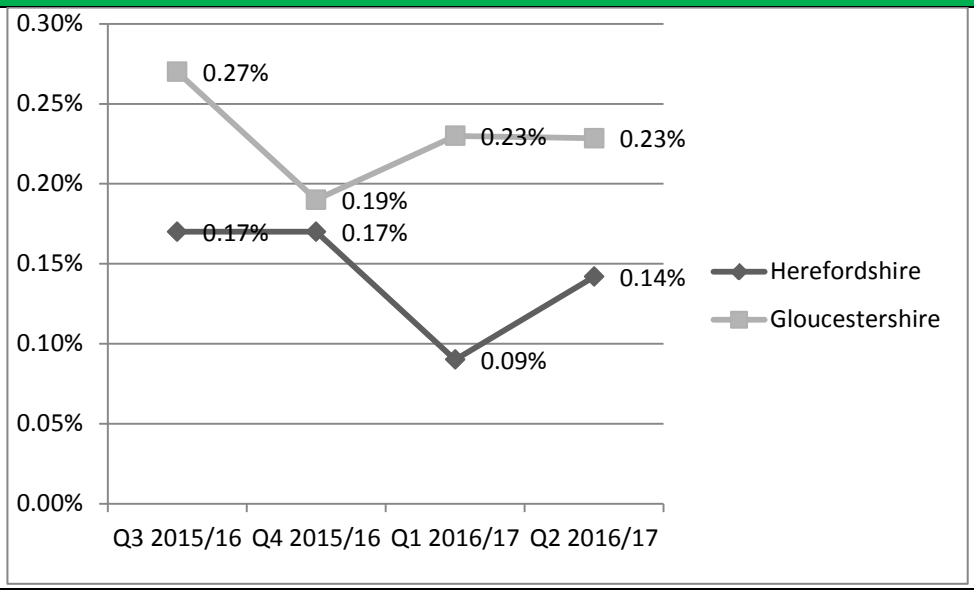
Formal complaints to NHS service providers are highly governed and responses must follow specific procedures (for more information, please see the Trust's Complaints Policy). Complaints are welcomed by the Trust. We value feedback from service users and those close to them relating to the services they receive as this enables us to make services even more responsive and supportive.

Table 1: Number of complaints received this quarter

County	Number (numerical direction)		Interpretation	Assurance
Gloucestershire	23	⇔	A similar number of complaints has been reported in Gloucestershire in both Quarters 1 and 2.(Q1 n=24)	Significant
Herefordshire	5	⇔	A similar number of complaints has been reported in Herefordshire in both Quarters 1 and 2 (Q1 n=6)	Significant
Total	28	⇔	The total number of complaints received is similar to the previous quarter (Q1 n=27) and the same as the same period in 2015/16 (n=28)	Significant

The number of individual complaints has remained stable for the first two quarters of this year. An emerging theme is that the number of individual complaints has reduced over the first 6 months of this year; however the number of issues within each complaint has increased. This means we are seeing an increase in both the depth and breadth of individual complaints leading to wider and more complex investigations

Table 2: Number of complaints by population seen

County	Contacts*	Chart showing percentage of complaints to contacts over the past year
Gloucestershire	10,067	
Herefordshire	3,525	

**this does not include primary care contacts*

The proportion of complaints to contacts remains relatively consistent.

Table 3: Number of complaints closed this quarter

County	Number (Numerical direction)		Interpretation	Assurance
Gloucestershire	22		The number of complaints closed for Gloucestershire is lower than last quarter (Q1 n=27)	Significant
Herefordshire	5		The number of complaints closed for Herefordshire is similar to the last quarter (Q1 n=6)	Significant
Total	27		The overall number of complaints closed is lower than last quarter (Q1 n=33)	Significant

The reduction in the closure rate reflects the reduction in the number of complaints received in Quarter 1.

Table 4: Responsiveness

Target	Number (numerical direction)		Interpretation	Assurance
Acknowledged with three days	100%		**All** complaints were acknowledged within target timeframes	Full
Complaint closed within agreed timescales	41%		This is much lower than last quarter (Q1 = 74%) and is predominantly due to delays in the investigation process (88%)	Limited
Concerns escalated to complaint	13%		Of 48 concerns received (Q1 = 57), 6 were not resolved and so were escalated this is a similar number to Quarter 1. (Q1= 12%).	Significant

The Service Experience Department have continued to acknowledge all complaints within the national standards for response times.

The rate of complaints closed within the agreed timescale has decreased significantly. The main contributory factor for this delay can be found within the investigation process. Difficulties have been found in allocating an investigator, investigators having no protected time to complete investigations and the increasing complexity of individual complaints meaning investigations are taking longer. Work has been undertaken with service leads to establish systems for the allocation of investigators. The Service Experience Department have increased the availability of training sessions for complaint investigators and have adopted a new approach to support and coach investigators throughout the process.

A further contributory factor was found to be in the final review process – a system has now been implemented to ensure a final review of complaint responses is available every week via the Chief Executive's office.

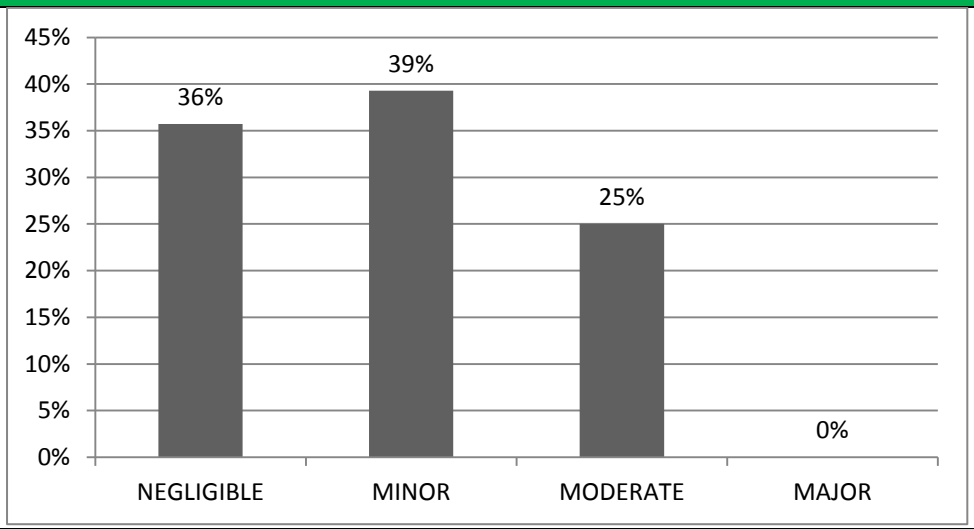
The continued implementation of a triage process at the point of initial contact with complainants has resulted in achieving more local resolutions to issues raised. This has resulted in a timely and less formal response to the issues raised. The relatively low number of concerns being escalated to complaints suggests that people are largely satisfied with this approach.

Table 5: Satisfaction with complaint process

Measure	Number (numerical direction)		Interpretation	Assurance
Reopened complaints	4	⇔	This figure is the same as the previous quarter (Q1 n=4) suggesting continued satisfaction with the complaint process in most cases.	**Significant**
Local Resolution Meetings	5	⇓	This figure is similar to that reported in the previous quarter (Q1 n=6) suggesting continued satisfaction with the complaint process in most cases.	**Significant**
Referrals to PHSO	2	⇑	Two new complaints have been referred to the PHSO this quarter. The PHSO have not confirmed if they are going to undertake a review of these two complaints at present. (Q1 n=1).	**Limited**

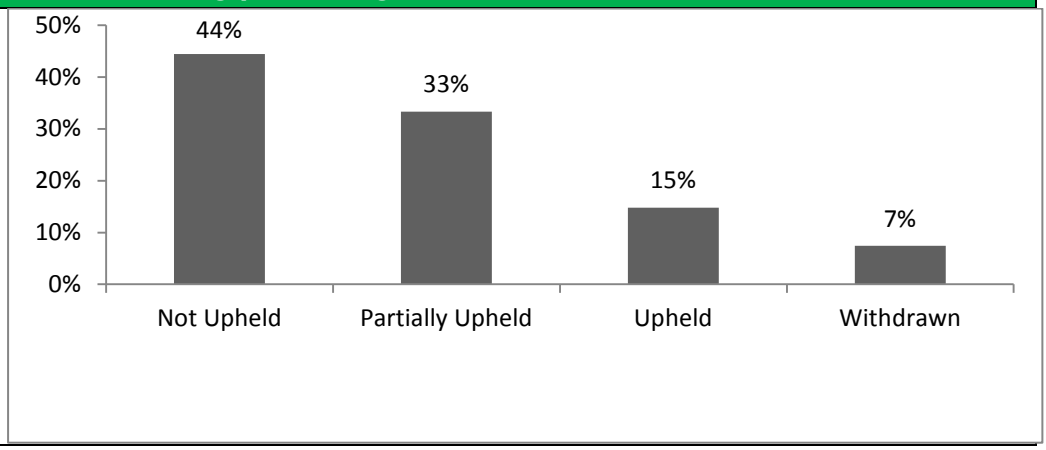
Following a reduction in Quarter 1 of the above satisfaction indicators, the continued stability in Quarter 2 provides some indication and assurance of general satisfaction, in most cases, with the concerns and complaints processes.

Table 6: Risk rating of complaints received this quarter

Rating	No.	Chart showing percentages
Negligible *Minimal impact on individual or organisation*	10	
Minor *Minor implications, reduced performance, single failure*	11	
Moderate *Significantly reduced effectiveness, failure to meet internal standards*	6	
Major *Complaint regarding serious harm or death*	0	

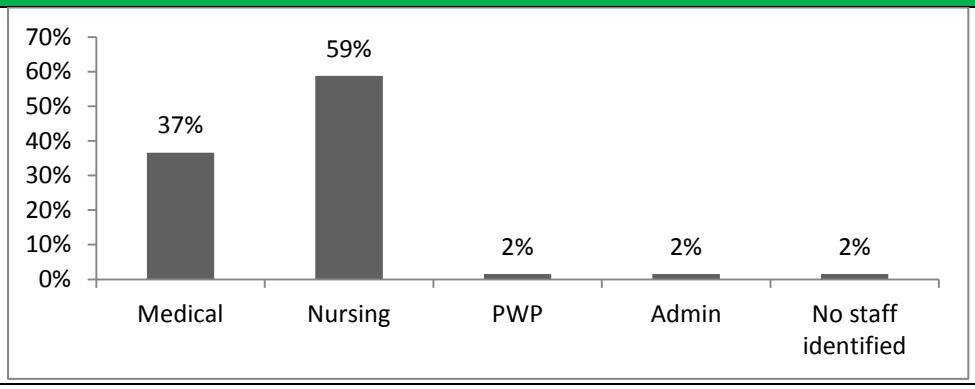
75% of the complaints received were classified as negligible or minor in terms of their impact on the individual or the organisation. This is similar to last quarter (Q1 = 78%) All complaints are regarded as important for individuals and resolution is a key aim.

Table 7: Outcome of complaints closed this quarter

Outcome	No.	Chart showing percentages
Not upheld *No element of the complaint was upheld*	12	
Partially upheld *Some elements of the complaint were upheld*	9	
Upheld *All elements of the complaint were upheld*	4	
Withdrawn *Complaint was withdrawn*	2	

48% of the complaints closed this quarter had their concerns upheld or partially upheld. This is lower than the previous quarter (55% partially upheld, 6% upheld).

Table 8: Breakdown of complaints by staff group for this quarter

Outcome	No.*	Chart showing percentages
Medical	71	
Nursing	114	
PWP (Psychological Wellbeing Practitioners)	3	
Admin	3	
No staff identified	3	

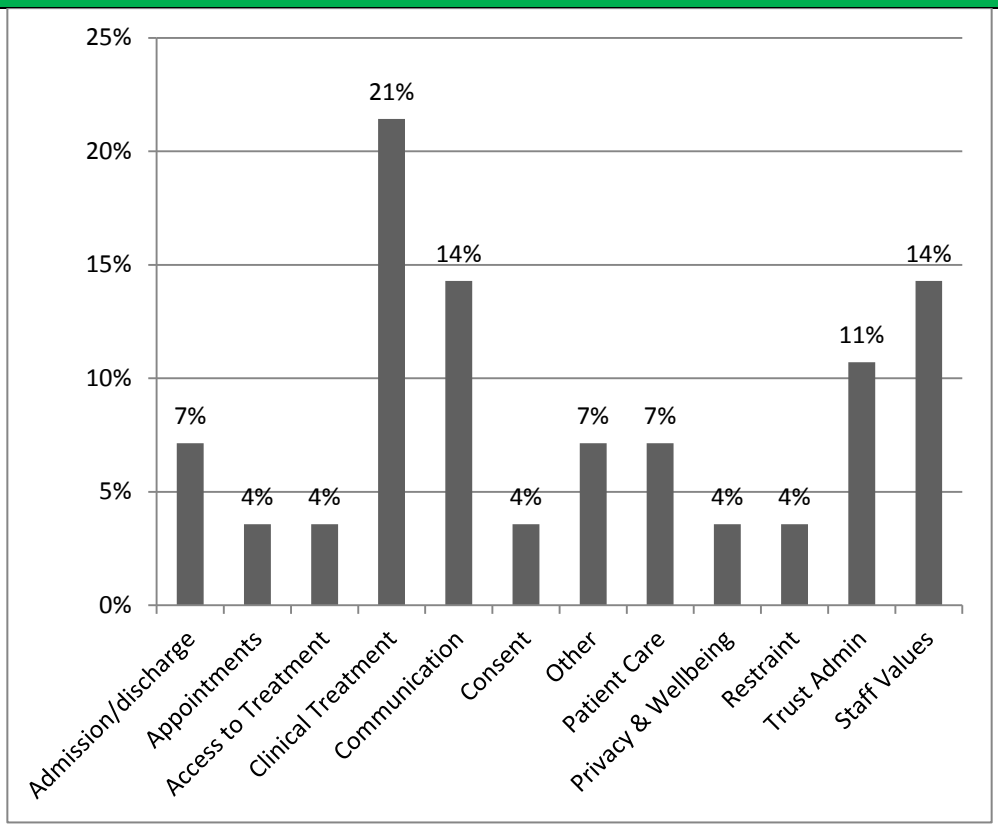
**The numbers represented in these data relate to a breakdown of individual complaint issues and relate to different staff groups.*

The number of complaint issues involving different disciplines and staff groups has been recorded for NHS Digital (previously known as Health and Social Care Information Centre (HSCIC) this year. It has been possible to categorise the complaint issues by staff group and these data are presented in the table above.

Nursing represents the largest staff group in the Trust and has the greatest number of contacts. Work is underway to ensure that professional leads are made aware of any themes relating to their professional group.

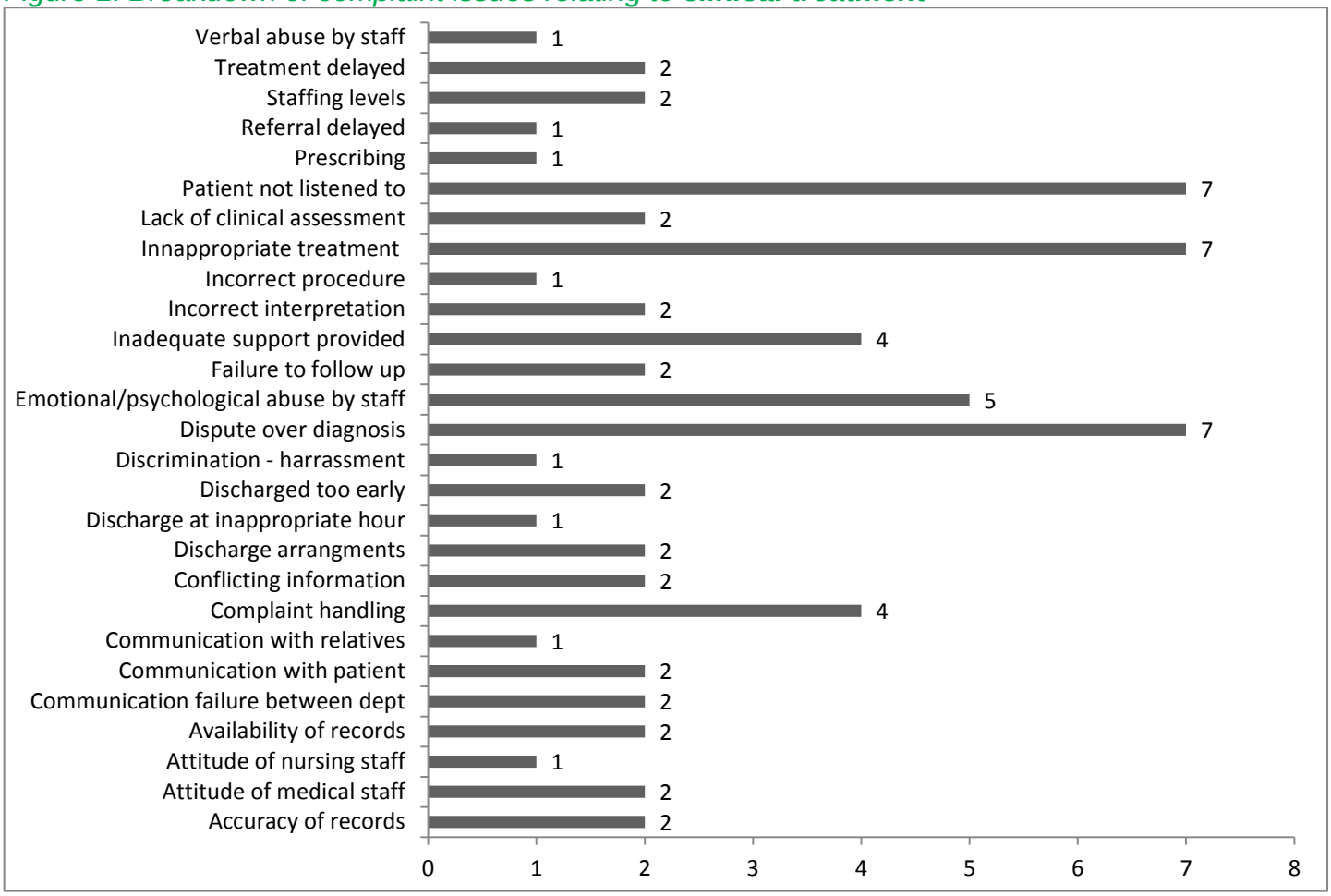
Table 9: Overarching complaint themes this quarter

Theme	No.	Chart showing percentages
Admission/discharge *Community or inpatient*	2	
Appointments *e.g. cancelled, staff DNA*	1	
Access to treatment *Treatment or medication*	1	
Clinical treatment *e.g. diagnosis, medication*	**6**	
Communication *Internal and external*	**4**	
Consent *e.g. to treatment, or sharing*	1	
Patient Care *e.g. observation, support*	2	
Privacy, Wellbeing *e.g. confidentiality, noise*	1	
Restraint *All aspects of PMVA*	1	
Trust Admin *e.g. Health Records, MHA*	3	
Staff Values *Attitude and action*	**4**	
Other *Any other issue*	2	



The main complaint themes are ***clinical treatment, communication*** and ***staff values***. These themes have been broken down into more detail in the chart below:

*Figure 1: Breakdown of complaint issues relating to **clinical treatment***



The Trust takes all issues detailed within individual complaints very seriously. The issues reflected in the table on the previous page are subject to ongoing investigation and conclusions have not yet been reached in relation to outcomes.

*Figure 2: Breakdown of complaint issues relating to **communication***

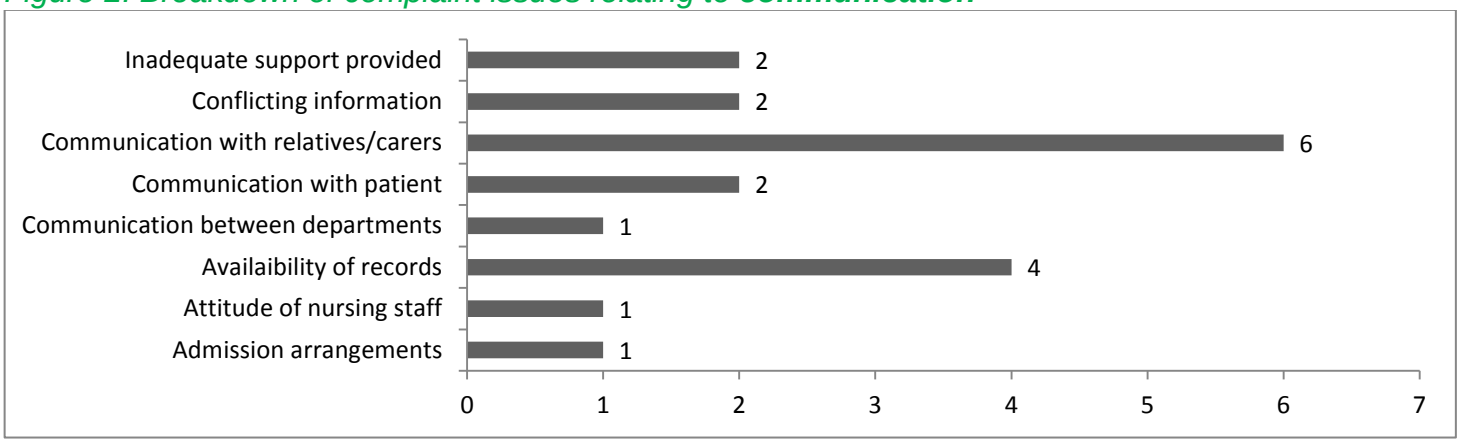
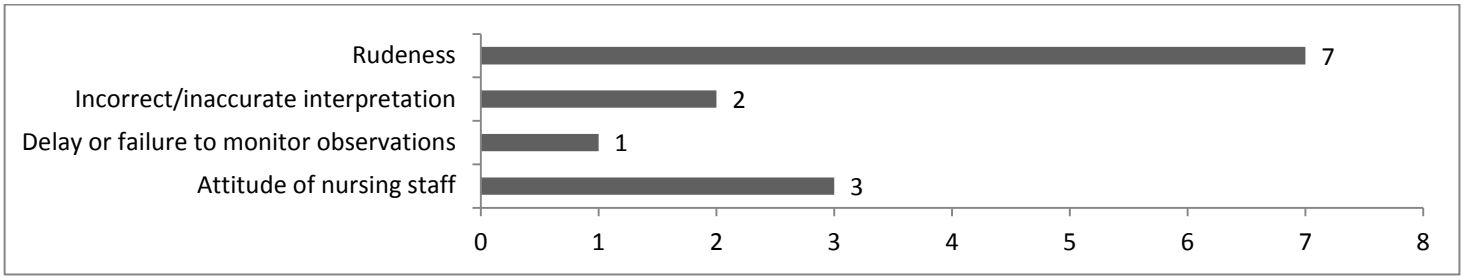


*Figure 3: Breakdown of complaint issues relating to **staff values***



Analysis of data is undertaken by the Service Experience Department in order to identify any patterns of clinical concern e.g. similar issues being raised regarding the same service or practitioner. No such themes have been identified within the above data. However, seven people report that they do not feel listened to and this is particularly important. The Time to Change Mental Health Practitioners work underway aims to address this. An additional 6 people identify communication with relatives/carers as an issue. The implementation of the Triangle of Care is a key project across the Trust and it highlights to colleagues the importance of involving families whenever possible.

Table 10: Examples of complaints and action taken

Example	You said	We did
Communication	You made five separate requests for a face to face or telephone conversation with a clinician about your relative over a two week period before somebody responded.	We apologised for the breakdown in communication. We explained why there was a delay in responding to you. We assured you it was not intentional but an error in internal processes.
Clinical Treatment	A planned admission to hospital was delayed. Your relative experienced a rapid deterioration in mental state and required an admission to hospital under the Mental Health Act.	We apologised and assured you that we constantly review our bed management processes and will continue to do so in relation to planned admissions.
Staff values	You told us you were unhappy that we did not listen to a recording you had made of a meeting with a member of our staff.	We apologised and informed you at this time the Trust did not have a policy in place regarding recording meetings. We assured you that in response to your experience and national guidance the trust is currently in the process of developing a policy to address the issue of recording.

2.2 Concerns

The Service Experience Department endeavour to be responsive to feedback and to resolve concerns with people at the point they are raised. This has resulted in complaint numbers being maintained at a lower level this quarter and a corresponding increase in the number of concerns over the first two quarters of this year.

DatixWeb, a complaints and concerns recording and reporting system, has continued to be used for Quarter 2. The information gathered allows greater data interrogation and improved opportunities for learning from feedback. Themes and trends have been analysed for Quarter 2 and are reflected in the charts below.

Table 11: Number of concerns received this quarter

County	Number (numerical direction)		Interpretation	Assurance
Gloucestershire	35	↓	There has been a decrease in the number of Gloucestershire concerns (Q1 n=47)	**Limited**
Herefordshire	10	↔	There were the same number of Herefordshire concerns (n=10)	**Significant**
Corporate	3	↑	There has been an increase in the number of Corporate concerns (Q1 n=0)	**Significant**
Total	48	↓	The overall number of concerns received has decreased (n=57)	**Limited**

Three concerns were raised this quarter relating to the Trust's Corporate directorate. Concerns about the Trusts Corporate services have not been raised previously. Each concern related to a different team within the directorate and provided the teams with opportunities to learn and improve services.

Table 12: Overarching concern themes this quarter

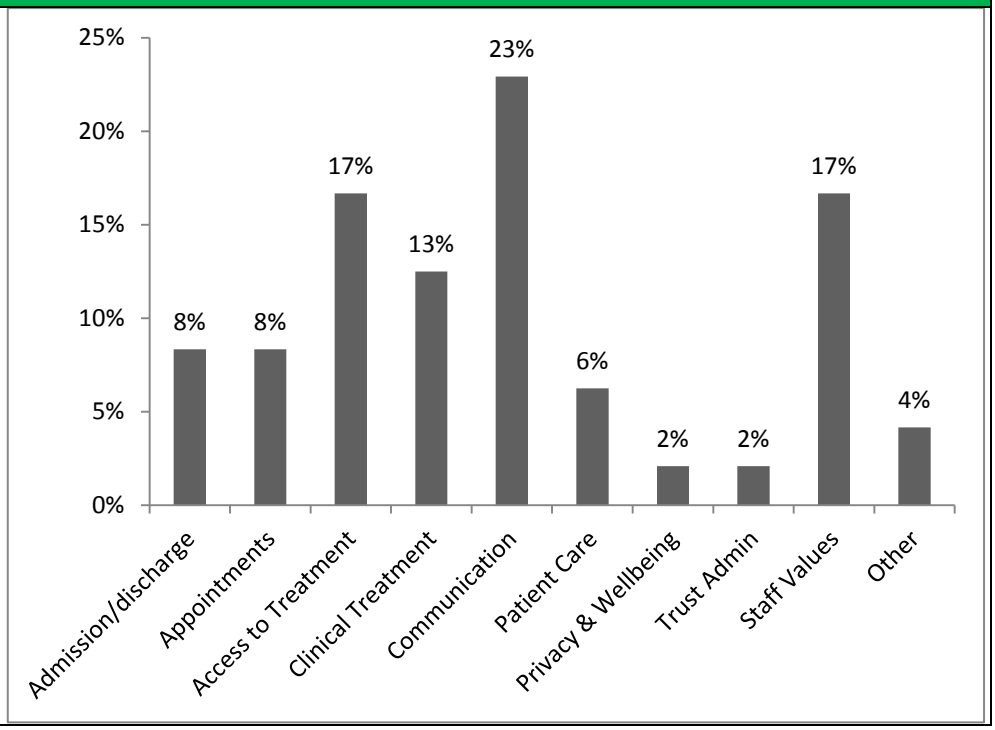
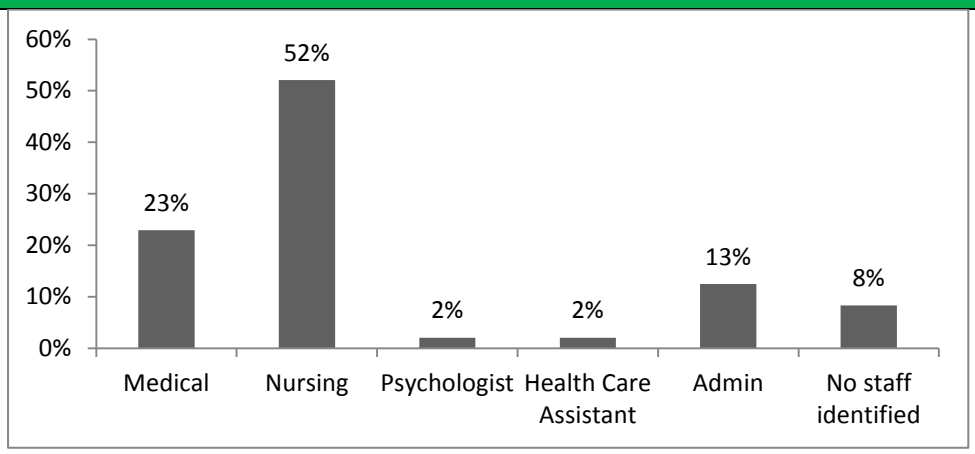
Theme	No.	Chart showing percentages
Admission/discharge *Community or inpatient*	2	
Appointments *e.g. cancelled, staff DNA*	1	
Access to treatment *Treatment or medication*	1	
Clinical treatment *e.g. diagnosis, medication*	6	
Communication *Internal and external*	4	
Patient Care *e.g. observation, support*	2	
Privacy, Wellbeing *e.g. confidentiality, noise*	1	
Trust Admin *e.g. Health Records, MHA*	3	
Staff Values *Attitude and action*	4	
Other *Any other issue*	2	

Table 13: Breakdown of concerns by staff group for this quarter

Outcome	No.*	Chart showing percentages
Medical	11	
Nursing	25	
Psychologist	1	
Health Care Assistant	1	
Admin	6	
No staff identified	4	

As previously reflected in complaint analysis, nursing represents the largest staff group in the Trust and has the greatest number of contacts. It is noted that themes around communication and clinical treatment are present within complaints also. Projects looking at co-production of care plans and implementation of Triangle of Care will ensure staff focus on these important areas.

Table 14: Number of concerns closed this quarter

County	Number (numerical direction)		Interpretation	Assurance
Gloucestershire	32		This is lower than last quarter (Q1 n=48)	Significant
Herefordshire	10		This is higher than last quarter (Q1 n=7)	Significant
Corporate	4		This is higher than last quarter (Q1 n=0)	Significant
Total	46		The overall number of concerns closed has decreased (Q1 n=55)	Significant

The reduction in the number of concerns closed reflects the decrease in number of concerns received this quarter.

Table 15: Other contacts and activity

Advice
There were 24 episodes of advice offered this quarter by the PALS Service
17 episodes advised people on how best to raise issues regarding their experiences, and which service would be best placed to support them
Advice was offered regarding how to access services, what advocacy is, and issues relating to the Mental Health Act
Signposting
There were 20 episodes of signposting this quarter by the PALS Service
11 were signposting to internal teams, such as Eating Disorders, Let's Talk, Wotton Lawn, and Accommodation
9 were signposting to external teams, such as the Wye Valley Trust, GHNHSFT, and advocacy

Examples of concerns and action taken

2.3 Compliments

Table 14: Number of compliments received

County	This quarter		Last quarter	Assurance
Gloucestershire	347	↓	513	Limited
Herefordshire	27	↑	15	Significant
Corporate	15	↑	5	Significant
Total	389	↓	533	Limited

**this does not include primary care contacts*

The numbers of compliments that have been reported over time is noted to fluctuate. Currently, there is limited assurance that compliment information is consistently forwarded for collation and reporting. The Service Experience Department are working with services to raise the profile of compliment reporting throughout the Trust. A dedicated email address has now been set up in order to ease the process for staff to report compliments that they have received. Compliments are being shared and regularly updated with colleagues via the Trust Intranet system to encourage reporting.

Example compliments

2.4 Comments received via HealthWatch

HealthWatch Gloucestershire gathers people's experiences and tries to understand people's needs in a variety of ways including:

- Supermarket information stands
- Events
- Working with Parish or Town Councils
- Working with specific groups, such as young people, BME communities, and people in the military

HealthWatch Gloucestershire has gathered 20 separate pieces of feedback relating to [2]gether Trust this quarter. The feedback can be broadly broken down into the following feedback areas:

- Good care and support offered from a variety of teams (n=4)
- Insufficient or inconsistent support offered by services (n=12)
- Unsure of what services can offer (n=4)

A selection of the comments can be seen below:

2.5 – Parliamentary and Health Service Ombudsman (PHSO)

Two new cases have been referred to the PHSO for review this quarter – as yet a decision has not been made by the PHSO whether these will be investigated by them.

We have received feedback from two open PHSO investigations during Quarter 2. The PHSO confirmed that in both cases that they have reviewed the Trust's investigation and responses to each individual complaint. The outcome of each review is that no recommendations have been made in relation to either case. This is encouraging news and reflects that our investigations and complaints processes are working well to address issues thoroughly.

A previous review by the PHSO made several recommendations for service developments within the trust. The review related to issues raised by a complainant between 2010 and 2013. The implementation of the action plan developed in response to the recommendations remains ongoing. It is anticipated the action plan will be completed and ready for closure in in Quarter 3.

2.6 Surveys

2.6.1 Friends and Family Test (FFT)

Service users are asked "*How likely are you to recommend our service to your friends and family if they needed similar care or treatment?*", and have six options from which to choose:

1. Extremely likely
2. Likely
3. Neither likely nor unlikely
4. Unlikely
5. Extremely unlikely
6. Don't know

The Trust has played a key role in the development of an Easy Read version of the FFT. Roll out of this version across our services ensures that all client groups are supported to provide feedback.

The table below details the number of responses received each month. The "FFT score" is the percentage of people who stated that they would be 'extremely likely' or 'likely' to recommend our services

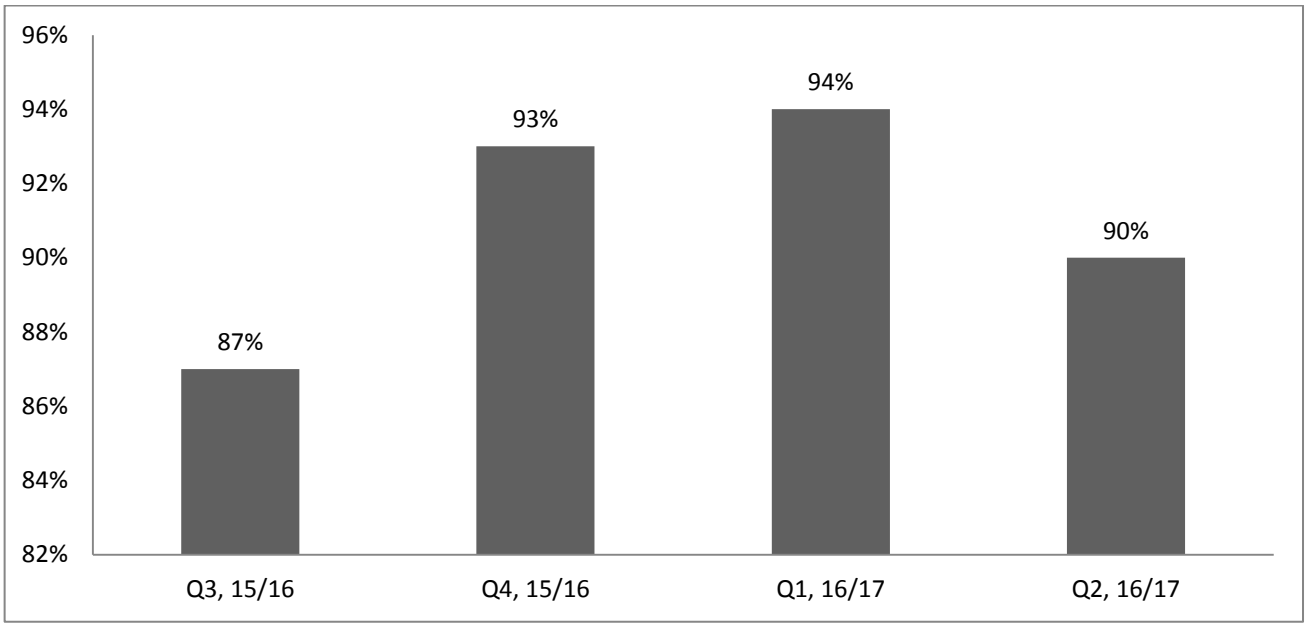
Table 15: Returns and responses to Friends and Family Test

	Number of responses	FFT Score (%)
July 2016	242	93%
August 2016	382	86%
September 2016	430	92%
Total	**1,087 (last quarter = 643)**	**90% (last quarter = 94%)**

It is encouraging to see a significant increase in response rates. This is something the Service Experience Department and Service Directors are looking to continue and improve. Service Managers are given feedback on a weekly and monthly basis about the FFT results and reposes relating to the services they manage.

Figure 3: Friends and Family Test Scores for [2]gether Trust for the past year

The following graph shows the FFT Scores for the past rolling year, including this quarter. The Trust has received consistently positive feedback, which has improved incrementally over the past year.



A slight decrease has been observed in the FFT score for Quarter 2; however the Trust continues to maintain a high percentage of people who would recommend our services.

Friends and Family Test Comments

What was good about the visit?

I have ASC on ASC assessment. It's all good.
ASC Gloucestershire

Staff were understanding and showed a willingness to understand our problem.
LDISS, Gloucestershire

The session was presented in a manner that kept me interested for the duration and all the information was very easy to follow and understand.
Managing Memory, Gloucestershire

Because twice I have been on Jenny Ward and the whole team fantastic.
Jenny Lind Ward, Stonebow

Learned lots, helpful, enjoyable.
Let's Talk, Herefordshire

The knowledge of the staff is excellent so they know exactly how to help me.
CAMHS, Herefordshire

Friendly faces and feeling my daughter/ our family is cared about.
CYPS, Gloucestershire

I feel like I was able to talk about my problems without being judged. I was nervous on arrival but was put at ease quite quickly. Thank you
Recovery West, Gloucestershire

The staff were very busy but always had time to speak to me about my mum and respond to emails.
Mulberry Ward, Charlton Lane Hospital

What would have made the visit better?

I was not keen on receiving over the phone therapy.
MHICT, Gloucester

Have some music playing in the waiting room
CYPS, Gloucestershire

On three visits 2 were found to be cancelled. No continuity of support and care.
Recovery North, Herefordshire

We had 4 different people and had to keep repeating ourselves.
LDISS, Gloucestershire

Feedback from surveys is analysed to ensure any themes are identified and is used to inform organisational learning.

Figure 4: Friends and Family Test Scores – comparison between 2gether Trust and other Mental Health Trusts across England

The following graph shows the FFT Scores for the past six months this quarter. The Trust receives typically higher percentage of recommendation than other mental health trusts in England in most months. (*September 2016 national data is not yet available*)

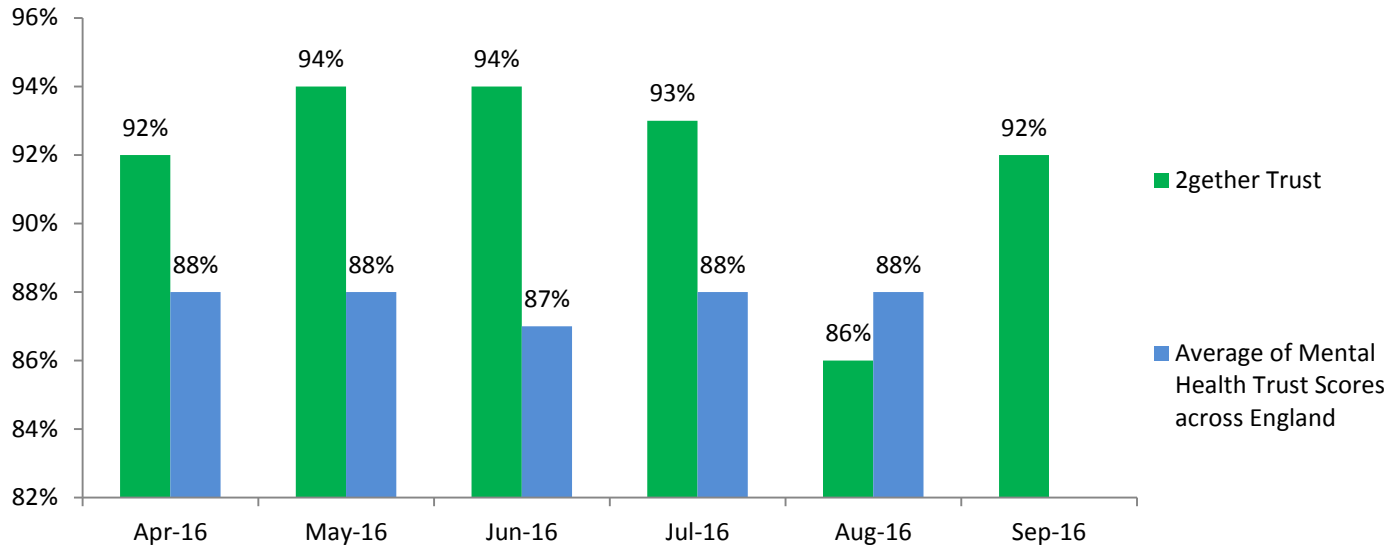
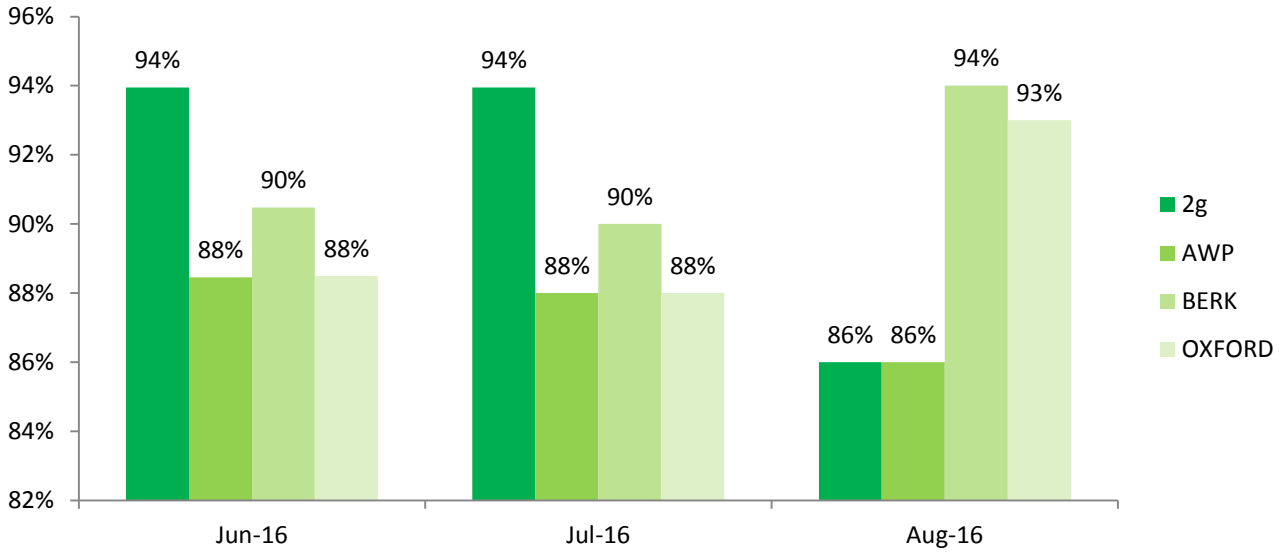


Figure 5: Friends and Family Test Scores – comparison between the 2gether Trust and other Mental Health Trusts in the NHS England South Central region

The following graph shows the FFT Scores for the June, July, and August 2016 (the most recent data available). The Trust generally receives a slightly higher percentage of recommendation than other mental health trusts in the region (*September 2016 data for the region is not yet available*)



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

2.6.2 Local Survey

The Local Survey provides people with an opportunity to comment on key aspects of the quality of their treatment. It is available as a paper questionnaire and an online survey. We currently receive low numbers of returns and work continues to increase awareness of this feedback survey so that the results have greater reliability.

Table 17: Local Survey questions and responses

	Question	Treatment setting	Sample size (Gloucestershire)	Number 'yes' (Gloucestershire)	Sample size (Herefordshire)	Number 'yes' (Herefordshire)	Total % giving 'yes' answer
1	Were you involved as much as you wanted to be in agreeing what care you will receive?	Inpatient	7	6	12	10	86%
		Community	63	52	30	28	TARGET
		Total Responses	70	58	42	38	78%

	Question	Treatment setting	Sample size (Gloucestershire)	Number 'yes' (Gloucestershire)	Sample size (Herefordshire)	Number 'yes' (Herefordshire)	Total % giving 'yes' answer
2	Were you involved as much as you wanted to be in decisions about which medicines to take?	Inpatient	7	6	12	9	79%
		Community	52	43	26	19	TARGET
		Total Responses	59	49	38	28	73%

	Question	Treatment setting	Sample size (Gloucestershire)	Number 'yes' (Gloucestershire)	Sample size (Herefordshire)	Number 'yes' (Herefordshire)	Total % giving 'yes' answer
3	Do you know who to contact out of office hours if you have a crisis?	Inpatient	7	6	12	8	80%
		Community	59	45	29	27	TARGET
		Total Responses	66	51	41	35	71%

	Question	Treatment setting	Sample size (Gloucestershire)	Number 'yes' (Gloucestershire)	Sample size (Herefordshire)	Number 'yes' (Herefordshire)	Total % giving 'yes' answer
4	Has someone given you advice about taking part in activities that are important to you?	Inpatient	7	7	12	9	75% TARGET 48%
		Community	61	38	29	28	
		Total Responses	68	45	41	37	

	Question	Treatment setting	Sample size (Gloucestershire)	Number 'yes' (Gloucestershire)	Sample size (Herefordshire)	Number 'yes' (Herefordshire)	Total % giving 'yes' answer
5	Has someone given you help or advice with finding support for physical needs?	Inpatient	7	6	9	5	71% TARGET NONE SET
		Community	45	28	18	17	
		Total Responses	52	34	27	22	

	Question	Treatment setting	Sample size (Gloucestershire)	Number 'yes' (Gloucestershire)	Sample size (Herefordshire)	Number 'yes' (Herefordshire)	Total % giving 'yes' answer
6	Do you feel safe in our services?	6	5	12	9	6	87% TARGET NONE SET
		63	55	30	28	63	
		69	60	42	37	69	

Targets have been exceeded in all of the six areas for feedback. This is good news and demonstrates that, of those people who responded to the survey, they are not only being involved in their care but are also feeling supported to meet their needs and explore other activities. This is positive reflection of the work undertaken within the Trust to improve performance in these key areas.

Section 3 – Learning from Service Experience Feedback

Section 3.1 – learning themes emerging from individual complaints

The Service Experience Team, in partnership with Service Managers, routinely record, report and take actions based upon the valuable feedback from complaints, concerns and comments. This table illustrates the lessons learnt from **individual** complaints and concerns. This includes learning when a complaint or concern has been upheld, partially upheld or not upheld.

*Table 18: Lessons learnt from **individual** complaints and concerns closed Quarter 2*

Learning	Action taken	Assurance of action
You told us you were unhappy with the way we referred to you in our letter detailing your assessment	We said we were sorry and advised you that the team had reflected and discussed the points raised by you.	Significant
	The team used your feedback to ensure that language used reflects the language used by the individual in future.	
You told us you felt you had been neglected by the service	We apologised that our process complicated things for you.	Significant
	We will review the wording of our routine letters to ensure similar confusion is not experienced by others.	
You failed to transfer me to another ward when I informed you I felt at risk from a person on the same ward.	We said we were sorry and identified learning that it would have been beneficial to have explored this transfer at the earliest opportunity.	Significant
I telephoned to speak with the team manager several times and my calls were not returned.	We said we were sorry that the calls were not returned. We explained that the manager was on leave at that time.	Significant
	We learnt that if a person is not available to take the call the caller should be informed.	
	We learnt that if the named person is not available to return the call that another person must return the call on their behalf.	
A member of your staff was rude and uncaring to me.	We apologised for your experience and acknowledged that your care plan was not followed.	Significant
	We reviewed and discussed this incident with the staff member involved.	
You reported to us that you did not have a care plan.	We said we were sorry and acknowledged that having a care plan in place would have been beneficial for you to address your needs.	Significant

Learning	Action taken	Assurance of action
I was promised weekly updates about my relative – they never happened. I was ignored.	We have apologised for this and explained there was a breakdown of communication within the team. This unfortunately meant you were not contacted; we assured you this was not intentional.	**Significant**

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

Effective dissemination of learning across the organisation is vital to ensure [2]gether's services are responsive to people's needs and that services continue to improve. The table illustrates points of learning from Service Experience feedback. Localities, in partnership with corporate services, are asked to develop action plans to ensure that the learning is incorporated into future practice.

Table 19: Points of learning from Service Experience feedback Q2 closed complaints– action plan to be sought from locality leads

Organisational Learning	Action Plan (to be sought)
• Requests for staff to supply reports for court submission need to be requested via a court order or a solicitor. Staff should not submit reports when requested to do so by service users and or carers/ relatives. *All staff to be informed of this requirement whilst Policy is being drafted for further direction.*	
• Clear and accurate communication must be made between our services, families and service users. All communication should be recorded so that any actions, verbal advice or support provided to families and service users is recorded with clinical notes. *A sample review of clinical notes to be undertaken to ensure information has been disseminated and implemented.*	.
• A person felt they had not been treated with dignity and respect, and experienced discrimination based upon their religion. *To ensure compliance with Equality and Diversity training requirements for all staff.*	

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

Effective dissemination of learning across the organisation is vital to ensure we are responsive to people's needs and that services continue to improve. This table illustrates the assurance that services have provided around actions that have been completed as a result of previous aggregated lessons learnt.

Table 20: Points of learning from Service Experience feedback Q1 – action plan has been completed

Organisational Learning	Locality Directorate Plan	Date Assurance provided
People can make recordings of their consultations if they wish: • Staff need to be familiar with new guidance 'Patients recording NHS staff in health and social care settings' May 2016 A Trust Policy is being developed to guide staff and this will be cascaded throughout the organisation once ratified.	**Children's Services across both counties** The NHS guidance was discussed at Gloucestershire CYPS Governance and distributed to staff. In Herefordshire CAMHS the NHS national guidance has been sent to all staff via Herefordshire Governance Committee. The Trust Policy will also be distributed to staff once ratified for release.	Sept 16
	Gloucestershire Staff awareness has been raised through sharing the NHS guidance and by discussion at Forums and team/clinical meetings that patients can make recordings of their consultations if they wish and this may be conducted either overtly or covertly. The Trust Policy will also be distributed to staff once ratified for release.	Sept 16
	Herefordshire Discussion regarding the NHS guidance was had at the governance meeting and disseminated to all service areas through team meetings The Trust Policy will also be distributed to staff once ratified for release.	Sept 16
A person said they felt at risk and staff did not listen to their concerns: • Staff need to ensure they regularly complete, record and review risk management plans including consideration of risks to others Risk assessment and management need to be carried out in collaboration with service users and other relevant individuals	**Children's Services across both counties** This issue is now included in the Band 5 and Band 6 internal training programme to enable clinicians to refresh their skills focusing on the paramount need to listen to children and young people and evidence their views and their voice, in the clinical record.	Sept 16
	Gloucestershire Managers will remind clinical staff (through Forums and team/clinical meetings) of the need to ensure they regularly complete, record and review risk management plans including consideration of risks to others. In the same way staff will be reminded of the importance to work in collaboration with service users and significant others when completing these assessments and management plans.	Sept 16
	Herefordshire In Herefordshire the personal safety risk plan which is produced with service users has been launched and addresses this issue.	Sept 16

Organisational Learning	Locality Directorate Plan	Date Assurance provided
People said they were unhappy that another statutory agency was given information about their or their family member's mental health: Staff to follow '*Common-sense Confidentiality - A guide for staff, carers, family and friends*' '*Data Protection & Confidentiality*' Policy, February 2016	**Children's Services across both counties** All staff complete safeguarding training and receive guidance on Information Sharing. All service users are given the option of giving consent to share with key family members and agencies. This is only overridden in cases where the safety of the child or young person is at risk.	Sept 16
	Gloucestershire Managers will remind staff of the Policy through team meetings/forums/clinical meetings.	Sept 16
	Herefordshire Assurance has been given that both the guide and Policy are in place and are followed by staff.	Sept 16

Agenda item 11 **Enclosure Paper E**

Report to: Trust Board 24th November 2016
Author: Nikki Richardson, Non-Executive Director
Jane Melton, Director of Engagement and Integration
Presented by: Nikki Richardson, Non-Executive Director

SUBJECT: **Non-Executive Director Audit of Complaints**

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

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

EXECUTIVE SUMMARY

An audit of the process in place to resolve complaints is undertaken by Non-Executive Directors (NEDs) on a quarterly basis.

This paper is in three parts with the first section providing a background position.

The second section provides a high level overview of the learning and assurance levels following the NED complaints audit for 2015/16 quarter 3 and 4 (see Section 2). This audit piloted the use of a revised audit process and template.

The audit feedback provided has been reviewed by the Service Experience Department (SED) and work is underway to implement the audit recommendations.

LEVEL OF ASSURANCE in relation to results of Quarter 3 and 4 audit of 2015/16 complaints

- **Significant assurance** regarding the timeliness of the complaint responses
- **Significant assurance** regarding the quality of the documentation
- **Significant assurance** regarding the quality of the investigation and whether it addressed the issues raised by the complainant
- **Limited assurance** regarding the accessibility and style of the final response letter
- **Limited assurance** regarding the learning and actions identified during the complaint process

The third part of the paper (see Section 3) outlines the proposed revisions to the quarterly NED complaints audit process. The proposed audit process and template for future audits features in Appendix 1 and 2.

RECOMMENDATIONS

The Board is asked to:

- Note the levels of assurance provided within this paper
- Endorse the proposed revisions of the Non-Executive complaints audit process and template
- Agree to the development of a programme (quarterly) of NED audit of complaints from Quarter 3 and 4 2016/17

Corporate Considerations	
Quality implications	Patient and carer experience is a key component to the delivery of high quality care. Appropriate handling and learning from complaints is essential if we are to continue to improve experience and learn from feedback.
Resource implications:	The NED complaints audit provides assurance that the Service Experience Department are utilising their resources appropriately to co-ordinate and oversee the complaints process.
Equalities implications:	The audit offers assurance that the Trust is attending to its responsibilities regarding equalities for service users and carers who raise issues.
Risk implications:	Feedback from complaints offers an insight into how services are received. The information provides a mechanism for identifying performance, reputational and clinical risks.

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

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

Reviewed by:		
	Date	

Where in the Trust has this been discussed before?		
	Date	

What consultation has there been?		
Deputy Director of Engagement Service Experience Clinical Manager	Date	November 2016

Explanation of acronyms used:	NED – Non-Executive Director SED – Service Experience Department SED Clinical Manager – the manager of the Service Experience Department, ²gether NHS Foundation Trust

1. INTRODUCTION

1.1 An audit of the process used to resolve complaints process has generally been undertaken by Non-Executive Directors (NEDs) on a quarterly basis. The broad aims of the audit is to provide assurance that standards are being met in relation to:

- 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 final response letter and other correspondence
- the learning and actions identified as a result of the complaint investigation process

1.2 Last year, the Trust Board requested a revision of the audit process with the aim of maximising the rigor of process and learning from undertaking the audit.

1.3 The updated audit process requires:

- The Service Experience Department (SED) to provide a list of all complaints closed in the timeframe of the quarterly period concerned
- The Non-Executive Director to randomly select 3 files to audit.
- The SED Clinical Manager to arrange printed copies of the initial complaint letter, investigation, and final response letter for the selected files.
- The SED Clinical Manager to complete section 1 of the audit template for each complaint file and provides all this information to the Non-Executive Directors.
- The Non-Executive Director to audit against the remainder of the template and provide feedback on their findings.
- The findings and recommendations to be presented in a Board paper

2. AUDIT FOR QUARTERS 3 and 4 2015/16

The complaint audit for quarters 3 and 4 2015/16 was recently completed. Three files were drawn from each quarter representing approximately 10% of

the complaints during each time period. The results suggested that during the time period represented the levels of assurance were as follows:

- **Significant assurance** regarding the timeliness of the complaint responses
- **Significant assurance** regarding the quality of the documentation
- **Significant assurance** regarding the quality of the investigation and whether it addressed the issues raised by the complainant
- **Limited assurance** regarding the accessibility and style of the final response letter
- **Limited assurance** regarding the learning and actions identified during the complaint process

2.1 In October 2016 a meeting was held between: Nikki Richardson and Martin Freeman, Non-Executive Directors; Jane Melton, Director of Engagement and Integration; and Lauren Wardman, Deputy Director of Engagement.

2.2 The aim of the meeting was to review the Non-Executive Director audit findings from quarters 3 and 4 of 2015/16. These are summarised below:

- Section 1 of the audit tool should be completed by Service Experience Department manager.
- The complaints process was followed in each case.
- There was evidence of sensitivity in some final response letters. In others, the language used could have been softened and less defensive.
- There was no section on the audit tool to review 'consent to share'.
- The investigation process was of an appropriate standard.
- The investigation reports could utilise a more sympathetic tone.
- Investigation reports and final response letters generally outlined organisational learning and how this would be effectively shared. However, one investigation identified no learning. This was raised as an issue as there are always lessons that can be learnt from feedback.
- The audit tool was helpful to structure the review of the complaint file but had nowhere for Non-Executive Directors to share their initial feelings and overall impressions of the investigation and response letter.

2.3 The final point in the above list (regarding overall impressions) resulted in a significant discussion. It was agreed that the Non-Executive Director review added real value in terms of sharing their emotional response to the complaints process and correspondence. An audit that considers this element would ensure that both quantitative and qualitative information would be captured.

2.4 The feedback outlined above has been discussed with the Service Experience Clinical Manager and work is underway to implement the recommendations of the audit.

3. REVISED NON-EXECUTIVE DIRECTOR COMPLAINTS AUDIT

This section outlines the proposed changes to the Non-Executive Audit of Complaints. It is proposed that:

- The Non-Executive Director audit process and template be revised in line with the comments and findings from the 2015-16 quarter 3 and 4 audit.

- The process provided in Appendix 1 and the template provided in the Appendix 2 will form the structure of the refreshed Non-Executive Director quarterly audit of complaints.

4. RECOMMENDATIONS

4.1 The Board is asked to:

- Note the levels of assurance provided within this paper
- Endorse the proposed revisions to the Non-Executive Director complaints audit process and tool (Appendix 1 and 2)
- Agree to the development of a programme (quarterly) of Non-Executive Director audit of complaints commencing Quarter 3 2016/17

Appendix 1 – Proposed revised NED complaints audit process

1. Service Experience Department to generate a list of all complaints closed in the selected quarter (excluding any complaints currently referred to Parliamentary Health Services Ombudsman)
2. Service Experience Department pass the list to the Non-Executive Director who randomly select 3 files to audit
3. Service Experience Department Clinical Manager completes section 1 of the audit tool
4. Service Experience Department print copies of the 3 complaint letters, investigation reports and the final response letters. A set is passed to each Non-Executive Director along with the partially completed audit tool for each file
5. Non-Executive Director undertake the audit
6. Feedback meeting between the Non-Executive Director, Director for Engagement and Integration and Service Experience Department Clinical Manager.

AUDIT PROCESS:

- SED generate a list of all complaints closed in the selected quarter (excluding any complaints referred to PHSO)
- SED pass the list to the NEDs who randomly select 3 files to audit (NEDs both review the same files)
- SED Clinical Manager completes section 1 of the audit tool
- SED print copies of the 3 complaint letters, investigation reports and the final response letters. A set is passed to each NED along with the partially completed audit tool for each file
- NEDs complete sections 2-4 of the audit
- Feedback meeting between the NEDs, Director for Engagement and Integration and SED Clinical Manager.

Non-Executive Director Quarterly Complaints Audit

Complaint no: ……..

	Yes	No	N/A	Comments
1. Service Experience Department to Audit				
a) Were complaint issues summarised?				
b) Was the deadline for a response to the complaint identified?				
c) Were details of advocacy provided?				
d) Was consent to share sought and gained (if appropriate)				
e) Were members of the Executive Team alerted to complaints with organisational risk?				
f) Were the safeguarding needs for adults and/or children considered?				
g) Is the complaint investigator independent of the complaint context?				

	Yes	No	N/A	Comments
h) Has the investigation template been followed?				
i) Is the investigation substantiated with an appropriate level of evidence (e.g. reference to clinical records, statements, policies, procedures)?				
j) Was any relevant investigation/evidence missing?				
k) Has an individual with appropriate seniority reviewed the findings and recommendations of the investigation, (e.g. CSM, Complaints Manager, Service/Locality Lead)				
l) Has the complainant been informed of how to pursue their complaint further within the organisation if they remain dissatisfied?				
m) Has the complainant been informed of how to pursue their complaint further outside of the organisation if they remain dissatisfied?				
2. Non-Executive Director to Audit				
a) Did the investigation seem appropriately critical, open, honest and transparent?				
b) Was the outcome of each issue of the complaint identified in the investigators report (upheld / partially upheld/not upheld)?				
c) Where there is a difference of opinion does the investigator make a judgement about the available evidence to suggest which opinion may be more reasonable?				
d) Address each of the issues raised by the complainant?				
e) Give apologies where they are due?				
f) Clearly state what (if appropriate) corrective action is being taken?				

	Yes	No	N/A	Comments
g) Clearly state what learning has been achieved				
h) In your opinion, could the response letter be considered by the organisation to constitute a full and honest account of events?				
i) Have an empathetic/understanding style/accessible language?				
3. Learning				
a) Was organisational learning identified as part of the complaint investigation process?				
b) Has action been highlighted to meet any learning identified as part of the complaint process?				
c) Is it clear who is accountable for the action, and by when?				
4. Overall impressions (please comment)				

Agenda item **12** **Paper** **F**

Report to: 2gether NHS Foundation Trust Board on 24th November 2016
Author: Shaun Clee – Chief Executive
Presented by: Shaun Clee – Chief Executive

SUBJECT: **Chief Executive's Report**

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

This Report is provided for:

Decision Endorsement Assurance **To Note**

EXECUTIVE SUMMARY

This paper provides the Board with:

1. An update on key national communications via the NHS England NHS News
2. A summary of key progress against organisational major projects

RECOMMENDATIONS

The Board is asked to note the contents of this report

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

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

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

Reviewed by:		
Executive Team	Date	

Where in the Trust has this been discussed before?		
CEO	Date	*11.11.16*

What consultation has there been?		
N/A	Date	

Explanation of acronyms used:	

1. CONTEXT

1.1 National Context

1.1.1 Children and Young People's Mental Health Research Campaign

As part of Children's Mental Health Week the National Institute for Health Research (NIHR) has launched a Children and Young People's Mental Health Research Campaign to highlight that children and young people have the right to take part in research. Mental health research offers children and young people the opportunity to access cutting-edge treatments and to have a say in how new treatments are developed.

1.1.2 One year on from Future in Mind - Vision to Implementation,

In March 2016 it will have been a year since the publication of Future in Mind, setting the direction of travel for children and young people's mental health. The focus of this event will be how to move forward from the vision of a joined up system to implementation. It is aimed at all partners helping to improve children and young people's mental health, whether within the NHS, a local authority, education or the third sector.

1.1.3 NHS commits to major transformation of mental health care with help for a million more people

The Mental Health Taskforce has published its Five Year Forward View with recommendations for changing and developing mental health care across the NHS. It calls for £1 billion investment to help over a million more people to access the services they need.

1.1.4 New training to support mental health professionals to tackle stigma and discrimination within services

A new training pack has been launched to help reduce the stigma and discrimination sometimes experienced by people when using mental health services. Insight from research, focus groups and individual interviews, demonstrated that a high number of people using mental health services felt they experienced stigma and discrimination. This helped Time To Change to work with mental health professionals and service users to identify examples of good practice as well as the barriers which can sometimes stand in the way of positive interactions. The resulting training pack focuses on the positive changes which can improve both team culture and working practices.

1.1.5 Inspiring leaders in learning disability services

Health Education England has launched a new campaign, to encourage leadership in learning disability services across health and social care. Strong leadership is vital for the delivery of change needed to achieve the aims of the Transforming Care Programme. Be inspired by Daniel Marsden's story and take a look at the leadership training courses available to you. You can also join the conversation on Twitter using #inspiringleadersinLD and say thank you to great leaders who've influenced your practice

1.2 Delivering our Three Strategic Priorities

1.2.1 Continuously Improving Quality

1.2.2 Building Engagement

Internal Board Engagement

02.09.16 The Chief Executive attended the Recovery College Graduation

02.09.16 The Director of Service Delivery attended a Medical Staffing Committee Meeting

05.09.16 The Chief Executive welcomed new colleagues at Corporate induction

05.09.16 The Chief Executive Chaired the Senior Leadership Forum

05.09.16 The Director of Service Delivery attended the Executive Development Meeting

05.09.16 The Director of Engagement and Integration attended the Senior Leadership Forum

05.09.16 The Director of Service Delivery attended the Senior Leadership Forum Meeting

05.09.16 The Director of Quality attended Exec Business Meeting at Rikenel

05.09.16 The Director of Quality attended Senior Leadership forum

07.09.16 The Director of Quality attended a Frontier Framework Meeting at Rikenel

07.09.16 The Director of Quality attend the Trust Wide Quality Improvement Project Board at Rikenel

07.09.16 The Director of Quality attended the Care & Compassion Conference at Kingsholm Stadium

07.09.16 The Director of Quality attended a Patient safety visit at Montpellier Unit, Wotton Lawn Hospital

08.09.16 The Chief Executive Chaired the Dementia Board

12.09.16 The Director of Quality attended Exec Business

12.09.16 The Director of Service Delivery attended the Executive Business Meeting

13.09.16 The Director of Service Delivery attended the Council of Governors Meeting

13.09.16 The Director of Engagement and Integration attended the Council of Governors meeting held at Rikenel

15.09.16 The Director of Quality attended the 2gether CQRF meeting in Hereford

15.09.16 The Director of Quality chaired a relatives meeting at Rikenel

16.09.16 The Director of Quality attended the Governance Committee at Rikenel

16.09.16 The Director of Engagement and Integration attended the Governance Committee held at Rikenel

16.09.16 The Director of Service Delivery attended the Mental Health Legislation Scrutiny Committee

19.09.16 The Director of Service Delivery attended the Executive Development Meeting

19.09.16 The Director of Engagement and Integration joined the 'meet and greet' new colleagues team at Dowty's Sports and Social Club

20.09.16 The Director of Engagement and Integration met with the new Director of Transformation as part of her induction programme

21.09.16 The Director of Engagement and Integration attended the Development Meeting held at Rikenel

22.09.16 The Director of Service Delivery attended the JNCC Meeting

23.09.16 The Medical Director was on the panel for Consultant Interviews

26.09.16 The Director of Engagement and Integration together with the Director of Quality visited Heads of Profession at Wotton Lawn Hospital

26.09.16 The Director of Quality attended Wotton Lawn with the Execs

27.09.16 The Director of Service Delivery attended the Delivery Committee Meeting

27.09.16 The Director of Quality held an Away day for the QMT team

28.09.16 The Director of Quality attended the Nursing Strategy Event

29.09.16 The Director of Service Delivery attended a Board Meeting.

29.09.16 The Director of Engagement and Integration attended the Board meeting

29.09.16 The Director of Quality attended Board at Rikenel

30.09.16 The Director of Quality chaired a relatives meeting at Rikenel

30.09.16 The Medical Director presented at the Specialty Doctors Away Day

03.09.16 The Chief Executive welcomed new colleagues at Corporate Induction

03.09.16 The Chief Executive Chaired the Leadership Forum

05.10.16 The Medical Director attended the Learning Disability Consultant Peer Group Meeting.

07.10.16 The Chief Executive attended the Medical Staffing Committee

07.10.16 The Medical Director attended the Medical Staffing Committee.

14.10.16 The Medical Director attended an Information Session for Educational Supervisors regarding the implementation of the new Junior Doctors Contract.

20.10.16 The Director of Engagement and Integration met with the Matron of Wotton Lawn Hospital

21.10.16 The Medical Director attended the Local Negotiating Committee.

21.10.16 The Director of Engagement and Integration attended the Trust's Governance Committee

27.10.16 The Director of Engagement and Integration attended the Board Meeting

28.10.16 The Director of Engagement and Integration took part in the Director of Organisational Development recruitment process

Board Stakeholder Engagement

05.09.16 The Director of Service Delivery attended an Urgent Care Strategy Meeting

06.09.16 The Director of Service Delivery attended the Network Transformation Project Board

06.09.16 The Director of Service Delivery attended the I.T Partnership Board

06.09.16 The Director of Service Delivery attended the IG GP Working Meeting

06.09.16 The Director of Service Delivery attended the Joining Up Your Information Projection Board Meeting

06.09.16 The Director of Engagement and Integration attended the Mental Health and Wellbeing Partnership Board meeting at Sanger House

06.09.16	The Director of Quality attended the Gloucestershire Safeguarding for Adults and Children Board meeting at Shire Hall
07.09.16	The Chief Executive attended the South West Secure Regional Clinical Group
07.09.16	The Director of Engagement and Integration hosted a visit to Charlton Lane Hospital for the Chief Executive Officer of Cobalt
08.09.16	The Director of Service Delivery attended the Mental Health Nurses in General Practice Meeting
08.09.16	The Director of Service Delivery attended the Clinical programme Board Meeting
08.09.16	The Director of Service Delivery attended the Opportunity to meet with a leader of World Class Health Alliance from New Zealand
09.09.16	The Director of Engagement and Integration met with professional colleagues at the University of Gloucestershire re future development of connections with the University
09.09.16	The Director of Engagement and Integration facilitated a CYPS focused workshop with members of Gloucestershire HCOSC at Shire Hall, Gloucester
09.09.16	The Director of Engagement and Integration attended an evening event hosted by the Airlift Charity in Hampnett
12.09.16	The Chief Executive attended the Worcestershire STP Programme Board
12.09.16	The Director of Service Delivery attended the Community Care in Gloucester going forward meeting
13.09.16	The Chief Executive attended Gloucester HOSC
13.09.16	The Chief Executive Chaired the Countywide IM&T Meeting
13.09.16	The Chief Executive attended the Council of Governors
13.09.16	The Director of Service Delivery attended the A&E Delivery Board

13.09.16 The Director of Service Delivery attended the Joint Resources Steering Group Meeting

13.09.16 The Director of Service Delivery attended the STP Programme Development Group Meeting

13.09.16 The Director of Service Delivery attended the Allocate Meeting 2 shift, 3 shift

13.09.16 The Director of Service Delivery attended the Countywide IM&T Meeting

13.09.16 The Director of Engagement and Integration attended the Gloucestershire HCOSC meeting held at Shire Hall, Gloucester

13.09.16 The Medical Director attended the STP Sustainability and Transformational Plan meeting for Mental Health

13.09.16 The Director of Quality attended a Frontier Framework webinar

14.09.16 The Director of Quality attended the STP Planning Group in Worcester

14.09.16 The Director of Engagement and Integration attended the Forest of Dean Community Services Review Steering Group held at Sanger House

14.09.16 The Director of Service Delivery attended the Herefordshire Service Specification discussion

14.09.16 The Director of Service Delivery attended the STP Planning Group Meeting

14.09.16 The Director of Service Delivery attended the Interface meeting

15.09.16 The Director of Engagement and Integration represented the Trust at the R&D Consortium meeting held at Rikenel

16.09.16 The Director of Service Delivery attended a Board Visit to Crisis Team & Psychiatric Liaison

19.09.16 The Director of Quality attended a Legionella & water Compliance Audit Training at Eastwood Park Training Centre

20.09.16 The Director of Quality attended a Legionella & water Compliance Audit Training at Eastwood Park Training Centre

21.09.16 The Director of Quality attended a Legionella & water Compliance Audit Training at Eastwood Park Training Centre

22.09.16 The Director of Quality attended an interview for the Top Managers programme with the King's Fund in London

22.09.16 The Director of Engagement and Integration chaired the Swindon Mind and 2gether Strategic Partnership meeting at Cirencester Memorial Hospital

19.09.16 The Director of Service Delivery attended the Urgent Care Programme Board

20.09.16 The Director of Service Delivery attended the Provider Board – Wye Valley Trust

20.09.16 The Director of Service Delivery attended a Greyfriars Patient Safety Visit

20.09.16 The Director of Service Delivery attended the North Cots 30,000 Meeting

20.09.16 The Medical Director attended the Provider Board STP Meeting at WVT

21.09.16 The Medical Director attended the Mental Health Medical Directors Network

22.09.16 The Director of Service Delivery attended the STP weekly AO Meeting

26.09.16 The Director of Service Delivery attended the EO Provider Alliance Meeting – Wye Valley Trust

27.09.16 The Medical Director attended the Gloucestershire CCG Commissioning Event

27.09.16 The Medical Director attended the Gloucestershire CCG AGM

27.09.16 The Director of Service Delivery attended the I.T Blueprint Programme Board

27.09.16 The Director of Service Delivery attended the Senior Management Team Meeting

27.09.16 The Director of Service Delivery attended the GCCG AGM

28.09.16 The Director of Service Delivery attended the TH Communication Meeting

28.09.16 The Director of Service Delivery attended the Community Care in Glos Going Forward Meeting

28.09.16 The Director of Service Delivery attended the Community Care Operational Implementation Group Meeting

29.09.16 The Director of Service Delivery attended the STP Weekly AO Meeting

30.09.16 The Director of Service Delivery attended the CYPS Discussion (Strategic Direction the under and over 11s debate)

30.09.16 The Director of Service Delivery attended the Stonebow Ward Accommodation Meeting.

30.09.16 The Director of Engagement and Integration conducted a visit to the Fritchie Centre in Cheltenham with professional colleagues from the University of Bristol

05.10.16 The Chief Executive chaired the Gloucestershire Workforce and OD workstream meeting

07.10.16 The Chief Executive chaired the Dementia Board

10.10.16 The Director of Engagement and Integration was an invited keynote speaker at the Heads Up Cheltenham event held at the Cheltenham Town Hall alongside an Expert by Experience

11.10.16 The Director of Engagement and Integration chaired the countywide and multiagency Tackling Mental Health Stigma Group meeting at the CCG Headquarters, Sanger House, Gloucestershire

11.10.16 The Director of Engagement and Integration attended the Discovery College at Gloucester College in Cheltenham

12.10.16 The Director of Engagement and Integration Chaired at Research Overview meeting with colleagues from 2gether and GHNHSFT

12.10.16 The Medical Director met with representatives from UWE with the Director of Medical Education.

14.10.16 The Medical Director had a meeting with relatives following a Serious Incident.

14.10.16 The Director of Engagement and Integration presented at the countywide Patient Participation Group Network meeting held at Churchdown Community Centre, Gloucestershire

18.10.16 The Director of Engagement and Integration met with colleagues from Pied Piper Charity

19.10.16 The Director of Engagement and Integration attended the Herefordshire HCOSC meeting held at Shire Hall

19.10.16 The Director of Engagement and Integration met with research and education colleagues at the University of Worcester

20.10.16 The Chief Executive chaired the Provider Board in Herefordshire

20.10.16 The Chief Executive attended Herefordshire HSCOSC

20.10.16 The Chief Executive chaired the Gloucestershire systems summit

20.10.16 The Medical Director attended a Mental Health Pilot meeting.

20.10.16 The Director of Engagement and Integration took part in a session for Gloucestershire Councillors at Wotton Lawn Hospital (hosted by the Trust Chair)

21.10.16 The Chief Executive attended the Gloucestershire STP Delivery Board

25.10.16 The Director of Engagement and Integration chaired a local complaint resolution meeting.

25.10.16 The Director of Engagement and Integration met with the CEO of Swindon Mind

20.10.16 The Medical Director attended the Gloucestershire Strategic Forum Five Year Forward View Workshop.

Board National Engagement

07.09.16 The Director of Service Delivery attended the South West Secure Regional Clinical Group

08.09.16 The Director of Engagement and Integration participated in a seminar hosted by Gloucestershire CCG at Sanger House. The session introduced a world class alliance from Canterbury, New Zealand

09.09.16 The Chief Executive Chaired the SW Mental Health CEO Forum

15.09.16 The Director of Service Delivery attended a Vanguard Visit to Dudley CCG

23.09.16 The Director of Engagement and Integration took part in a Defence Medical Services Key Leader Engagement Event at Sandhurst

26.09.16 The Director of Service Delivery attended the Triangulation of STP Access Tertiary Systems of Care (Mental Health)

28.09.16 The Director of Engagement and Integration chaired a viva panel for the Nye Bevan Leadership Academy Programme in Leeds

30.09.16 The Director of Engagement and Integration met with the Director of Quality for the Academic Health Science Network

19.10.16 The Medical Director attended the South West NHS England Responsible Officer Network.

26.10.16 The Medical Director attended the GMC South West Regional Day with the Director of Medical Education.

31.10.16 The Medical Director attended the NHS England Annual National Medical Leaders in England Conference.

Major Project Update – November 2016

Temporary Staffing Demand **quality/sustainability**

The Executive Team continues to monitor, on a weekly basis, the use of agency (agency spend and shifts covered), and the effectiveness of the improvement actions.

A number of actions to reduce expenditure came into effect in October (e.g. 19 newly qualified nurses commenced employment, a student practitioner scheme was introduced in Herefordshire, and the recovery of specialling costs from the CCG). E-rostering is due to be implemented during the final quarter of 2016/17. Other actions are being pursued including

the use of ‘direct engagement’ of locums, use of partnership working to achieve improved agency rates, and weekly pay for staff bank. The aim is to be within 25% of the 2016/17 agency spend ceiling set by the NHSI (the ceiling set was 38% less than the 2015/16 actual spend).

In addition to a weekly return on agency use, the NHSI now requires detailed information on breach price caps, maximum wage rates, regular information on the highest earning agency staff, agency staff employed more than six months, and senior manager agency rates that exceed £750 per day. From 23 November all framework overrides have to be signed off by the Chief Executive, and on 30 November the Trust must submit an agency self-certification checklist signed by the Chief Executive and Trust Chair.

SLR/PLICS 2016/17 **quality**

The Q1 figures for 2016/17 are currently being input, and once completed the 2015/16 figures will accordingly be amended, and then the Q2 2016/17 figures will be entered. Prior to rolling out access to nominated users, the Executive Team will be presented with updated information on the scheme, which includes a Business Rules & Assumption Manual.

In readiness for roll out, a number of papers have been drawn up, e.g. an SLR training paper and training manual, and a Qlikview policy on use and reporting. These papers have already been presented to and signed off by the SLR Project Board.

Discussions have taken place to ensure that SLR/PLICS will easily fit into the day to day working environment. These discussions have looked at the resource implications of this change, with a focus on the finance and informatics teams. They have now agreed a plan of action and this plan is currently being drawn up.

The Capital Resources Group was asked to accept the need for an additional £40k to cover the requirement for an additional server to host the Qlikview software and additional RAM to keep processing speeds at an optimal level.

Improving Care Through Technology **sustainability**

Over a ten week, period two hundred users in Herefordshire were provided with new laptops and set-up with 2gether accounts. The 2gether domain has now been made available via fixed line Ethernet and Wi-Fi at all Trust buildings in Herefordshire except Stonebow.

Technical input is required “at the desk” to move each user from Shakespeare to 2gether, and due to resourcing and technical difficulties, this part of the rollout has not kept pace with the laptop handover.

CITS service desk began taking calls for our ICTT users at the beginning of August, and since then pressure on the 2gether project team has reduced significantly, allowing the team to focus more resource on the project.

Digital Transcription and Speech Recognition (DTSR) **sustainability**

Since August DTSR has been rolled out to Herefordshire, and the team is now conducting the final part of the user training which includes daily floor-walking support across Herefordshire. During September both Cirencester Recovery and South Cotswolds went live on BigHand with minimal issues being reported. DTSR is now being rolled out to the Gloucestershire Crisis Teams and Colliers Court, and, working through team managers to ensure all staff are covered, the aim is that those teams are live by the end of November.

In line with the laptop rollout project, DTSR implementation across Gloucestershire (based on learning from Herefordshire) is scheduled between 28 November and 20 January, with an aim to have all community staff using BigHand by the end of March 2017. Over the coming months support will continue for those who have gone live on BigHand (MAS Gloucestershire, CLDT Stroud, Recovery Ciren, Widemarsh HFD, St Owens Street HFD, Belmont HFD, Goal Street HFD, Stonebow HFD and Oak House HFD). The DTSR team will start to attend service/team meetings going forward to provide support and gather feedback.

Agenda item 13 **Enclosure No** **Paper G**

Report to:	2gether NHS Foundation Trust Board 24th November 2016
Author:	Stephen Andrews, Deputy Director of Finance
Presented by:	Andrew Lee, Director of Finance and Commerce

SUBJECT: **Finance report for period ending 31st October 2016**

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

This Report is provided for:

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

EXECUTIVE SUMMARY

- The month 7 position is a deficit of £57k in line with the planned position. The budgets have been revised to include the £650k Sustainability and Transformation Fund monies that have been allocated to the Trust. Two quarters of this fund have been included at the month 7 position.
- The Trust was allocated £650k from the Sustainability and Transformation Fund (STF) by NHS Improvement. The Trust also had its 2016/17 control total of a surplus of £4k adjusted upward by £650k to a revised 2016/17 revenue control total of £654k surplus.
- The month 7 forecast outturn is a £654k surplus, excluding impairments, as per the revised revenue control total and Trust budgets. The Trust is anticipating it will meet its targets and receive the full allocation from the STF.
- The Trust has a confirmed Financial Sustainability Risk Rating of 4 at Q1. NHS Improvement has introduced a new Oversight Framework from the 1st October. Under this framework the Trust has been informed that our shadow segment is a 1 the highest score, 4 being the lowest.
- The Trust has a revised forecast agency spend taking into account the impact of the considerable number of actions taken of £4.251m at month 7, which is above the £3.404m control total, but £1.25m below the spend in 2015/16. This equates to achievement of 60% of NHS I's required reduction in agency spend in 2016/17. The Trust also projects it will meet the run rate to fully deliver the target reduction in 2017/18.
- The Trust has commenced budget setting for next year to support preparation of the Operational Plan and has updated its financial projections for the next five years in this report.

RECOMMENDATIONS

It is recommended that the Board:

- note the month 7 position

Corporate Considerations	
Quality implications:	None identified
Resource implications:	Identified in the report
Equalities implications:	None
Risk implications:	Identified in the report

WHICH TRUST KEY STRATEGIC OBJECTIVES DOES THIS PAPER PROGRESS OR CHALLENGE?			
Quality and Safety		Skilled workforce	
Getting the basics right		Using better information	
Social inclusion		Growth and financial efficiency	x
Seeking involvement		Legislation and governance	

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

Reviewed by: Andrew Lee, Director of Finance and Commerce		
	Date	15th November 2016

Where in the Trust has this been discussed before?		
	Date	

What consultation has there been?		
	Date	

Explanation of acronyms used:	See footnotes

1. CONTEXT

The Board has a responsibility to monitor and manage the performance of the Trust. This report presents the financial position and forecasts for consideration by the Board.

2. EXECUTIVE SUMMARY

The following table details headline financial performance indicators for the Trust in a traffic light format driven by the parameters detailed below. Red indicates that significant variance from plan, amber that performance is close to plan and green that performance is in line with plan or better.

Indicator	**Measure**		
Year End I&E	Financial Sustainability Risk Rating	4.00	Confirmed by NHS I at quarter 1
Income	FOT vs FT Plan	102.5%	
Operating Expenditure	FOT vs FT Plan	102.0%	
Cash	Number of creditor days	24	Balance of £13.6m (including investments) which equates to 24 creditor days.
PSPP	%age of invoices paid within 30 days	97.0%	87% paid in 10 days
Capital Income	Monthly vs FT Plan	98.8%	
Capital Expenditure	Monthly vs FT Plan	90.5%	£7,775k expenditure.

The parameters for the traffic light dashboard are detailed below:

INDICATOR	RED 	AMBER 	GREEN 
Monitor FOT Financial Risk Rating	<2.5	2.5 - 3	>3
INCOME FOT vs FT Plan	<99%	99% - 100%	>100%
Expenditure FOT vs FT Plan	>100%	99% - 100%	<99%
CASH	<15 days	15-40	>40 days
Public Sector Payment Policy - YTD	<80%	80% - 95%	>95%
Capital Income - Monthly vs FT Plan	<90%	90% - 100%	>100%
Capital Expenditure - Monthly vs FT P	>115% or <85%	110% - 115% or 85% to 90%	>90% to <110%

- The financial position of the Trust at month 7 is a deficit of £57k which is in line with the plan.
- Income is £1,188k over recovered against budget and operational expenditure is £751k over spent, and non-operational items are £436k over spent.

The table below highlights the performance against expenditure budgets for all localities and directorates for the year to date, plus the total income position.

Trust Summary	Annual Budget £000	Budget to Date £000	Actuals to Date £000	Variance to Date £000	Year End Forecast £000	Year End Variance £000
Cheltenham & N Cots Locality	(4,871)	(2,836)	(2,826)	10	(4,894)	(23)
Stroud & S Cots Locality	(3,976)	(2,319)	(2,514)	(194)	(4,374)	(398)
Gloucester & Forest Locality	(4,226)	(2,465)	(2,449)	16	(4,170)	56
Social Care Management	(3,806)	(2,220)	(2,891)	(671)	(4,969)	(1,163)
Entry Level	(5,234)	(3,053)	(3,211)	(158)	(5,313)	(80)
Countywide	(29,457)	(17,177)	(17,410)	(233)	(30,053)	(596)
Children & Young People's Service	(4,981)	(2,905)	(2,542)	363	(4,723)	257
Herefordshire Services	(13,705)	(7,962)	(8,149)	(187)	(14,074)	(369)
Medical	(14,837)	(8,656)	(9,089)	(433)	(15,681)	(844)
Board	(1,658)	(967)	(936)	31	(1,713)	(55)
Internal Customer Services	(1,789)	(1,051)	(872)	178	(1,718)	71
Finance & Commerce	(6,605)	(3,788)	(3,660)	127	(6,397)	207
HR & Organisational Development	(3,159)	(1,835)	(1,950)	(115)	(3,229)	(71)
Quality & Performance	(2,678)	(1,537)	(1,604)	(67)	(2,758)	(80)
Engagement & Integration	(1,344)	(784)	(781)	3	(1,378)	(34)
Operations Directorate	(1,150)	(671)	(699)	(29)	(1,252)	(102)
Other (incl. provisional / savings / dep'n / PDC)	(4,716)	(3,017)	(2,826)	191	(4,201)	515
Income	108,846	63,184	64,352	1,167	111,554	2,708
TOTAL	**654**	**(58)**	**(57)**	**1**	**654**	**0**

The key points are summarised below;

In month

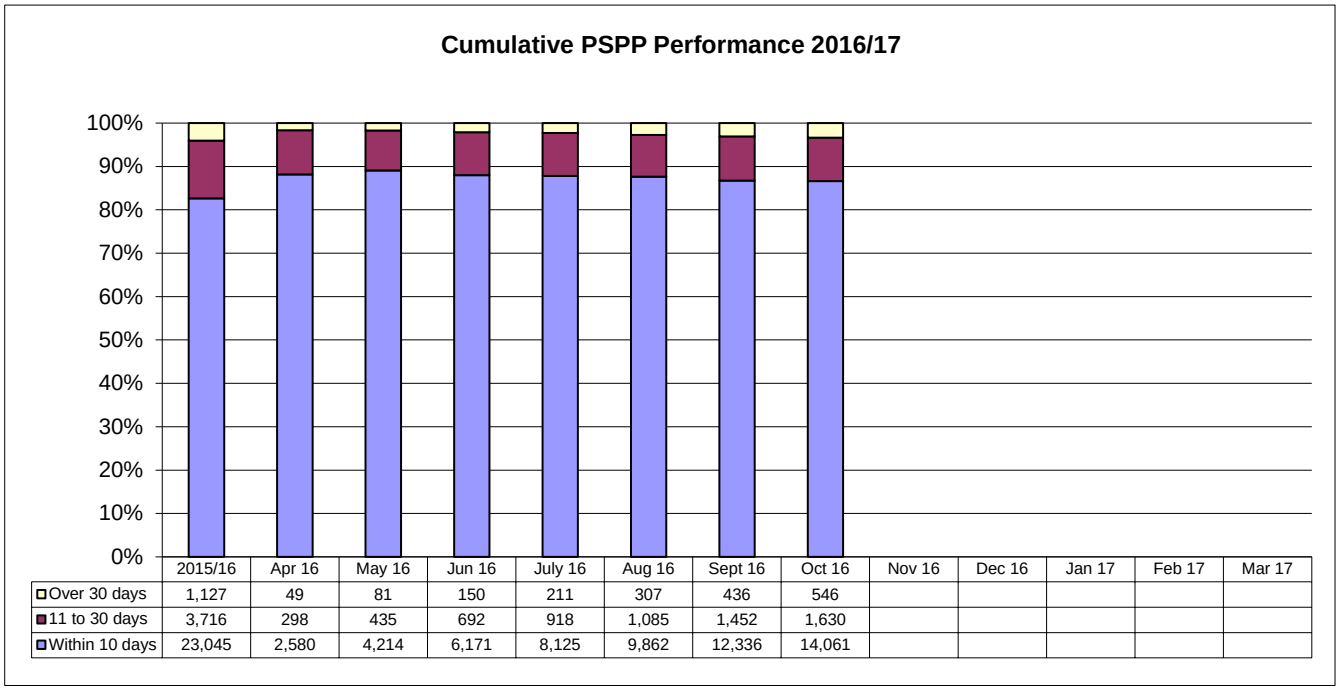
- Stroud locality was over spent due to higher than budgeted Supporting People costs. This is matched by additional income.
- Social Care Management was over spent due to over performance against the funded level for Community Care, which is offset by additional income.
- Entry level was over spent due to agency costs to cover the increased staffing requirement in the IAPT service and the need to reduce waiting lists.
- Herefordshire was over spent due to agency costs to cover specialling costs on Mortimer and Cantilupe wards, and significant vacancies across the wards.
- CYPs was under spent due to a number of vacancies across many services.
- Medical budgets over spent due to agency usage in Countywide, Children and Young People, Herefordshire, Localities and Learning Disabilities to cover vacancies, sickness and maternity leave.
- Countywide was over spent due to complex care costs from new high cost placements and additional inpatient costs covering vacancies and clinical need.
- Other was under spent due to development funds not being utilised.
- Income is over recovered due to additional funds from Supporting People, Community Care and development income.

Forecast Outturn

- Stroud locality is forecast to be over spent due to higher than budgeted Supporting People costs. This is matched by additional income.
- Social Care Management is forecast to be over spent due to over performance against the funded level for Community Care, which is offset by additional income.
- Countywide is forecast to be over spent due to complex care costs from new high cost placements and additional inpatient costs covering vacancies and clinical need.
- Herefordshire is forecast to be over spent due to agency costs to cover specialling and vacancies across all wards.
- Medical costs are forecast to be over spent due to agency usage across many areas.
- Income will over recover due to additional funds for Supporting People, Community Care, Improving Patient Safety and development income.

A mid year review of the financial position was undertaken and has been reflected in the report. All aspects of financial performance were reviewed from budgets to agency spend and savings and capital. The review concluded that the Trust remains on track to deliver its financial control total of a £654k surplus in 2016/17. As part of the review the financial plans and assumptions for 2017/18 were updated to reflect the latest assumptions on income, expenditure, capital, savings and reserves in light of the work on the Sustainability and Transformation Plans process, and the recently announced control totals for 2017-19. The figures in this report will form the basis of the financial plans to be submitted to NHS Improvement on the 24th November, subject to further refinement and a review by the Executive Committee.

The cumulative Public Sector Payment Policy (PSPP) performance up to month 7 is 87% of invoices paid in 10 days and 97% paid in 30 days. The cumulative performance to date is depicted in the chart below and compared with last year's position. It highlights that the Trust has a strong balance sheet and has the cash available to consistently pay its invoices promptly and meet the Public Sector Payment Policy target of 95% of invoices paid within 30 days.



	2015/16	Apr 16	May 16	Jun 16	July 16	Aug 16	Sept 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17
Over 30 days	1,127	49	81	150	211	307	436	546					
11 to 30 days	3,716	298	435	692	918	1,085	1,452	1,630					
Within 10 days	23,045	2,580	4,214	6,171	8,125	9,862	12,336	14,061					

Agenda item **14** **Enclosure** **Paper H**

Report to: Trust Board, 24 November 2016
Author: John McIlveen, Trust Secretary
Presented by: John McIlveen, Trust Secretary

SUBJECT: **ASSURANCE MAP REPORT**

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

EXECUTIVE SUMMARY

The Board has previously received Board Assurance Framework report twice each year. Following its development session on risk management in April, the Board agreed to move to a new model (the assurance map) to replace the traditional Board Assurance Framework document. The Audit Committee now receives at each meeting an updated Assurance Map which has been scrutinised beforehand by the Executive Committee.

The Assurance Map is similar to the Board Assurance Framework in that it:

- Is a dynamic document, comprising strategic risks to the achievement of the Trust's strategy, with risks being added and removed as they are identified or mitigated.
- Contains only those risks in the corporate risk register scoring 12 or more.
- Identifies 'Top 5' risks.
- Indicates overall assurance levels.
- Identifies Committee 'ownership' of risks, along with lead Executive Director.

The Assurance Map differs from the Board Assurance Framework reports received previously by the Board, in a number of respects:

- Risks are grouped by category.
- Risk trend is shown.
- Controls are set out in accordance with the '3 lines of defence' model which represents good practice in terms of risk management.
- Assurances obtained through each of these lines of defence are indicated by RAG-rated bullets. However, detailed assurances and controls are not listed as these will be available through the risk register reports provided to the Board and to each of the Board's Committees on a quarterly basis.
- The Assurance Map approach makes clear to the Audit Committee and the Board those risks which have not been subject to independent verification. The Audit Committee in particular is thus able to draw on this information when considering the content of the Internal Audit plan.
- The format also enables the Audit Committee and the Board better to judge the adequacy of controls and assurances by comparing the target and current risk scores.

The Assurance Map presented to the Board today was reviewed by the Executive Committee on 10 October, and the Audit Committee on 2 November, and Executive leads have reviewed their respective risks.

As with the previous Board Assurance Framework, the Assurance Map is a dynamic document with risks added and removed as their risk score rises or falls. The Assurance Map now contains 11 risks, two of which (numbers AM 12 and 13, both highlighted in green on the Assurance Map and relating respectively to the risk of exceeding the Trust's control total for agency spend, and to safeguarding risks associated with incomplete RiO records) have been added recently. These two risks are in the process of being fully documented and mitigating actions agreed.

The risk regarding **delivery of cost saving plans** was removed prior to the review of the Assurance Map by the Audit Committee in November, as further mitigation measures have been applied (as set out to the Board in the mid-year financial review) which resulted in its risk score being reduced to below the threshold for inclusion.

Since the Audit Committee's November review, further work has been undertaken to review and where necessary revise the risk wording, target score, current risk scores, and assurance levels. As a result of this exercise, the following changes have been made:

- A risk score matrix has been added to the Assurance Map spreadsheet to make clearer the relative likelihood and impact elements of each risk.
- Two Top 5 risks (stakeholder relationships and financial/demand pressures) have been combined into a single Top 5 risk which appears at AM7 on the Assurance Map
- The workforce risk (reference AM4) has had its risk score reduced from 16 to 12 in light of the mitigating actions and plans currently in place. The target score has been increased from 6 to 9, which is a more realistic level given the complexity contained within this risk. The risk wording remains unchanged, and assurance remains at 'Limited'. This risk is one of the Board's 'top 5' risks.
- The financial risk (AM10) has had its target score increased from 4 to 9, which is a more realistic level. Risk score remains at 12 and assurance remains at Significant'. This is one of the Board's 'Top 5' risks.
- The wording of the safety/clinical risk (AM7 – IAPT services) has been amended as shown on the Assurance Map to reflect the fact that the risk is one to patients' access to safe and effective services. The target score for this risk has been increased from 5 to 9, which is a more realistic level. The current risk score has been reduced from 15 to 12, which reflects the progress being made by the Trust in implementing the agreed recovery plans for IAPT services.
- The wording of the safety/clinical risk (AM8 – CYPS Tier 4 services) has been amended as shown on the Assurance Map to reflect the fact that the element of risk which the Trust can control is the provision of adequate safeguards in the event of an under 18 admission to an adult inpatient ward, rather than the provision of Tier 4 services. Given this revised wording, the current risk score has been reduced from 16 to 18, reflecting the comprehensive safeguarding measures which the Trust puts in place whenever an under 18 admission takes place, and which are reported to the Board. The threshold for inclusion on the Assurance Map is a risk score of 12 or more. Consequently, this risk would normally come off the Assurance Map at the next iteration. However, as this risk is one of the Board's Top 5 risks, the Board is asked to agree to its removal, and to decide whether it should remain as a Top 5 risk. The risk will remain on the Corporate Risk Register and will thus be subject to quarterly review by the Governance Committee.

This report offers **significant assurance** regarding the process of identification, mitigation and regular review of risks which may affect the quality or safety of services provided by the Trust. Assurance offered in respect of individual risks varies as shown in the Assurance Map.

RECOMMENDATIONS

The Board is asked to:

- Note the assurance provided within this report, and
- Agree to the removal of the Top 5 risk about CYPS tier 4 services (reference AM8) from the next iteration of the Assurance Map, and
- Determine whether the CYPS Tier 4 risk should continue to be one of the Board's Top 5 risks, given its revised wording and risk score

Corporate Considerations	
Quality implications:	None other than those identified in this report
Resource implications:	None other than those identified in this report
Equalities implications:	None other than those identified in this report
Risk implications:	None other than those identified in this report. Risks are identified within the risk register and presented to the relevant Committee for regular review.

WHICH TRUST VALUESIVES DOES THIS PAPER PROGRESS OR CHALLENGE?			
Supporting clinical care	P	Skilled workforce	
Getting the basics right	P	Using better information	
Social inclusion		Financial efficiency	P
Seeking involvement		Legislation	P

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

Reviewed by:		
Executive Committee Audit Committee	Date	10 October 2016 2 November 2016

Where in the Trust has this been discussed before?		
Audit Committee Board development session - Risk Executive Committee	Date	November 2016 April 2016 October 2016

What consultation has there been?		
Updates obtained from Risk Manager Executive risk leads	Date	October 2016 November 2016

Explanation of acronyms used:	CQC – Care Quality Commission HSE – Health & Safety Executive NRLS – National Reporting and Learning System

	NHSI – NHS Improvement IAPT – Improving Access to Psychological Therapies SIRI – Serious Incident Requiring Investigation CYPS – Children & Young People Service CCG – Clinical Commissioning Group RIDDOR – Reporting of Injuries, Diseases and Dangerous Occurrence Regulations

ASSURANCE MAP - NOVEMBER 2016

Assurance Map Reference	Risk Register reference	High scoring risks	Top 5 Risk	Corporate Objective	Primary Assurance Committee	Lead executive	1st Line of Defence **Management Control**			2nd Line of Defence **Corporate Oversight**									3rd Line of Defence **Independent Verification**							**Corrective Action**				**Risk and Assurance Analysis**			
							Management Oversight	Project Team Oversight	Sub-Committee	Clinical Audit/Peer review	Governance Committee	Audit Committee	MHL Scrutiny Committee	Development ommittee	Executive Committee	Ratings and formal declarations	Delivery Committee	Board	Internal Audit	External Audit	Expert Review/Accreditation	External Review	CCG	NHS Improvement	CQC/HSE	Action Plan	Increase Assurance	Validate Assurance	Add to IA Plan	**Overall Assurance Level** (From Risk Register)	**Maximum Acceptable Risk** (Target Risk Score)	**Current Risk Score** (Risk After Control)	**Risk Trend** (versus last report)
Governance Risk																																
AM1	38	If Trust fails to have in place an effective incident reporting system that holds accurate and complete data then this may adversely impact on actions where reliance is placed on that data, thereby meeting statutory and mandatory reporting requirements (e.g RIDDOR and NRLS, SIRIS)		1	G	MC	●	●			●	●			●				●							✓	✓		✓	LTD	9	12	↔
AM13	121	If Trust fails to ensure that RiO records are accurate and complete (regarding safeguarding) then this may result in a serious incident.		1	G	MC	●				●																✓			LTD	8	12	
AM2	6	Risk that a serious incident occurs that is judged to have been preventable and for which the organisation is negligent and which catastrophically destabilises clinical and/or financial governance.	✓	1	G	MC	●				●							●	●			●				✓				SIG	12	12	↔
People Risk																																
AM3	10	If the CQC, HSE, NHS I or other significant regulator determines that there are concerns, improvements, compliance actions required of our services - this will require significant management and clinical resources and attention		1	G	MC	●	●			●				●			●							●	✓	✓		✓	SIG	8	12	↔
AM4	48	That we fail to secure the workforce and evolve the organisational culture necessary to deliver our strategic objectives. (Appropriately skilled, engaged, equipped and led).	✓	1	Del	CS	●	●							●		●		●							✓	✓			LTD	9	12	↑
Safety/Clinical Risk																																
AM5	13	Risk of injury to staff, patients and others from patients being violent and aggressive		1	G	CM	●				●				●		●								●	✓	✓			LTD	9	12	↔
AM6	20	There is evidence to show that crisis contingency/relapse plans are not consistently recorded in the appropriate section of RiO, and that these, where evident, are not being reviewed regularly, leading to an increased clinical/safety risk for service users.		1	G	CM	●	●		●	●				●											✓	✓			LTD	8	12	↔
AM7	112	If the Trust IAPT Services (Gloucestershire & Herefordshire) fails to meet national performance standards and/or Commissioners fail to agree the necessary investments in our IAPT Service then patients will not have access to appropriate services ~~and the Trust may be at risk of losing the service~~.		1	Del	CM	●	●							●		●					●		●		✓	✓			LTD	9	12	↑
AM8	14	Uncertain commissioning arrangements with regard to the procurement of secure services and CYPS Tier 4 services may ~~adversely impact on our service users~~ result in children and young people being admitted to our adult inpatient services unit without appropriate safeguards being put in place.	✓	1	G	CM	●				●				●												✓			SIG	6	8	↑
Strategic Risk																																
AM10	7	Risk that financial and demand pressures within the health and social care community result in financial pressures on 2gether to a degree that it is beyond that which can be managed effectively without destabilising either Clinical or Financial Governance, and that we fail to secure and sustain positive and productive relationships with stakeholders to the extent that discretionary positive impact is lost	✓	3	E	SC	●							●	●			●		●							✓			SIG	9	12	↔
Financial Risk																																
AM12	116	If the Trust continues to spend at its current rate on agency staff then it will breach its Agency control total set by NHS Improvement (NHS I)and this will impact on services.	✓	3	G	MC	●								●			●									✓			LTD	4	16	

ASSURANCE MAP - NOVEMBER 2016

Assurance Map Reference	Risk Register reference	High scoring risks	Top 5 Risk	Corporate Objective	Primary Assurance Committee	Lead executive	1st Line of Defence **Management Control**			2nd Line of Defence **Corporate Oversight**								3rd Line of Defence **Independent Verification**							**Corrective Action**				**Risk and Assurance Analysis**			
							Management Oversight	Project Team Oversight	Sub-Committee	Clinical Audit/Peer review	Governance Committee	Audit Committee	MHL Scrutiny Committee	Development ommittee	Executive Committee	Ratings and formal declarations	Delivery Committee	Board	Internal Audit	External Audit	Expert Review/Accreditation	External Review	CCG	NHS Improvement	CQC/HSE	Action Plan	Increase Assurance	Validate Assurance	Add to IA Plan	**Overall Assurance Level** (From Risk Register)	**Maximum Acceptable Risk** (Target Risk Score)	**Current Risk Score** (Risk After Control)	**Risk Trend** (versus last report)

KEY to Bullets and Assurance Levels

●	**Negative Assurance**: gaps in the application of controls as designed by management have opened the system to risk of significant failure to achieve its objectives and left it open to abuse or error
●	**Limited Assurance** gaps in the application of controls as designed by management put the achievement of objectives at risk
●	**Significant assurance**: a sound system of controls has, for the most part, been consistently applied, minor inconsistencies have occurred but there is no evidence to suggest that the system's objectives have been put at risk
●	**Full assurance**: a sound system of controls has been effectively applied and manages the risks to the achievement of objectives.

Key to Strategic Objectives

1	Continuous quality improvements
2	Engagement to support delivery of a challenging agenda
3	Transformation to support internal and external sustainability

Key to Primary Assurance Committees

G	Governance Committee
Del	Delivery Committee
Dev	Development Committee
MHL	Mental Health Legislation Scrutiny Committee
E	Executive Committee

Key to Risk Scores

Low
Moderate
High
Extreme

Key to Risk Trend

↑	Improving
↔	Static
↓	Worsening

Risk Score Matrix

Impact	Likelihood				
	1 Rare	**2 Unlikely**	**3 Possible**	**4 Likely**	**5 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

Agenda item **15** **Enclosure** **Paper I**

Report to: Trust Board - 24th November 2016
Author: Alan Bourne-Jones, Risk Manager
Presented by: Marie Crofts, Director of Quality

SUBJECT: **Risk Management Framework Policy Document**

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

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

EXECUTIVE SUMMARY

The purpose of this paper is to obtain Trust Board endorsement of the Trust's Risk Management Framework document (formerly entitled Risk Management Strategy). **(Appendix 1).**

The Risk Management Framework (formerly Risk Management Strategy) has been reviewed and updated to reflect some significant changes to the Trust's risk management framework. The key changes contained within the Risk Management Framework are;

- Risk Appetite / 3 Lines of Defence model
- Directorates - Oversight Committees / Meetings – Terms of Reference
- Levels of Assurance
- Risk Co-ordinator role / Datix risk module

The publication of this document is an important initial step to meet the objective of embedding a robust risk management framework. However, work continues throughout the Trust to ensure that this fully achieved.

A key driver for these changes emanated from the annual internal review by PricewaterhouseCoopers (PwC). A draft version of this document was provided to PwC as evidence of compliance with their recommendations. The Risk Management Framework document will be presented to November Governance and Board in November for agreement.

RECOMMENDATIONS

The Board is asked to approve the Risk Management Framework document.

Corporate Considerations	
Quality implications	Evidence of effective risk management provides assurance that risks are being identified and addressed thereby improving the safety of staff and patients.
Resource implications:	This paper presents a model of risk management and the potential resource implication of embedding it within the Trust.
Equalities implications:	N/A
Risk implications:	This paper highlights the need to ensure risks are effectively managed between Directorates.

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

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

Reviewed by:		
Marie Crofts – Director of Quality	Date	8th November 2016

Where in the Trust has this been discussed before?		
Governance Committee	Date	18 November 2016
What consultation has there been?		
N/A	Date	

Explanation of acronyms used:	

1. INTRODUCTION

1.1 The Risk Management Framework (formerly Risk Management Strategy) has been reviewed and updated to reflect some significant changes to the Trust's risk management framework. The key changes are highlighted in this paper.

1.2 A key driver for these changes emanated from the annual internal review by PricewaterhouseCoopers (PwC). A draft version of this document was provided to PwC as evidence.

1.2 The Risk management Strategy has been reviewed and feedback obtained from;

- Internal audit – PwC
- Risk Co-ordinators
- Director of Quality / Assistant Director Governance & Compliance
- Trust Secretary

2. KEY CHANGES

The following areas are identified as significant changes;

2.1 **Risk Appetite** (page 8)

The following statement was presented by PwC and agreed at April 2016 Board Development Session:

'The Trust recognises that its long term sustainability depends upon the delivery of its strategic objectives and its relationships with its patients, the public and strategic partners. As such, the Trust will not accept risks that materially impact on patient safety. However the Trust has a greater appetite to take considered risks in terms of their impact on organisational issues. The Trust has greatest appetite to pursue innovation and challenge current working practices and reputational risk in terms of its willingness to take opportunities where positive gains can be anticipated, within the constraints of the regulatory environment." (Agreed 28/4/2016 PwC Board Development Session)

2.2 **3 x Lines of Defence model** (page 9 - 12)

In line with best practice and recommendation by internal audit, the Trust has adopted a *Three Lines of Defence* model. This is designed to provide a simple and effective way to enhance communications on risk management and control by clarifying essential roles and duties.

Adopting this model will help ensure;

- Risk management is embedded within the organisation;
- Risks are monitored more effectively by their owners;
- Actions are aligned with the risk;
- Risks are escalated to board committees appropriately;
- Risks are monitored consistently.

This was reviewed and agreed by the Executive Committee in September and October 2016.

2.3 **Directorates - Oversight Committees / Meetings** (page 41)

The Executive Committee requested that the Oversight Committees/meetings reporting arrangements were strengthened to ensure that risks impacting on more than one area was adequately reported/highlighted. A standardised Terms of Reference and agenda has been produced for these meetings to address this issue.

2.4 **Levels of Assurance** (page 32)

Over the last 12 months board committees have increasingly relied upon the Level of Assurance when reviewing reports. The opportunity has been taken to update these and add some guidance on their correct use for use by the authors of reports

However, it should be noted that the Levels of Assurance have been linked to a RAG (Red, Amber, Green) rating, with only Full Assurance receiving a Green rating. The bar has been set quite high to achieve a Full (Green) Assurance rating. The impact of this is that documents (e.g. Risk Dashboard) will predominately feature significant assurance (amber) ratings which may reflect a more cautious approach to reporting.

(Note; this was a Governance Committee Action)

2.5 **Risk Co-ordinator role** (page 40)

The Executive Committee (October 2016) recognised the key nature of the role of Risk Co-ordinator. This has been recognised by developing a "job description" to ensure consistency and the profile of the role. It is proposed that Risk Co-ordinators meet regularly until the framework becomes embedded.

2.6 **Datix risk module**

Whilst the new risk management framework was being developed a new risk register module was delivered in July 2016. This web-based system provides enhanced functionality to help deliver the new framework in terms of reports and effective use of tracking actions.

As with all new systems there are on-going refinements required as the system is used. However, each Directorate has had adequate training to update their risks and produce their own risk register reports.

3. SUMMARY

3.1 The Risk Management Framework is a significant document and is available for inspection by external organisations. It contains a large amount of information but it has to date provided adequate assurance to the CQC and our auditors that it is fit for purpose.

3.1 The review and update of this document was prompted by a PwC internal audit review which has resulted in a significant overhaul of our risk management structure and coincided with the delivery of the new risk module on Datix. This work of embedding arrangements is still on-going.

3.3 A number of the key elements contained in the document and that form part of the framework have been addressed and agreed in the last 6 months by the Executive (Executive Committee) and Non-Executive Directors (Board Development Session).

3.4 it is recognised that the publication of this document is an important initial step in embedding a robust risk management framework within the Trust. However, work remains in progress to ensure that this is now achieved.

3.4 It is proposed that the document will be presented to the November 2016 Board for final approval.

APPENDIX 1

RISK MANAGEMENT FRAMEWORK
(Formerly Risk Management Strategy)

(NOTE: This document is separate and distinct from the Trust Wide Policy on Assessing & Managing Clinical Risk & Safety in Health & Social Care Practice)

Version:	**V1.7**
Consultation:	Executive Committee – 24th October 2016 Director of Quality Assistant Director of Compliance & Governance Governance Committee Directorate / Locality Risk Co-ordinators Trust Secretary Internal Audit (PwC)
Ratified by:	Trust Board
Date ratified:	November 2016
Name of originator/author:	Alan Bourne-Jones
Date issued:	November 2016
Review date:	November 2019
Audience	All Staff

1. VERSION HISTORY

Version	Date	Reason for Change

1	October 2009	Full review as required by policy
2	February 2011	Full review as required by policy
3	August 2011	To reflect organisational changes
4	May 2012	To reflect organisational changes / policy standards
5	October 2013	To reflect organisational changes / policy standards – internal audit recommendations (not published on intranet – see V6). Reviewed by Governance October 2013 Committee before passing to Board.
6	November 2013	Updated to reflect October 2013 Board discussion and amendments
7	November 2016	Update to reflect significant reporting changes, Internal audit Report, Well Led Review, NED feedback and implementation of new Datix web based system

2. OWNERSHIP & CONSULTATION

The owner of this document is the Director of Quality

Consultation was undertaken with:

- Executive Committee – 24th October 2016
- Director of Quality
- Assistant Director of Governance & Compliance
- Locality Directors
- Directorate & Locality Risk Co-ordinators
- Governance Committee
- Internal Audit (PwC)

3. RATIFICATION DETAILS

This policy is reviewed by the Governance Committee and then ratified by the Board.

4. REVIEW ARRANGEMENTS

The Risk Management Framework will be reviewed every 3 years, in line with Trust policy.

EXECUTIVE STATEMENT

Delivering services responsibly requires us to manage risk effectively. We need to make the right decisions and do the right things for our patients, stakeholders and staff.

We have a Risk Management Framework in place to steer the way we identify, prioritise, manage and mitigate the risks we face. It ensures we tackle risk in a consistent way, with robust internal controls, and that every colleague understands their personal and collective risk-related responsibilities. The Framework meets external (CQC) and internal governance (Board, Internal Audit) requirements and is owned by Director of Quality.

Shaun Clee
Chief Executive

Ruth FitzJohn
Trust Chair

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SECTION 1 - INTRODUCTION

1. INTRODUCTION

1. INTRODUCTION

[2]gether NHS Foundation Trust provides health and social care to people with mental health problems and people with learning disabilities of all ages Across all services the Trust seeks to manage positively all risks to service users, their families and carers, staff, the wider public, the organisation and its objectives.

2. PURPOSE

This purpose of this document is to provide a comprehensive overview of the Trust's risk management framework

3. SCOPE

3.1 This policy applies to all staff (including management, students, locum & agency staff, volunteers and staff on honorary contracts and staff contractors) working at the 2gether NHS Foundation Trust.

3.2 The Trust uses a national IT system Datix which is configured to support the Trust's risk management processes and incident reporting requirements.

4. POLICY STATEMENT

The Trust's overall strategic aim with reference to risk management is to make the effective management of risk an integral part of management practice.

The Trust is committed to the development of a framework for managing risk in a co-ordinated, systematic and focused way.

Risk Management is an important aspect of every employee's role and is critical to the Trust's ability to provide quality services in an appropriate environment. Every member of staff has a responsibility for the management of and escalation of significant risks.

The Trust takes a holistic approach to risk management incorporating both clinical and non-clinical risks.

However, the Trust acknowledges that some risks will always exist and never be completely eliminated and accepts responsibility where such risk occurs, for ensuring robust mitigation is in place to minimise such risks.

5. UNDERLYING PRINCIPLES

The underlying principles of risk management in the Trust are that:

- Risk management is integral and central to the management and delivery of services;
- Every member of staff has a responsibility for the identification and management of risks;
- Suitable arrangements are in place to promote a culture of identifying both potential risks (i.e. pre-emptive) as well as actual (re-active), usually through Team meetings
- The Trust will create an transparent environment, where risks are openly and honestly discussed; where learning to improve services from all incidents is the key driver and dealt with in a positive and responsive way. All employees have a major role to play in identifying and minimising risks – both clinical and non-clinical. This can only be achieved if there is a progressive, honest and open work environment, where 'near misses' and untoward incidents are identified quickly and acted upon in a constructive way, without unnecessary recourse to disciplinary procedures;
- The Trust will aim to develop and maintain a reputation based on strong performance, competence in health and social care, reliability and openness.
- At all times the Duty of Candour will be the principle by which the Trust will operate where the risks are associated with care delivery to service users and families

All activities and decisions will be made against a backdrop of demonstrating the above principles. The Trust will seek to involve service users, carers, the local community and its own staff in matters that affect them, and ensure the manner of their participation is proactive and engaging that the Trust and its employees will always act professionally - listening and taking account of their views.

6. RISK MANAGEMENT - AIMS

The key aims are;

- Delivery of high quality safe and effective services which improve outcomes for service users and cause no harm
- Ensure people who use the Trust's services are cared for and treated by staff who practise in a knowledgeable and competent way;
- Maintain a safe environment for people who work in our services;
- Establish systems to identify, assess, manage, and monitor risk;
- Apply the principles of risk management throughout the Trust;
- Encourage the active participation of all staff in the management of risk;
- Create an environment where staff are committed to develop and change practice and systems in the light of research, good practice and evidence;
- Put in place adequate financial controls to minimise financial loss, maximising use of resources and safeguarding income;
- Fulfil its obligations to regulatory and statutory bodies and be accountable to local people and commissioners of services.

7. OBJECTIVES

To accomplish the aims the following objectives need to be achieved:

- The establishment and implementation of policies and procedures to ensure effective risk management;
- The regular monitoring and audit of policies and procedures;
- The regular reporting on the management of risks in the Trust to ensure lessons learned influence future action;
- The clear definition of roles and responsibilities and the provision of appropriate training for individuals, to enable them to undertake their role and responsibility competently;
- The establishment of processes to facilitate communication between individuals and groups, on all issues related to risks;
- The business planning and service development processes are informed and supported by risk management processes, the Trust risk register and Trust assurance framework.

8. DEFINITIONS

8.1 Risk Management is defined as;

An active and continual process which aims to reduce or eliminate the possibility of harm, damage or loss to people, property and services including deviation from expected organisational performance or the achievement of objectives.

8.2 Risk is defined as;

An event or series of events that could occur, generally as a result of a control failure caused by people, systems or external situation thereby impacting on the Trust's ability to meet its key objectives.

8.3 The Trust's three key strategic priorities are;

- Improve **quality** – safety, outcomes and experience;
- Increase internal and external **engagement;**
- Ensure we are **sustainable** and an effective partner, employer and advocate.

SECTION 2 - RISK MANAGEMENT FRAMEWORK

1 RISK MANAGEMENT FRAMEWORK – OVERVIEW

1.1 The Trust's risk framework consists of the following key elements;

- Risk Management Strategy;
- Risk Appetite / Tolerance;
- Three Lines of Defence model;
- Roles & responsibilities.

2. RISK MANAGEMENT STRATEGY

2.1 It is a requirement under the Trust's Standing orders that this document is approved by the Trust Board.

3. RISK APPETITE / TOLERANCE

3.1 This refers to the amount and type of risk that the Trust is prepared to accept or tolerate.

3.2 The Trust's risk appetite is established and approved by the Board for communication throughout the organisation.

General Risk Appetite Statement

'The Trust recognises that its long term sustainability depends upon the delivery of its strategic objectives and its relationships with its patients, the public and strategic partners. As such, the Trust will not accept risks that materially impact on patient safety. However the Trust has a greater appetite to take considered risks in terms of their impact on organisational issues. The Trust has greatest appetite to pursue innovation and challenge current working practices and reputational risk in terms of its willingness to take opportunities where positive gains can be anticipated, within the constraints of the regulatory environment." (Agreed 28/4/2016 PwC Board Development Session)

3.3 *Materiality* is defined/measured by reference to the Trust's Risk Scoring Tool which is found in Intranet - Risk Model Matrix **(Also Appendix 1)**

3.4. When a risk has been assessed and a score has been determined then it should be reviewed in the context of the following risk appetite matrix to ensure that appropriate response has been made in respect of the risk.

Risk Description	Risk Score	Risk Appetite, Management Action and examples of possible response
Extreme risk	**15 - 25**	**Outside Appetite** Escalate immediately upwards to Executive. Active management required and regular review. Consider risk avoidance strategies such as ending the activity or selecting a different method of achieving the objective.
High Risk	**Score 12**	**Risk Score 12** - Escalate immediately upwards to Executive to confirm within appetite. Reporting Threshold to Board Committees and BAF (Board Assurance Framework).
	8 - 10	**Within Appetite** Active management required and regular review. Aim to reduce risk level by reducing the probability or potential impact, or transfer the risk if possible.
Moderate risk	**4 - 6**	**Within Appetite** Actively manage locally and monitor changes in risk profile
Low risk	**1 - 3**	**Within Appetite** Monitor locally changes in risk profile and consider whether risk needs to remain on risk register in medium term

4. RISK ESCALATION

If the new risk scores 12 (or higher) then this should be escalated to the Executive Director responsible for the risk.

5. THREE LINES of DEFENCE

In line with best practice and recommendation by internal audit, the Trust has adopted a *Three Lines of Defence* model. This is designed to provide a simple and effective way to enhance communications on risk management and control by clarifying essential roles and duties.

Adopting this model will help ensure;

- Risk management is embedded within the organisation;
- Risks are monitored more effectively by their owners;
- Actions are aligned with the risk;
- Risks are escalated to board committees appropriately;
- Risks are monitored consistently.

5.1 FIRST LINE OF DEFENCE - OPERATIONAL

As the first Line of Defence, operational managers own and manage risks. They are also responsible for implementing corrective actions to address process and control deficiencies.

Operational management is responsible for maintaining effective internal controls and for executing risk and control procedures on a day-to-day basis. Operational management identifies, assesses, controls, and mitigates risks, guiding the development and implementation of internal policies and procedures and ensuring that activities are consistent with goals and objectives.

Operational management naturally serves as the first line of defence because controls are designed into systems and processes under their guidance of operational management. There should be adequate managerial and supervisory controls in place to ensure compliance and to highlight control breakdown, inadequate processes, and unexpected events.

This model has been refined to include the Executive Committee (1st line of defence) to provide appropriate oversight of risks before reporting to the Board Committees (2nd line of Defence). Other key forums for the oversight of risk include;

- Quality & Clinical Risk Committee;
- Operational Management meeting;
- SEIL (Senior Engagement & Integration Leads meeting);
- Associate Medical Directors meeting;
- Finance – Heads Of Finance Meeting;
- Locality Governance/Board Meetings.

5.2 SECOND LINE OF DEFENCE - OVERSIGHT

The second line is created by the oversight function(s) made up of Board committees, compliance and risk management. These functions set and monitor policies, define work practices and oversee the business frontlines with regard to risk and compliance.

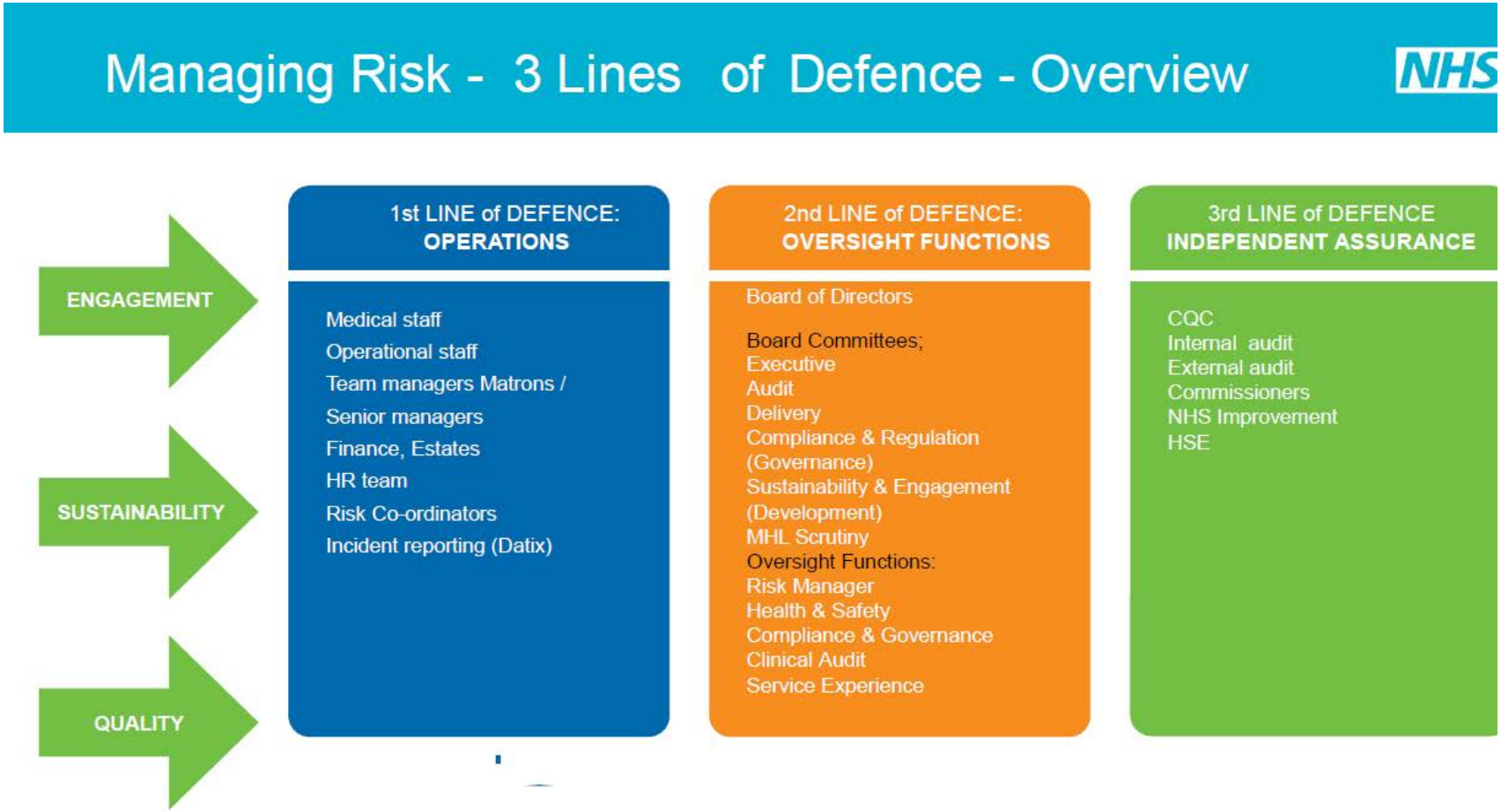
A key feature of the second line of defence is the Trust's committee structure.

5.3 THIRD LINE OF DEFENCE - INDEPENDENT OVERSIGHT

The third and final line of defence is that of auditors and external regulators. Both internal and external auditors regularly review both the business frontlines and the oversight functions to ensure that they are carrying out their tasks to the required level of competency.

Directors receive reports from audit, oversight and the business, and will act on any items of concern from any party; they will also ensure that the 'Three Lines of Defence' are operating effectively and according to best practice.

In addition, the Trust's Executive and Non-executive Directors will receive ad-hoc reports from NHS Improvement (NHSI) and Care Quality Commission that provide assurance around the well-being of patients and the organisation.


Managing Risk - 3 Lines of Defence - Overview
NHS
ENGAGEMENT
SUSTAINABILITY
QUALITY
1st LINE of DEFENCE:
OPERATIONS
Medical staff
Operational staff
Team managers Matrons /
Senior managers
Finance, Estates
HR team
Risk Co-ordinators
Incident reporting (Datix)
2nd LINE of DEFENCE:
OVERSIGHT FUNCTIONS
Board of Directors
Board Committees;
Executive
Audit
Delivery
Compliance & Regulation
(Governance)
Sustainability & Engagement
(Development)
MHL Scrutiny
Oversight Functions:
Risk Manager
Health & Safety
Compliance & Governance
Clinical Audit
Service Experience
3rd LINE of DEFENCE
INDEPENDENT ASSURANCE
CQC
Internal audit
External audit
Commissioners
NHS Improvement
HSE

3 LINES of DEFENCE MODEL – DETAILED STRUCTURE

Figure 1

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</table>

6. DUTIES ROLES & RESPONSIBILITIES

6.1 Chief Executive

- To be responsible for risk management in the Trust;
- To ensure that the appropriate arrangements are in place to manage risk across the Trust;
- To ensure staff are aware of their specific responsibilities, and processes are in place to identify and respond to training needs of employees;
- Ensure the Board is aware of the most significant risks for the organisation;
- Integrate risk management and line management responsibilities.

6.2 Executive Team

The Executive Team have a corporate responsibility to work with and challenge their executive director colleagues on the management of all corporate risks.

6.3 Medical Director

- To provide strategic medical leadership within the Trust and advise the Board on all medical issues;
- In partnership with the Director of Quality (Nursing &Social Care) and the Director of Engagement and Integration (AHPs) to take a lead role in the development, leadership and monitoring of clinical governance policy and arrangements within the Trust;
- To undertake the role of Responsible Officer in relation to medical revalidation.
- Caldicott Guardian.

6.4 Director of Quality

- To lead the Trust's Quality & Safety Programme;
- To develop a Quality Strategy for the Trust;
- To ensure the implementation of clinical governance policies, frameworks, standards, and support programmes;
- To ensure processes are in place for the management of clinical risk, the management of all incidents including serious incidents requiring investigation (SIRIs) and the management of poor clinical performance;
- To ensure all registered nursing staff maintain registration and revalidation in line with the Nursing and Midwifery Council Code of Conduct

6.5 Director of Finance and Commerce

- To co-ordinate the Trust's approach to financial risk management;
- To ensure processes are in place for the identification and management of financial risks;
- To ensure the implementation of an effective system of financial control;
- All matters of Estates management, including compliance with statutory requirements, Department of Health and National Standards, and the provision of a client orientated, cost effective maintenance and estate management service;
- To lead the development of estates, facilities, and IT to facilitate the Trust meeting its strategic objectives, values and vision.
- To Lead & co-ordinate on incidents of fraud

6.6 Director of Organisational Development

- To be responsible for Health and Safety;
- To be responsible for Occupational Health.

6.7 Director of Service Delivery/ Deputy Chief Executive

- To ensure that the Trust meets the national standards for tackling violence and general security management measures, and any subsequent advice or guidance issued by the NHS Security Management Service (SMS);
- To ensure effective delivery of services;
- Senior Information Risk Owner (SIRO).

6.8 Director of Engagement & Integration

- To be responsible for the development, delivery and governance of Social Inclusion activity;
- In line with Social Inclusion Strategy and in conjunction with the Director of Quality and lead professionals ensure the delivery of safe, effective evidence based practice, treatment and care consistent with the Trust's responsibilities that are underpinned by the principles of social inclusion.

6.9 Non-Executive Directors

- Ensure that financial and clinical quality controls and systems of risk management and governance are robust and implemented;
- As members of the Board they ensure that they are receiving sufficient assurance that the process of risk management is effective and that they key risks to the Trust are being effectively managed.

6.10 Trust Secretary

- Responsible for ensuring that the Trust complies with relevant legislation, constitutional and regulatory requirements and with the governance elements of the Provider Licence issued by NHS Improvement and the Trust Constitution;
- Establish procedures for the sound governance of the Trust, and will advise the Trust Board and Council of Governors on developments in governance issues;
- Information Governance;
- Board Assurance Framework (BAF).

6.11 Risk Manager

Whilst not owning the risks on the Risk Register, the Risk Manager will provide support, advice, challenge and guidance to management and staff on the management of their risks:

- Responsible for the development, implementation and maintenance of risk management systems;
- To develop and maintain a risk register for the Trust ensuring;
- Records identify risks in a structured way;
- Dependencies between risks are identified;
- Linkages between lower level risks and higher level risks are recognised and key risks are highlighted;
- Assignment of ownership of risks is at a level which has authority to assign resources to the management of the relevant risk;

- Risks are properly evaluated using the defined criteria which are applied consistently;
- To ensure that all new significant risks are escalated in a timely manner to the Trust Secretary and the appropriate executive;
- To maintain an overview of staff training in relation to risk management and ensure the Governance Committee is kept informed as to progress and difficulties.to manage litigation risks and prepare a half yearly report for the Governance Committee;
- Risk Manager will be supported by a Risk Co-ordinator from each Locality/Directorate.

6.12 Clinical Leads

- To advise and develop Clinical Governance in the light of national policy and research;
- To advise managers on issues related to poor clinical performance;
- To lead the development of standards of practice;
- To advise on the appropriate training provision.

6.13 Managers and Service Directors

- To ensure relevant policies, procedures and standards are communicated to staff and are implemented in each locality/directorate;
- To monitor the implementation and operation of risk management arrangements;
- To ensure business continuity arrangements and contingency plans are reviewed and kept up to date;
- To work in accordance with the Code of Conduct for NHS Managers;
- To implement specialist/clinical advice.

6.14 All Practitioners and Employees

- To work within Trust policies/procedures and standards;
- To work within relevant professional codes of practice;
- To bring to the attention of managers and/or professional leads any potential risks;
- To take responsibility for working safely and for identifying and monitoring risks to themselves and others;
- To listen carefully to issues raised by service users, carers and members of the public and take responsibility for alerting managers to any potential risks;
- To take responsibility for identifying and action own learning needs.

6.14 Specialist Advisors (e.g. Health & Safety, Occupational Health, Fire, Back Care, Facilities & Local Security Management Specialist**)**

- To advise managers/clinicians on Clinical Governance in the light of national policy;
- To advise when unsafe systems of work have been identified and ensure appropriate action is taken;
- To advise on the development of safe systems of work;
- Periodically, to systematically review all incidents to identify patterns and potential areas of risk;
- To report incidents to the HSE, MHRA, CFSMS;
- To identify unresolved risks in Governance Committee;

- To advise on the appropriate training provision.

6.15 Service Experience Clinical Manager (includes Patient Advice & Liaison Manager (PALS)

- To record all issues raised by service users, carers and members of the public and take responsibility for alerting managers to any potential risks identified;
- Periodically, to systematically review all inquiries, comments, suggestions and complaints to identify patterns of referral and potential areas of risk;
- To follow up any matters referred to managers to ensure appropriate action to manage identified risks has been taken;
- To identify unresolved risks in a report to the Governance Committee.

6.16 Council of Governors

- Council of Governors act as the voice for Staff and public members of the Trust. The Council of Governors meets on a bi-monthly basis;
- The Council has no direct responsibility for risk. However, one of its statutory duties is to hold the Non-Executive Directors (NED) individually & collectively responsible for the performance of the Board. This means that in each holding to account session at bi monthly council meeting it will receive assurance from relevant individual NED regarding assurance around risk to performance and actions to address.

6.17 Risk Co-ordinator (Locality & Directorate)

The Risk Co-ordinator has a number of responsibilities (see Job Description – Appendix 2)

- To provide day to day contact on risk issues for the Locality;
- To liaise with the Risk Manager to ensure Risk Register is maintained and monitored by the Locality Board;
- To ensure that new significant risks are escalated to the Risk Manager in a timely manner;
- To help develop good working practices through regular liaison with the Risk Manager and other Risk Co-ordinators.

6.18 Contractors

The Trust has a policy to ensure that: robust procedures for the management and control of contractors who are employed to carry out work or provide services, thereby ensuring that it meets its responsibility for the health, safety and welfare of its employees, so far as its reasonably practicable as required by Health & Safety legislation. Contractors Policy

6.19 Shared services (IT, Finance)

These arrangements are monitored through Oversight Boards and Service Level Agreements (SLA's). The Finance SLA is signed and agreed annually.

7. AUTHORITY

Based upon an assessment of risk all managers are authorised to:

- Use the resources within their management control to identify and control risks in the areas for which they have accountability.

Based upon an assessment of risk (to a level appropriate to the circumstances), all staff are authorised to:

- Take urgent action to prevent immediate and significant risk of harm, damage or loss.

SECTION 3 - RISK MANAGEMENT PROCESS

1. RISK MANAGEMENT PROCESS

The Trust's risk management process has the following key components;

- DATIX – Risk Module
- Risk Identification
- Reporting of risks
- Risk assessment (Risk Score/Categorisation)
- Risk Controls
- Risk Ownership
- Action Plans & Owners
- Committee Oversight
- Risk Reporting arrangements

2. RESPONSIBILITIES

2.1 The responsibility for the oversight of risks lies primarily with the following;

- Risk Manager
- Risk Co-ordinators (See Appendix 2)
- Risk Handlers/Owners

2.2 Responsibilities would include:

- Accuracy of risk record
- Risk score
- Level of Assurance
- Risk Categorisation
- Monitoring Actions

2.3 Where Actions to mitigate risks have been allocated to individuals then it is their responsibility to monitor and update the action on the Datix system. This is achieved by the regular checking of their Datix "To Do List" on the Datix system.

2. DATIX WEB

2.1 Datix is web-based patient safety software for healthcare risk management applications. The system delivers safety, risk and governance elements through a variety of integrated software modules, enabling a comprehensive oversight of risk management activities within the Trust.

3. RISK IDENTIFICATION

To identify and document key risks and threats to achieving the Trust's business objectives.

3.1 FRONTLINE STAFF

The Trust encourages staff to raise risks through their Team Managers who are responsible for onward reporting of risks.

Procedures and systems are in place to help ensure that Team meeting agendas consider the risks raised and the Team Manager to agree that they need escalation to their Risk Co-ordinator or Risk Manager.

3.2 RISK IDENTIFICATION WORKSHOP - ANNUAL

An annual Risk Identification Workshop will be facilitated by the Risk Co-ordinator in each Locality and Directorate and will involve frontline staff.

3.2 ORGANISATIONAL REPORTING

It is recognised that risks will be identified through other sources and a number of these are listed below:

- Incident Reports (Datix system);
- Risk assessments;
- Board & Committees (Corporate & Locality);
- Audit Reports;
- Project Risk Registers;
- Strategic/Business plans;
- Recommendations (External);
- Coroner reports (Regulation 28, Prevention of Future Death Reports**).**

Risks will be identified in a wide variety of ways including:

- Mandatory annual assessment by managers with health and safety responsibility of risks in their area's activities;
- Monthly review of financial risks by cost centre managers in line with budget reporting cycle;
- Each incident or adverse event report will trigger a risk assessment by the person responsible for that area of activity;
- Regular review by Board committees or the Board of trends in relation to incident reports, complaints, PALS referrals, performance data, business plan, financial;
- Information, health and safety audits and activities, clinical audits, claims, risk register data and changes;
- Independent audit, inspection and assurances that are reported to the Board;
- Committees;

- Board papers are required to discuss risk implications;
- The business planning process will include an assessment of risk;
- A regular assessment of strategic risks, controls and independent assurances is carried out by the Board.

It is the responsibility of Managers to report these when they become aware of risks arising from such sources to their Risk Co-ordinator or Risk Manager.

4 REPORTING OF RISKS

Once a risk has been identified it should be reported using the risk module of the Datix system. Datix: Log in to Datix

5. RISK ASSESSMENT (Risk Score / Categorisation)

Once the risk has been entered onto the risk register through the Datix system, the Risk Manager or Risk Co-ordinator is responsible for an initial assessment of the risk. This will involve the following steps;

5.1 RISK SCORE

- Undertake and confirm an initial risk score using the Trust's Risk Scoring Tool Intranet - Risk Model Matrix;
- Key components in determining the risk score are; the ***impact*** (of the risk if it happens) and the ***probability*** of the risk happening;
- Impact and probability are scored individually before multiplying together to produce a final risk score.

Example

IMPACT	X	PROBABILITY	RISK SCORE
3	X	4	= 12

5.2 TARGET RISK SCORE

- Record a target score which is the score that is aimed for once all mitigating actions have been completed.

6. RISK CATEGORISATION

Allocate the risk to one of the following categories;

- CLINICAL (Public health and Patient Focus);
- SAFETY (People and Estates);
- STAFFING & COMPETENCY;
- FINANCIAL (Financial Soundness & Internal Control);
- GOVERNANCE (Legal & Regulatory**);**
- OPERATIONAL (Continuity of Service & IT systems);
- STRATEGY (Change and Marketing);
- SECURITY (Violence & aggression, Theft).

This will be important in ensuring that the risk is overseen by the correct Trust Committee.

7. RISK CATEGORIES

Some of the key areas of risk are detailed in this section;

7.1 CLINICAL **(**Public health and Patient Focus) Clinical Policy Framework

The Trust will ensure that a clinical policy framework is in place that provides guidance to staff for the delivery of clinical services and complies with external requirements, e.g. control of infection, care programme approach, NICE guidelines.

Prevention & Control of Infection

The Trust has overall responsibility for infection prevention and control and will monitor promotion of these issues through the receipt of the annual infection control report, work and action plan.

The Infection Control Sub-Committee will regularly agree and review the work programme for the Infection Prevention and Control to ensure Trusts issues are identified and prioritised across the areas of:

- Education and training;
- Audit;
- Surveillance;
- Outbreak management;
- General advice and support.

They will advise on national policies, procedures and guidelines. The sub-Committee also should ensure that compliance with the Health and Social Care Act 2008.

Service User and Carer Involvement

The Service Experience Team and the Social Inclusion Team have important roles in the Trust's approach to Patient and Public Involvement. These services will be the first point of call for many with an enquiry, concern, suggestion or complaint. Other engagement meetings between staff and those in receipt of services also provide important feedback. The Trust will use these opportunities to learn from the concerns of or difficulties experienced by individuals or families to identify risks and ensure they are appropriately addressed.

Consent to Treat

The Trust will ensure that sound processes are in place to obtain the valid consent or authority for treatment of the people who use our services.

Mental Health Act 1983 (Amended 2007) and Mental Capacity Act 2005

The Mental Health Act and Mental Capacity Act (and the Codes of Practice) form the main framework for the delivery of support to people who fall within its scope. The Trust, individual practitioners and managers have specific duties and responsibilities under the Act. The Trust will ensure there are adequate systems in place to safeguard the rights of service users (and nearest

relatives) and ensure the duties and responsibilities of staff and the Trust are fulfilled.

The Board has established a Committee of the Board to be known as the Mental Health Legislation Scrutiny Committee. Its overall duty is to ensure that the Trust complies with the Mental Health and Human Rights Acts and any associated codes of practice in relation to patients detained under the MHA; MCA or those subject to supervised community treatment.

7.2 FINANCIAL (Financial Soundness & Internal Control) Internal Control

The Trust is a complex organisation operating with a high degree of delegated authority in an environment of very significant demand for services. The risks to proper financial control are substantial. The Trust will maintain an effective system of internal control for all financial management systems thereby ensuring that financial losses are minimised, resources are used to realise the maximum benefit and that income is safeguarded. Particular care will be taken to ensure risk sharing arrangements are documented with responsibilities clearly attributed. Such agreements will be regularly monitored and reviewed.

External Influences

Risk involving external financial pressures within NHS which may increase financial pressures internally. This may result in the quality of services being adversely affected.

Significant Control Issues

Significant control issues need to be reported to NHS Improvement and others. A single definition of a "significant internal control issue" is not possible. The Department of Health advises that the Trust will need to exercise judgement in deciding whether or not a particular issue should be regarded as falling into this category. Factors which may be helpful in exercising that judgement include:

- The issue seriously prejudiced or prevented achievement of a principal objective;
- The issue has resulted in a need to seek additional funding to allow it to be resolved, or has resulted in significant diversion of resources from another aspect of the business;
- The external auditor regards the issue as having a material impact on the accounts;
- The Audit Committee advises the issue should be considered significant for this purpose;
- The Head of Internal Audit reports on the issue as significant, for this purpose, in their annual opinion on the whole of risk, control and governance;
- The issue or its impact has attracted significant public interest or has seriously damaged the reputation of the organisation.

7.3 GOVERNANCE (Legal & Regulatory)

NHSImprovment (NHSI)

NHS Improvement (formerly Monitor and the Trust development Authority TDA)) regulates all NHS Trusts including Foundation Trusts. They ensure they are well-managed and financially strong so that they can deliver safe effective and value for money healthcare for patients. The Trust is obliged to act within its

terms of Authorisation. The Board of Directors and Council of Governors will ensure the Trust remains within its terms of authorisation at all times. The Board of Directors will manage any risks relating to its terms of authorisation and ensure NHSI is informed of any breach or potential breaches.

Care Quality Commission

The Care Quality Commission (CQC) is the independent regulator of all health and adult social care in England and looks after the interests of people detained under the Mental Health Act with effect from April 2009.

The Trust is required under the Health & Social Care Act 2008 to register with CQC and declare compliance against a set of Outcomes for each location we operate from. The Board of Directors will ensure the Trust maintains and manages any risks to its registration and any subsequent actions identified from the registration process.

Employment Legislation

As an employer the Trust is required to comply with current employment legislation. It is, therefore, important that policies, procedures and practice are in place to minimise the risk of the Trust contravening this legislation. The Trust should also ensure in implementing these policies that responsibilities are clearly defined, training is provided and information and support is given to those who carry out these roles to enable them to perform their roles effectively.

Equality Act 2010

The Equality Act aims to simplify the law by bringing together several pieces of anti- discrimination legislation. The Government has stated its intention to make sure that equality and fairness are at the centre of its overall approach and the Equality Act is a key means of achieving this

Equality Impact Assessment

Under the Equality Act 2010 the Trust has a statutory duty to publish:

- Evidence of analysis that has been undertaken to establish whether our policies and practices have (or would) further the aims of the general equality duty;
- Details of the information that we considered in carrying out this analysis;
- Details of engagement (consultation / involvement) that we undertook with people whom we consider would have an interest in furthering the aims of the general equality duty1.

In order to meet the requirements of this duty the Trust will use the Equality Impact Assessment screening tool or full tool which has been developed to be compliant with the Equality Act 2010.

Safeguarding

Children - Section 11 of the Children Act 2004 places a duty on NHS Foundation Trusts to make arrangements to ensure that, in discharging their functions, they have processes which safeguard and promote the welfare of children In order to do this the Trust agrees that the general principles they should apply (as set out in 'Working Together to Safeguard Children' DOH 2010). The Trust has in place a Safeguarding Children policy available to all staff on the Trust intranet.

Adults – The Trust, along with every significant statutory agency in Gloucestershire and Herefordshire are signed up to the respective multi agency Safeguarding Adult Policy and Procedures. The Trust has in place a Safeguarding Adults Policy available to all staff on the Trust's intranet.
The Trust Policy and Procedures set out how professionals should work to:

- Prevent abuse from happening;
- Protect those who have allegedly been abused;
- Improve the lives of those who have suffered the negative impact of abuse.

Health Records
Health Records are central for the provision of care to the people to whom the Trust provides services. Errors in diagnosis and treatment can occur, if the information in health records is either absent or illegible. The Trust will ensure the standards set for Health Records are clearly communicated, and adhered to by staff. Regular monitoring of these standards will be undertaken, and their findings reported to the Trust's Health & Social Care Records Sub-Committee.

7.4 OPERATIONAL (Continuity of Service & IT systems)
Communication
The Trust recognises its responsibility to establish the right environment in which communication takes place, and also the systems through which it can be facilitated. Individuals also have a responsibility to ensure appropriate communication takes place. This includes communication between team members, different professional groups, between staff and service users or carers, and between different parts of the health service and other appropriate agencies. The failure of communications can lead to serious consequences for service users and carers.

Loss of Services
The Trust needs to maintain a strategic and operational process which foresees changes to service delivery and enables risks to be identified and controlled. This will be through a Business Continuity Strategy.

Information Systems
Information systems are an important aspect in the management of risk. It is essential that the Trust complies with data protection and freedom of information legislation and also ensures that data is safeguarded, properly stored and available for appropriate access. The Trust will maintain sound systems of information governance

7.5 SAFETY (People and Estates)
Suicide Prevention
Suicide is a major cause of death. Mental ill health and the misuse of alcohol and drugs are significant risk factors. The Trust will contribute towards the development, implementation and maintenance of a multi-agency suicide prevention strategy with key external stakeholders. The Trust will regularly audit the physical environment within its hospitals and community services and consider any recommendations that will assist in minimising the risk of suicide or serious self-harm.

Serious Incident Reviews

The Trust is committed to ensuring that thorough investigations of serious incidents, complex complaints and claims are undertaken. These reviews where possible will be in conjunction with service user and family involvement under the Duty of Candour principles.

Learning from these events is the key driver and establishing actions and mechanisms to put in place to avoid, wherever possible, the recurrence of similar events.

Health and Safety

Health and Safety legislation is wide ranging. The key principles which are incorporated into the legislation are that employers:

- Assess the risks and hazards;
- Design and operate safe systems of work;
- Provide training, instruction, information and supervision;
- Monitor and maintain safe systems of work.

Key areas that need to be addressed by the Trust are:

- Handling and movement;
- Personal safety;
- Monitoring contractors;
- Control of substances hazardous to health;
- Occupational Diseases;
- Hazards arising from buildings or equipment.

To respond to these significant issues the Trust will develop a Health and Safety plan that will identify and manage its priorities.

Environmental Risks

- Fire;
- Control of infection;
- Waste and environmental issues;
- Major incidents.

The Trust will maintain plans to address these issues.

Shared Premises

The Trust operates a number of services out of buildings that it does not own, and Trust staff work in premises belonging to other agencies. In addition, Trust premises are used by external contractors and private individuals.

It is essential that agreements are drawn up to reflect the responsibilities of respective parties to safeguard the Trust and its employees.

7.6 SECURITY

Key areas that need to be addressed by the Trust are:

- Security for servicer users, their families, carers and staff.

7.7 STAFFING & COMPETENCY

In order to provide quality care it is important to deploy staff with the appropriate skills, knowledge and attitudes.

. The Trust will ensure there are systems in place to:

- Recruit staff with the skills, experience and knowledge to undertake the job;
- Verify the qualification and registration of all staff including temporary and locum staff, and induct these staff appropriately into the workplace;
- Train, supervise and support staff in the execution of their duties;
- Monitor the utilisation and skill mix of staff;
- Plan for future staffing needs;
- Provide opportunities for staff to continuously develop;
- Supervise and support individuals in the execution of their duties and through periods of change;
- Manage performance where it does not meet the required standard.

The Director of Quality; Medical Director and Director of Engagement and Integration have responsibility for the professional development of all health and social care professionals. They also have responsibility for the articulation of clinical and professional standards that staff are to operate within through such mechanisms and policies and procedures. In addition registered staff are expected to work within their relevant code of professional practice and have their own professional accountability. Such professional over sight structures will be developed in close collaboration with the Director of Human Resources, operational managers and clinical leads.

7.8 STRATEGY (Change and Marketing)

External and Strategic Risks

The political environment, policy developments, legislative and regulatory changes, movements in public opinion and media attention are among the many factors that may influence the Trust's ability to fulfil its objectives. The Trust must ensure it has mechanisms which highlight such influences and plans for such risks to the achievement of its purposes through regular Chief Executive and Chair's reports to the Board. Board reviews of progress with its business plan and the treatment of key risks and iterations of its Annual Plan where strategic risks are identified, ranked and addressed, must be addressed as far as is reasonably practicable.

The Development Committee has the specific role of scanning the business horizon for such external and strategic risks and the Board Assurance Framework assists in the management and control of these risks.

8. RISK ALLOCATION

A risk should be allocated to;

- Locality (CYPS, Herefordshire, Countywide & Gloucestershire Localities);
- Directorate (Finance & Commerce, Quality, Organisational development, Service Delivery, Engagement & Integration and Medical)

9. RISK OWNERSHIP

- Risk Owners are generally allocated to senior management and this usually at Service Director/Executive level;
- Responsible for management of the risk to ensure that suitable actions taken to mitigate;

- To ensure risks are escalated through line management where risk is failing to respond to appropriate actions.

10. CONTROLS

Record details of key controls currently in place to mitigate the risk

11. ACTION PLANS & OWNERS

Identify and record details of actions planned to mitigate risks;
Details of action

- Person responsible for Action (i.e. Action Owner);
- Dates for completion.

Staff allocated action plans will be notified.

11.1 Action Owner (Handler)

- To undertake day to day responsibility for leading actions to mitigate risk;
- To report concerns to the risk owner.

12. RISK REJECTION

The ability to reject risks is limited to Datix Administration users in order to provide a strong control environment around this functionality. An additional level of control is that the Datix system provides an audit trail where this has occurred. However, it is essential that all staff are both fully aware of how to raise a risk and how to escalate within the organisation should they feel it is necessary to do so. The Trust's approach is one of openness and transparency to the raising of risks and encourage staff to have robust conversations at team meetings and locality Governance meetings to ensure their voice is heard appropriately,

SECTION 4 – OVERSIGHT & REPORTING

1. BOARD COMMITTEE OVERSIGHT (SECOND LINE OF DEFENCE)

Each Risk shall be allocated to one of the following Board Committee for oversight purposes;

- Audit Committee;
- Compliance & Regulation (formerly Governance);
- Mental Health Legislation Scrutiny Committee;
- Sustainability & Engagement (formerly Development);
- Delivery.

2.1 BOARD COMMITTEE - RESPONSIBILITIES

AUDIT COMMITTEE

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. The Audit Committee will monitor the implementation of the Trust's strategic risk management objectives and plans; ensuring appropriate integration with the wider organisational objectives and will be responsible for receiving and challenging assurance in respect of all strategic and corporate risks.

BOARD COMMITTEES

Through monitoring of allocated corporate and strategic risks from the Trust risk register these Committees will seek assurance that potential threats at strategic and operational levels are systematically identified, assessed and, as far as is reasonably practicable, mitigated.

2. REPORTING ARRANGEMENTS

EXECUTIVE COMMITTEE (FIRST LINE OF DEFENCE)

1.1 The Executive Committee has a key role in ensuring that risks are reported appropriately to Board Committees. The Executive Committee will receive reports on;

- Trust's designated "Top 5 Risks";
- Risks with risk score 12 and above (see risk appetite);
- Higher scoring risks (with a score of 9 and above) with Limited Assurance;
- New Higher scoring risks

1.2 This review will ensure that risks have been adequately challenged and appropriate actions in place before being reported to the appropriate Board Committee.

2. DIRECTORATE/LOCALITY REVIEWS (FIRST LINE OF DEFENCE)

2.1 Each Directorate and Locality will review the risks owned by their respective Executive/Service Director. This will be undertaken formally at;
- Directorates - Senior Management Team meetings/Committees
- Locality Governance / Boards.

(See figure 1 for details)

2.2 This review will ensure that risks have been adequately challenged and appropriate actions in place before being reported to the appropriate Board Committee.

3. RISK REGISTERS

The Trust needs a mechanism to understand its comprehensive risk profile. The risk register is a single document that is a central log of clinical and non-clinical risks that threaten success in achieving the Trust's aims and objectives. It provides a structure for collating information about risks that helps both in the analysis of risks and in decisions about whether or how those risks should be treated. The Risk manager will oversee management of the risk register through Datix.

Risk Appetite

In line with the Trust's risk appetite, only those risks with a risk score of 12 and above are reviewed by Board Committees. Risks below this risk score will be reviewed by Locality and Directorate meetings (Including the Quality & Clinical Risk Sub-Committee).

Reporting Frequencies

The risk register is generally reviewed each quarter by Board Committees (including Audit Committee) on behalf of the Trust Board.. The Trust Board then directly reviews the risk register annually.

The Executive Committee will review key risks each month with a comprehensive review each quarter.

Other Directorate/Locality oversight committees/meetings will be reviewed at least quarterly, but this will generally be monthly.

4. RISK DASHBOARD

This document is produced by the Risk Manager each quarter for the Executive Committee. The purpose of the Dashboard is to provide the committee, with a view of the Trust's risk management performance in respect a range of activities by using KRIs (Key Risk Indicators).

5. BAF (BOARD ASSURANCE FRAMEWORK)

5.1 The Trust will maintain a Board Assurance Framework to provide it with a comprehensive method for the effective and focused management of the principal risks to meeting its objectives. The assurance framework will provide a balance of assurances across all the organisation's key business areas without becoming unnecessarily detailed.

5.2 The Board will ensure the assurance framework adequately covers the principal **objectives and risks to achieving them, the controls to manage these risks,** assurances about the effectiveness of the operation of the controls and identifies to the Board where there are significant control weaknesses and/or lack of assurance. To achieve this, each element will be incorporated in the assurance framework as it is developed so that the whole framework grows evenly across all of the main areas of activity (suitably weighted to reflect importance). Significant actions arising from framework monitoring will be incorporated into the Trust business plan and reported upon quarterly.

5.3 The content of the BAF is influenced by the higher scoring risks that appear on the corporate risk registers. The Risk manager and Board Secretary consider those risks that have a risk score of 12 and above.

5.4 The BAF is presented to the Trust Board twice a year and to the Audit and Executive Committees quarterly.

6. ASSURANCE LEVELS

6.1 Boards can only properly fulfil their responsibilities if they have a sound understanding of the principal risks facing the organisation. Boards then need to determine the level of assurance that should be available to them with regard to those risks.

6.2 The Trust will ensure that external reviews are effectively co-ordinated and any recommendations considered by the Board and where appropriate recommendations are implemented.

6.2 To assist with this process and provide a consistent approach, Levels of Assurance are defined as follows:

Figure 3 – Levels of Assurance

Classification	Description	Assurance Level = identify at least 2 x factors from each level:	Control
Full assurance	A sound system of controls has been effectively applied and manages the risks to the achievement of the objectives	• No incidents/failures in last 12 months • Management confidence high that controls are embedded and evident that risks managed • There has been independent verification within the last 12 months to confirm this level e.g Internal / External Audit Report, CQC inspection report or other (Internal Audit Report – Low Risk) • Either no Action plans required or that Action Plans are complete with verified evidence	• Assurance Levels to be signed off by Executive Lead • Changes to Assurance Levels should be reported to the Board committee with oversight. (particularly Negative/Limited moving to Significant/Full) • Higher Scoring Risks (12 and above) can have Significant /assurance if it can be demonstrated that no further action can be taken to reduce the risk score, possibly due to outside forces (e.g. recruitment market, economic factors)
Significant assurance	A sound system of controls has, for the most part, been consistently applied, minor inconsistencies have occurred but there is no evidence to suggest that the system's objectives have been put at risk	• Whilst there may be incidents reported there have been no significant failures/incidents in the last 12 months. • The risk is being adequately managed and with appropriate action plans in place. • An independent review (Internal audit report -Low Risk) • Action Plans in place, well progressed and monitored effectively	
Limited assurance	Gaps in the application of controls as designed by management put the achievement of objectives at risk	• These risks give concern as it is recognised that the risk has materialised with a number of incidents or a serious incident. • Unable to confidently confirm the risk is adequately managed by management • An independent review has highlighted a number of weaknesses (Internal audit Report medium / high risk). • Action Plans which will take at least 6 months to complete but are being monitored effectively	
Negative assurance	Gaps in the application of controls as designed by management have opened the system to risk of significant failure to achieve its objectives and left it open to abuse or error	• Risk poses an immediate, significant immediate threat evidenced by a number of or a serious incident that has actually occurred • Risk is not controlled and little prospect of this happening in next quarter. • Independent Review with a number of significant findings (Internal Audit Report = High Risk) with Action Plans not completed. • Action Plans & monitoring arrangements being developed , not yet in place	

SECTION 5 – OVERSIGHT & REPORTING

1. TRAINING

1.1 Appropriate training is an essential prerequisite of safe working. The Trust will assess the risk management training needs of all staff and develop, implement, monitor and training compliance ensures staff receive adequate training and professional education to enable them to carry out their duties safely.

1.2 Particular attention will be paid to the need for appropriate induction and training in risk assessment, risk management, health and safety, fire safety, managing violence, resuscitation, responding to complaints and professional updating.

1.3 Training arrangements are contained on training profiles which reflect specific roles and responsibilities.

1.4 Training records will be kept, monitored and reviewed and inadequate attendance rectified. The Trust maintains a comprehensive Training Needs Analysis document that identifies staff groups and the training that is applicable to them. This document is managed by the Trust's Training & Education department.

1.5 <u>Risk Management Awareness Training for Trust Board Members</u>
Risk Management awareness training for Board members will be provided as an integral part of the Board Development Programme. A risk management awareness session will be held on at least an annual basis. This will normally be related to developments in the service, national publications or investigations e.g. Investigation into Mid Staffordshire NHS Foundation Trust

1.6 Board Development days will take place on an ad hoc basis during the course of the year. At least one of these will examine risk and risk management.

2. AUDIT/INSPECTION

2.1 <u>Clinical Audit</u>
Clinical Audit is a clinical initiative that seeks to improve the quality of any outcome of patient care through structured peer review, whereby clinicians examine their practices and results against agreed national (eg NICE) or local standards and modify their practice where indicated. It is intended to support healthcare practitioners to measure the extent to which their day-to-day practice is consistent with what is believed to be best practice, and to make improvements in actual practice if needed. The Trust regards clinical audit as

an important tool in promoting the adoption of clinically effective practice and is committed to maintaining an effective programme of review.

2.2 Internal Audit

The integrity of the Trust's arrangements for financial, clinical and operational management and control is a fundamental prerequisite of sound risk management. The Trust will actively support a comprehensive programme of internal audit based on an assessment of risk and respond positively to the auditor's findings and recommendations.

2.3 Safety Audit

Compliance with safety requirements including health and safety legislation and internal policies is central to the welfare of staff and service users. An annual audit of Health & Safety policy implementation will be carried out in accordance with the guidance provided. A report of the annual audits will be presented to the Governance (Compliance and Regulation) Committee. Significant risks will be reported to the Risk Manager for inclusion on the risk register**.**

2.4 Health & Safety Manual

The Trust operates a Health & Safety Manual which incorporates annual self-assessment processes. Managers and Team Leaders have responsibility for a range of health and safety functions for the areas of work, staff, contractors and volunteers covered. The Health & Safety Manual is a source of information and advice about the discharge of these responsibilities, a record of the performance of these duties and a plan to help identify and meet further health and safety needs.

2.5 External Audit

The NHS Foundation Trust Council of Governors is responsible for appointing auditors. The Council must ensure that, as part of the appointment process, the appointed auditors meet the criteria specified in legislation, and must have regard to NHS Improvement's guidance on appointment.

3. PROCESS for MONITORING COMPLIANCE

To ensure compliance an audit of the Risk Management Framework will be undertaken every three years, commissioned by the Trust Secretary.

The audit criteria will include assessing compliance against the following standards:

- Ensuring that there is an organisational risk management structure, together with all committees/sub committees/groups have some responsibility for risk;
- How the Trust Board or high level committees review the organisation-wide Risk Register;
- Process for the management of risk locally, which reflects the organisation-wide risk management strategy;
- Duties of key individuals in respect of risk management activities;
- Authority of all managers with regard to managing risk;

- Process for assessing all types of risk;
- Process for ensuring a continual, systematic approach to all risk assessments is followed throughout the organisation;
- Assignment of management responsibility for different levels of risk within the organisation.

The results of the audit will be presented to the Governance Committee who will be responsible for the development and monitoring of any identified actions within the scope of the audit.

In addition, as part of their annual reporting requirement, the Trust's internal auditors review and report on the adequacy of the risk management arrangements at the Trust.

4. COMMUNICATION OF THIS STRATEGY

A copy of this document will be made available to all staff on the Trust's intranet site. There is no restriction to the distribution of this policy.

5. CONCLUSION

The Trust is committed to the development of a framework for managing risk in a co-ordinated, systematic and focused way, and this enables employees to take appropriate and proportionate risks, in accordance with agreed procedures. The Trust seeks to manage positively all risks to service users, their families and carers, and staff across all services.

6. ASSOCIATED DOCUMENTATION

The Equality Impact Assessment appears on the Trust's intranet.

APPENDIX 1

Table 1 Consequence scores

Choose the most appropriate domain for the identified risk from the left hand side of the table Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards

Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Table 2 Likelihood score (L)

What is the likelihood of the consequence occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood score	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur,possibly frequently

Note: the above table can be tailored to meet the needs of the individual organisation.

Some organisations may want to use probability for scoring likelihood, especially for specific areas of risk which are time limited. For a detailed discussion about frequency and probability see the guidance notes.

Table 3 Risk scoring = consequence x likelihood (C x L)

	Likelihood				
Likelihood score	**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

Note: the above table can to be adapted to meet the needs of the individual trust.

For grading risk, the scores obtained from the risk matrix are assigned grades as follows

1 - 3	Low risk
4 - 6	Moderate risk
8 - 12	High risk
15 - 25	Extreme risk

Instructions for use

1 Define the risk(s) explicitly in terms of the adverse consequence(s) that might arise from the risk.

2 Use table 1 (page 13) to determine the consequence score(s) (C) for the potential adverse outcome(s) relevant to the risk being evaluated.

3 Use table 2 (above) to determine the likelihood score(s) (L) for those adverse outcomes. If possible, score the likelihood by assigning a predicted frequency of occurrence of the adverse outcome. If this is not possible, assign a probability to the adverse outcome occurring within a given time frame, such as the lifetime of a project or a patient care episode. If it is not possible to

determine a numerical probability then use the probability descriptions to determine the most appropriate score.

4 Calculate the risk score the risk multiplying the consequence by the likelihood: C (consequence) x L (likelihood) = R (risk score)

1. 5 Identify the level at which the risk will be managed in the organisation, assign priorities for remedial action, and determine whether risks are to be accepted on the basis of the colour bandings and risk ratings, and the organisation's risk management system. Include the risk in the organisation risk register at the appropriate level.

For grading risk, the scores obtained from the risk matrix are assigned grades as follows

1 - 3	Low risk
4 - 6	Moderate risk
8 - 12	High risk
15 - 25	Extreme risk

APPENDIX 2

JOB DESCRIPTION

RISK CO-ORDINATOR

The person appointed will be a senior member of staff and will be appointed by the Locality Director / Directorate Executive

RESPONSIBILITIES / DELIVERABLES

- To attend Risk Co-ordinator meetings or arrange for appropriate deputy to attend
- To ensure that risks entered on the Datix risk module are assessed and agreed in a timely manner.
- To have overall responsibility for the risk management process as laid out in the Risk Management Strategy
- To ensure that oversight committees/ Team meetings review their Locality / Directorate risks each month.(See standard Agenda – appendix 3)
- To ensure that mitigating Action Plans are addressed and that completion dates are monitored/escalated.
- To provide accurate, complete assurance reports at Locality Boards / Directorate Meetings.
- To ensure that risks impacting on other Localities / Directorates are reported to them.
- Liaise and escalate risks scoring 12 and above immediately to;
  - Service Directors
  - Executive
  - Risk Manager
- To undertake a Risk Identification Workshop annually, with the involvement of frontline staff
- To provide internal auditor, regulatory bodies and Risk Manager with evidence of compliance with the above
- To put in place arrangements to allocate mitigating actions onto the Datix risk module and monitor their progress. This is achieved by contacting/ensuring/promoting Action Owners to review their “To Do List” daily

SKILLS

To be trained in the use of the Datix risk module to the level of;

- To input new risks
- To produce reports
- To add Actions
- To train other users

APPENDIX 3

[2]GETHER NHS FOUNDATION TRUST
RISK OVERSIGHT COMMITTEES/MEETINGS

TERMS OF REFERENCE – STANDARD

Constitution

1. The Board has endorsed the Trust's Risk Management Framework document (November 2016). This document details the 3 Lines of Defence model that is designed to provide a simple and effective way to enhance communications on risk management and control by clarifying essential roles and duties. (Appendix 1)

2. A key element of this model is the Oversight Committees/Meetings and this standardised Terms of Reference is provided for each of these forums to adopt.

3. The Oversight Committees Meetings are:
   - Operational Risk Management Meeting
   - Associate Medical Directors meeting
   - HR Team Leads Meeting
   - Finance – HOF Function Meeting
   - Quality & Clinical Risk Committee
   - Senior Engagement & integration Leads

Membership

4. The membership will comprise of;
   - Lead Executive – Chair
   - Directorate Risk Co-ordinator – Secretary

   At the discretion of the Chair, the membership of the committee will be senior staff from within their Directorate.

Quorum

5. 3 members.

In Attendance

6. At the discretion of the Chair, other officers of the Trust may be invited to attend meetings of the Executive Team for specific items.

Substitutes

7. The Chair may nominate a suitably qualified substitute to attend the meeting.

Frequency of Meetings

8. These meetings will meet each quarter as a minimum to consider and review their risks.

Purpose / Duties

9. The Oversight Committee/Meetings are responsible for ensuring that existing risks are reviewed and that appropriate mitigation is in place with documented actions.

   To ensure that adequate arrangements are in place to identify new risks.

   To ensure that arrangements are in place to ensure that other Directorates are aware of those risks that impact on them.

   To ensure that risk registers are accurate and complete on the Datix system

Reporting

10. Each Oversight Committee/meeting will report key risks to the Executive Committee (1st Line of Defence) in the first instance and before escalating to the appropriate board committee (2nd Line of Defence)

Other Matters

11. It is recognised that a number of Oversight committees/meetings are already established. These Terms of Reference should be formally considered and adopted by each of the Oversight Committee/Meetings.

Oversight Committees / Meetings

AGENDA - Standard

1. To present Directorate Risk Register from Datix

2. To review mitigating actions noting;
   - Actions completed/overdue

3. To consider and confirm
   - Current risk score – current
   - Level of Assurance
   - Risk Ownership
   - Risk Handler

4. To consider if risks should be;
   - Escalated to Executive Committee
   - Referred to other Directorate
   - Closed with rationale

5. To record any new risks

Appendix 4

TRUST POLICIES

The following key policies and links are provided as they are particularly relevant to the management of risks within the Trust;

Risk Policy - 2gether Trust wide policy on assessing and managing clinical risk in health and social care

Safeguarding Adults Policy

Safeguarding Children

Health and Safety Policy (2015)

Fire Safety Policy

Risk Assessment Policy (2011)

Health and Safety Policy (2015)

Assessment and Care Management Policy incorporating principles of the Care Programme Approach

Whistleblowing Policy (2015)

Data Protection & Confidentiality Policy

Information Security Policy

Policies - Estates

Violence & Aggression Policy (2016)

Security and Resilience Policies

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Audit Committee

DATE OF COMMITTEE MEETING: 2 November 2016

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

Internal Audit Progress Report
The Committee received an update on progress against the Internal Audit Plan and noted changes to the start dates for some reviews, which would now begin in Q4. A review of phase 2 of the Service Line Reporting project would now be included in the 2017/18 plan. Four final reports were received by the Committee.

Contract Review Phase 1
This review had been classified as low risk, with 1 low risk finding relating to inadequate detail in the NHS England and Herefordshire CCG contracts regarding reporting periods and timeliness of reporting. Several areas of good practice had been identified. The equivalent review last year had produced a medium risk classification. Phase 2 of the review was due to commence later in November 2016.

CQC Implementation Plan
This review produced an overall classification of low risk. The audit report highlighted a number of areas of good practice, with 14 out of the 15 actions sampled having been progressed significantly. There was 1 medium risk finding regarding insufficient evidence to demonstrate completion of one CQC action, for the Trust to ensure that all covert medication is administered in accordance with Trust policy. The Committee noted that the Governance Committee had scrutinised the CQC action plan in detail and it had received good assurance regarding the completion of CQC actions.

HR Bank and Agency Staff
This review produced an overall classification of medium risk. There were 4 medium risk findings and 2 low risk findings. Medium risk findings referred to a lack of documented evidence of authorisation to hire agency staff, no formal control for identifying temporary staff who are new to a service area/ward, the lack of a formal induction process for agency staff who are new to a service area, and unjustified authorisation of the control in the temporary staffing booking system that checks whether the qualification of the temporary staff matches the requirement. Several areas of good practice were identified. The Committee asked the Director of Quality to circulate assurance to Committee members regarding completion of the actions in this report.

Procurement
This review produced an overall classification of medium risk, the same as previous reviews. There were 2 medium risk findings, 3 low risk findings and 1 advisory finding, compared to 3 medium and 2 low risk findings in the previous review. Medium findings related to Key Performance Indicators and Cost Improvement Plans not being monitored for the year to date, and a lack of adequate communication between procurement staff and staff at the Trust, leading to avoidable errors. Low risks related to the lack of a signed Service Level Agreement for 2016/17, and a lack of budget holder awareness of the procurement policy and process. The Director of Finance assured the Committee that the SLA with Finance Shared Services had

been signed since the review was completed. The Committee received assurance that procurement processes within the Trust were robust, and that it was not possible for the same person to raise and authorise a purchase order. The Committee noted that in undertaking their reviews, the Internal Auditor would where appropriate liaise with the Local Counter Fraud Specialist as an additional source of assurance. The Committee asked that the issues raised in this procurement review be referred to the risk register.

Internal Audit Recommendations Tracker
The Committee noted that 3 of the 5 recommendations from the 2014/15 review on E-Expenses had now been completed and validated. The remaining 2 recommendations were in progress and due. The Committee asked the Director of Finance and Commerce to provide an update and expected completion date for these recommendations within the next week.

Good progress had been made on the 2015/16 recommendations, with 13 out of 16 having been validated at the time of the Audit Committee meeting. The remaining recommendations were not yet due.

The Committee noted that in many audit reviews, the due dates for management actions had already passed by the time the Committee receives the audit report, and the Committee asked that assurance be provided in advance of future meetings as to whether actions set out in audit reports had been completed by the agreed deadline, by adding all agreed actions immediately to the audit recommendations tracker.

External Audit Report
The Committee received an update on planning for the 2016/17 audit, and noted that a planning meeting had been held with the Trust. No issues had surfaced at that meeting, and an audit plan would be received by the Committee at its next meeting.

The Committee received the Sector Developments report providing intelligence on

- The National Audit Office report on financial sustainability challenges in the NHS
- A report by the Financial Reporting Council on corporate culture and the role of Boards
- A Government consultation on mandatory reporting of the gender pay gap
- Planning guidance for 2017/18 and 2018/19 issued by NHS England and NHS improvement
- A ‘reset’ report issued by NHSI and NHSE regarding NHS bodies’ legal obligations to remain within funding limits.

The Committee noted the content of the report and agreed to make it available to Governors for information.

Counter Fraud
The Committee noted that all activity was progressing and it was anticipated that all actions within the Counter Fraud Action Plan would be completed by year end. For the period April - October 2016, Counter Fraud had participated in all Trust inductions and provided fraud awareness to 247 staff. Two Counter Fraud newsletters and three Counter Fraud bulletins had been published and were now accessible to staff via the Trust’s intranet. Counter Fraud material including posters is being distributed to be displayed in staff areas.

The Committee received and noted a verbal update on current Counter Fraud investigative activity.

Assurance Map
The Committee received an updated Assurance Map report and noted the assurance provided. The Committee agreed that the Assurance Map should be presented to the November Board.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to note the contents of this summary.

SUMMARY PREPARED BY: Marcia Gallagher ROLE: Committee Chair

DATE: 2 November 2016

2gether
Making life better

2gether NHS Foundation Trust

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Delivery Committee

DATE OF COMMITTEE MEETING: 27th September 2016

KEY POINTS TO DRAW TO THE COMMITTEE'S ATTENTION

PERFORMANCE DASHBOARD

Of the 141 performance indicators:

- 86 are reportable in August 2016
- 72 compliant
- 14 non-compliant.

Of the non-compliant 7 relate to IAPT (reported later in this summary). Plans to investigate and address the remaining 7 were reviewed by the Committee

CQUIN (Commissioning for Quality and Innovation) IMPLEMENTATION REPORT

Quarter 1 reports have been submitted for 2016/17 and confirmation was given that the Trust is fully compliant in relation to all of the Herefordshire and Low Secure CQUINs. Final confirmation of the Perinatal and Transitions CQUIN in Gloucester is awaited.

Significant assurance can be given that the CQUINs will be met.

LOCALITY EXCEPTION REPORTS

Highlights to report:

a) Gloucestershire and Countywide Locality:
   Gloucestershire Locality
   - Underspent by £161k at 4months
   - Compliance Stat and mandatory training 71%, Appraisal 83%, Sickness absence 5.0%

   Countywide:
   - Overspent at month 4 by £157k.
   - Compliance Stat and Mandatory training 63%, Appraisal 83%, Staff sickness 6.7%

b) Herefordshire
   - Overspent by £138k (Stonebow overspent by £333k)
   - Compliance Statutory and Mandatory Training not reported, Appraisal 76%, staff sickness 4.6%

c) Children and Young Peoples Service
   - Underspent by £259k at month 4
   - Compliance Statutory and Mandatory Training 64%, Appraisal 82%, Sickness absence 2.64%

d) General discussion re Localities.
   - Financial balance – underspends occur in community services as a result of vacancies. Overspends are common in in-patient facilities as result of high occupation rates, and need for additional staffing ratios for some patients with high need. Steps are being

taken to adjust budgets for more realistic budgets.

- Statutory and Mandatory training. The introduction of the new Learn2Gether digital reporting system has resulted in a drop in reported compliance. See later item for full discussion.
- Sickness absence figures have traditionally demonstrated higher rates for inpatient services, lower in community services. Despite this a wide variation is noted and further work will be considered to understand and address this.

IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES (IAPT) SERVICE IMPROVEMENT PLAN UPDATE

This update provided the Delivery Committee with an overview of the key issues relating to the progress made against the IAPT Service Development Improvement Plan for both Herefordshire and Gloucestershire. The report demonstrated plans and trajectory for compliance against the different areas including waiting list clearance, access rates, recovery rates and waiting time thresholds.

Assurance remains limited regarding compliance with the contractual requirements. Increasing assurance is offered in respect of the Service Delivery Improvement Plan being implemented.

Further actions requested by the committee included:

- Increased detail on staff productivity – including what is planned and what is delivered.
- Additional detail regarding staff training.
- External assurance – the NHS Improvement Support Team to be invited to offer a further opinion on the plan and implementation of recovery of the IAPT service.

CYPS WAITING LIST MANAGEMENT REPORT

Gloucestershire Clinical Commissioning Group supported a 6 month pilot testing a revised Key Performance Indicator method for calculating referral to treatment (Partnership) waiting times:

- The 80% of CYP achieving referral to Partnership treatment was unchanged
- The 95% 10 week target was reduced to 90%

Performance data for Q1 2016/17 demonstrates the following achievements:

- CYPS is compliant for both KPIs for May and June 2016
- There is a 30% decrease between Q4 and Q1 in the total number waiting beyond 8weeks (54 to 38)
- There is a 46% decrease between Q4 and Q1 in the total number of cases waiting over 10 weeks(28 to 15)

The revised Key Performance Indicator will be reviewed in October 2016.

The Committee was assured that significant progress has been made in reducing the waiting times for referral to Partnership Treatment.

DEMENTIA SERVICES REPORT

Reports were presented in respect of the Dementia Services in both Gloucestershire and Herefordshire. Points discussed included:

- Referrals to Memory Assessment Service (MAS) high in Gloucestershire (greater than 500/quarter) and rising, lower in Herefordshire (140/quarter) and slowly dropping.
- Reasons for different referral patterns in the 2 counties
- Differing Clinical Commissioning Groups contractual requirements
- Referral to final diagnosis 6months in Gloucestershire, 4.5 months in Herefordshire. Delays relating to waiting lists for psychology and assessment of complex presentation
- Common problems, appropriateness of dementia drugs monitoring by MAS teams, and

use of RiO in Primary Care facing services
- Implications of STP work streams on dementia services.

LOCALITY REVIEW – GLOUCESTERSHIRE NORTH

The work of the Gloucestershire North Team was presented to the Committee. The Committee found it very informative to look at the range of care given in this way and noted that delivery of these issues is regularly considered in formal agenda discussions.

EMERGENCY PLANNING

a) Winter Resilience Plan
The Trust is required to demonstrate its ability to adapt to variations in demand throughout the year, with particular emphasis placed on the winter period. The Operational Resilience and Capacity Plan, and the Pandemic Flu Action Plan represent 2 core aspects of the assurance process.

The report and related plans led the Committee to offer significant assurance to the board of the Trusts readiness for the winter period 2016/17

b) Emergency Planning Core Standards
This report set out the Trusts current position against the Emergency Preparedness, Resilience and Response Core Standards (EPRR). These are the minimum requirements for health and social care settings and are reported to the Herefordshire and Gloucestershire Clinical Commissioning Groups. The Trust's current compliance is partial.

The Committee noted the improvement plan to address standards requiring progress with timeline for improving compliance. Areas requiring further work include business continuity management and strategies for EPRR learning and development and EPRR testing and exercising.

The Committee noted the oversight and rigour in the work plan. Current assurance level is limited regarding compliance with EPRR Core Standards, with increasing assurance that an appropriate plan is in place to achieve full compliance by December 2017.

STAFF SURVEY RESULTS

Following the 2015 Annual NHS Staff Attitude Survey the Executive Committee agreed an action plan to address the highest priority key findings. Overall the results of the survey were encouraging but the response rate was lower than expected at 40%, down from 46% in the previous year (national average 42%). 6 actions were identified as actions to progress. In July 2016 the Executive Committee agreed that the 2016 Staff Survey will be sent to all staff in September rather than a random sample.

The Trust has continued to deliver the Staff Friends and Family Test during 2016/17

Significant assurance was received that the Staff Survey action plan has been progressed.

Significant assurance was received that the Staff Friends and Family Test continues to be delivered in accordance with the national requirements and that the Executive Committee has oversight of the process, response rates and feedback.

Assurance is limited that progression of the actions arising from the Staff Attitudes Survey or Staff Friends and Family test will improve the working environment of staff, the engagement of staff or positively impact on future surveys. Results of ongoing surveys are necessary for this assurance.

ROLL OUT OF THE TRAINING SYSTEM

Learn2Gether is the new software that now holds all statutory and mandatory training data. It is also the new platform for some key e-learning which has been updated to better meet Trust needs. It provides real time training compliance data for managers and staff. It also generates reminder e-mails of expiry of training.

It had been expected that compliance rates for statutory and mandatory training would be improved. Currently, the rates are lower than reported previously. Further work is required to improve accuracy of data.

Significant assurance is offered that:

- The system meets the needs of managers and staff better and is more flexible and adaptable than the previous system (ESR)
- Training continues to be provided for system users
- The software providers are continuing to work with the Trust to refine the system.

Limited assurance is provided that the current compliance rates are accurate.

The Committee considered steps required to improve assurance. Actions agreed include:

- A project management approach with Service Director leadership and Executive Committee oversight
- Milestones to improved assurance to include additional training to those managing the system, sign off of responsibility, confirmation of staff profile and progress to compliance with defined standards
- Monthly manual checks of defined areas for training for interim assurance.

INFORMATION TECHNOLOGY (IT)– Progress on delivery plan & Statement of Assurance

Highlights include

- Review of the Action Plan demonstrated significant movement from amber to green in all 14 areas.
- 6 areas had shown improved assurance from limited to significant (including network, remote access, new user computer equipment, file storage, and backup).
- The Improving Care through Technology programme will have rolled out new end user equipment to all staff in Herefordshire and all community staff within Gloucestershire by the end of this financial year.

These reports provided significant assurance that the IT Delivery Plan is aligned and meeting the requirements of service delivery and the business objectives of the Trust.

The Committee reflected on the need to ensure the realisation of the potential benefits that these improvements support.

PROCUREMENT ANNUAL ASSURANCE STATEMENT

The Trust is required to make an efficiency saving of approximately 4% and looks to its procurement provider to support the delivery and identification of further efficiency savings. The Trust contracts with the Gloucestershire Financial Shared Services to buy its procurement services.

Savings plan: The overall spend in 2015/16 was £111,974,391 of which £21,520,453 could possibly be influenced by procurement. The agreed saving target from procurement for 2015/16 was £125,000. The achieved savings value was £19,988 (16% of plan)

The level of performance was noted by the committee to be below that which would be expected within the service specification.

Limited assurance is received in respect of the annual procurement statement. The Committee recommended actions to address this with further work to be undertaken by the Procurement Shared Services in discussion with the Finance Department for 2Gether Trust.

ACTIONS REQUIRED BY THE COMMITTEE

The Board are asked to note the content of this report.

SUMMARY PREPARED BY: Martin Freeman ROLE: Acting Chair

DATE: 5 October 2016

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Delivery Committee

DATE OF COMMITTEE MEETING: 24 October 2016

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

PERFORMANCE DASHBOARD OUTTURN REPORT

The Committee reviewed the Trust's performance against NHS Improvement (NHSI), Department of Health (DOH) and Contractual measures to the end of September 2016. Out of 96 indicators reportable for September, 79 were compliant and 17 non-compliant at the end of the reporting period. Seven of the non compliant indicators related to IAPT[1], now referred to as 'Let's Talk'. IAPT services were the subject of a separate report to the Committee (see below for commentary).

Department of Health

- *No children under 18 admitted to adult in-patient wards:* There was one admission in Gloucestershire. The patient was placed on section 138 after absconding from a care home, before being admitted under section 2 until a suitable bed could be sourced.
- *Interim report for all Serious Incidents received within 5 working days of identification:* There was 1 initial report submitted late in Herefordshire. Processes for submission had been reviewed and changes made to ensure future compliance.

NHSI

- *Number of C Diff[2] cases:* There was one case in Herefordshire and a review to ascertain cause has now established that this was unavoidable
- *Care Programme Approach – follow-up contact within 7 days of discharge:* There were 2 cases not followed up within 7 days in Herefordshire. The reasons for both have since been investigated and as one was found to be a reporting error, overall the Trust was in fact compliant.
- *New psychosis (EI) cases as per contract:* Both counties are 1 new case below the monthly threshold, which is 6 in Gloucestershire and 2 in Herefordshire. Compliance on this indicator fluctuates by month and the decision had been made to start reporting both threshold and performance cumulatively from now on.
- *IAPT Waiting times – Referral to Treatment within 6 weeks (Gloucestershire and Herefordshire): 33%* performance against a threshold of 75%
- *IAPT Waiting times – Referral to Treatment within 18 weeks (Gloucestershire):* Performance of 83% against a threshold of 95%

Gloucestershire CCG (GCCG) Contract

- *Percentage of service users asked if they have a carer:* Reported performance was improving and was slightly ahead of the planned trajectory, having risen from 9% to 26% against the 100% threshold. Work was ongoing to inform staff about the new way to record carer information and compliance was still anticipated by the end of Q4.
- *Percentage with a carer that have been offered a carer's assessment*: Reported performance was improving, having risen from 37% to 45% against the 100% threshold in line with the planned trajectory.
- *IAPT Recovery rate:* Performance of 41% against a 50% threshold
- *IAPT Access rate:* Performance of 3.72% against a 7.5% threshold
- *CYPS[3] Level 2 and 3 Referral to treatment within 8 weeks*: For Q2 performance was 4% below the

[1] Improving Access to Psychological Therapies
[2] Clostridium Difficile

80% threshold. The service experiences lower attendance rates during the school holiday period and compliance was expected to be achieved for Q3.

- *IAPT integrated service: 14 days from referral to screening assessment:* Performance of 61% against an 85% threshold. This indicator relates to one of the performance thresholds within the IAPT care pathway which is under review. Once a contract variation is finalized the indicator will change to report on Nursing activity only and will not be compliant until this work is complete. Reporting is expected from Q3.

Herefordshire CCG (HCCG)

- *IAPT Recovery rate – those who have completed treatment and have 'caseness':* Performance of 48% against a threshold of 50%
- *IAPT maintain 15% of patients entering the service against prevalence:* Cumulative performance of 712 (number) against a threshold of 1089.
- *Emergency referrals to CRHT[4] seen within 4 hours of referral (8am*-6pm): There was one case not seen and this has been confirmed as a recording error which has since been rectified.
- *All admitted patients 65+ must have a completed MUST assessment:* There were 2 admissions without this assessment; in both cases the admissions refused and their decision was not recorded on the clinical system. This has now been rectified.

Risks: The Trust underperforms against statutory, contractual and Trust targets, posing risks to the provision of a quality service, contractual income and the Trust's reputation.
Assurance: Significant as the majority of indicators are compliant, limited on specific indicators not meeting required performance thresholds, in particular IAPT indicators.

IAPT (LET'S TALK) SERVICE IMPROVEMENT PLAN UPDATE

The Committee received the IAPT Service Improvement Plan which provided a comprehensive summary of the key issues relating to the progress for both Gloucestershire and Herefordshire.

Good progress was reported in waiting list backlog clearance, in line with the planed trajectory for completion by the end of October. This remained the highest priority in the initial phase of the recovery plan. Staffing capacity was running at lower levels than planned, however positive progress was reported in recruiting staff and productivity was increasing. Access rates were below planned trajectory in both counties, due to interdependency with the backlog clearance work. Referrals were also running at higher levels than anticipated. Recovery rates were below target levels, reflecting the challenges of waiting list clearance, engaging some patients into treatment after long waits and a high level of DNAs[5]. The Trust was on track to introduce the new clinical pathway from 1st November, which would remove the screening process. This, combined with the on-going clearance of the backlog waiting list, would enable patients to be seen more quickly and reduce the unplanned level of DNAs. It was therefore expected that the overall recovery rate would stabilise and improve moving forward. In both counties performance against 6 week national waiting time indicators for Step 2 treatment was on track or ahead of trajectory. Both counties were slightly behind plan for the 18 weeks indicator. For Step 3 treatment Herefordshire was behind plan on both waiting list indicators and Gloucestershire was ahead of plan for 6 weeks and behind for 18 weeks. Further work to recruit staff was being undertaken to address delays.

The Committee noted this very detailed report and asked that it continue to be received monthly, with the addition of key messages on the key indicators and actions in the Executive Summary.

Risks: The Trust continues to underperform against IAPT targets, posing risks to the Trust's Governance rating from NHSI, provision of a quality service, contractual income and the Trust's reputation.
Assurance: Limited until the impact of Service Improvement Plans is clear.

[3] Children and Young People Services
[4] Crisis Resolution Home Treatment team
[5] Did Not Attend

BENCHMARKING UPDATE AND ACTION PLAN
The Committee received a report summarising the main points from the National Benchmarking 2016 activity submission for 2gether's Adult and Older Adult Mental Health Services. Work to compare this year's results with those provided last year had been carried out and this was reported, along with an action plan for improvement activity.

The report identified areas where Gloucestershire and Herefordshire could share learning in relation to inpatient outcomes. The Committee requested further work on exploring the Gloucestershire DToC[6] and length of stay figures to understand these further and on the measurement of CRHT response times within 4 hours.

It was agreed that an updated position against the Benchmarking improvement plan would be provided to senior management quarterly so that progress could be monitored.

Risks: The Trust fails to understand its performance benchmarked against other Trusts and fails to make improvements, impacting on the provision of high quality services to patients.
Assurance: Significant that information is available for this understanding to be developed and that work is in progress to develop and implement appropriate actions resulting from this.

REVIEW OF SPECIALIST COMMUNITY LEARNING DISABILITY SERVICES
The Committee received an update on the Specialist Community Learning Disability (LD) Services Action Plan for Gloucestershire, reporting on progress with 5 key work streams encompassing 18 recommendations/outcomes from the review, including care pathways, easy read care plans, caseload management tool and primary care liaison. Good progress was being made in those areas within the Trust's control. The Committee enquired about risks to the plan overall; these included the Primary Care Liaison proposals, which were above the activity levels the Trust agreed and this was being worked through with the Council, to scope the required resources. In addition, the new community service specification needed to be finalised and a specialist LD commissioner appointed. The Trust would be working with the Council to resolve these issues.

Risks: A lack of progress on defining and commissioning the Specialist Community Learning Disability Service in line with the Action Plan leads to poor quality service delivery and patient outcomes.
Assurance: Significant that the Trust is progressing the actions it can control, limited in relation to achieving a finalised specification and identified lead for commissioning.

LOCALITY REVIEW – CHILDREN AND YOUNG PEOPLE SERVICE (CYPS)
The Committee received the CYPS Locality Review and heard that overall the service was performing well against contract measures. Positive outcomes from the CQC inspection and Quality Network for Community CAMHS[7] visits were highlighted and the Committee heard that good partnership working with Action for Children and Teens in Crisis was continuing. The Committee noted the shift in caseload age profile, with 73% now involving 12-18 years olds, whereas previously this had been 50% with the other 50% involving under 11s.

Risks: Poor service performance impacts on quality of service and contractual income
Assurance: Significant

LOCALITY EXCEPTION REPORTS
The Committee received exception reports from each Locality.

- Gloucestershire Localities were under spent by £161k and reported statutory and mandatory training compliance of 71%, with appraisal compliance at 90%.
- Countywide was overspent by £157k. and the Committee noted that inpatient budgets had not yet been adjusted as planned. Statutory and mandatory training compliance stood at 63% and appraisal compliance at 77%.
- Herefordshire was overspent by £161k. There was continued difficulty filling vacancies and a large number of agency shifts were still being used in inpatient services, with work continuing to

[6] Delayed Transfers of Care
[7] Child and Adolescent Mental Health Services

improve the robustness of bank to meet staffing needs. Compliance with statutory and mandatory training was 73% and appraisal compliance stood at 79%.

- CYPS was underspent by £308k, mainly due to staff vacancies. Compliance with statutory and mandatory training stood at 64% with appraisal compliance at 91%.

Risks: Poor service performance impacts on quality of service and contractual income
Assurance: Limited assurance around workforce.

WORKFORCE INDICATORS REPORT Q2
The Committee received the Workforce Indicators Report for Q2 which contained compliance figures for appraisals and sickness absence, along with the current position on staff turnover. Appraisals were at 78% (target 100%) and sickness absences 5.23% (target 4%). Turnover had reduced, which was believed to be due to increased recruitment.

The Committee expressed concern about the lack of significant improvement on reported appraisal figures and noted that Locality Directors still believed these were being under reported in some areas. The Committee asked the Executive Team to consider whether the currently reported performance on appraisals was a matter of concern and if so what action could be taken to address this.

Sickness absence was on a slight downward trajectory; however the Committee asked to see more granularity by staff group and services in future reports, along with trend analysis and benchmarking information. Sickness absence levels in some services were significantly lower than in others and the Committee suggested further work be carried out to share learning.

Information on statutory and mandatory training was not included due to the issues arising from the introduction of the new recording system. Service Directors reported that training compliance figures had significantly reduced since the new system had been implemented and team managers had been asked to manually reconcile figures on a monthly basis. The Committee expressed concern on the continuing lack of visibility of performance in this area and was assured that actions were in place to properly configure the new system and ensure managers were enabled to use it correctly. The Committee requested manual reports on high risk training areas at future meetings, starting with fire training and physical intervention.

Risks: Failure to engage with staff via the appraisal process risks demotivating staff and not identifying issues impacting on performance; high sickness absence rates risk staff remaining in work being subject to greater demands and reduced motivation. Teams are more likely to work with high numbers of bank or agency staff, which may risk reduced continuity of care and increases the costs of care.
Assurance: Limited; appraisals performance (needs to increase) is below target and largely unchanged, sickness absence (needs to decrease) is below target. There is a lack of information to provide assurance on statutory and mandatory training.

TELEPHONY SERVICES ANNUAL ASSURANCE STATEMENT
The Committee received the Annual Telephony Services Assurance Statement. The report provided assurance that overall services operated reliably and adequately to support the needs of the Trust. The systems are well supported and monitored and where issues occur the support team responds quickly to restore services. Levels of assurance on specific areas of provision are shown below. A revenue cost issue was emerging from the issue of smart phones and an audit was planned to try to reduce the number of contracts, starting with non clinical teams.

Risks: Telephony services fail leading to an inability of staff to communicate with each other and with service users, impacting on the safety and quality of care.
Assurance: Significant on fax services and pagers for both counties and on telephony services for Gloucestershire. Limited on mobile and video conferencing for both counties and on telephony services for Herefordshire.

FACILITIES MANAGEMENT ANNUAL ASSURANCE STATEMENT

The Committee received the annual Facilities Management Assurance report. Trust PLACE[8] scores for cleaning and catering were reported to be above national averages for mental health and learning disability inpatient units. Quality issues highlighted would be addressed through changes in services; ending the Trust's relationship with the catering and cleaning contractor Sodexo in Herefordshire from end March 2017 and managing the service directly; changing food preparation at the Honeybourne Unit from cookfreeze to fresh preparation; changing suppliers at Stonebow; and improvements in staffing at Oak House to address the cleanliness scores. The Committee noted the high unit cost of patient meals in Westrigde and Hollybrook, which was due in part to changes in data definitions and partly to poor economies of scale from a low number of patients and staff costs from providing and taking meals with service users.

Risks: Poor catering and cleaning services impact on the quality of patient care and the service user experience

Assurance: Significant; performance is above average overall and issues are being addressed in areas with lower PLACE scores.

ESTATES ANNUAL ASSURANCE STATEMENT

The Committee received the annual Estates Report providing a review of management arrangements for Estates, 2015/16 Estates cost data, Estates maintenance performance data, 2015 PLACE results and Estate Strategy key performance indicators (KPIs). The Committee was informed that a new Estates Strategy had been signed off by the Development Committee and work would commence to update the key performance indicators in line with this. However, there was significant assurance about progress against the current KPIs. The Committee's attention was drawn to action that had been taken in relation to the contract with NHS Property Services, provided by MITIE, in Herefordshire for maintenance on Widemarsh Street, Oak House and the Benet Building. Since April 1st there had been no evidence of maintenance taking place, increasing water and fire safety risks, and from 12 October the Trust gave notice to NHS Property Services and instructed Wye Valley Trust to recommence maintenance. The Committee sought and receive assurance that the Executive Committee was sighted on this development and the associated risks. The Committee noted a disapointing PLACE Score for the Stonebow Unit and was advised that along with Oak House, which had also received a score below the national average, Stonebow was in need of investment. A refurbishment plan was in place for the Stonebow Unit.

Risks: Poor Estates management impacts negatively on service user experience and staff morale.
Assurance: Significant based on high PLACE scores and delivery of KPIs

ACTIONS REQUIRED BY THE BOARD

The Board is asked to note the contents of this summary.

SUMMARY PREPARED BY: Charlotte Hitchings **ROLE: Committee Chair**

DATE: 24 October 2016

[8] Patient Led Assessment of the Care Environment

2gether
Making life better

2gether NHS Foundation Trust

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Governance Committee

DATE OF COMMITTEE MEETING: 16th September 2016

KEY POINTS TO DRAW TO THE COMMITTEE'S ATTENTION

Patient Safety/Serious Incident (SI) Update

There were 4 new SIs reported during August 2016, 3 serious incidents were reported for Gloucestershire and 1 serious incident for Herefordshire. There had been zero Never Events occurring within Trust services and all required reports were submitted within agreed timescales. The SI rate per 1000 caseload for August 2016 was 0.18.

It was reported that there had been 16 suspected suicides during this period and that "suspected suicide" and "attempted suicide" remained the most frequently reported incidents.

The Committee reviewed patient safety incidents and near misses occurring within the period 1 April to 30 June 2016. Points to note include:

- Incidents within Learning Disabilities Inpatient/Residential Care had increased significantly in Q1 2016/17 (394 incidents) when compared against Q4 2015/16 (208 incidents).
- Reporting at Charlton Lane Centre had decreased with 172 incidents in Q1 2016/17 compared to 224 incidents for Q4 2015/16; this included a decrease in slips, trips and falls.
- There had been 3 medication errors reported in Recovery Inpatient Units. No trends had been identified.
- in Herefordshire there were a total of 200 patient safety incidents reported on Datix for the period 1 April – 30 June 2016 (up from Q4's 134). 170 of those (85%) were reported by Stonebow Unit with Mortimer Ward the highest reporter; this related to two particular patients.
- There has been an increase in the recording of patient deaths; this relates to the new Mortality Review Process and the resulting recording of patient deaths associated with older age / natural causes within the Memory Assessment Service (MAS) and Community Dementia Nurses service (CDN).
- Discussions were held about the above observations to understand background and planned actions.

The Locality Governance Leads confirmed that this report provided them with the information required to discuss within the Localities and the availability of live data was noted.

Datix progress report

Significant assurance was given regarding the implementation of the new Datix system. However, limited assurance was offered regarding data quality at this point in time. The numbers of Patient Safety incidents had increased, but Health and Safety incidents had decreased. There is no category for separately recording the Health and Safety incidents in the programme.

There have been significant improvements to the quality of data held within Datix. This new Datix system went live on 1 April 2016 and therefore the Quarter 1 report was unable to demonstrate meaningful long-term statistical data. The Committee discussed how assurance can be given during this interim period of change. Tandem reporting of some information (old alongside new) would be necessary for a short time.

Safe Staffing Report

The Committee noted the Safe Staffing data for August 2016:

- No staffing issues were escalated to the Director of Quality or the Deputy Director.
- Where staffing levels dipped below the planned fill rates of 100% for qualified nurses this was usually offset by increasing staffing numbers of unqualified nurses based on ward acuity and dependency and the professional judgement of the nurse in charge of the shift.

Safeguarding Children and adults – Training update.

The Committee had requested an update concerning known limited assurance of compliance with Safeguarding training. Current compliance for training at level 3 safeguarding children is recorded as Gloucestershire 89%, Herefordshire 63% and compliance for training at level 3 safeguarding of adults is Gloucestershire 74%, Herefordshire 58%. The work plan for recovery of this compliance was noted by the committee. Limited assurance is offered regarding current training compliance, increasing assurance is offered as a result of the current work plan. This will continue to be monitored by the Committee

Staff Incident Quarterly Report

a) Health and Safety

The report provided a breakdown of the Health & Safety related incidents reported on the Datix Risk Management System for Quarter 1 ending 30th June 2016 and given 'Final Approval' (closed) by line managers.

The Committee noted that in this quarter there were 51 Health and Safety incidents recorded of which 40 had been closed. These included incidents to staff, visitors contractors etc. However, of the 40 Health & Safety incidents recorded 6 were wrongly categorised, making a final total of 34 closed incidents reported; the overall number of reported incidents had reduced.

The Committee noted that from April 2016 there was no longer a specific category for Health and Safety incidents and therefore data for previous quarters was not comparable. It was agreed that ways of improving the collection of Health and Safety data would be investigated.

There were 2 RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) incidents in this quarter and this was consistent with previous quarters. It was noted that one of these incidents was a member of staff trapping a finger in a door; this was the third incident of its kind although each incident had been different in nature. The Committee asked that a further review of these incidents be undertaken and feedback to be provided to the Committee.

Limited assurance was also noted regarding the reporting of Health and Safety incidents on Datix given the significant reduction in overall numbers when compared with previous quarters.

b) Security

The Committee was significantly assured

- that all relevant security policies and procedures were current and in place and
- that all Security related Datix reports were accurate and correctly reported.

Limited assurance was noted regarding violence and aggression pending completion of departmental risk assessments and verification checks by the Local Security Management Service.

Research Governance Annual Report

Significant assurance was received that the Trust continued to provide a comprehensive level of research governance for all research activities, whether local or national programmes.

Significant assurance was received that the team was on target to meet research recruitment figures and that Year 1 performance objectives of the Trust's Research Strategy were also on target. The Committee noted that the Trust had a 100% record for recruiting to studies within 70 days of a valid research application being submitted.

Professional Regulation - Health and Social Care Update

This update provided assurance of professional regulation for the following professional disciplines:

Dietetics, Nursing, Occupational Therapy, Physiotherapy, Psychological Services, Social Work, and Speech and Language Therapy.

The Committee noted that the Director of Engagement and Integration (with responsibility for Allied Health and Psychological Professions) and Director of Quality (Nursing and Social Care) worked collaboratively with the respective professional leads to provide assurance of professional regulation.

Significant assurance was provided that the Trust's Heads of Profession were sighted to and engaged in professional regulation and engaged in practice development. Most professional groups had described full or significant assurance of robust clinical supervision opportunities and uptake of supervision, however Nursing and Occupational Therapy continued to report limited assurance. The Committee noted that a meeting had been set between the Head of Profession for Nursing, the Head of Profession for Occupational Therapy, the Director of Quality and the Director of Engagement and Integration to seek mitigation for the limited assurance of clinical supervision reported for these disciplines. It was agreed that an assurance report would be brought to this Committee in November.

Information Governance Toolkit

The Governance Committee received an annual Information Governance report in March 2016 which included the Trust's performance on the Information Governance Toolkit v13. This demonstrated an overall result of level 2 which was deemed 'satisfactory'; there were 23 key indicators scoring at level 3, 21 key indicators scoring at level 2, and 1 key indicator deemed not relevant. The Committee asked that consideration be given to any additional areas where the Trust could aspire to level 3.

The Committee noted that the Information Governance Advisory Committee had considered the feasibility of increasing the number of level 3 scores for the v14 Toolkit. Increasing these scores had been discounted for most of the 21 Toolkit requirements currently scoring level 2, nevertheless the IG Advisory Committee had identified 2 criteria where the Trust's scores could be increased

Whistle Blowing Annual Review

To support staff the Trust has in place a number of different policies and procedures offering guidance and advice to both staff and managers to enable staff to raise issues of concern. The Whistleblowing Policy was one such key document and specifically responded to the Public Interest Disclosure Act 1998. The current Whistleblowing Policy was revised in light of the 'Freedom to Speak Up' consultation of June 2015 and the Department of Health's response published in July 2015.

The Committee noted related pieces of work:

- 'Freedom to Speak Up Guardian'. Rob Newman had now been appointed and the Whistleblowing Policy would be revised with his input.
- 'Speak in Confidence' as a secure and anonymous method to enable staff to raise issues. The nature of those issues may not always fall within the scope of the Whistleblowing Policy, but should this be the case, it offered both the Trust and the individual a supported and confidential environment in which to correspond about concerns. Since being introduced in October 2015 eight conversations had been initiated by the end of March 2016 and a further ten by the end of August 2016.

The Director of Organisational Development reported that no cases had been raised under the Whistleblowing Policy during 2015/16.

The Committee was significantly assured that a range of actions had taken place over the last 12 months and would continue to take place to nurture and support a culture of openness and transparency. These actions were part of the Trust's response to the Francis review and were encompassed within the Organisational Development implementation plan.

Herefordshire Library Update

A review of the Library service in Herefordshire for staff had highlighted a number of areas that required improvement/investigation based upon standards specified in the Learning & Development Agreement from HEE (Health Education England);

- Identifying key individuals involved in staff education & training
- Providing and returning of books using Trust transport

- Communication – staff awareness of services available
- Future Plans –enhancing the service (e.g., Library staff on site, possible collaborative working with Hereford County Hospital Library)
- Finance – understanding cost impact of potential changes

The Committee noted that as a result of this review, a number of actions had been identified and allocated ownership and timescales. It was noted that the finance position needed to be clarified with Health Education England and until such time that this Action Plan was complete, Limited Assurance was provided. However, it was anticipated that adequate progress could be made to move to significant assurance by Quarter 4 2016/17

ACTIONS REQUIRED BY THE COMMITTEE

The Board is asked to note the content of this report

SUMMARY PREPARED BY: Martin Freeman ROLE: Chair

DATE: 16 September 2016

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Governance Committee

DATE OF COMMITTEE MEETING: 21 October 2016

KEY POINTS TO DRAW TO THE COMMITTEE'S ATTENTION

Future of the Governance Committee

Meetings have been taking place to discuss the future shape of the Governance Committee and the establishment of a Quality and Clinical Risk sub-committee. It is proposed that the new QCR Committee will meet on a monthly basis and will discuss the operational information in detail. The Governance Committee will meet bi-monthly and act as the assurance committee.

The new committee structure would aim to commence in January 2017, and a 6 month review would be scheduled to take place in July 2017.

Patient Safety

There had been 3 SIs in September – 2 in Gloucestershire and 1 in Herefordshire. One initial investigation report was submitted outside of the 72 hour target to the CCG. The rate per 1000 was 0.14 which was comparable with previous months.

The Committee noted that there had been significant work on the SI action plan, with only a handful of outstanding actions from 2015/16 remaining. The 2016/17 plan had 9 amber actions and 7 red actions. The Committee thanked the Patient Safety Manager for his efforts in progressing and closing down actions within the plan.

The patient safety report had been updated in line with comments received from members of the Committee and Board.

National Confidential Inquiry into Suicide and Homicide

The Committee received a summary of the key findings from the national report and agreed that this was extremely helpful. Members were encouraged to read the full report. Work would commence on developing the Trust's analysis, comparisons and response to the report and this would be presented to the Committee in January 2017.

HSE Update

It was noted that the HSE investigation had now concluded and they had confirmed that no further action or prosecution from the HSE was expected. NHS England would now commence an external homicide inquiry; however, the start date for this was still to be confirmed. An HSE Investigation close down report would be produced for the next meeting in November.

Datix Progress

It was reported that Datix was progressing well. There had been a delay in the development of the new Datix Policy; however, training was going well and there had been a lot of positive

feedback on the new system. A new server was being set up to host the Datix system which it was hoped would speed it up. A written briefing on progress continued to be presented to the Executive Committee monthly.

Safe Staffing Levels

The Committee received the safe staffing levels report for September, noting that there was a good level of assurance that this continued to be monitored and safe staffing levels were being maintained.

The National Quality Board had published its safe staffing guidance, with the MH workstream being published in November 2016.

Restrictive Physical Intervention Report

This report focused on data relating to the recording and monitoring and use of restrictive physical interventions over a 6 month period (April 2016 – September 2016). Since the introduction of the new Datix platform, there was significant assurance that the data presented was reliable. This was a considerable improvement from last year's position, particularly with regard to data relating to rapid tranquillisation.

The Committee noted that data for Hollybrook had been captured separately due to multiple interventions involving just one patient. Assurance was received that an internal review had been carried out and current practice was appropriate. It was noted that this was discussed monthly at the countywide locality meetings alongside LD developments generally. The Committee said that they would like to hear more about staff involvement and what support was given to staff at Hollybrook who carried out this challenging work.

A recent NHS Benchmarking report stated that 2gether was mid-high for prone restraint. Learning would be sought from other Trust's around the country who had managed to reduce their levels of prone restraint to see what developments could be out in place.

Training compliance for PMVA and PBM remained static; however, reporting had now been moved across to the new Learn2gether system and was awaiting validation.

Quantitative and Qualitative Risk Audit

The Committee received limited assurance that Risk Assessments were in place and limited assurance that Risk was being included within care plans. It was agreed that themed reports from each of the localities on current compliance with risk assessments would be helpful as more focus was needed on this as. As well as themed reports, it was agreed that this matter be escalated to the Executive Committee for attention. A number of actions were already in train via the localities and these would continue to be progressed. A process had been agreed however there appeared to be a need to operationalise this.

Staff Incidents Report – Fire

There had been an improvement in training compliance in Herefordshire but the Gloucestershire performance had dropped significantly. The Committee expressed their disappointment at this position. Verbal assurance was received that the actual statistics were much better than reported and suggested that the Learn2gether system was still finding its feet. However, an assurance report would be received on the current position at the next meeting.

The concerns of the Committee would be included within the Board summary report and assurance would be sought that training compliance was being addressed, as well as the Learn2gether system functionality, by the Delivery Committee.

Expert Reference Groups

The Committee noted that work had been carried out to review the structures of the ERGS and this had reflected on the important work carried out by the ERGs so far. How the ERGs would fit in to the overall Committee structure was being considered and a recommendation would be worked up and presented to the Trust Board for approval. It was agreed that further input should be sought from the ERG leads about future developments.

Revalidation of Nursing Staff

The Committee noted this report and received good assurance that work was progressing and was on track. Reporting on the local position would be received by the Committee quarterly.

Voluntary Services Strategy

Progress with the implementation of the Voluntary Services strategy was noted. There was some disappointment as to the delay in implementation; however, there was a need to embed things further, such as the role of volunteers and the evaluation of the impact that volunteers made. Assurance was received that work was progressing. The Trust was not currently recruiting widely for volunteers until the work to clearly define the roles and impact had been agreed.

ACTIONS REQUIRED BY THE COMMITTEE

The Board is asked to note the content of this report

SUMMARY PREPARED BY: Martin Freeman ROLE: Chair

DATE: 21 October 2016

BOARD OF TRUSTEES COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Charitable Funds Committee

DATE OF COMMITTEE MEETING: 2 November 2016

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

Charitable Funds Financial Activity Report

The Committee received a report outlining charitable funds spending in Gloucestershire and Herefordshire localities for the period 1 April to 30 September 2016. Expenditure had generally been low during the period, at £37.5k. In Gloucestershire use of funds included expenditure for patient welfare purposes such as Dance and Dementia classes, for Gloucester Rugby tickets for Montpellier Unit patients, and for mountain bikes and accessories in the Countywide locality. In Herefordshire charitable funds had been used to fund a photography course at The Knoll, and a mindfulness course for Herefordshire staff. Legacies totalling £19k had been received, and the overall balance of charitable funds at the end of the period was £126,965.23.

Charitable Fund Accounts and Annual Trustee Report 2015/16

The Committee received the Annual Report of the Trustees and Charitable Fund Annual Accounts for the financial year ending 31 March 2016. The Committee noted that the Balance Sheet for Charitable Funds stood at £144.6k at the end of the financial year. Income for the year was principally from a £22,500 legacy.

The Trustee Report outlined significant expenditure during the reporting year, which included £92k in respect of the Research Centre. Other notable items of expenditure included funding for Special Olympics schemes, Music in Hospitals schemes, the Big Health Check Day, and a Football Project.

The Committee noted that as income during the reporting year had been below £25k, no audit was required and consequently no Letter of Representation was required. In accordance with its delegated powers the Committee approved the Annual Accounts and Trustee Report and for the year ending 31 March 2016, subject to correction of a small number of typographical errors. The Committee requested that consideration be given to the production of an Easy Read summary of the Trustee Report.

Charitable Funds Committee Terms of Reference

This Committee reviewed its Terms of Reference and agreed a number of changes making clear that the Committee's reporting relationship is to the Board in its role as the charity's Board of Trustees. The revised Terms of Reference are attached for approval.

ACTIONS REQUIRED BY THE BOARD

The Board of Trustees is asked to note this summary report, and approve the changes to the Committee's terms of reference

SUMMARY PREPARED BY: Duncan Sutherland **ROLE:** Chair

DATE: 2 November 2016

THE CHARITABLE FUNDS COMMITTEE
OF 2GETHER NHS FOUNDATION TRUST

TERMS OF REFERENCE

CONSTITUTION

1. The Board of Trustees hereby resolves to establish a committee ~~of the Board~~ to be known as the Charitable Funds Committee. The Committee has no executive powers other than those delegated by these terms of reference. The Chair of the Committee will be a Non-executive Director appointed by the ~~Directors~~ Trustees of the Trust Charitable Funds

TRUSTEES

2. All members of the Foundation Trust Board are Trustees of the Trust Charitable Funds. As Trustees of the Funds they have, and must accept, ultimate responsibility for directing the affairs of the charity, and ensuring that it is solvent, well-run, and meeting the needs for which it has been set up.

Trustees must:

- ensure that the charity complies with charity law, and with the requirements of the Charity Commission as regulator; in particular ensure that the charity prepares reports, Annual Returns and accounts as required by law
- ensure that the charity does not breach any of the requirements or rules set out in its governing document and remains true to the charitable purpose and objects set out there
- comply with the requirements of other legislation and regulators which govern the activities of the charity
- act with integrity, and avoid any personal conflicts of interest or misuse of charity funds or assets

CORE MEMBERSHIP

3. Nominated Non-Executive Director, Chair
Nominated Non-Executive Director, Vice Chair
Director of Finance and Commerce, (Lead Executive)

All other Executive and Non-Executive Directors are Members of the Committee in their role as Trustees of the Charity

Co-option

The Committee will have the power to co-opt other people to the Committee. Co-opted members of the Committee will be non-voting and will not count towards any quorum.

In Attendance

The Finance Department Officer dealing with Charitable Funds
Trust Secretary

QUORUM

4. A quorum is to be three members comprising at least one Non Executive member and one Executive member.

FREQUENCY

5. The Committee will meet at least three times a year.

AUTHORITY

6. The Committee is authorised by the Board of Trustees to review and consider any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the committee. The committee is authorised by the Board to obtain outside legal or other independent advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

7. The Committee has full delegated authority to manage the Trust's Charitable Funds on behalf of the Board of Trustees and acts as the governing body of the charity. It is authorised to approve strategies, local policies, procedures and annual reports and plans that relate to its areas of responsibility.

ACTIVITIES OF THE COMMITTEE

8. The purpose of the Committee is to direct the management of charitable fund income and provide the Board of Trustees with assurance regarding compliance with statutory obligations.

9. The following activities are within the remit of the Committee:

- Ensure compliance with all legal and regulatory requirements
- Approve policies and procedures for the control of charity income, investments and expenditure and establish/maintain monitoring and review systems to ensure that procedures are correctly applied.
- Approval of the annual financial statements and Charitable Fund annual report
- Approve the registration and objects of the umbrella charity and special purpose charities as appropriate; ensuring such registrations meet the needs of the Trust's charitable purposes.
- Consider applications from the fund managers for the creation of new funds and approve the governing documents under which these will be administered.
- Nominate NHS officers to have delegated authority for the commitment of expenditure, management of VAT implications and liaison with the investment broker for deposits and withdrawals.

- Ensure the procedures under which these NHS staff act for the Trustees are monitored, ensuring conformity to the delegated purchasing limits in accordance with the Scheme of Delegation.
- Ensure legacy income is monitored and approve the actions of the legacy officer to ensure receipt of all legacy entitlements.
- Oversee the development of an investment policy for Board of Trustees approval.
- If directed by the Board of Trustees, oversee the appointment of an investment manager and the implementation of appropriate procedures to monitor the investment arrangements and ensure compliance with the current relevant legislation.
- Act as the control mechanism for any approved fund-raising appeals which may be initiated, and ensure that the appointment and control of fund-raisers is in line with current regulations and guidance
- Ensure appropriate liaison with the Charity Commission and/or legal advisors to confirm/support any recommendation or action that the Trustees may wish to make.
- Oversee the development of plans to increase awareness amongst staff and the wider community of the availability and potential uses of charitable funds.
- Consider and approve for recommendation to the Trust Board any Standing Financial Instructions applying to the management and control of charitable funds.
- Receive and consider bids for the application of monies in accordance with the Standing Financial Instructions.
- Consider any identified abuses of the charitable funds or ^{2}gether NHS Foundation Trust's name in unapproved fund raising activities and initiate appropriate action.
- Commission and review audit reports on charitable funds and initiate appropriate action.
- Oversee the development of a fund raising strategy for approval by the Board of Trustees.

OTHER MATTERS

10. The Committee shall be supported administratively by the Trust Secretary, whose duties in this respect will include:

    - Agreement of agenda with Chair and attendees and collation of papers
    - Issuing agendas and papers at least three working days in advance of any meeting
    - Ensuring the minutes are taken and a record of matters arising kept and issues carried forward
    - Advising the Committee on pertinent areas

11. The Trust Secretary will produce an annual plan for the Committee which will outline the business to be discussed at each meeting.

12. Core members of the Committee will aim to achieve at least two-thirds attendance

13. The activities of the Committee will be formally recorded and reported to the Board of Trustees. The Chair of the Committee will report to the ~~Trust~~ Board of Trustees and highlight any major issues and any items requiring resolution by the Board of Trustees.

Agenda item 17 **Enclosure Paper K**

Report to: Trust Board, 24 November 2016
Author: Ruth FitzJohn, Trust Chair
Presented by: Ruth FitzJohn, Trust Chair

SUBJECT: **CHAIR'S REPORT**

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

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

1. PURPOSE, ASSURANCE AND RECOMENDATION

This report sets out the key activities of the Trust Chair and Non-Executive Directors for the period 17 September – 16 November 2016.

The report offers full assurance that regular, targeted and purposeful engagement is being undertaken by the Chair and Non-Executive Directors aiming to support the strategic goals of the Trust.

This report is for information only and the Board is invited to note the report.

2. CHAIR'S KEY ACTIVITIES

- Chairing two Board meetings in Gloucester
- Chairing a Council of Governors in Gloucester
- Progressing the capital expenditure matter delegated by Board including initiating an ad hoc Development Committee
- Hosting a visit for Governors to Charlton Lane Hospital
- Hosting a visit for Governors to the Stonebow Unit in Hereford
- Attending the Gloucestershire Sustainability and Transformation Plan Oversight Board

- Attending the Gloucestershire Clinical Commissioning Group's Annual General Meeting at Prestbury Park in Cheltenham
- Attending a Gloucestershire Sustainability and Transformation Plan meeting for Non-Executive Directors
- Participating in a Gloucestershire Strategic Framework Five Year Forward View workshop in Ullenwood
- Attending NHS Improvement's Relentless Delivery and Making Change Happen event together with the Chief Executive in Leeds
- Attending the Gloucestershire Clinical Commissioning Group's event in Cheltenham
- Participating in a South Chairs Networking Event in Reading
- Attending the Gloucestershire Health and Social Care Awards at Gloucester Cathedral
- Hosting the Trust's Volunteers and Experts by Experience Annual Tea Party 2016 at Gloucester Rugby Club in Gloucester
- Visiting the Supported Accommodation Team based in Fieldview in Stroud
- Attending the T4Carers event at Charlton Lane Hospital in Cheltenham
- Receiving formally at Acorn House the donation of technology to the Children and Young People Service from the Pied Piper Appeal
- Meeting with the Chair from the Black Country Partnership NHS Foundation Trust
- Meeting with the outgoing Chair of Wye Valley NHS Trust
- Meeting twice with the Chair of Gloucestershire Care Services NHS Trust
- Meeting with the Independent Chair of the Gloucestershire Sustainability and Transformation Plan
- Meeting with the Inpatient Services Manager
- Meeting with the newly appointed Modern Matron for Wotton Lawn Hospital
- Meeting with an aspiring Non-Executive Director
- Meeting with the Managing Director of The Wiggly Worm
- Meeting a senior member of the judiciary together with the Director of Engagement and Integration
- Hosting a visit of Gloucestershire Councillors to Wotton Lawn Hospital
- Hosting a visit of the Bishop of Gloucester to the Children and Young People Service

- Meeting with the Member of Parliament for The Cotswolds in Cirencester
- Meeting with a Gloucestershire community leader
- Participating in a programme on BBC Radio Gloucestershire
- Meeting with a representative from Kingfisher Church at Treasure Seekers in Gloucester
- Meeting with The Ugly Duckling Charity from the Forest of Dean
- Meeting with the Non-Executive Directors
- Telephone meeting with the newly recruited Non-Executive Director
- Meeting with the Lead Governor, a Non-Executive Director and the newly appointed Non-Executive Director
- Participating in appraisal discussions for three Executive Directors
- Participating in the recruitment of our new Director of Organisational Development
- Meeting with the newly appointed Non-Executive Director as part of their induction
- Supporting the recruitment of a Chair for Gloucestershire Hospitals NHS Foundation Trust including calls and attending the stakeholder presentation event
- Supporting the recruitment of a Chair for Avon and Wiltshire Partnership NHS Trust with reference calls
- Contributing to the appraisal of a fellow Chair
- Having my flu jab and becoming a Flu Fighter
- Additional regular background activities include:
    - attending and planning for smaller ad hoc or informal meetings
    - dealing with letters and e-mails
    - reading many background papers and other documents.

3. NON-EXECUTIVE DIRECTORS' ACTIVITIES

Martin Freeman (left 31 October 2016)

Since his last report Martin Freeman has;

- Attended the September board meeting and the October closed board meeting.
- Met with Quinton Quayle and Nikki Richardson for handover of chair of Mental Health Legislation Scrutiny Committee.
- Met with the 3 Clinical Executive Directors, Nikki Richardson and Trust Secretary to review work of Governance Committee and planned Sub Committee for Quality and Clinical Risk.
- Prepared for and chaired a meeting of the Governance Committee
- Met with Jane Melton, Lauren Wardman, Angie Fletcher and Nikki Richardson to finalise NED audit of complaints and future template proposal.

Charlotte Hitchings

Since her last report Charlotte Hitchings has:

- Prepared for and chaired the October and November Delivery Committees
- Attended a meeting of the Gloucestershire Strategic Forum
- Prepared for and attended the Audit Committee
- Prepared for and attended a meeting of the Council of Governors
- Attended the Gloucestershire Constabulary Open Day
- Participated in a Board Visit to the Working Well team in Gloucester
- Met with Maria Bond, new Non-Executive Director, as part of her induction
- Participated in the recruitment process for the appointment of the Director of Organisational Development

Jonathan Vickers

Since his last report Jonathan Vickers has;

- Prepared for and attended the September and October board meetings
- Prepared for and attended a SI review
- joined a board visit to the Cirencester recovery team
- held discussions with the director of finance on Pullman Place
- prepared for and attended a meeting on CITS integration
- prepared for and chaired a meeting of the development committee
- prepared for and participated in the recruitment process for the OD director
- prepared for and attended a meeting of the Appointments and Terms of Service committee
- prepared for and attended a meeting of the Audit committee
- prepared for and attended a meeting of the Charitable funds committee
- attended a chair's lunch
- attended a Council of Governors meeting
- held discussion with the chair and chief executive about the Gloucester hub project

Nikki Richardson

Since her last report Nikki has;

- Prepared for and attended the October and November Board Meeting
- Met with the Chair and lead Executives re Governance Committee
- Took part in the judging for the Gloucester Health and Social Care Awards and attended the Awards ceremony
- Attendance at Gloucester Care Services AGM
- Met with Marie Crofts
- Met with Head of Communications
- Prepared for and attended the October and November Governance Committees
- Prepared for and attended the October and November Delivery Committees
- Met re NED complaints review
- Had a telephone call with Carol Sparks re Friends and Family test
- Interview Panel member for Executive Director of OD recruitment
- Prepared for and attended a Serious Incident Review
- Attended an Appointments and Terms of Service Committee
- Prepared for and attended an Audit Committee
- Prepared for and attended the Charitable Funds Committee
- Reviewed a draft of the Trust's Risk Framework
- Prepared for and attended a MHLS Committee
- Prepared for and attended a Council of Governors meeting
- Attended a recent NEDs lunch meeting

Marcia Gallagher
Since her last report Marcia has;

- Met with the Director of Finance to receive a briefing on Charitable Funds
- Met with the Director of Finance and the Counter Fraud Manager to receive a briefing on 2G FT Counter Fraud arrangements
- Had a teleconference with Director of Finance re: Financial Report
- Prepared for and attended the October Board meeting
- Attended a farewell lunch for Dr Martin Freeman, Non-Executive Director
- Attended an Appointment and Terms of Service Committee
- Prepared for and Chaired the November Audit Committee
- Prepared for and attended the Charitable Funds Committee
- Visited the Thorn Centre and Benet Building in Hereford
- Attended NEDs / Chair lunch
- Attended and prepared for Governors meeting including a Holding to Account session
- Prepared for and attended November Board meeting in Hereford
- Met with the Head of Art Therapy in preparation for a visit.

Duncan Sutherland
Since his last report Duncan has;

- Prepared for and attended the September Board Meeting
- Attended an STP discussion meeting at Gloucester CCG
- Observed at 3 Mental Health Act Panel at Wotton Lawn
- Participated in a Mental Health Act Training session at Wotton Lawn

Quinton Quayle
Since his last report, Quinton Quayle has:

- Prepared for and attended interviews for 2gether Consultant Psychiatrists
- Prepared for and attended the September, October and November meetings of the Delivery Committee
- Prepared for and attended the September and October board meetings
- Attended the Mental Health Act Managers Induction Training Day
- Met the Matron of Wotton Lawn and visited the wards
- Had a meeting with the Learning Disability Manager, Hereford
- Had a meeting with the Community Services Manager, Hereford
- Prepared for and chaired the Mental Health Legislation Scrutiny Committee
- Prepared for and attended a meeting of the Governors

Maria Bond
Maria commenced in post on 1 November 2016 and is currently carrying out a local induction programme. Maria will Chair the Delivery Committee from December onwards.

4. OTHER MATTERS TO REPORT

Charlotte Hitchings has been appointed as Chair of Avon and Wiltshire Partnership NHS Trust from 7 November 2016. We have agreed a formal leaving date of 30 November 2016 for her time with us giving time for a well-managed handover. In order to minimise the potential conflict of interest we have agreed that Charlotte will not be attend the November Board meeting.

I know the Board will join me in thanking her for her tremendous service to the Trust and those it serves.

The Council of Governors has agreed to the commencement of a recruitment process for a Non-Executive Director.

2gether Making life better

2gether NHS Foundation Trust

PAPER L

2GETHER NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS MEETING
TUESDAY 13 SEPTEMBER 2016
BUSINESS CONTINUITY ROOM, RIKENEL, GLOUCESTER

PRESENT:	Charlotte Hitchings *(Chair)*	Paul Grimer	Alan Thomas
	Vic Godding	Jo Smith	Dawn Lewis
	Rob Blagden	Paul Toleman	Amjad Uppal
	Cherry Newton	Jenny Bartlett	Jennifer Thomson
	Tristan Lench	Elaine Davies	Ann Elias
	Richard Butt-Evans	Said Hansdot	Hilary Bowen

IN ATTENDANCE: Shaun Clee, Chief Executive
Marie Crofts, Director of Quality
Marcia Gallagher, Non-Executive Director
Anna Hilditch, Assistant Trust Secretary
John McIlveen, Trust Secretary
Jane Melton, Director of Engagement and Integration
Colin Merker, Director of Service Delivery
Amanda Pearce, Membership Volunteer
Quinton Quayle, Non-Executive Director
Nikki Richardson, Non-Executive Director
Andrew Smart, Head of Communications
Carol Sparks, Director of Organisational Development
Duncan Sutherland, Non-Executive Director
Jonathan Vickers, Non-Executive Director

1. WELCOMES AND APOLOGIES

1.1 Apologies for the meeting were received from Roger Wilson, Mervyn Dawe, Svetlin Vrabtchev, Pat Ayres, Katie Clark and Simon Hairsnape. Apologies were also received from Ruth FitzJohn and the Council welcomed Charlotte Hitchings who would be chairing the meeting in Ruth's absence.

1.2 Since the last meeting of the Council in July Governors were asked to note that Dee Drinan, Public Governor for the Cotswolds had tendered her resignation.

2. DECLARATION OF INTERESTS

2.1 Hilary Bowen advised that she was a Governor of the Barnwood House Trust.

2.2 Al Thomas informed the Council that he had been appointed as a Patient and Public Representative on the Overview Group for the National Mortality Case Records Review Programme.

2.3 Dawn Lewis had been elected as Chair of the Carers Forum for the Royal College of Psychiatrists.

3. COUNCIL OF GOVERNOR MINUTES

3.1 The minutes of the Council meeting held on 14 July were agreed as a correct record, subject to an amendment at 4.8 to read "Alzheimer's Action Group" rather than Dementia Alliance Group.

4. MATTERS ARISING, ACTION POINTS AND EVALUATION FORM

4.1 The Council reviewed the actions arising from the previous meeting and noted that the majority of actions had been completed, or were progressing to plan. The inclusion of more detail against "completed" actions was helpful by way of tracking progress and adding additional assurance of completion.

4.2 Colin Merker apologised that a briefing for Governors on Delayed Transfers of Care had yet to be circulated. He agreed to ensure that this was produced and sent out to all Governors as soon as possible.

4.3 Shaun Clee agreed to provide the Council with an update on the One Herefordshire work as part of the STP Report on the agenda.

4.4 Paul Toleman said that a colleague had been in touch with 2gether about applying for a Non-Executive Director position, but had been told that there were currently no vacancies. Carol Sparks advised that the Trust would be starting the recruitment process for a new NED to commence in March 2017; however, as this process had not yet commenced the information given to Paul's colleague had been correct. It was agreed that Paul Toleman would contact Carol Sparks directly to discuss the timetable for recruitment to this post.

4.5 The Council received the collated evaluation form from the last meeting. Charlotte Hitchings noted that only 7 forms had been received and asked all Governors present at the meeting to complete and return these to Anna Hilditch.

5. SUSTAINABILITY AND TRANSFORMATION PLANNING (STP)

5.1 Shaun Clee informed the Council that 2gether continued to be actively engaged in both the Gloucestershire STP and Herefordshire and Worcestershire STP in order to both effectively influence and be influenced, and to inform our strategic thinking and inform the strategic thinking of partners. In both STP footprints 2gether has strong representation throughout the STP structure.

5.2 In H&W STP, the Herefordshire component of the STP was being delivered via the One Herefordshire Alliance Board. The One Herefordshire Alliance Board is a way of bringing commissioners and providers together, to develop and agree a strategic direction for the County's Health and Social care priorities and the way in which services will be developed and delivered to achieve these. Under the One Herefordshire Alliance there will be a joint commissioning alliance - this will focus on translating strategic priorities into contractual outcomes to be delivered. There will also be a Provider Alliance. This will be an alliance of healthcare providers, working together to take responsibility for the cost and quality of care for a defined population.

5.3 The Chief Executive advised that the Alliance Board was a partnership agreement only, it was not a legal entity and currently there would be no implications for Trust Governors. A meeting was taking place with partners on 25 September and it was proposed that a full written brief would then be made available setting out the developments in more detail. This briefing would be made available to Governors once it was issued.

ACTION: One Herefordshire/Alliance Board briefing to be circulated to Governors for information

5.4 Al Thomas asked about the communication that was being made available around the STP process to keep people up to date on developments. Shaun Clee advised that Accountable Officers would be agreeing a coordinated response and this would be made available to all stakeholders.

6. CHIEF EXECUTIVE'S REPORT

6.1 The Chief Executive's report to the Council of Governors is intended to draw Governors' attention to key areas for awareness, information or for exploring further if of sufficient interest.

6.2 NHSI CEO Jim Mackey has written to all provider CEOs informing us that a revised Single Oversight Framework will be introduced from 1st October this year. The revised oversight framework will replace the current Monitor Risk Assessment Framework. Each organisation will be placed in a "segment" and we will be informed in the next couple of weeks of a shadow segment that we would be in based on our performance over the last 2 months.

6.3 The Annual Staff Survey was about to commence. As a part of the national process usually only a small percentage of staff are offered the opportunity to participate in the annual survey. This year, for the first time, 2gether have decided to expand the contract with the independent contractor to enable all of our staff who were in post on 1st September to participate.

6.4 Shaun Clee apologised to the Council for not providing a written Chief Executive's report in advance of the meeting. He said that things were moving at such a pace that a written report would be out of date by the time the meeting took place and he wanted to ensure that Governors received the most up to date information. Rob Blagden said that the Council acknowledged the fast paced environment; however, collectively the Governors would welcome a written report. It was agreed that there was a need to strike a balance and Shaun Clee therefore offered to provide Governors with a retrospective report following the meeting of the verbal update that he had given at the meeting.

ACTION: Written briefing to be provided for Governors following future Council meetings to capture the key points raised within the Chief Executive's report

7. APPOINTMENT OF THE EXTERNAL AUDITORS

7.1 The Council was informed that the External Audit Tender Project Group had met to agree the tendering process for the new External Auditor. Three firms had submitted bids and presentations would be taking place on 23 and 27 September. A formal recommendation would then be presented to the Council at its November meeting for approval.

8. JOINT BOARD AND GOVERNOR DEVELOPMENT PROGRAMME UPDATE

8.1 This report provided an update on the joint Board/Governor development programme, and on implementation of the recommendations agreed at previous Council meetings.

8.2 A revised process for Holding to Account (HTA) has been implemented and a flowchart setting out the process and indicative timings was presented. Holding to account topics for 2017 would be agreed in due course.

8.3 An induction session for new Governors was held on 25 August, with 5 new Governors attending along with 2 experienced Governors, the Trust Chair, Senior Independent Director, Chief Executive and Director of Service Delivery. As agreed by the Council, the induction session format was modified this time to include:

- An introductory meet and greet session enabling new Governors to meet each other and some of the Trust's Executive Directors
- A video presentation on the recovery college giving a service user's view of mental illness
- Presentations which were less 'wordy' and more visual
- The induction session was extended to three hours instead of two hours.

8.4 It was noted that each new Governor would have an individual follow-up session with Ruth FitzJohn in around 6 months' time and the learning from these sessions would inform the format of future inductions.

8.5 It was agreed that those Governors who were unable to attend the induction in August would be offered an individual one to one induction to ensure that they had the necessary information to carry out their role.

ACTION: One to one sessions to be arranged for those new Governors who had been unable to attend the induction session in August

8.6 The Council agreed that the joint development work had produced some excellent outcomes. The majority of the workstreams were now complete and recommendations implemented. It was agreed that a final close down report would be presented at the next meeting in November, with a follow up report to be scheduled for May 2017.

ACTION: A final close down report on the joint Board/Governor development work to be presented at the November meeting

9. GOVERNORS' CODE OF CONDUCT

9.1 The Code of Conduct for Governors was agreed in June 2013 and was therefore due for review. At its last meeting the Council noted a revised draft which sought to introduce a series of more proportionate responses to alleged misconduct. The Council requested amendments to the draft Code to make clear the process by which any alleged breach of the Code of Conduct would be addressed. A revised draft, which had been reviewed by the Lead Governor prior to today's meeting, was attached, and included a new Section setting out the process whereby allegations of misconduct would be investigated.

9.2 Subject to some minor typos, the Council of Governors approved the Code of Conduct. The new Code would be sent out to all Governors to complete the declaration. Governors would be asked to sign up to the Code of Conduct on an annual basis.

ACTION: New Code of Conduct to be shared with all Governors for completion

10. HOLDING TO ACCOUNT – SUSTAINABLE SERVICES - IAPT

10.1 Charlotte Hitchings and Colin Merker gave the Council a presentation focussing on providing sustainable services, with particular focus on IAPT services.

10.2 Improving Access to Psychological Therapy (IAPT) is a free NHS service for people in Gloucestershire and Herefordshire experiencing common mental health issues associated with anxiety and/or depression. The service was introduced to provide treatment for people who otherwise may not have received a service and/or would have been supported by their GP. The Service offers guidance, courses and talking therapies to support people with skills and techniques to manage their conditions better and improve their overall wellbeing. IAPT Services are currently expected to support circa 2,178 people a year in Herefordshire and 10,298 people a year in Gloucestershire. This is a high volume service accounting for 20-25% of the people that 2gether sees in a year.

10.3 The IAPT service has a high profile nationally and there is a real drive to expand access and deliver good outcomes. 2gether is measured against key performance indicators including a Recovery Rate (50% target) and Access Rate (15% target).

10.4 A number of issues had come to light over the past 18 to 24 months in relation to the provision of IAPT services, and 2gether asked the NHS Improvement (NHSi) Intensive Support Team (IST) to undertake an in-depth on site review of both Services independently with Commissioners to help identify any underlying issues not visible to date. The IST Review outcomes were reported back to the Trust in June 2016. Since then, a number of actions have been put in place, including:

- The overall care pathway has been redesigned in line with IST recommendations
- Service Improvement Plans are in place and signed off by Commissioners
- Governance arrangements in place: Project Board with Commissioner representatives, detailed monthly reporting to Delivery Committee, meetings with NHS England and NHSi
- New patient tracking lists and waiting list information reports produced
- Backlog waiting list clearance plans being implemented
- Funding agreed by Commissioners for both services to increase capacity
- Staff being recruited and trained
- Staff productivity improvements being made
- Trajectories in place for all performance measures

10.5 Charlotte Hitchings informed the Council that the Delivery Committee had received an IAPT Service Performance Report in June 2015 which highlighted issues of under performance attributed to acuity levels (Recovery Rates), the need for investment (Herefordshire Access Rates) and data quality issues.

Since that report was received, the Committee asked to receive assurance monthly on the actions being taken to rectify the problems. Red flags were requested to prioritise investigation of underlying issues, trajectories for improvement were requested and additional Service Performance Focus reports were requested, once the issues and actions were made clear. The Delivery Committee was reporting Limited assurance around IAPT services to Board from June 2015.

10.6 Charlotte Hitchings informed the Council that despite the concerns, a number of areas of good practice had been seen including proactive action to investigate root causes, fast and effective responses once the causes were understood, a robust approach to governance within the Trust and with Commissioners and the development of robust Improvement plans, approved by NHS England and NHSI, avoiding the risk of a negative effect on the Trust's governance rating.

10.7 However, there were also some key learning points and areas for improvement, including the development of skills for Trust managers (data analysis and understanding of data), Management Training and Information reporting (visibility of issues, in particular waiting times). Waiting time reports for all services are now presented to the Delivery Committee and work is underway to look at how the new reporting tools for IAPT could be developed for other services.

10.8 Rob Blagden said that he had been observing the Delivery Committee and reported that he had received very good assurance from that and from the level and detail of questioning and challenge at the Committee. However, discussions that had taken place at the Governor pre-meeting had highlighted some concerns from Governors as to why more information about the issues with IAPT had not been raised with them previously. Shaun Clee said that the information had been raised verbally at Council meetings and at Board meetings; however, it was acknowledged that a fuller and complete briefing on the current position would have been helpful for the Governors to give the full picture.

10.9 Jenny Bartlett asked about the Trust's interaction with the IST and queried whether making contact with them and asking them to come in sooner to carry out their review would have made any difference. It was not felt that contacting the IST earlier would have impacted on the current position. The Council was informed that the problems arising with IAPT services were being seen nationally.

10.10 Al Thomas thanked colleagues for the presentation and briefing paper on IAPT. He asked whether it was felt that 2gether was getting sufficient support from Commissioners, in particular in relation to resourcing. Colin Merker said that both Commissioners had been very supportive and additional funding had now been agreed with Gloucestershire and Herefordshire.

10.11 The Council was informed that the Delivery Committee received and reviewed the monthly performance dashboard in detail at each meeting. A query was raised as to whether the Performance Dashboard could be shared regularly with Governors. It was noted that this was published in full as part of the Board meeting papers so was in the public domain; however, it was agreed that a new

section would be created on the Governor Portal for Governors to get direct access to the dashboard and information about IAPT. This would mean that Governors could see the trajectories and receive assurance that these were on track, rather than digging through lots of papers to find the detail.

ACTION: Governor Portal to be updated with a new section for the Performance Dashboard

10.12 Colin Merker said that he would be happy to organise a visit to IAPT services for any interested Governors. Anyone who wished to participate was asked to let Anna Hilditch know.

ACTION: Governor visit to IAPT services to be arranged

10.13 The Council thanked Colin Merker and Charlotte Hitchings for their presentations which had been very helpful and informative.

11. MEMBERSHIP REPORT

Membership Activity Report

11.1 This report provided an update for the Council of Governors about membership activity, the membership development plan and Governor Engagement Events.

11.2 The latest edition of our membership newsletter, Up2Date, was being written and would be published in mid-October. Governors were invited to send their story suggestions to the Communications Team via Anna Hilditch. Newsletters were published quarterly and articles/news items were always welcomed.

11.3 In terms of membership statistics, the Council noted that there continued to be a steady increase in the number of members; however, the need for more focus on increasing membership amongst young people was noted.

11.4 Plans were being made for Governor engagement events, including another Cirencester event in September, an event in Hereford to coincide with World Mental Health Day in October and a young people's engagement event in Cheltenham in November. Governors were encouraged to liaise with the Communications Team if they wished to set up an event within their constituency.

Membership Strategy Refresh

11.5 The Council received the draft 2016/17 Trust Membership Strategy. This strategy had been presented to and endorsed by the Trust's Executive Committee and some activity to enact the strategy was already underway, and the Lead Governor has reviewed the work and offered suggestions.

11.6 The main purpose of the Trust's Membership Strategy is to:

- Promote and increase membership among groups who are currently under-represented
- Retain our current members

- Enhance membership engagement by building opportunities for members to communicate with their Governor and the Trust
- Encourage members to get involved in Governor elections
- Support the Trust's Social Inclusion strategy
- Raise public awareness of mental health issues

11.7 The strategy would be reviewed annually and the Annual Tactical Plan reviewed quarterly. A report on the success of the strategy would also be included in the Trust's Annual Report.

11.8 The Council of Governors were happy to note and endorse the updated 2016/17 draft Trust Membership Strategy.

12. KEY ISSUES FOR DISCUSSION FROM THE GOVERNOR PRE-MEETING

12.1 Rob Blagden said that a number of the key discussion points from the pre-meeting had already been raised and responded to elsewhere in the meeting.

12.2 A request was made that information about the Committee Observation process be circulated to all new Governors, along with other engagement opportunities to see if people wished to get involved.

ACTION: Information about the Governor observation at Board Committees and upcoming engagement events to be shared with all Governors

13. GOVERNOR ACTIVITY

13.1 Those Governors who had attended the induction session on 25 August said that they had found this to be a valuable experience and had welcomed the opportunity.

14. ANY OTHER BUSINESS

14.1 There was no other business.

15. DATE OF NEXT MEETINGS

Council of Governor Meetings

Business Continuity Room, Trust HQ, Rikenel		
Date	**Governor Pre-meeting**	**Council Meeting**
2016		
Thursday 10 November	1.30 – 2.30pm	3.00 – 5.00pm
2017		
Tuesday 17 January	9.00 – 10.00am	10.30 – 12.30pm
Thursday 9 March	1.30 – 2.30pm	3.00 – 5.00pm
Tuesday 9 May	4.00 – 5.00pm	5.30 – 7.30pm
Thursday 13 July	9.00 – 10.00am	10.30 - 12.30pm
Tuesday 12 September	4.00 – 5.00pm	5.30 – 7.30pm
Thursday 9 November	1.30 – 2.30pm	3.00 – 5.00pm

Board Meetings

2016		
Thursday 24 November	10.00 – 1.00pm	Kindle Centre, Hereford
2017		
Thursday 26 January	10.00 – 1.00pm	Business Continuity Room, Rikenel
Thursday 30 March	10.00 – 1.00pm	Business Continuity Room, Rikenel
Thursday 25 May	10.00 – 1.00pm	Hereford
Thursday 27 July	10.00 – 1.00pm	Business Continuity Room, Rikenel
Thursday 28 September	10.00 – 1.00pm	Business Continuity Room, Rikenel
Thursday 30 November	10.00 – 1.00pm	Hereford

Governor Visits to Trust Sites

Venue	Location	Date	Time
Honeybourne, Laurel House and Brownhill Centre	Cheltenham	Tuesday 22nd November	9.30am – 11.30am
Wotton Lawn	Gloucester	Thursday 15th December	3.00pm – 5.00pm

Council of Governors – Action Points

Item	Action	Lead	Progress
14 July 2016			
4.4	Review of the Membership Application form to be carried forward to the November meeting.	Head of Communications	Our Communications Team has considered reviewing the membership application form to include a question about whether the person applying is a current or past Trust service user. Consultation with service users suggested that this may prove unpopular, particularly when many applications take place in public venues where people may feel uncomfortable about discussing their mental health history. However, the team is happy to add a question to the form when the document is next reviewed to ask how someone heard about the Trust. This gives the option to disclose previous experience of using services, should the applicant wish to do so
5.6	Briefing paper on the current Delayed Transfers of Care position to be produced and circulated to Governors for information	Colin Merker	**Complete**
13 September 2016			
5.3	One Herefordshire/Alliance Board briefing to be circulated to Governors for information	Shaun Clee / Anna Hilditch	Verbal update at the November meeting

6.4	Written briefing to be provided for Governors following future Council meetings to capture the key points raised within the Chief Executive's report	Shaun Clee / Anna Hilditch	Chief Executive to share the key points after the meeting for inclusion in the minutes
8.5	One to one sessions to be arranged for those new Governors who had been unable to attend the induction session in August	Anna Hilditch	**Ongoing** Contact has been made with those Governors who were unable to attend the main induction session, offering a tailored one to one session
8.6	A final close down report on the joint Board/Governor development work to be presented at the November meeting	John McIlveen	**Complete** On agenda for November meeting
9.2	New Code of Conduct to be shared with all Governors for completion	Anna Hilditch	Hard copies to be shared at the November meeting for completion
10.11	Governor Portal to be updated with a new section for the Performance Dashboard	Anna Hilditch	**Complete** New section for Performance Information add to the Governor Portal
10.12	Governor visit to IAPT services to be arranged	Anna Hilditch	**Complete** Visit arranged for Wednesday 30th November at 2.00 – 4.00pm at Belmont, Hereford. Governors who wish to attend are asked to notify Anna Hilditch
12.2	Information about the Governor observation at Board Committees and upcoming engagement events to be shared with all Governors	Anna Hilditch	A review of the Board Committee observation trial will be taking place at the January 2017 Council meeting. Following this a new schedule of meetings will be issued and all Governors will be given the opportunity to participate in the process of observation

Agenda item **19** **Enclosure** **Paper M**

Report to: Trust Board, 24 November 2016
Author: John McIlveen, Trust Secretary
Presented by: John McIlveen, Trust Secretary

SUBJECT: **USE OF THE TRUST SEAL**

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

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

PURPOSE

To present the Board with a report on the use of the Trust Seal for the period July to September 2016 (Q2 2016/17).

SUMMARY OF KEY POINTS

Section 10.3 of the Trust's Standing Orders requires that use of the Trust Seal is reported to the Board on a quarterly basis.

"10.3 Register of Sealing - The Chief Executive shall keep a register in which he/she, or another manager of the Authority authorised by him/her, shall enter a record of the sealing of every document. Use of the seal will be reported to the Board quarterly."

During the quarter, the Seal was used once:

Pullman Place – Transfer of Registered Title to 2gether NHS Foundation Trust
Signed: Shaun Clee, Chief Executive and Andrew Lee, Director of Finance and Commerce
Date: 14 July 2016

RECOMMENDATIONS

The Board is asked to note the use of the Trust seal for the period July - September 2016