with you, for you

Gloucestershire Health and Care
NHS Foundation Trust

TRUST BOARD MEETING

PUBLIC SESSION

Thursday, 30 May 2024

10:00 – 13:00

To be held at Churchdown Community Centre

AGENDA

TIME	Agenda Item	Title	Purpose	Comms	Presenter
OPENING BUSINESS					
10:00	01/0524	Apologies for absence and quorum	Assurance	Verbal	Chair
	02/0524	Declarations of Interest	Assurance	Verbal	Chair
10:05	03/0524	Service User Story Presentation	Assurance	Verbal	A-DoNTQ
10:30	04/0524	Minutes of the meeting held on 28th March 2024	Approve	**Paper**	Chair
	05/0524	Matters arising and Action Log	Assurance	**Paper**	Chair
10:35	06/0524	Questions from the Public	Assurance	Verbal	Chair
PERFORMANCE AND PATIENT EXPERIENCE					
10:40	07/0524	Finance Report	Assurance	**Paper**	DoF
10:50	08/0524	Performance Report	Assurance	**Paper**	DoF
11:10	09/0524	Quality Dashboard Report	Assurance	**Paper**	A-DoNTQ
BREAK – 11:30 (10 minutes)					
STRATEGIC ISSUES					
11:40	10/0524	Report from the Chair	Assurance	**Paper**	Chair
11:50	11/0524	Report from Chief Executive	Assurance	**Paper**	CEO
12:05	12/0524	Board Assurance Framework	Assurance	**Paper**	DoCG
12:15	13/0524	Freedom to Speak Up 6 Monthly Report	Assurance	**Paper**	FTSU Gdn
GOVERNANCE					
12:30	14/0524	SIRO Report 2023/2024	Assurance	**Paper**	DoF
12:40	15/0524	Appointment of Deputy Chair and SID	Approve	**Paper**	Chair
12:45	16/0524	Use of the Trust Seal 2023/24	Assurance	**Paper**	DoCG
TO NOTE	17/0524	Council of Governor Minutes - 13 March 2024	Information	**Paper**	DoCG

TIME	Agenda Item	Title	Purpose	Comms	Presenter
BOARD COMMITTEE SUMMARY ASSURANCE REPORTS					
12:50 **TO NOTE**	18/0524	Forest of Dean Assurance Committee (21 May)	Assurance	**Paper**	FoD Chair
	19/0524	Working Together Advisory Committee (10 April)	Information	**Paper**	WTAC Chair
	20/0524	Mental Health Legislation Scrutiny Committee (24 April)	Information	**Paper**	MHLS Chair
	21/0524	Resources Committee (25 April)	Information	**Paper**	Resources Chair
	22/0524	Great Place to Work Committee (25 April)	Information	**Paper**	GPTW Chair
	23/0524	Quality Committee (2 May)	Information	**Paper**	Quality Chair
	24/0524	Audit & Assurance Committee (9 May)	Information	**Paper**	Audit Chair
CLOSING BUSINESS					
13:00	25/0524	Any other business	Note	Verbal	Chair
	26/0524	**Date of Next Meetings** **<u>Board Meetings 2024</u>** Thursday, 25th July Thursday, 26th September Thursday, 28th November	Note	Verbal	All

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AGENDA ITEM: 04/0524

MINUTES OF THE TRUST BOARD MEETING

Thursday, 28 March 2024
Gloucestershire Deaf Association, Barnwood, Gloucester

PRESENT:
Ingrid Barker, Trust Chair
Steve Alvis, Non-Executive Director (NED)
Sandra Betney, Director of Finance
Douglas Blair, Chief Executive
Sumita Hutchison, Non-Executive Director
Nicola de Iongh, Non-Executive Director
Vicci Livingstone-Thompson, Associate Non-Executive Director
Jan Marriott, Non-Executive Director
David Noyes, Chief Operating Officer
Angela Potter, Director of Strategy and Partnerships
Neil Savage, Director of Human Resources (HR) & Organisational Development
Hannah Williams, Acting Director of Nursing, Therapies and Quality
Dr Amjad Uppal, Medical Director

IN ATTENDANCE:
Andrew Cotterill, Appointed Governor (Inclusion Gloucestershire)
Anna Hilditch, Assistant Trust Secretary
Abi Lee, Student Specialist Practitioner District Nurse
Louise Moss, Assistant Director of Corporate Governance
Annie Nightingale, Deputy Head of Communications
Lily Wheldon, Student Specialist Practitioner District Nurse

1. WELCOME AND APOLOGIES

1.1 The Chair welcomed everyone to the meeting. Apologies had been received from Marcia Gallagher, Graham Russell, Helen Goodey and Lavinia Rowsell.

2. DECLARATIONS OF INTEREST

2.1 There were no new declarations of interest.

3. SERVICE STORY PRESENTATION

3.1 The Board welcomed Sian Ryan, Community Manager and Sian Fitter, Community Nursing Lead for the Cheltenham Integrated Care Team (ICT).

3.2 Sian and Sian were in attendance to present a case study to the Board where the ICT as a whole had supported a patient. Each Locality has Integrated Community Teams (ICTs) with staff including Community Nurses, Occupational Therapists, Physiotherapists and Home First & Reablement. The case looked at a 74-year-old gentleman, who had been discharged home on the Home First pathway, from acute care following a 6-month admission

3.3 Jan Marriott noted the reference to a Wellbeing co-ordinator and it was noted that this was a new role within Home First & Reablement that was being gradually rolled out to all localities.

3.4 Neil Savage said that the presentation had demonstrated the great examples of multi-disciplinary team working to provide the appropriate care and support to this gentleman. Neil asked what colleagues would do if they had a magic wand and could change things or do something differently. Sian Ryan said that timelier meetings and communications with GHFT would be helpful, as well as more staff within the service. She said that having the time to share these stories with the Board and clinicians was also helpful as it was important to remind people of the importance of these services and the impact that they have.

3.5 The Board noted that the gentleman in the case study had been very clear about the ongoing support and care that he wished to receive. Douglas Blair asked how confident colleagues felt that the service was adapting and learning to ensure that those patients who didn't have such a strong voice still had their wishes carried out. Sian Ryan advised that all patients coming through the service were offered the same treatment and opportunities, but it was about communication and really speaking to and listening to the patient to fully understand their wishes.

3.6 David Noyes said that work was taking place to review the mental health teams and to bring these into the same footprint as the ICTs. This would make it a fully holistic approach.

3.7 The Board thanks Sian and Sian for attending and presenting. It was agreed that the study really demonstrated the impact of integrated working and Multi agency involvement – looking at the patient journey, focussing on 'what matters to me', and the patients' experience receiving care within the ICT.

4. MINUTES OF THE PREVIOUS BOARD MEETING

4.1 The Board received the minutes from the previous Board meeting held on 28 March 2024. The minutes were accepted as a true and accurate record of the meeting, subject to the following amendment:

- At paragraph 7.8, Sumita Hutchison clarified that when she noted that there had been no pressure ulcers reported at RUH Bath she was referring to one ward, not the whole Trust. This was noted and the minute would be updated to reflect this.

5. MATTERS ARISING AND ACTION LOG

5.1 The Board noted that all actions had now been completed or were progressing to plan.

5.2 Steve Alvis thanked colleagues for providing the figures around bed occupancy in the Forest of Dean. He said that it would be helpful to keep a close eye on this going forward. David Noyes advised that the Trust would be monitoring the transition of the

transferred patients into the new forest hospital, and BI colleagues would be looking at the future inclusion of a small bespoke section within the body of the performance dashboard report around occupancy.

6. QUESTIONS FROM THE PUBLIC

6.1 There were no questions from the public.

7. PERFORMANCE DASHBOARD

7.1 Sandra Betney presented the Performance Dashboard to the Board for the period February 2024 (Month 11 2023/24).

7.2 In terms of Business Intelligence, the Board noted a focus toward 2024/25 business planning and updating the performance indicator portfolio to incorporate Operational Planning measures and ICB Contract updates for the new year. Statistical Process Control (SPC) methodology is being reviewed in preparation for 2024/25 which BI intend to use to inform an update on internal indicator thresholds. Revising methodology could increase some exceptions as statistical control limit parameters may be reduced for some indicators.

7.3 The Trust's Data Quality Policy has been reviewed and has received some comments from the Business Intelligence Management Group (BIMG). This paper will proceed to the Information Governance (IG) Group in April 2024.

7.4 A development plan has begun between Business Intelligence and the Workforce Team to present a closer dashboard view on workforce challenges that may otherwise be masked by compliant aggregated indicators. Initial reporting examples were presented in March's Business Intelligence Management Group, will pass through Executives and will be taken to April's Resources Committee.

7.5 **Nationally measured domain** - Sandra Betney reported that Adolescent Eating Disorders routine referral within 4 weeks (N11) was the only indicator under threshold for the period but presents an improving position both in performance and waiting numbers.

7.6 **Specialised & directly commissioned domain** – The Board noted that 2 health visiting indicators (S02 & S09) were within Statistical Process Control limits but remain slightly behind their thresholds for the period. Pleasingly, this is a reduced number of indicators in exception within this domain than is routinely monitored.

7.7 **Integrated Care System (ICS) Agreed domain** - The only indicator in exception for this period was the Social Care Package Reviews within 8 weeks of commencement (L19). There was only one non-compliant case and that missed its review by one day.

7.8 **Board focus domain** – The Board was asked to note that Mental Health (B04) and Physical Health (B05) Bed Occupancy levels both remain consistently high for the period. Ward level breakdowns were provided with Tewkesbury the only ward under

threshold. The Data Quality Maturity Index (DQMI) remains in exception due to physical health clinical system challenges. Appraisal and Sickness absence measures remain in exception with Directorate performance noted.

7.9 The Board noted that the overall number of indicators in exception had reduced for the period, however, Sandra Betney asked the Board to be mindful that an increase may be seen once the previously mentioned SPC threshold review had been carried out.

7.10 The Board noted that the Talking Therapies Access Rates (L02) was within SPC limits, although under threshold and referrals remain low nationally. Additionally, the measurement of Talking Therapies is changing in 2024/25 from 'Access' to 'Completed Treatments' (Reliable improvement) and the service is already preparing its approach to deliver this.

7.11 David Noyes presented the Chief Operating Officer report to the Board highlighting key points to note around system flow, Minor Injury and Illness Unit (MIIU) usage, HomeFirst and an update of the Working as One admission criteria.

7.12 David Noyes reported that the Trust had exceeded the 80% target for referral to assessment within 4 weeks in core CAMHS service, achieving 82.4%, with an average wait of 18 days. No-one has waited more than 2 years on the list, and the overall numbers have reduced slightly to 563. Our improvement plan continues and is updated monthly. The Board were reminded that full recovery in this area was expected to take at least another 12-18months.

7.13 Steve Alvis thanked colleagues for this report and joined fellow Board members in welcoming the larger size font used. Steve noted that the MIIUs continued to deliver very strongly, achieving the 4 hours target over 99% of the time and continuing to deal with between 300 and 400 patient contacts a day.

7.14 While not yet a significant concern, David Noyes advised that the Trust was closely monitoring the performance of Echocardio which was on a downward trajectory and naturally has a knock-on impact on our heart failure service. High level discussions with commissioners would be required.

7.15 Jan Marriott noted that the delays in discharges from Wotton Lawn were in the main related to onward accommodation issues, as previously discussed at Board, however, she queried whether there were any other factors impacting on this position. David Noyes said that cultural issues also played a role and the need to get the right people in the right places. A lot of work continued to take place to try to manage discharges from acute MH beds, including setting up daily ward rounds. Amjad Uppal said that a meeting had taken place with consultants at Wotton Lawn and Charlton Lane and there were concerns that patients were being admitted later than required due to there being no beds available. Having Social Workers on the wards was a helpful development. It was recognised that the Trust needed to manage the beds better as there were sufficient numbers to accommodate the population. Hannah Williams advised that it was in the Trust's gift to improve the position at Wotton Lawn

and work was taking place with senior leaders to address this. This work would continue.

7.16 The Board noted the assurance provided and thanked colleagues for this detailed and informative report. Ingrid Barker said that the report demonstrated that some real improvements were being seen under enormous pressures, and congratulated colleagues across the Trust for their hard work and effort.

8. FINANCE REPORT

8.1 At month 11 the Trust has a surplus of £3.347m compared with a plan of £0.023m. The Trust's month 11 forecast position is a £1.939m surplus, after deficit risk share and before adjusting income by £956k. 2023/24 net Capital spend to month 11 is £10.809m against an original plan of £13.475m, and the forecast outturn is £13.497m. Cash at the end of month 11 is £50.013m, an increase of £3m on last month.

8.2 The Cost improvement programme has delivered £4.34m of recurring savings against a ytd plan of £5.18m. The forecast is £5.443m against plan of £5.443m, however £324k is at very high risk of non-delivery. Non-recurring savings have been delivered to date of £4.071m compared with the plan of £4.070m. The forecast is £4.440m against plan of £4.440m.

8.3 The Trust spent £7.060m on agency staff up to month 11. This equates to 3.59% ytd of total pay, excluding centrally funded employers' contribution to pensions of 6.3%, and is below the agency expenditure ceiling of 3.7%. The Board noted that this continued to be a key area of focus for the Trust. Sumita Hutchison asked what the consequences of reducing agency staffing would be. Sandra Betney advised that most of the agency was being used for inpatient services, however, a reduction was good news as this meant that there would be increased continuity of care, better care and the use of agency staff was very expensive. The reduction in agency staff was a positive action.

8.4 The System position at month 11 is a £5.237m favourable variance to plan. The reported system forecast is a £0.507m surplus. The Trust anticipates that the system treatment of S117 costs will not lead to increased costs for the Trust as an agreement has been reached on the funding arrangements for 2023/24.

9. QUALITY DASHBOARD REPORT

9.1 This report provided an overview of the Trust's quality activities for February 2024.

9.2 Hannah Williams informed the Board that overall, the report demonstrated that some positive work was being carried out and high-quality services were being delivered. This month's report also included additional information regarding: Learning from Deaths Q3, Guardian of Safe Working Update Q3 and Non-Executive Directors Quality Visits Q3. It was noted that the next report would include the results from the 2023 CQC Community Mental Health Service User Survey.

9.3 Hannah Williams advised that the Berkeley House Care Quality Commission report was published on 1st March 2024 and confirms the change in rating to inadequate. This does not affect the overall rating for the Trust which remains as 'Good'. We continue to facilitate monthly meetings with the Care Quality Commission, Integrated Care Board and NHS England to assure them of delivery against the agreed improvement plan. All partners recognise the progress that has been made and will support the application for the removal of the Section 31 notice we have in place.

9.4 Quality issues showing positive improvement this month included:

- Re-introduction of PALS (Patient Advice and Liaison Service) visits at Berkeley House.
- Fifth consecutive month of improved performance in Cardio-metabolic assessment within Mental Health inpatients with improvements also noted in community, this follows a focussed program of work from the lead nurse for Physical Health in Mental Health.
- As part of the Friends and Family Test Quality Improvement project, a pilot to share feedback through 'You Said, We Did' Boards has commenced.
- Significant sustained reduction over time in moderate harm falls incidents, much of this can be attributed to falls reduction work at Charlton Lane. Learning from this area of work is now being embedded across Community Hospitals.
- A reduction in pressure ulcer (PU) moderate harm incidents with a 65% reduction in deep tissue injury across all localities and a 16% reduction in unstageable pressure ulcers across all services. This reflects the ongoing focus with teams to support accurate assessment and categorisation of pressure ulcers which has been identified as an area that required improvement following a thematic review of pressure ulcers led by the Head of Profession for Community Nursing and the Patient Safety team.
- Good progress has been made in more detailed reporting of Statutory and Mandatory training and Clinical Supervision but more work is required to be able to use this data for full assurance.
- The Business Intelligence team have developed a clinical system to automatically report safeguarding referrals to the local authority which will replace the manual workaround put in place thus releasing time for operational colleagues. The system will go live in April 2024.

9.5 Quality issues that require additional focus development included:

- Continued work regarding quality concerns at Berkeley House, noting ongoing challenges with staffing vacancies, particularly within the Therapy and Health Care Support Worker provision.
- Continued focussed work within the Safeguarding team reprioritised to address the backlog of MARAC (Multi Agency Risk Assessment Committee) action plans awaiting administrative uploading to records noting the improvements that have been realised following a review of administrative process.
- Ongoing development and expansion of work to prevent against the risks associated with Closed Culture which includes methods of reporting and associated assurance from 'Ward to Board'.

- To expand current patient safety data set and analysis to include themes related to restrictive practice. Particular attention is being applied to improving recording of rapid tranquilisation and the clinical observations post administration.
- Focussed work led by the Trust Safeguarding leads to address low uptake of Children's and Adult safeguarding group supervision, this will be undertaken in partnership with operational leads.

9.6 Nicola de Iongh referred to the slide within dashboard which set out the training compliance levels of the different services. She expressed concern that some inpatient areas were reporting below compliance on a number of key areas. Hannah Williams said that her team were working in partnership with operations to look at this and to try and release staff in a timely way to be able to carry out their training. Some of the training required a full day, face to face session which could be challenging in terms of releasing staff. Amjad Uppal said that he found this to be an issue for medical colleagues as well and there was a need to look at protected time for people to complete their training and a need to prioritise this. Sandra Betney confirmed that the Trust did have the granular detail available and was therefore able to confirm which staff members had / had not completed their training so there was the ability to focus in and see what the barriers may be. Further work would continue outside the meeting with NQT and Operational colleagues to look at how best to address these concerns.

9.7 Jan Marriott noted the number of incidents reported for Tewkesbury Hospital Theatre and asked for further information about the nature of these incidents. Hannah Williams advised that these incidents related to an external supplier performance issue and the delivery of clean/sterile equipment for use by the theatre. This had been reported to them and discussions were ongoing. Hannah Williams assured the Board that the Trust's Infection Prevention Control Team had been fully engaged and IPC audits carried out.

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

10. CHAIR'S REPORT

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

10.2 Ingrid Barker advised that the recruitment for a new Trust Chair concluded on 8th March. Following a rigorous recruitment process overseen by Senior Independent Director, Marcia Gallagher, and our Governors' Nominations and Remuneration Committee, she was delighted to advise that Graham Russell, Vice-Chair has been appointed as Trust Chair. Graham would commence in his new role within the Trust on 1 May 2024. Steve Alvis asked whether there were any plans in place to recruit

to the vacant NED position given Graham's new appointment. Ingrid Barker advised that recruitment was currently underway for two NEDs and a further round of recruitment to include this new vacancy was planned for later in May. The Nominations and Remuneration Committee would be presented with a report at its June meeting setting out the proposals, to include a full review of the NED skill mix.

10.3 Ingrid Barker and the Chair of the Gloucestershire Hospitals NHS Foundation Trust, Deborah Evans continue to meet on a regular basis to discuss matters of mutual interest. Deborah Evans, Professor Jane Cummings, Deputy Integrated Care System (ICS) Chair and Non-Executive Director for System Quality and Ingrid undertook a joint Chair's visit on 21st February. The visit was hosted at Pullman Place and focussed on Adult Mental Health services. The visit was to better understand community mental health services in Gloucestershire and to appreciate their strengths, challenges and interfaces with other services. They met colleagues from Crisis Resolution and Home Treatment, Complex Psychological Interventions, Assertive Outreach/Later Life, Perinatal, Recovery, Individual placement Support (into work), Administrative Services and Community Health Transformation. Colleagues were invited to talk about their achievements and challenges. Ingrid Barker said that the visit was immensely useful and inspiring and she expressed her thanks to Justine Hill, Deputy Service Director Mental Health Community Services for organising the visit and for the commitment shown to this important area of the Trust's work.

10.4 More than 135 colleagues gathered to celebrate our Better Care Together Awards at Hatherley Manor Hotel on 7th March with winners crowned in eight categories. The occasion was a chance to celebrate the wide range of teams and services nominated and the contribution of colleagues, volunteers and Experts by Experience across the Trust. We had 171 nominations in total. Ingrid Barker said that she was honoured to present the awards alongside the Chief Executive.

10.5 Ingrid Barker said that she was delighted to be invited to the Friends and Family Open Day of the Montpellier Therapeutic Allotment on 22nd March. Colleagues were joined by special guest, BBC Countryfile presenter Adam Henson, who kindly agreed to officially open our long-awaited eco-cabin.

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

11. CHIEF EXECUTIVE'S REPORT

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

11.2 Douglas Blair had continued to carry out service visits, team meetings and to 'hot desk' from different sites. He said that he had welcomed the opportunity to meet with

colleagues, learn about their roles and understand any of the challenges facing their service areas.

11.3 On 1st March, the Care Quality Commission published a report following an unannounced inspection of Berkeley House, in Stroud. Berkeley House is a six-bedded inpatient unit for people with learning disabilities. The inspection took place on 10th and 11th October 2023 and the report confirmed the rating for the service has been downgraded from 'good' to 'inadequate'. While the report does detail some positive elements of care and treatment and positive feedback from families and carers there are, unfortunately, a number of elements highlighted that fall below the standards we aspire to. We had already identified specific quality of care concerns at the unit in summer 2023, through feedback from Trust colleagues and had informed the Care Quality Commission. The Trust has been working with NHS Gloucestershire as well as Gloucestershire County Council and the NHS England Specialist Learning Disability support team to carry out further reviews and seek additional support on improvements being made. The majority of CQC recommendations have already been partially or completely resolved. The inspection outcome and downgrading of the unit is clearly deeply regrettable but we are grateful to the CQC for the independent scrutiny they have given our service. Our overall priority will always be the health and wellbeing of the people in our care. We are in regular contact with the families of the six people being cared for at Berkeley House and we are supporting them throughout.

11.4 The Board noted that the review of the second phase of small grants as part of the Community MH Transformation (CMHT) programme had now been completed and has been able to successfully approve seven Voluntary, Community and Social Enterprise applications with a value of £200,369. This means that in 2023/24 the Community Mental Health Transformation programme was able to allocate a total of c£300k in small grants to voluntary sector partners across the county.

11.5 Gloucestershire Integrated Care Board (ICB) held a Board Development session on 28th February. The session focussed on a number of important issues. In his capacity as Joint Senior Responsible Owner for health inequalities (with Siobhan Farmer, Director of Public Health), Douglas Blair presented an update on Gloucestershire's approach to tackling health inequalities and proposed a framework for contributory activity, targeted interventions and improvements to mainstream service delivery. This would be developed further as a result.

11.6 The Board received an update on the proposed dates for the handover and moves of different services to the new Forest of Dean community hospital.

11.7 The Trust's Better Care Together event took place at Forest Green Rovers in Nailsworth on 20th March. The event was well attended and was an excellent opporuntity to raise awareness around the NHS contribution to the UK's carbon footprint and its implications on the environment. Sumita Hutchison had attended the event and said that it had a real energy about it with lots of good ideas being generated. She asked what would now happen in terms of follow up. Douglas Blair agreed, noting that it demonstrated the importance of taking a broader sustainability lens to service developments. Angela Potter said that the intention was for the Sustainability Programme Board to receive and review the outputs from the event for

further action. Angela said that it had been great to see so many clinical colleagues at the event which had helped to generate some real hands on ideas.

11.8 As part of the Trust's continuous improvement programme, Healthwatch were invited into Wotton Lawn hospital to provide us with an unbiased insight into what it feels like to be a patient staying in the hospital. Healthwatch carried out seven separate visits to the Hospital between October and December 2023, across weekdays, evenings and weekends. We were pleased to receive the report which is overall very positive with feedback indicating that most of the people they spoke to felt that the staff were approachable, well-trained and communicated well and patients & carers described feeling safe in the hospital but did raise some concerns in relation to the lighting outside of the hospital when visitors were arriving or leaving in the dark. Healthwatch noted that the hospital had good staffing levels and that staff described a supportive working environment where they felt able to raise concerns. They also described being offered debriefs after being involved in, or witnessing, incidents. Healthwatch made a number of recommendations which we will consider how we take forward as part of our approach to continuous improvement at the hospital. As a Trust we welcome all opportunities to receive independent feedback and would like to thank Healthwatch colleagues for their time in undertaking the visits and providing the report.

11.9 Ofsted and the Care Quality Commission (CQC) visited Gloucestershire during December 2023 to assess how effective the local education, health, and care services are at identifying and meeting the needs of children and young people with Special Educational Needs and Disabilities (SEND) aged 0-25. Inspectors recognised the range of improvements made by Gloucestershire's Local Area Partnership, whilst also highlighting the need to do more to make sure experiences and outcomes are more consistent for all children and young people with SEND.

11.10 Health Education England has published the results of the 2023 National Education and Training Survey (NETS), revealing that GHC has ranked second overall in the South West. The NETS is open to all learners undertaking a practice placement or training post in all health and care services across England. The survey opens once each year in October, with the aim of understanding experience of students and doctors in training. In the South West, 78% of learners rated their overall educational experience as 'good' or 'outstanding'. Gloucestershire Health and Care NHS Foundation Trust ranked second overall, with a rating of 84.68%.

11.11 The results of the Patient Led Assessment of the Care Environment (PLACE), which were completed at all Gloucestershire Health and Care NHS Foundation Trust inpatient sites between September to November 2023, have recently been published. PLACE is the only assessment and collection of data for non-clinical services within a hospital and all the assessments are led by patient representatives. GHC previously completed the assessment in 2022, the first as a newly merged Trust, due to it being cancelled in 2021 and 2022 as a result of the pandemic. The results are on the whole very promising, with areas such as Cleanliness, Ward Food, Privacy, Dignity and Wellbeing and Condition Appearance and Maintenance, all above the national average. Where areas have fallen below expected standards, local teams are working on making the necessary improvements and this will be captured in a Trust wide action plan. It was noted that the Trust had received lower scores for the categories of Dementia and Disability.

11.12 Hannah Williams informed the Board that Amy Barnes, an Infection Prevention and Control Nurse at GHC had been shortlisted and came second at the recent Regional Sustainability Awards. The Board congratulated Amy on her achievement.

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

12. BUSINESS PLAN 2024/25

12.1 The purpose of this report was to set out the Trust Annual Business Planning process for 2024/25 and the proposed Business Planning Objectives for operational and corporate teams.

12.2 The business planning process was launched in November last year to support Directorates and Teams in developing their business planning objectives for 2024/25 and beyond. The business plan is key to the delivery of the Trust Strategy and the business planning structure is underpinned by our four strategic aims. This paper also set out the known national and local priorities that have informed the business planning objectives.

12.3 The Board noted that a business planning refresh was proposed in quarter 1 of 2024/25 to ensure the business plan is updated to include any system changes resulting from the publication of the National Planning Guidance when known.

12.4 Sandra Betney advised that this year the quality assurance process has been further enhanced to include a more detailed assessment of the supporting resources required to deliver the business planning objectives and milestones. As a result, a new resource allocation tool has been developed to enable corporate leads to optimise the resource allocation required for the business plan. The business plan will be refreshed quarterly allowing resources to be flexed where possible.

12.5 The Board noted that there were 190 objectives, and these were listed within the Appendix to the report. Sandra Betney said that this did seem like a large number of objectives; however, Board members referred to the 2023/24 outcome section of the report and noted that there were 218 objectives at the beginning of 2023/24, with 777 milestones for delivery by the end of the year. On review, just 5% of the business plan milestones (41) would not be achieved by year end. Sandra Betney said that the identified objectives for 2024/25 felt real and current.

12.6 This report also provided Board members with an overview of the key achievements for the Trust business plan for 2023/24.

12.7 The Board received this report and approved the business planning objectives. It was noted that there would be a planned refresh during quarter 1 to ensure alignment with the National Planning Guidance. Board members thanked all colleagues who had contributed to preparing this report.

13. BUDGET SETTING 2024/25

13.1 The purpose of this paper was to set out the budget setting process for 24/25. It highlights the links with the NHS England (NHSE) planning, contracting and business planning processes and sets out risks and opportunities within the financial targets that have been set for each service and directorate.

13.2 The Trust has continued with its usual thorough process to develop a set of budgets that reflect the plans of the business and has also been mindful of the system's financial position and the resource constraints within the Gloucestershire system. It was noted that these budgets provide a clear financial framework in which all Trust staff can continue to operate and make financial decisions and form the basis of the plans on which the Trust will deliver its business planning objectives and strategic aims for the year ahead.

13.3 In order to deliver the proposed budgets, recurrent cost improvement schemes of £7.225m will be required. In addition, significant non-recurrent savings of £3.647m will need to be found to support non-recurrent expenditure and non-recurrent cost pressures. During budget setting 60% (£6.561m) of the total savings target has been delivered or identified.

13.4 Sandra Betney highlighted the 3 highest scoring risks to the Board, as follows;

- There is a risk that because Cost Improvement plans (CIP) are not all yet worked up this may impact on delivery of the financial plan.
- There is a risk that cost share changes for Section 117 patients leads to additional costs not reimbursed by ICB.
- The risk of system balance discussions lead to the Trust taking a share of deficit as a reduction in Trust income or increased CIP.

13.5 All recurrent CIP schemes will require Quality Equality Impact Assessments (QEIAs) to be completed to assess the impact on services. Jan Marriott asked what processes were in place to review these assessments. Sandra Betney advised that each scheme would be assessed to see whether it required a full QEIA. If it did, the QEIA would be completed and submitted to the Nursing Therapies and Quality Directorate. If a scheme was felt to be low risk, it would be presented to the Improving Care Group for consideration and recording. If it was felt to be a higher risk the QEIA would be passed through the Quality Assurance Group (QAG) for full sign off. Sandra Betney added that the monthly CIP Management Group reviewed all QEIAs as part of a standing agenda item on Quality. A review process had also been developed so all CIPs were assessed at the mid-point as well as at the start to monitor any impact.

13.6 The Board noted the budget setting process and linkages with business planning. The risks associated with the proposed budgets for 2024/25 were noted. The Board approved the revenue and capital budgets for 24/25 and approved in principle the capital plan.

14. STAFF SURVEY RESULTS 2023

14.1 The purpose of this report was to present the results from the 2023 national Staff Survey. This is GHCs fourth single Staff Survey feedback report, covering data gathered from colleagues between October and November 2023.

14.2 Colleagues rated the Trust 1st = across NHS provider trusts in the South West, and for the Friends and Family Test "Would you recommend the Trust as an employer" they have rated the Trust as 5th in England across mental health, learning disabilities and community trusts.

14.3 Neil Savage said that the results presented a largely positive and improving view of how staff rate the Trust as an employer. However, there remain hot spot questions and services which the survey results provide signposting to in order to prioritise actions over the coming year.

14.4 Actions for follow up as a result of the 2023 Staff Survey are being worked up following the GPTW Committee Deep Dive and through engagement at the planned Trust Staff Survey briefing sessions, Senior Leadership Network and the Workforce Management Group. The Board was asked to note that four thematic areas had been identified which are of particular interest:

a. Anti-discrimination (particularly harassment and violence at work from patients): Results illustrate an increase in the number of incidents staff are subjected to from patients & families. Discrimination on the grounds of ethnicity is a hot spot with a 9% increase over last year. We have begun a programme or work on this, launching our new Anti-discrimination Abuse Road Map and toolkit earlier in March.
b. Flexible working: We will be looking to find out what we could do to get from average to top quartile in our working flexibly scores. The appointment of our new People Promise Manager will support this.
c. Health and Wellbeing (HWB): We are continuing to identify themes & hot spots across our services areas / teams, & planning to take further targeted action.
d. Internationally Educated Nurses (IEN): Responses suggest we need to better understand the often-different experiences of our IEN workforce. We've started working with our IEN Council on these. This is particularly in order to help support our top Trust priorities of Recruitment and Retention.

14.5 Steve Alvis said that the report demonstrated some encouraging results. He suggested that there was still an issue of confidentiality to tackle and ensuring that colleagues understood that their survey responses were private and non-identifiable as this could still be a barrier as to why people did not complete the survey.

14.6 Sandra Betney thanked colleagues for the clear and well-presented report. She said that it might be helpful to look at those areas who were performing well and to try and share learning from those areas. She said that it was normal practice to look at those areas where the scores were lowest, or where fewer returns had been received but perhaps focus should turn to those performing well for learning.

14.7 The Board noted this report and the results from the 2023 survey alongside the resultant areas of focus. The final action plans for the Trust and directorates would be reported to the April GPTW Committee who will oversee and monitor progress over the coming year, reporting by exception to the Board as necessary.

15. GENDER PAY GAP ANNUAL REPORT

15.1 The purpose of this report was to inform the Board of the latest 2023 gender pay gap across Gloucestershire Health & Care NHS Foundation Trust (GHC), and, provide an update on related actions from the last report alongside an outline of next steps and actions.

15.2 The UK Gender Pay Gap legislation requires NHS Trusts and other public sector employers to annually publish a series of details and calculations highlighting the employed workforce's gender pay gap. For this latest reporting period, the information and report must be published on both the Trust and Gov.UK website by 30th March 2024.

15.3 The Board noted that this latest report contains the requisite statutory calculations, presenting the pay gap against the six indicators. These are calculated from the Trust's workforce on the required date in 2023 and are summarised below:

- Mean average gender pay gap. Women earn less than men by 12.42%. This is an improvement and compares with a previous 2022 gap of 15.13%

- Median average gender pay gap. Women earn less than men by 4.72%. This is an improvement and compares with a previous 2022 gap of 7.09%

- Mean average bonus gender pay gap. Women are paid similar than men, a difference of 0.17% which compares with women being paid 7.25% more than men in 2022. This is thought to be almost exclusively due to the temporary pandemic changes in payment of Clinical Excellence Awards as an equal quantum to all consultants rather than the usual competitive process.

- Median average bonus gender pay gap. Women are paid more than men by 51%. This compares with a previous 2022 gap of 40%.

- Employee numbers by quartile. The proportion of men and women (when divided into four groups) ordered from lowest to highest pay shows there are a higher proportion of women in all quartiles and the gap closes with progression toward the upper quartile.

15.4 Neil Savage advised that the Trust's People Strategy makes a key strategic commitment to equality, diversity and inclusion. Reducing, and ultimately removing, the pay gap is a key element to operationally delivering on this commitment alongside our actions on the Workforce Race and Disability Equality Schemes.

15.5 The Board noted that while this past year's data generally presents a modest improving picture for the Trust, it also shows that there is still far to go to reach the desired equity. The data also continues to demonstrate the scale of challenge and the inherent inequity globally and in the nation more widely.

15.6 The Board noted the work that had taken place since the publication of last year's report and the action plan for 2024/25. Neil Savage highlighted that in Q1 2024/25 the Trust will develop its first Pay Gap Report covering gender, ethnicity and disability.

15.7 Nicola de Iongh said that she commended Neil Savage and the wider team for their non-complacent attitude to the gender pay gap. The Trust was performing well but we can do better, and colleagues were always striving to improve, and this was welcomed.

15.8 Vicci Livingstone-Thompson agreed and said that she welcomed the proposed future addition of other characteristics such as disability and ethnicity within the pay gap report. She said that she was really proud of the Trust's work in this area.

15.9 The Board noted the report and agreed the proposed actions as set out. The Board also agreed to publish this report on the Trust website and submit the data to the government website, and agreed the following statement is recommitted to, and then published on the Trust website and via the government website.

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

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

16. COUNCIL OF GOVERNOR MINUTES

16.1 The Board received and noted the minutes from the Council of Governors meeting held on 17 January 2024.

17. BOARD COMMITTEE SUMMARY REPORTS

17.1 **Audit & Assurance Committee**
The Board received and noted the summary report from the Audit & Assurance Committee meeting held on 8 February 2024.

17.2 **Resources Committee**
The Board received and noted the summary report from the Resources Committee meeting held on 22 February 2024.

17.3 **Great Place to Work Committee**
The Board received and noted the summary report from the Great Place to Work Committee meeting held on 22 February 2024.

17.4 **Appointments and Terms of Service Committee (ATOS)**
The Board received and noted the summary report from the ATOS Committee meeting held on 6 March 2024.

17.5 **Quality Committee**
The Board received and noted the summary report from the Quality Committee meeting held on 7 March 2024.

18. ANY OTHER BUSINESS

18.1 Douglas Blair informed the Board that over 1000 colleagues had now signed the LGBTQ pledge and were promoting this through the wearing of the rainbow lanyard which was really positive.

19. DATE OF NEXT MEETING

19.1 The next meeting would take place on Thursday, 30 May 2024.

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AGENDA ITEM: 05/0524

TRUST BOARD PUBLIC SESSION: Matters Arising and Action Log – 30 May 2024

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

Meeting Date	Item No.	Action Description	Assigned to	Target Completion Date	Progress Update	Status
25 January 2024	5.1	A conversation had taken place regarding Health Visiting services and the need to look at this in more detail around the potential change in service to better meet family commitments. It was agreed that an action would be picked up for further consideration by the Executive Team.	David Noyes	May 2024	The Executive reviewed a paper on the transformation agenda for Health Visitors on 16 April. A verbal report will be provided at the meeting by the Deputy COO.	
	5.2	It was agreed that a Peer Support Worker Strategic Framework would be scoped and a progress report presented at the July Board.	Angela Potter	July 2024	Scheduled for July Board	
	7.7	The Board noted the concerns around delayed discharges from IP MH Services due to housing issues. Douglas Blair agreed to consider where best to escalate these discussions, noting it could potentially be done through the system housing groups.	Douglas Blair	May 2024	This is currently being followed up with ICB colleagues to ensure we have maximised our influence in existing partnership arrangements	
28 March 2024		No actions identified				

REPORT TO: **TRUST BOARD PUBLIC SESSION – 30 May 2024**

PRESENTED BY: Sandra Betney, Director of Finance and Deputy CEO

AUTHOR: Stephen Andrews, Deputy Director of Finance

SUBJECT: **FINANCE REPORT FOR PERIOD ENDING 30th April 2024**

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

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

The purpose of this report is to

Provide an update of the financial position of the Trust.

Recommendations and decisions required

The Trust Board is asked to **NOTE** the month 1 position.

Executive summary

- At month 1 the Trust has a deficit of (£0.036m) compared with a budget of (£0.191m)
- 24/25 Capital spend in month 1 is £0.310m against an original plan of £Nil, and the full year plan is £9.217m
- Cash at the end of month 1 is £55.143m
- Cost Improvement Programme (CIP) has delivered £2.302m of recurring savings through budget setting. Target for the year is £7.319m
- The Payroll slide is not included as the full data is not available due to the lighter touch approach to M1 reporting.
- 1.94% of M1 pay bill was spent on agency. System cap ceiling is 3.2%
- Process of assessing Risks identified on the March Budget Setting Paper continues and it is expected that many of the Risk scores will be reduced further in the next few months.

Risks associated with meeting the Trust's values
Risks included within the paper.

Corporate considerations	
Quality Implications	
Resource Implications	
Equality Implications	

Where has this issue been discussed before?

Appendices:	Finance Report

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

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AGENDA ITEM: 07.1/0524

Finance Report
Month 1

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Overview

- Draft accounts submitted 24th April 2024, being audited by KPMG, audited accounts are due 30th June 2024
- There were no material amendments to the position from the Resource Committee summary in April, and the year end performance for GHC was a performance surplus of £0.984m
- The system plan at 2nd May was a £15m deficit and the Trust's plan was a £70k deficit
- At month 1 the Trust has a deficit of £0.036m compared to the plan of £0.191m
- 24/25 Capital plan is £9.454m with £4.000m of disposals leaving a net £5,454m programme. Spend to month 1 is £0.310m against a budget of £Nil
- Cash at the end of month 1 is £55.143m
- Cost improvement programme has delivered £2.302m of recurring savings through budget setting with £1,584m having a QEIA. Target for the year is £7.319m.
- The Trust spent £0.377m on agency staff in month 1. This equates to 2% of total pay compared to the agency ceiling of 3.2%.
- Better Payment Policy shows 92.4% of invoices by value paid within 30 days, the national target is 95%. This is 82.7% by number of invoices.
- The 7 day performance at the end of March was 67.1% of invoices by value paid and 31.0% by number of invoices.

GHC Income and Expenditure

Gloucestershire Health and Care NHS Foundation Trust

	2024/25 NHSE Plan	2024/25 Revised budget	2024/25 YTD revised budget	2024/25 YTD Actuals
Operating income from patient care activities	271,912	272,338	23,471	23,601
Other operating income	16,991	16,991	1,416	1,575
Employee expenses - substantive	(198,389)	(219,940)	(18,041)	(17,644)
Bank	(17,978)	(2,133)	(943)	(1,458)
Agency	(7,152)	(1,122)	(395)	(377)
Operating expenses excluding employee expenses	(63,530)	(66,467)	(5,539)	(5,805)
PDC dividends payable/refundable	(2,624)	(2,624)	(219)	(219)
Finance Income	825	825	69	293
Finance expenses	(212)	(212)	(18)	(19)
Surplus/(deficit) before impairments & transfers	**(157)**	**(2,344)**	**(199)**	**(52)**
Gains/ (losses) from disposal of assets				0
Remove capital donations/grants I&E impact	87	87	7	16
Surplus/(deficit)	**(70)**	**(2,257)**	**(191)**	**(36)**
Adjust (gains)/losses on transfers by absorption/impairments			0	**0**
Remove net impact of consumables donated from other DHSC bodies				0
Revised Surplus/(deficit)			**(191)**	**(36)**

Balance Sheet

NHS
Gloucestershire Health and Care

STATEMENT OF FINANCIAL POSITION (all figures £000)		2023/24	2024/25			
		Actual	Plan	YTD Plan	YTD Actual	Variance
Non-current assets	Intangible assets	1,618	2,300	1,245	1,572	327
	Property, plant and equipment: other	120,516	115,133	116,488	120,026	3,537
	Right of use assets*	17,358	15,960	17,031	17,217	186
	Receivables	324	1,067	1,067	1,010	(57)
	Total non-current assets	**139,816**	**134,460**	**135,831**	**139,825**	**3,994**
Current assets	Inventories	356	398	398	356	(42)
	NHS receivables	3,062	6,156	6,156	3,538	(2,618)
	Non-NHS receivables	9,370	6,441	6,441	9,734	3,293
	Credit Loss Allowances	(1,565)	(1,665)	(1,665)	(1,565)	100
	Property held for Sale	5,522	734	5,522	5,024	(498)
	Cash and cash equivalents:	51,433	53,494	47,741	55,143	7,401
	Total current assets	**68,178**	**65,558**	**64,593**	**72,231**	**7,637**
Current liabilities	Trade and other payables: capital	(2,666)	(4,341)	(3,341)	(1,730)	1,611
	Trade and other payables: non-capital	(35,320)	(30,764)	(29,764)	(40,711)	(10,947)
	Borrowings*	(1,454)	(1,237)	(1,298)	(1,295)	3
	Provisions	(8,465)	(7,638)	(8,555)	(8,464)	90
	Other liabilities: deferred income including contract liabilities	(1,086)	(1,936)	(1,936)	(959)	977
	Total current liabilities	**(48,990)**	**(45,916)**	**(44,894)**	**(53,159)**	**(8,265)**
Non-current liabilities	Borrowings	(14,925)	(13,460)	(14,747)	(14,869)	(122)
	Provisions	(2,509)	(2,580)	(2,580)	(2,510)	70
	Total net assets employed	**141,569**	**138,062**	**138,204**	**141,517**	**3,314**

Taxpayers Equity	Public dividend capital	131,876	131,876	131,876	131,876	(0)
	Revaluation reserve	14,676	10,052	10,052	13,821	3,769
	Other reserves	(1,241)	(1,241)	(1,241)	(1,241)	0
	Income and expenditure reserve	(4,217)	(2,625)	(2,483)	(2,888)	(405)
	Income and expenditure reserve (current y	475	0	0	(52)	(52)
	Total taxpayers' and others' equity	**141,569**	**138,062**	**138,204**	**141,517**	**3,313**

Cash Flow Summary

Gloucestershire Health and Care NHS Foundation Trust

Statement of Cash Flow £000	YEAR END 23/24		YTD ACTUAL 24/25	
Cash and cash equivalents at start of period		**48,836**		**51,433**
Cash flows from operating activities				
Operating surplus/(deficit)	479		(107)	
Add back: Depreciation on donated assets	189		16	
Adjusted Operating surplus/(deficit) per I&E	**668**		**(91)**	
Add back: Depreciation on Right of use assets				
Add back: Depreciation on owned assets	9,856		856	
Add back: Impairment	277		0	
(Increase)/Decrease in inventories	50		0	
(Increase)/Decrease in trade & other receivables	8,268		(973)	
Increase/(Decrease) in provisions	501			
Increase/(Decrease) in trade and other payables	(3,550)		5,305	
Increase/(Decrease) in other liabilities	(21)		(127)	
Net cash generated from / (used in) operations		**16,048**		**4,970**
Cash flows from investing activities				
Interest received	2,852		293	
Interest paid			(1)	
Asset Held for Sale				
Purchase of property, plant and equipment	(15,381)		(1,323)	
Sale of Property	1,356			
Net cash generated used in investing activities		**(11,173)**		**(1,031)**
Cash flows from financing activities				
PDC Dividend Received	1,710			
PDC Dividend (Paid)	(2,409)			
Finance lease receipts - Rent	219		4	
Finance lease receipts - Interest	(8)			
Finance Lease Rental Payments	(1,559)		(214)	
Finance Lease Rental Interest	(231)		(18)	
		(2,278)		**(228)**
Cash and cash equivalents at end of period		**51,433**		**55,143**

Capital – Five year Plan

Gloucestershire Health and Care
NHS Foundation Trust

Capital Plan	Full Year Plan	Plan ytd	Actuals to date	Plan	Plan	Plan	Plan
£000s	2024/25	2024/25	2024/25	2025/26	2026/27	2027/28	2028/29
Land and Buildings							
Buildings	1,477	0	(14)	3,000	3,000	3,000	3,000
Backlog Maintenance	1,612	0	0	1,393	1,393	1,393	1,393
Buildings - Finance Leases	255	0	0	989	250	250	250
Vehicle - Finance Leases	239	0	0	0	250	250	250
Other Leases	721	0	0	0			
Net Zero Carbon	645	0	0	500	500	500	500
LD Assessment & Treatment Unit				2,000	0	0	0
Cirencester Scheme				5,000	0	0	0
Medical Equipment	903	0	0	1,030	1,030	1,030	1,030
IT							
IT Device and software upgrade	600	0	(13)	600	600	600	600
IT Infrastructure	1,715	0	0	1,300	1,300	1,300	1,300
Transforming Care Digitally	1,050	0	0	980	790	250	250
Sub Total	**9,217**	**0**	**(27)**	**16,792**	**9,113**	**8,573**	**8,573**
Forest of Dean	237	0	338	0	0	0	0
Total of Updated Programme	**9,454**	**0**	**310**	**16,792**	**9,113**	**8,573**	**8,573**
Disposals	(4,000)	0	0	(6,233)	0	(500)	0
Total CDEL spend	**5,454**	**0**	**310**	**10,559**	**9,113**	**8,073**	**8,573**

Risks

Gloucestershire Health and Care
NHS Foundation Trust

24/25 potential risks are as set out below:

Risks 24/25	Mitigations	Likelihood	Impact	RISK SCORE
There is a risk that because CIP plans are not yet worked up, this may impact on delivery of the financial plan	Non recurrent savings. Close monitoring by the CIP management board	4	4	16
System balance discussions lead to Trust taking share of deficit as reduction in Trust income or increased CIP	Continued negotiation with system partners. Review all costs. Identify additional savings.	4	3	12
There is a risk that the Trust will not be able to reduce costs by as much as income if there is a reduction in LD patient numbers.	A review of budgets will be undertaken to ensure the appropriate level of funding is provided on the ward	4	2	8
There is a risk that controls on agency fail to stop the use of agencies that are outside of national frameworks and/or above national price cap rates, particularly to fill needs in Nursing	Sustainable Staffing Oversight Group continue to monitor off framework agency usage. Strengthen recruitment pipeline. Non recurrent savings and establishment budgets.	3	2	6
Risk that the system breaches its agency spend cap leading to increased scrutiny, reputational damage and /or reduced access to funding	Monitoring at system level. Scrutiny and joint working across the system of all the controls and levers in place to reduce agency spend.	3	2	6
Loss of DPD income after being funded for the last three years will cause a cost pressure in the training programme.	Monitor training spend and understand level of funding required	3	2	6
There is a risk that not sufficient budget available for Safer staffing project.	Business case to identify and set out funding arrangements.	2	3	6
Risk that the allowance for unavailability cover is insufficient in Mental Health Urgent Care and Inpatients , and Physical Health Urgent Care and Inpatients	Work under way to review the level of allowance for maternity, sickness and absence cover. Link in with safer staffing business case.	3	2	6
Risk that the International Recruitment funding is reduced and leads to a further cost pressure.	Continue to seek additional funds and manage level of expenditure closely	3	2	6
Utility, fuel and waste costs may rise further due to inflationary pressures above the additional funding added to budget.	Continued monitoring and early warning of cost pressures. Dialogue with NHSE/I to highlight cost pressure.	3	2	6
Adult Mental Health inpatients require Out of Area beds	Work under way within Directorate to ensure lengths of stay are shortened, staffing establishment is filled with the aim of ensuring less need for out of county bed usage	3	2	6
Maintenance and materials costs may rise due to inflationary and demand pressures above budget.	Continued monitoring and early warning of cost pressures. Dialogue with NHSE/I to highlight cost pressure.	2	2	4
A risk of Safer Staffing implementation plan does not go to plan and costs are greater than expected.	Clear implementation plan and recruitment strategy to underpin business case.	2	2	4
Increased revenue implications once Forest of Dean Community hospital is operational	Review business case assumptions. Assess cost implications.	2	2	4
The impact of all the inflationary pressures might have been underestimated in budgets.	Monitor non pay. Prepare options to reduce costs	2	2	4
Cost Improvement budget may have been removed before all QEIAs and may lead to savings being rejected.	QEIAs to be promptly completed to allow time for alternative ideas to be identified. Careful monitoring by CIP Management Board	2	1	2
There is a risk that unplanned legal costs might impact on the Corporate Governance budget	Review of usage and the process for purchasing to be undertaken. Monitoring of spend.	2	1	2
A risk that Bone Health prescripting for Zolendric Acid will continue to increase and the service will be required to give all three treatments rather than just the one at present.	Monitor prescripting levels by team and working practice	2	1	2
Adult Community directorate cost pressure from increased travel proves to be sustained and non recurring.	Review of mileage usage by team and working practices to assess if permanent or not.	2	1	2
Unpredictable expenditure in employment matters leads to increased costs	Identify non recurring costs if additional costs materialise	2	1	2
Subject Access enquiries are increasing and there is a risk of increased cost above budget.	Continual monitoring and assessment of appropriateness of enquiries.	2	1	2

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REPORT TO: **TRUST BOARD PUBLIC SESSION – 30 May 2024**

PRESENTED BY: Sandra Betney, Director of Finance and Deputy CEO

AUTHOR: Chris Woon, Deputy Director of Business Intelligence

SUBJECT: **PERFORMANCE DASHBOARD APRIL 2024/25 (MONTH 1)**

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

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

The purpose of this report is to
This performance dashboard report provides a high-level view of performance indicators in exception across the organisation. Performance covers the period to the end of April (Month 1 2024/25). Where performance is not achieving the desired threshold, operational service leads are prioritising appropriately to address issues. Service led Operational & Governance reports are presented to the operational governance forums and more widely account for performance indicators in exception and outline service-level improvement plans. Data quality progress will be more formally monitored through the Clinical & Corporate Records Group, now the Performance & Governance Lead within Operational services has started in post.

Recommendations and decisions required
The Trust Board are asked to:

- **Note** the Performance Dashboard Report for April 2024/25 as a **significant level of assurance** that the Trust's performance measures are being met or,
- Appropriate service action plans are being developed or are in place to address areas requiring improvement.

Executive summary

Business Intelligence Update

Business Intelligence summary updates are presented on page 1. Highlights include the activities to update the performance indicator portfolio to incorporate 2024/25 Operational Planning expectations and GICB Contract updates for the new financial year. The Trust's application of Statistical Process Control (SPC) methodology is also currently being reviewed to inform an update on indicator threshold setting and escalation criteria. When complete, this update may lead to an increase in exceptions as escalation parameters may be reduced for some indicators. This will be encapsulated into an update of the Trust's Performance Management

Framework which will progress through the Business Intelligence Management Group (BIMG).

The Trust's Data Quality Policy was ratified by the Information Governance Group in April 2024.

In response to feedback from the Board regarding the length of Performance Dashboard narrative, this month's Performance Dashboard presents a new reduced detail format.

It was agreed within May's BIMG to present and integrated service report presentation for Podiatry Services to the August Resources Committee.

- **Chief Operating Report**
  The Chief Operating Officer's Report is presented on page 2&3 of the performance dashboard.

- **Performance Update**
  The performance dashboard is presented from page 4 within the Board's four domain format:

- **Nationally measured domain** (under threshold)
  There are 4 indicators in exception. Timely discharge follow-ups (N03) and transfer of care coordination (N04) are two current areas of improvement for operational services. Although in exception, Adolescent Eating Disorders routine waits within 4 weeks (N11) continues to show sustained improvement.

- **Specialised & directly commissioned domain** (under threshold)
  3 health visiting indicators (S02, S03 & S04) remain very slightly behind their thresholds for the period but they are all within normal variation (Statistical Process Control (SPC)). Pleasingly, there continues to be a reduced number of indicators in exception within this domain.

- **Integrated Care System (ICS) Agreed domain** (under threshold & outside of statistical control rules).
  Social Care Package Reviews within 8 weeks of commencement (L19) remains in exception and remains a focus for stakeholders to resolve. Adult Eating Disorders wait for adult assessments within 4 weeks (L07) is positively showing a continual reduction in its waiting list to a sustainable size.

- **Board Focus Domain** (under threshold & outside of statistical control rules)
  April saw 3 moderate harm falls incidents (B15) which has presented the indicator in exception but they are unrelated. Length of stay for PH Inpatients (B23) and PH Stroke Rehab (B25) both increased in April. Although a slight improvement from March, Appraisals (B28) remain in exception and there is some focused activity in Corporate service areas to raise performance.

- **Performance to note**
  There are sometimes indicators that are not formally highlighted for exception, but they are useful for Board's awareness. These indicators are all routinely monitored by operational and support services within the online Tableau reporting server. This month these highlights (on page 8) include:

- Adult Eating Disorders 16 week wait time (L08) was compliant at 100%. The last time it was above the threshold was in July 2023.
- The Gloucestershire Hospitals NHS Foundation Trust measure for *Percentage of patients waiting less than 6 weeks from referral for a diagnostic test* (B13) continues to be challenged and is at its lowest performance since December 2022.
- Although slightly over threshold for the period, Turnover (B31) is within SPC limits and is positively at the lowest level it has been for 11 months.

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

Corporate considerations	
Quality Implications	The information provided in this report can be an indicator into the quality-of-care patients and service users receive. Where services are not meeting performance thresholds this may also indicate an impact on the quality of the service/ care provided. Data quality measures were introduced in 2023/24 and will be monitored through the Clinical & Corporate Records Group.
Resource Implications	The Business Intelligence Service works alongside other Corporate service areas to provide the support to operational services to ensure the robust review of performance data and co-ordination of the combined corporate performance dashboard and its narrative.
Equality Implications	Equality information is monitored within BI reporting. The font size of the report was increased in March 2024.

Where has this issue been discussed before?
BIMG on the 16 May 2024

Appendices:	Performance Dashboard Month 1

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

NHS
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NHS Foundation Trust

Snapshot Month
April

Performance Dashboard Report & BI Update

Aligned for the period to the end April 2024 (month 1)

In line with the planned Performance Indicator Portfolio reconfiguration, this report presents performance indicators across four domains including **Nationally measured**, **Specialised & Direct Commissioning**, **ICS Agreed** and the **Board Focus**. The **Operational domain** is presented to Resources Committee, *not* Trust Board. Furthermore, the detailed narrative within this month's Board dashboard has been reduced in response to member's feedback. Detailed narrative is still examined within the Business Intelligence Management Group (BIMG). This format will be the adopted approach for Board going forward.

In support of indicators in exception, a monthly Operational Performance & Governance summary (with action planning, where appropriate) is routinely presented to the Business Intelligence Management Group (BIMG). An operationally led Patient and Corporate Record (Quality) Group will also be reporting into BIMG when fully operational and will led by the Deputy Chief Operational Officers alongside their Operational Governance and Performance Lead.

Performance Dashboard Summary

An Executive level observation of operational performance for the period is routinely provided through the Chief Operating Officer's *'Chief Operating Report*' (on page 2 & 3).

The Dashboard itself (from page 4-8) provides a high level view of Performance Indicators in exception across the organisation for the period. Indicators within this report are underperforming against their threshold or are showing special cause variation (as defined by Statistical Process Control SPC rules) and therefore warrant escalation and wider oversight. To note, confirmed data quality or administrative issues that are being imminently resolved will inform any escalation decision unless there has been consecutive, unresolved issues across periods. A full list of all indicators (in exception or otherwise) are available to all staff within the dynamic, online server version of this Tableau report. Services are using this tool, alongside their operational reporting portfolios and Service Level Dashboards to monitor wider performance.

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

Areas of note are presented at the end of the report on pages 8 entitled '**Performance to note**'. Indicators within this section *are not in formal exception* but acknowledge either positive progress, possible areas for close monitoring or offer context to wider indicators that may be in exception.

Business Intelligence Summary Update

The Business Intelligence Service are updating the 2023/24 performance indicator portfolio with 2024/25 operational planning and GICB 2024/25 contractual requirements. These will be integrated into the planned development programme. As planned, Statistical Process Control (SPC) methodology is also being reviewed for the new financial year and in addition, learning will be used to inform an update the Performance Dashboard escalation approach for 2024/25, and revise thresholds for internal domains. This will lead to an update of the Performance Management Framework in June 2024. An update to the Data Quality Policy has been ratified through the Trust's IG Group having passed through BIMG in April 2024.

Chief Operating Officer's Report

David Noyes, Chief Operating Officer (COO)

A reasonable month in terms of capacity and flow through Community Hospitals, although not as consistent as during April, with some periods of high system pressure particularly in early May, and particularly in the Acute Trust, generated by unusual levels of demand for urgent and emergency care at the start of the month (where we also experienced very high attendances at MiiU), and some poor onward flow due to care market capacity. Unfortunately, the flow issue, combined with high acuity amongst patients has impacted on our average Length of Stay, with a set back this month from the previous downward trend, up to 35 days. Bed occupancy remains very high at 97.6%. Unplanned readmissions within 30 days remains in a good position at 2.3%

MiiU continue to perform well, achieving the 4 hours target 99.5% of the time and continuing to deal with on occasion more than 400 patient contacts a day at busy times. Rapid Response achieved 78.6% responded to within 2 hours (target 70%), and exceeded their target figure for patients (target now average 338 per month) by seeing 475 contacts.

I'm delighted to report that all services have now successfully migrated to the new Forest of Dean hospital, and our people worked extremely hard to ensure the transition was seamless, and delivered with minimal disruption to service offer.

In the Homefirst intermediate service we have continued to deliver broadly 50 starts a week, which is the current commissioned capacity (noteworthy that significant system work is going on since we all recognise that this isn't sufficient capacity, so alternative approaches to grow capacity are going to be trialled). Our average length of stay remains really competitive at around 20 days (Mean in Apr 24 and Median 20). 71% of patients who used the service benefitted from completing the pathway with a reduced dependency (number of visits required).

The growing maturity of and our ability to utilise a red to green dashboard is helping to focus in on where the main causes of delay to discharge are within Acute Mental Health beds. The vast majority are due to difficulty in sourcing accommodation and delays within our own social care processes, so naturally we are focussing on both areas. It is the case that we are seeing a shift in the distribution graphs for patient stays, and slowly we are starting to see less patients with extended stays and growth in numbers in the 3-30day bracket, a trend we need to continue. As previously reported, we are now using far fewer out of areas beds which is also progress.

In the last month the KPI (95% target) for Care Programme Approach (CPA) was missed, with achievement sitting at 86,8%, but for assurance of the 5 cases this involves, 3 were essentially technical misses as the patients were transferred to other providers; of the remaining two, one patient unfortunately went missing and could not be contacted, and one case did miss the deadline due to staff sickness.

In Core CAMHS despite a deterioration in the performance against the 4-week target for assessment, which dropped to 49.5% (target 80%), 86.7% were offered a first appointment within 5 weeks and 80.6% attended a first appointment within 5 weeks. There is also better news regarding the size of the wait list which has dropped to 520 (still too high but down from c780 during early 2022), and really pleasingly a notable drop in both vacancy and sickness within the teams – a trend with colleagues I hope to see continue, albeit a little too early to be sure that it will. Pleasingly, while naturally the service attend to the list by prioritising clinical need, they have been able to reduce some of the long waiters (no-one over 2 years) and the numbers on the list between 18 months and 2 years have been reduced in last month from 81 to 68. The latest trajectory projections show that on current assumptions of workforce capacity and demand, we should be back to a normalised and sustainable position (around 200 on the waiting list and referral to treatment time of 4 months) by the end ot 2024.

Narrative continued on next page...

Continued from last page...

In Childrens OT the Urgent Referrals (4 week wait) performance was 66.6% - there were 3 such referrals in the month, of which the one where target was missed was a re-prioritised case from routine to urgent who was seen within a week following recategorization. Routine Referrals (18 weeks) was achieved 39.3% of the time, but as recovery continues the service are focussed on tacking the longest waits as a priority to bring the entire list back into balance, which should be achieved by the autumn. Numbers on the waiting list are at 396, down from 810 in Dec 22. The average waiting time now is steadily reducing and is now 12.5 weeks, but the KPI compliance is naturally impacted as the service tackles the long waits tail – for context when recovery action started in Feb 23 this was 33 weeks.

In children's Physio February performance achieved 31.8% against the 4-week referral to treatment (RTT) target of 95%, this represents 91 referrals of which 62 waited more than 4 weeks. Of those 23 were seen 4-6 weeks, 17 6-8 weeks and 19 8-12 weeks, with 3 declining. Routine within 18 weeks achieved 76%. Demand for the service remains high, and the team are continuing to redesign and remodel their approach to better target their endeavours now that we have introduced the new measures that delineate urgent activity from routine.

Childrens Speech and Language achieved 100% against the urgent 4-week target and 47.3% for the 18-week routine (both targets 95%), although I expect the latter to take a few more months to recover as the service tackle the tail of long waiters.

In the Adult ICT physio and OT areas, OT achieved 82.7% for routine (18 weeks). Physio achieved 88.9% for routine at 18 weeks. As reported to resources committee, there is a significant issue with a large backlog of P3 patients on the OT waiting list. These are service users in need of an assessment to support long term disability or complex health conditions to promote that individual's well-being including the ability to live as independently as possible at home. We are working on a recovery plan alongside partners from GCC, which includes some temporary additional OT capacity to clear the a bulge or backlog in the list. Once this is achieved, along with some service improvements, there should be sufficient capacity within the service to manage demand.
While with the ICTs, following some focussed work earlier this year, the recruitment pipeline for community nurses is looking extremely positive, with a combination of colleagues in the pipeline to join, some students and international recruits, which if all mature will greatly improve the resilience of this vital service.

In community mental health, board colleagues will doubtless notice that we missed the KPI for New psychosis (EI) cases to be treated within 2 weeks of referral, with April performance at 18.1% against a performance threshold of 60% (9 non-compliant cases out of 11). Three of these were attributed to patient non-attendance, and all of those have since been seen for assessment. The remaining six were actually seen within 2 weeks but did not have an EI care coordinator recorded as allocated within 2 weeks. I have asked the team to ensure they work hard to ensure a timelier allocation of care coordination.
In podiatry, performance against 18-week RTT target of 95% has achieved 95.2%. MSK Physio the 18-week RTT achieved 97.1% (target 95%) and MSKAPS achieved 99% against the 18 week target.

By way of an update on the recovering Eating Disorders service, as Board colleagues are aware the huge backlog in assessments have been brought broadly under control, and we continue to work alongside our partners BEAT and TIC plus in this service. At the time of writing (24 May), there were 3 Adolescents waiting urgent assessment and 11 Adolescents waiting routine; for Adults the figures were 12 urgent and 21 routine. If all patients attend as booked this is containable within service capacity and is of course hugely improved over the past 2 years. As predicted, the focus now turns to addressing what remain quite high numbers on the treatment lists, with 127 Adolescents and 231 Adults waiting to start the post assessment treatment, and a total of 462 actively in treatment. The team are modelling the timeline to achieve bringing the treatment numbers back into balance, which I anticipate will take at least 18 months.

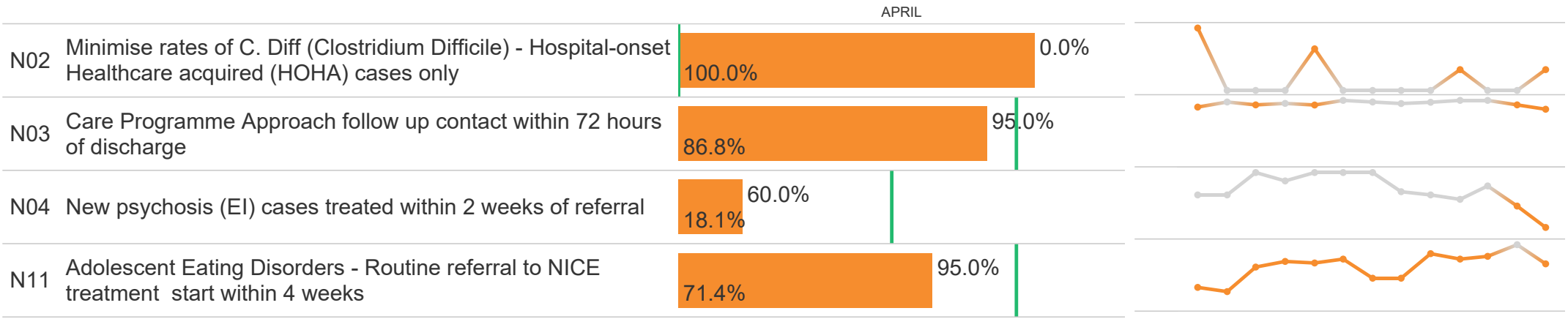
Performance Dashboard: *National Contract Domain*

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Compliant Non Compliant

National Contract Domain



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

N02 - Minimise rates of C. Diff (Clostridium Difficile) - Hospital-onset Healthcare acquired (HOHA) cases only
One patient tested positive to C.diff gene in GHT; the patient then went on to develop further symptoms so an additional sample tested positive to C.diff toxin. Further treatment has commenced and compliance to treatment has been poor due to patient's mental health.

N03 - Care Programme Approach follow up contact within 72 hours of discharge
April is reported at 86.8% against a performance threshold of 95% with 5 of 38 patients not contacted within 72 hours, (March was 91.1%). This is below the lower control limit and a focus was requested of Operational Services to improve MH discharge follow-up processes and recording within BIMG.

N04 - New psychosis (EI) cases treated within 2 weeks of referral
April performance is reported at 18.1% against a performance threshold of 60%. There were 9 non compliant cases out of 11.

The service continues to work to ensure a timelier transfer of care coordination. The service has also seen an increase in referrals and high sickness rates. There were 42 referrals in Q4 of 2023/24, an increase from Q3 at 36. The sickness absence rate for April is 8.4%.

N11 - Adolescent Eating Disorders - Routine referral to NICE treatment start within 4 weeks
April performance is reported at 71.4% against a performance threshold of 95%. There were 2 non compliant cases reported in April out of 7.

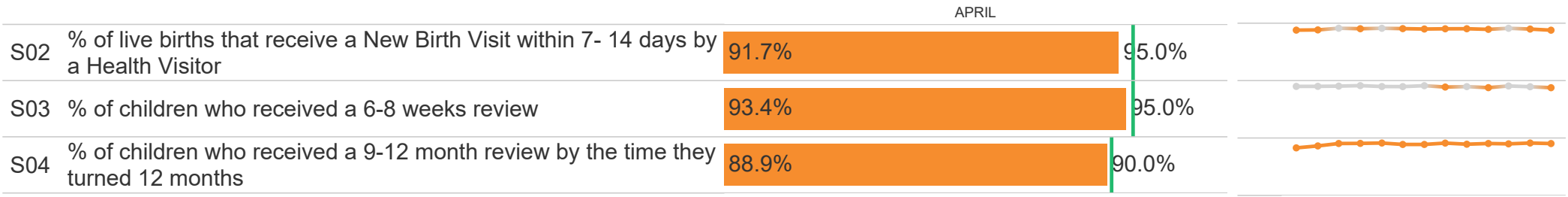
The routine adolescent treatment waiting list was 33 at the end of April, an increase from 32 in March. The Business Intelligence service waiting list model provides an indication of capacity required to address the routine treatment waiting list backlog, of which assumptions rely on patients only receiving 20 sessions. Currently 25.7% of the under 19 caseload have received more than 20 treatment appointments. This reflects the challenges within the service of freeing up clinician capacity for patients to be allocated for treatment. The service has now managed the backlog of assessments meaning that now all patients are offered an assessment to start treatment within 4 weeks.

Performance Dashboard: *Specialised Commissioning Domain*

KPI Breakdown

Non Compliant

Specialised Commissioning Domain



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

S02 - % of live births that receive a New Birth Visit within 7- 14 days by a Health Visitor
Performance in April was 91.7% (March was 93.7%) compared to a threshold of 95.0%, with 40 out of 486 babies not being seen within the 14 day target timeframe. Performance is within control limits, but below the average of 94.0%.

As of 1st April 2024, this KPI switched to face-to-face contacts as the only form of compliant contact. This is in line with national standards

S03 - % of children who received a 6-8 weeks review
April performance was 93.4% (March was 95.0%) compared to a threshold of 95.0%, with 33 out of 507 infants showing as not seen within the 56 day target timeframe. Performance is within SPC control limits, but below the average of 95.0%.

As of 1st April 2024, this KPI switched to face-to-face contacts as the only method of compliant contact. This is in line with national standards and has impacted on performance for April, with 6 of the exceptions completed by telephone. It will be made clear to staff in the locality reports that the only form of compliant contact is through face-to-face means. In these instances, the appointments were completed by telephone as the staff were too unwell to perform face-to-face visits. The appointments should have been transferred to the wider team to complete in timeframe, and this will be reiterated.

S04 - % of children who received a 9-12 month review by the time they turned 12 months
April performance was 88.9% (March was 89.6%) compared to a threshold of 90.0%, with 50 out of 451 infants showing as not having received a 9-12 month review by the time they turned 12 months. Based on SPC data over the last 24 months, current performance is within control limits, and above the average of 83.0%.

A non-attendance project is underway across the county. Early reports suggest that it is working well in rural localities such as the Cotswolds, but it is not performing well in urban localities such as Gloucester. Feedback from the Gloucester locality suggests that if parents / children do not attend the first appointment, they will not attend any future appointments, irrespective of where (clinic or home) the appointment is re-scheduled to, and April's figures reflect this.

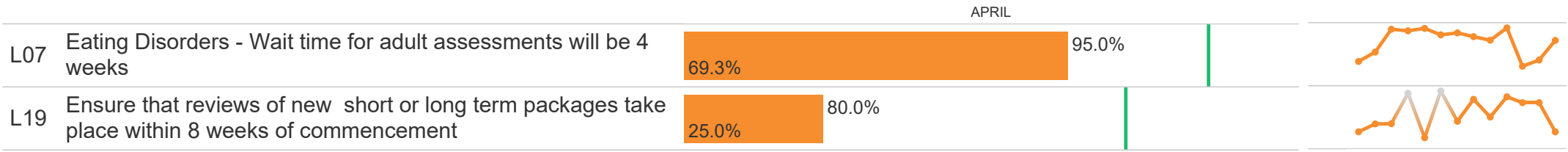
Performance Dashboard: *ICS Agreed Domain*

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Non Compliant

ICS Agreed Domain



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

L07 - Eating Disorders - Wait time for adult assessments will be 4 weeks
April performance is reported at 69.3% against a 95.0% performance threshold. There were 15 non-compliant cases reported in April out of 49. The number of adults waiting for assessment at the end of April was 46, a decrease from 67 in March.

Due to the length of time on the waiting list, performance is expected to be below the threshold. However, the waiting list size is approaching the Business Intelligence service modelled sustainable waiting list size of 33.

The service has managed the backlog of assessments for the majority of patients. All patients are offered an assessment to start treatment within 4 weeks. The service continues to work with BEAT (an eating disorders charity) for adults on the momentum programme and with TIC plus for under 25's to refer patients to a counselling programme and then discharge from the caseload.

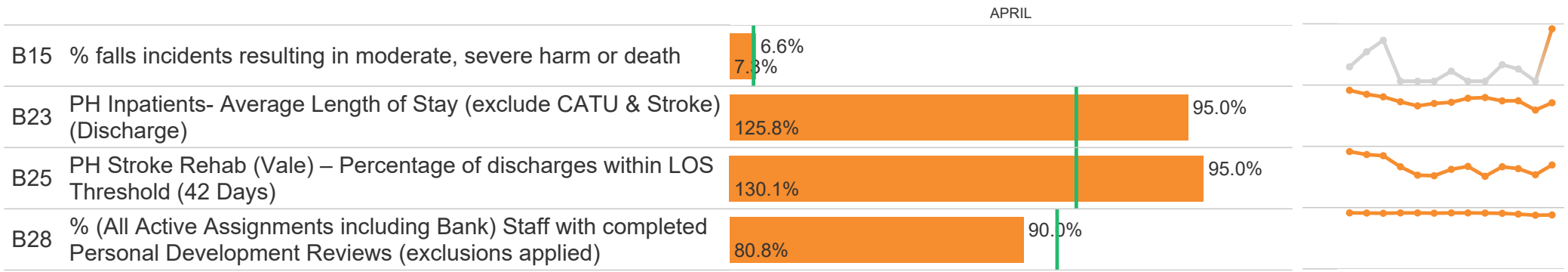
Establishment WTE and skill mix have been reviewed to increase recruitment into hard-to-fill posts. The service recently appointed four Band 6 clinicians, who now all have start dates. The service continues to rely on bank staff and staff from the wider trust offering additional hours. This set of indicators has a service improvement plan and is on the performance governance tracker. This is on the risk register ID 149 (score 16).

L19 - Ensure that reviews of new short or long term packages take place within 8 weeks of commencement
April performance is reported at 25.0% against an 80% performance threshold. There were 6 non-compliant cases recorded in April, two of which are duplicate entries, and the service are looking to correct these.

The service and BI have a meeting planned to revisit the agreed methodology for this indicator so it better reflects the service pathway.

KPI Breakdown

Board Focus Domain



<u>Performance Thresholds not being achieved in Month</u> - *All indicators have been in exception previously within the last 12 months with the exception of B15.*

B15 - % falls incidents resulting in moderate, severe harm or death
Performance in April was 7.3% (March was 0%) compared to a 7.0% threshold. 3 out of 41 falls were recorded as having a moderate or greater level of harm. SPC rules do not apply due to the low incidence of moderate or greater harm falls. The cases were at different sites and all unwitnessed. Appropriate management and observations were provided.

B23 - PH Inpatients- Average Length of Stay (exclude CATU & Stroke) (Discharge)
In April the average LOS for a community hospital patient (not in CATU or stroke rehab) was 32.7 days, which was 25.8% longer the threshold Length of stay of 26 days, (compared to March which was 27 days – 5% above the threshold LOS). Of the 127 patients discharged from a community hospital stay in April, 74 exceeded the length of stay threshold. For the patients who exceeded 26 days the average length of stay of these patients was 49.7 days. (March was 45.3).

B25 - PH Stroke Rehab (Vale) – Percentage of discharges within LOS Threshold (42 Days)
In April the average LOS for a stroke rehab patient was 54.6 days, which was 30.1% longer the threshold Length of stay of 42 days, (compared to March which was 42 days the same as the threshold). Of the 9 stroke rehab patients discharged from a community hospital stay, 7 exceeded the length of stay threshold of 42 days. For the patients who exceeded 42 days the average length of stay of these patients was 67.5 days. (March was 58.5).

Additional commentary for B23 && B25
These KPIs are currently under redevelopment to match the methodology of B24 : PH CATU - Percentage of Discharges within LOS Threshold (10 days), which looks at the percentage of discharges that exceeded the threshold rather than the average Length of Stay.

B28 - % (All Active Assignments including Bank) Staff with completed Personal Development Reviews (exclusions applied)
Performance for April was 80.8%, (an increase from 78.9% in March) and compared to a threshold of 90%. Performance is below the lower SPC chart control limit of 81.7% for the second consecutive month. The appraisal performance figure includes Bank Staff.

The Finance and Operations Directorates improved their position compared to the previous month. The Executive Directorate and Strategy and Partnerships Directorate's position is both at 79%. The Medical Directorate is at 78%, the same as last month. The Nursing, Therapies and Quality Directorate is at 72%. Whilst The lowest performing is HR at 51%, although they are at 75% if bank is excluded. BIMG is seeking an improvement in Corporate appraisal rates.

The following performance indicators are not in exception but are highlighted for note:

- **L08 - Eating Disorders - Wait time for adult psychological interventions will be 16 weeks**

April performance was 100%, above the 95% threshold. The KPI was last above the threshold in July 2023.

The current waiting list for treatment is is 146 for routine referrals. The improvement in offering timely assessment appointments has positively impacted on the service's ability to start treatment within the 16 weeks.

- **B13 - Percentage of patients waiting less than 6 weeks from referral for a diagnostic test**

GHC is no longer responsible for the national submission for this activity which is now made by Gloucestershire Hospitals NHS Foundation Trust.

Submitted data (by GHNHSFT) for GHC patients in April 2024 indicates a performance of 23% (compared with 61% in Mar) 176 out of 231 patients referred for an echocardiogram had been waiting 6 weeks or more for the scan at the end of Apr 2024. This is within SPC control limits, however April is the lowest performance since December 2022.

The GHC Heart Failure service reported that on 1st May 2024, 38 patients are on the Priority Echo waiting list for an echocardiogram, and 200 patients on the Routine Echo Waiting list, which has increased since the previous month (175). 35 patients are still to be triaged for Echo which includes awaiting GPSI opinion.

A meeting within the Heart Failure Service has determined that the current demand exceeds contracted capacity. This is being discussed as per contract negotiations.

Specialist triage is effective with a 50%+ diagnosis of heart failure pick up rate, which is excellent compared to national figures. The service have reviewed referral criteria, making some small adjustments to ensure appropriateness for Echocardiogram in the frail population.

- **B31 - Turnover (12 month rolling)**

Turnover FTE (LTR) was 11.5% in April (for the 12 months 1 May 2023 – 30 April 2024) compared to a threshold of 11%. (March was 11.9%)

This is within SPC control limits and is at the lowest level for the last 11 months.

Turnover FTE (LTR) was 11.5% in April (for the 12 months 1 May 2023 – 30 April 2024) compared to a threshold of 11%. (March was 11.9%)

This is within SPC control limits and is at the lowest level for the last 11 months.

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AGENDA ITEM: 09/0524

REPORT TO: **TRUST BOARD PUBLIC SESSION, 30 MAY 2024**

PRESENTED BY: Hannah Williams, Acting Director of Nursing, Therapies and Quality

AUTHOR: Hannah Williams, Acting Director of Nursing, Therapies and Quality

SUBJECT: **QUALITY DASHBOARD REPORT – APRIL 2024 DATA**

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

This report is provided for:

Decision ☐ Endorsement ☐ Assurance ☑ Information ☐

The purpose of this report is to:

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

Recommendations and decisions required

The Board are asked to **Receive, Note** and **Discuss** the April 2024 Quality Dashboard.

Executive summary

This report provides an overview of the Trust's quality activities for April 2024. This report is produced monthly for Trust Board, Quality Committee, Operational Delivery and Governance Forums for assurance.

This month's report also includes additional information regarding:

- NED audit of complaints Q4 2023/2024
- Continued development of 'Closed Culture' data and narrative
- H2 update on Trust Quality Priorities

Quality issues showing positive improvement this month include:

- The new data capture process within clinical systems, that automatically reports safeguarding referrals to the local authority, has gone live. This replaces the manual workaround put in place, thus releasing time for operational colleagues.
- The refreshed internal MARAC process continue to demonstrate success, with no backlog of MARAC action plans awaiting administrative uploading to records for the second successive month.
- Continued reduction in deep tissue pressure injuries across all Integrated Care Team localities.
- Introduction of a new offer of adult safeguarding supervision enabling a 'menu' of options that are specific to individuals' roles within the Trust. The offer has been co-produced with colleagues.
- Good progress continues with more detailed reporting of Statutory and Mandatory training and Clinical Supervision, the Trust's Clinical Supervision group is supporting colleagues in understanding the recording process to improve compliance figures.
- Expanded restrictive practice data that is site specific.

Quality issues that require additional focus development include:

- Specific and targeted work to be led by the safeguarding team to support operational colleagues in the accurate recording of household contact details following a full review of the risk.
- Additional NTQ support required to ensure PALS visits at Berkeley House are maintained.
- Continued expansion of restrictive practice data and analysis.
- Ongoing work regarding quality concerns at Berkeley House, noting the challenges with staffing vacancies, complexity of discharges and subsequent building infrastructure challenges.
- Continued focus on the recording of observations post rapid tranquilisation, noting there have been some improvements.
- Continue to provide in partnership with operational colleague's, additional focus to safeguarding supervision attendance noting a small improvement in month.

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

Corporate considerations	
Quality Implications	By the setting and monitoring of quality outcomes this provides an escalation process to ensure we identify and monitor early warning signs and quality risks, helps us monitor the plans we have in place to transform our services and celebrates our successes.

Resource Implications	Improving and maintaining quality is core Trust business.
Equality Implications	No issues identified within this report

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

Appendices:	Quality Dashboard Report - April 2024 Data

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

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Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 09.1/0524

Quality Dashboard 2023/24

Physical Health, Mental Health and Learning Disability Services

Data covering April 2024

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

Executive Summary

This Quality Dashboard reports quality focussed performance, activity, and developments regarding key quality measures and priorities for 2023/24 and highlights data and performance. This data includes national and local contractual requirements. Certain data sets contained within this report are also reported via the Trust Resources Committee; they are included in this report where it has been identified as having an impact on quality matters. Feedback on the content of this report is welcomed and should be directed to Hannah Williams, Acting Director of Nursing, Therapies and Quality (NTQ).

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

Are our services SAFE?

The business intelligence team have developed a clinical system to automatically report safeguarding referrals to the local authority. This went live on 22nd April 2024. There has been a slight improvement in attendance at Children's Group Supervision Sessions with positive feedback being received from attendees. A new offer/model of Adult Safeguarding Supervision has been developed to address low attendance and progress will be closely monitored. The offer/model is beginning to be rolled out across teams and localities. GHC PU reporting is in line with regional and national community Trusts recognising that a) PU prevention and management is a system issue rather than a single provider issue and b) a significant proportion of GHC patients enter our services with a PU developed outside of the Trusts services**.** We are looking at the accuracy of coding PU's that are classified as "Developed prior to admission to the Trust" to further validate this. This month we note an overall increase in pressure ulcer harm incidents, however, April 2024 data has not been fully validated. Therefore, PU classification is likely to alter due to duplication of reporting etc. 59% of skin integrity incidents from April 2024 had been reviewed and closed by 13/05/2024 with a further reduction in deep tissue injury across all localities. This reflects the good work being undertaken in the ICT's to support accurate assessment and categorisation. There were a total of 1035 patient incidents reported in April. 952 were reported as No and Low harm incidents and 83 as Moderate, Severe or Catastrophic incidents. The top four overall categories of incident, excluding skin integrity, were falls, clinical care, medical emergencies and self-harm. Four serious incidents/Care review reports were undertaken in April. Eight After Action Reviews took place in April and learning from these has been shared with clinical teams and governance forums. Progress continues with restrictive practice reduction in the Trust and this month we present the data by hospital site. The numbers of interventions during April remain elevated and can be attributed to a small number of patients requiring high frequency interventions and a continued raised patient acuity at Wotton Lawn. The most restrictive interventions, prone and supine restraint, continue to account for only 0% & 4% respectively, with seated restraint being the most used intervention at 31%. None of these interventions resulted in physical harm to patients. Work is ongoing relating to sexual safety, including exploring the possibility of obtaining a corporate licence to install a Working Alone Safely App (Zecure) on community nurses' mobile phones. Benefits of the Zecure app and costs for organisational licences have been shared with HR & OD colleagues.

Are our services EFFECTIVE?

The Multi Agency Safeguarding Hub (MASH) now undertake and co-ordinate the strategy meetings for all of health organisations within Gloucestershire. There have been no reported issues arising from this transfer of workload. The Trust have recruited additional staff to manage the increased workload and all staff are now in post. The Operational data included in previous dashboards was a snap shot of data created to monitor performance whilst the Operational Governance structures were being redesigned. This process is now complete and Operational data is highly visible across a number of Board committees across the Trust. As previously agreed, operational data has not been included in this dashboard to reduce data duplication in reporting. Safer staffing data acknowledges the challenges but recognises the improvements that have been made through International Recruitment. This month we see a reduction in HCSW vacancy, currently at 70.59% which is reflective of the ongoing good work within teams responsible for recruitment. We continue with exception reporting in relation to Statutory and Mandatory training, where there are 5 or more teams not reaching the threshold for compliance. Access to individual team data is now available to support team managers to identify areas that require support. Essential to Role (E2R) training is included this month (mainly MH) and further detail will be added as we progress through 2024. Appendix 2 details progress made in relation to the first year of the planned two-year Trust wide Quality Priorities. There has been a consistent level of work undertaken throughout the year by the Quality Priority workstreams. There are no barriers to completion that have been identified and no reportable concerns. All priorities are tracking as green. The final year end detailed summaries will flow through to the Quality Account.

Are our services CARING?

This month we present the findings from the Q4 NED audit of complaints demonstrating good assurance that the Trust is responding in a timely and appropriate way to complaints. PALS visits have recommenced at Berkeley House. Whilst these visits are limited in number, due to the complex and challenging environment, all efforts are made to facilitate visits. FFT responses increased slightly this month and the percentage of respondents reporting having had a positive experience is just below target at 94%. 8 formal complaints were received in April. 82**%** of complaints were closed within three months (target 50%) and 100**%** closed within six months (target 80%). There were 3 re-opened complaints in April. The Patient Carer Experience Team continues to work with operational colleagues to achieve improved governance/oversight of all feedback received in order to embed learning and recommendations. A pilot to share feedback through '**You Said, We Did'** Boards has commenced as part of the FFT QI project. The new complaints management process launched on 1st August 2023, in line with the revised PHSO standards, is now firmly embedded within the Trust.

CQC Update

The enhanced monitoring at Berkeley House (BH) is continuing in line with the requirements of the Section 31 notice. We have now provided 5 consecutive months of data, analysis and description of activity linked to the quality of life indicators to the CQC. We presented this activity to the ICB led Berkeley House Quality Improvement Group in April and system members of the group supported our application to have the conditions of the Section 31 notice removed, noting the improved position. The application to have this removed has started. As we move into Q2 of the programme of work for BH, the Matron will lead a self-assessment, beginning in May, of all patients in line with the CQC's Quality of Life tool. This will provide a benchmark of progress against the criteria likely to be used in the reinspection of services. One patient was discharged as planned in April with 2 further discharges expected in May and June with weekly executive oversight of discharge plans in place. a weekly progress report maintains oversight of the remaining patients. The new Forest of Dean Hospital was fully registered with the CQC in time for the planned opening of the hospital. We have not received any further Mental Health Act inspections but these are expected. The CAHMS Service have begun peer reviews starting with the Young Adults team and Young Minds Matter planned for early June 2024.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

Quality Priorities 2023-2025:

A summary of quality priority activity in H2 2023-24 is provided below. This is a 2 year work programme and a definitive compliant/non compliant rating will be issued at the end of Q8. A detailed summary of progress against each priority was presented to Quality Committee in January 2024. and a year end summary will be produced in next months dashboard and then flow into the Quality Account.

SUMMARY QUALITY PRIORITIES 2023-2025

Priority	Description	Status 23/24
1	• Tissue Viability (TVN) - with a focus on reducing performance through improvement in the recognition, reporting, and clinical management of chronic wounds.	During the year there has been a consistent level of work undertaken in relation to the Quality Priority workstreams, all involved teams remain engaged and motivated. A summary of Trust wide progress was presented to Quality Committee in January and to Governors at their March meeting. Governors welcomed the opportunity to add, contribute and comment at the next meeting on 15th May. There was an opportunity for Governors to request the supporting work/progress templates if required, however, no requests were received. There are no barriers to completion that have been identified. Feedback received has noted that “having the ability to flex the workstreams to make amendments and alterations where required is beneficial.as there have been instances where the original work plans have required amendment after the testing cycles”. The final year end detailed summaries are included in Appendix 2 and will flow through to the Quality Account. It is pleasing to report there are no reportable concerns or barriers noted and all priorities are tracking as green.
2	• Dementia Education - with focus on Increase staff awareness of dementia through training and education, to improve the care and support that is delivered to people living with dementia and their supporters across Gloucestershire.	
3	• Falls prevention – with a focus on reduction in medium to high harm falls within all inpatient environments based on 2021/22 data.	
4	• End of Life Care (EoLC) – with a focus on patient centered decisions, including the extent by which the patient wishes to be involved in the End of Life Care decisions.	
5	• Friends and Family Test (FFT) – with a focus of building upon the findings of the 22/23 CQC Adult Community Mental Health Survey action plan.	
6	• Reducing suicides – with a focus on incorporating the NHS Zero Suicide Initiative, developing strategies to improve awareness, support, and timely access to services.	
7	• Reducing Restrictive Practice – with a focus on continuing our strategy in line with the Southwest Patient Safety Strategy to include restraint and rapid tranqulisation.	
8	• Learning disabilities – with a focus on developing a consistent approach to training and delivering *trauma informed* Positive Behavioral Support (PBS) Plans in line with National Learning Disability Improvement Standards. This includes training all learning disability staff in PBS by April 2025.	
9	• Children’s services – with a focus on the implementation of the SEND and alternative provision improvement plan.	
10	• Embedding learning following patient safety incidents – with a focus on the implementation of the Patient Safety Improvement Plan.	
11	• Carers – with a focus on achieving the Triangle of Care Stage 3 accreditation.	

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

	Reporting Level	Threshold	2023/24 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2024/25 YTD	Notes
Number of Friends and Family Test Responses Received	N - R		30,519	2,471												2,471	
% of respondents indicating a positive experience of our services	N - T	95%	94%	94%												94%	
Number of compliments received in month	L - R		2,506	151												151	As reported on last day of the month, noting compliments can be added retrospectively
Number of enquiries (other contacts) received in month	L - R		1,222	150												150	
Number of complaints received in month *Includes ALL complaints (closer look complaint / early resolution complaint)*	N - R		161	8												8	
Of complaints received in month, how many were early resolution complaints	L - R			8												8	
Number of open complaints (not all opened within month) *Includes ALL complaints (closer look complaint / early resolution complaint)*	L - R			24													
Percentage of complaints acknowledged within 3 working days	N - T	100%	100%	100%												100%	
Number of complaints closed in month *Includes ALL complaints (closer look complaint / early resolution complaint)*	L - R			11												11	
Number of complaints closed within 3 months	L - I			9												9	We have adjusted our local KPIs in line with the NHS Complaints Standards targets
Number of re-opened complaints (not all opened within month)	L- R			3													
Number of external reviews (not all opened within month)	L - R			7													

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

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

Key Highlights:.

- Numbers are reported by operational channels/directorates, then by type.
- Directorate level data is shared with senior operational leads each month to enable interrogation of service specific feedback; this time is also used to discuss ongoing investigations and emerging themes/learning.

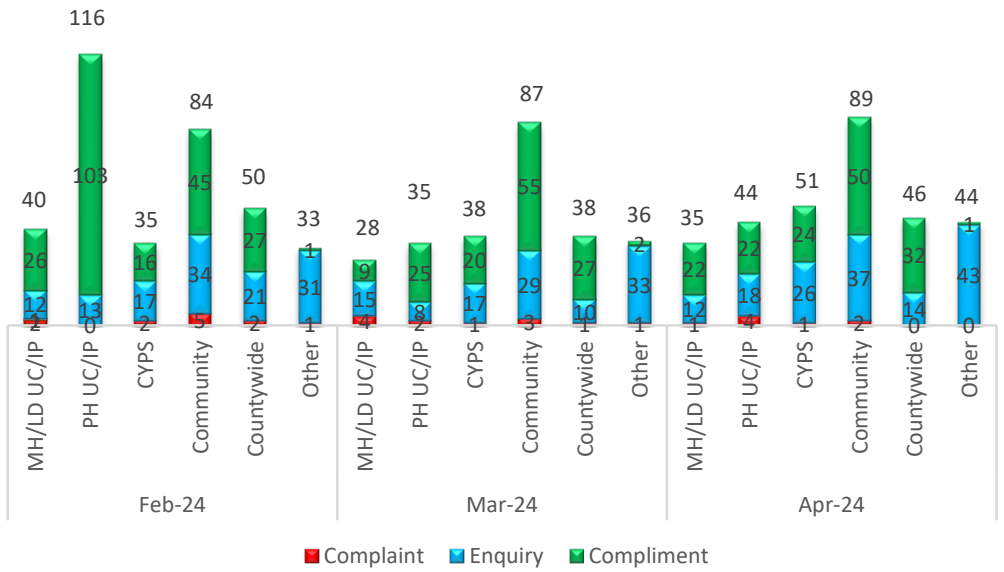
This table shows all reported PCET data received this month by type and directorate
It is important to note that this is a snapshot and does not consider footfall/caseloads/acuity of patients.

Directorate	Complaint			Enquiry	Compliment
MH/LD urgent care and inpatient	1	Early resolution:	**1**	12	22
		Closer look:	**0**		
PH urgent care and inpatient	4	Early resolution:	**4**	18	22
		Closer look:	**0**		
CYPS	1	Early resolution:	**1**	26	24
		Closer look:	**0**		
PH/MH/LD Community	2	Early resolution:	**2**	37	50
		Closer look:	**0**		
Countywide	0	Early resolution:	**0**	14	32
		Closer look:	**0**		
Other	0	Early resolution:	**0**	43	1
		Closer look:	**0**		
Totals	8	Early resolution:	**8**	150	151
		Closer look:	**0**		

Examples of complaints [as reported] for each directorate:

- **PH UC/IP:** Son of a patient who died unhappy with care received at the Dilke Hospital.
- **MH UC/IP:** Patient wishing to complain about a violent incident on Priory Ward and the staff reluctantly came to help.
- **Community:** Patient unhappy with care received from Care Coordinator when they were under the Recovery Team.
- **CYPS**: Mother of patient unhappy with the lack of contact from the SCAAS team.

Directorate feedback over the past three months



The above graph shows feedback by type and directorate over the past three months.
Whilst we continue to welcome complaints as an opportunity to improve our services, there have been significantly more compliments across every directorate. Moving forward, we want to start shifting our focus to learning from excellence too.

The new NHS Complaint Standards were implemented in August 2023 – feedback is no longer categorised as a concern, and is instead either a complaint or an enquiry:

- **Complaints**: now divided into early resolution complaints (like concerns, except with a formal response) and closer look complaints (like formal complaints)
- **Enquiries:** this category now includes feedback that may have previously been categorised as a *concern*

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

The below table shows all complaints CLOSED this month by outcome and directorate.
These include closer look and early resolution complaints.

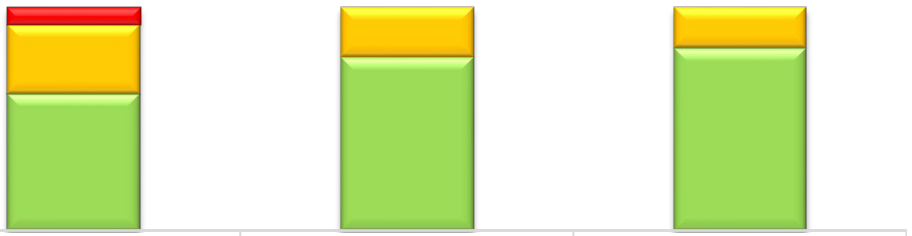
Directorate	Upheld	Partially upheld	Not upheld	Withdrawn	Other	Total
MH/LD urgent care, inpatient	0	0	0	0	0	0
PH urgent care, inpatient	0	0	2	1	1	4
CYPS	0	1	2	0	0	3
PH/MH/LD Community	0	0	1	0	0	1
Countywide	0	0	2	0	0	2
Other	1	0	0	0	0	1
Totals	**1**	**1**	**7**	**1**	**1**	**11**

The below table shows upheld COMPLAINT THEMES this month.
These include closer look and early resolution complaints.

Directorate	Upheld themes for complaints closed this month
CYPS	**There is a lack of transparency around the referral process and how the system works, which should be made clearer for parents. (Communication).**
Other (Records Management)	**MH Nurse gave information without consent. (Trust admin, including record management).** **MH Nurse requested further information when explicitly informed not to by the patient (Trust admin, including record management)**

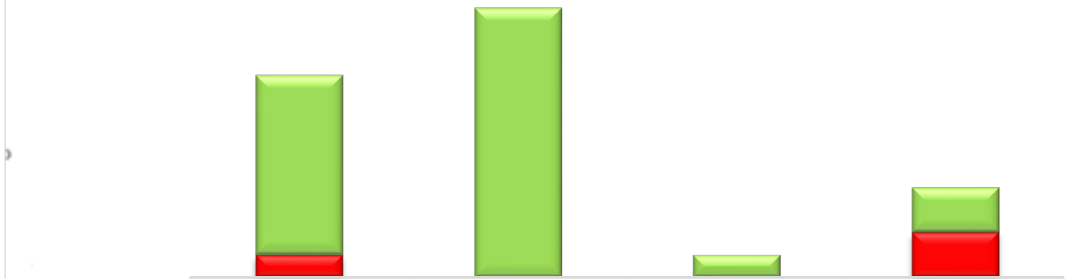
The below graph shows improvements in the length of time taken to close complaints.

- This month, 82**%** were closed within three months (target = 50%), 100**%** closed within six months (target = 80%)



	Feb-24	Mar-24	Apr-24
7-12 months	8%	0%	0%
4-6 months	31%	22%	18%
1-3 months	62%	78%	82%

The chart below shows the themes highlighted in all complaints closed over the past month



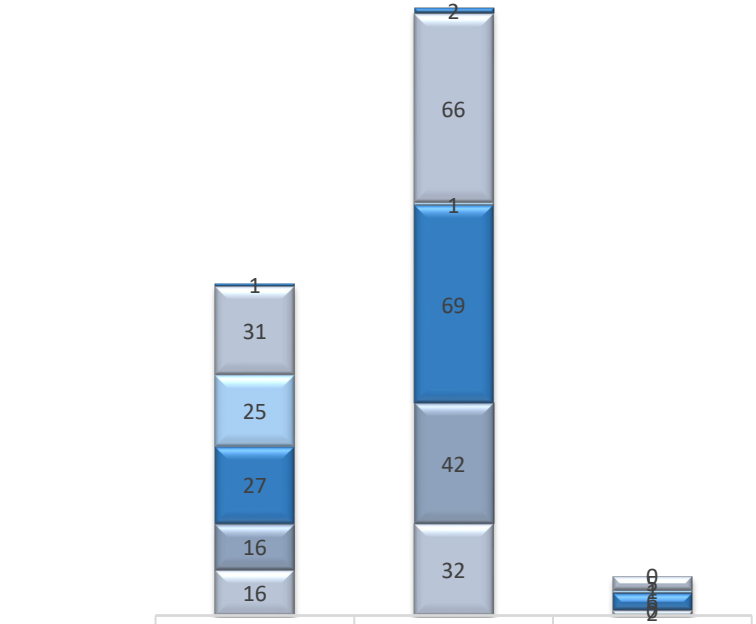
	Communication | attitude	Care | treatment	Access to services	Other
Not upheld	8	12	1	2
Upheld	1	0	0	2

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

The table below is a sample of compliments received this month, and the chart opposite shows all COMPLIMENTS received this month by theme and directorate.

The 151 compliments recorded contained comments that were distributed over **10** different themes. **Some compliments contained more than one theme.** It is very likely that more compliments were received but not recorded, therefore, not reported.- This is due to operational challenges in some teams.

Date	ID	Team	Compliment
08/04/2024	13553	ICT Chelt OT	Call received from Patient to compliment OT for going above and beyond their job role. They have improved there life so much by helping obtain all the equipment for the home to enable some independence, also help was given in looking for a dog walker. Thank you would highly recommend to friends."
22/04/2024	13713	Reablement TNS	I am super grateful for the support and care that you have all provided and wanted you all to know. I have really enjoyed working with you and having the company.
22/04/2024	13695	Homeless Healthcare Team	Message left on team answerphone from SAS patient thanking us for 'the kind welcome' she received today at her first appointment with us, she said she really appreciated it.
02/04/2024	13479	Ciren Hosp - Windrush Ward	To all the staff at the Windrush Ward. We would like to express our sincere gratitude for your incredible care for our Dad. Lisa, Scott, Andrew and Sue.
24/04/2024	13750	Wotton Lawn - Abbey Ward	The ward had a warm and welcoming feel to it and it was great to see nurses out on the ward, engaging with patients.
29/04/2024	13763	MIiU - Forest of Dean	Fantastic service While visiting the area I stood barefoot on some broken glass. The nurse in minor injuries removed it quickly without any fuss & was absolutely lovely. Speed of service was great. And all the staff were just so helpful.
24/04/2024	13725	Sexual Assault Referral SARC	Verbal comment from client ' Thank you for making this horrible experience that little bit easier.
05/04/2024	13520	Cardiac Rehabilitation Service	Email from a lady who completed the Cardiac Rehabilitation programme at our venue in Matson. She was thanking us for our help and support
03/04/2024	13499	Recovery Ciren & South Cots	A letter was received from an ex-service user thanking Val Hurst and Jane Vickers for their help. She went on to say that she is now working and very happy with her life.

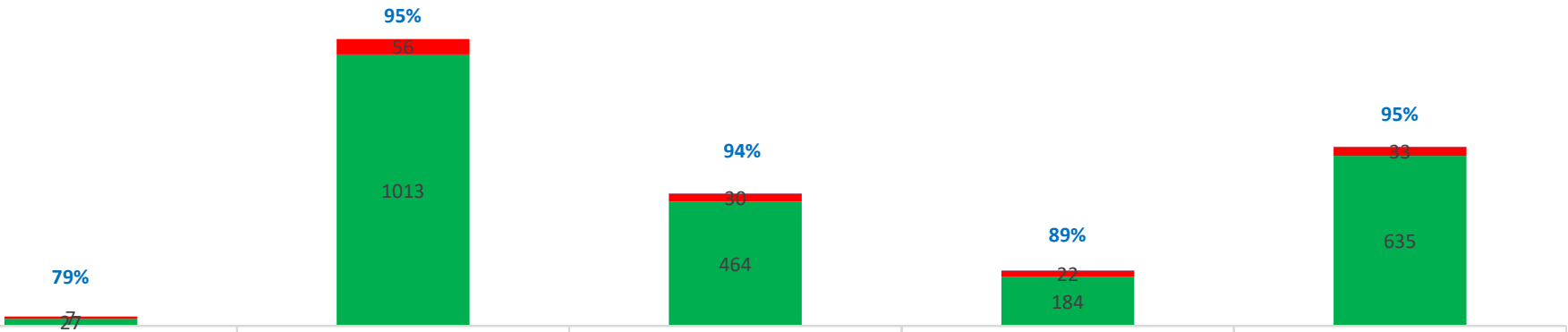


	Communication | attitude	Care | treatment	Other
Other	1	2	0
Countywide	31	66	5
CYPS	25	1	1
Community	27	69	6
PH UC/IP	16	42	0
MH UC/IP	16	32	2

MH UC/IP PH UC/IP Community CYPS Countywide Other

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

FFT scores by month and directorate



	MH UC / IP	PH UC / IP	CYPS	Community	Countywide
			Apr-24		
Postive score	79%	95%	94%	89%	95%
No. of negative responses	7	56	30	22	33
No. of positive responses	27	1013	464	184	635

No. of positive responses No. of negative responses Postive score

Highlights for this month:

- The overall positive experience rating is 94% which is back in line with previous month after a 1% drop in March.
- Of the 2,471 FFT responses, 36 were from carers (positive score of 89%)
- We are continuing to work with services where responses are low to promote a variety of survey methods, such as iPads, QR codes and paper where this is appropriate.
- A pilot to share feedback through 'You Said, We Did' Boards is underway as part of the FFT QI project. Boards are being introduced in Wotton Lawn Hospital in May.
- Service users made 8 requests for contact/action through the FFT open question.

ARE SERVICES SAFE? Non-Executive Director audit of complaints Q4 2023/24

INTRODUCTION

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

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

PROCESS

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

SUMMARY OF FINDINGS

- Audit findings are summarized within the table on the following slide
- The Q4 2022/23 audit provides **good** assurance that overall, the Trust is investigating and responding to complaints appropriately.
- The Trust's responsiveness to complaints is monitored via the monthly Quality Dashboard.

FUTURE AUDITS

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

RECOMMENDATIONS

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

ARE SERVICES SAFE? Non-Executive Director audit of complaints Q4 2023/24

	Time scale of response	Quality of investigation	Accessibility, style and tone of letter	Learning actions identified	Comments
Complaint 1 Husband of patient unhappy with treatment received from the staff on the ward, states some of the night staff sleep and unhappy with the suitability of placement	**FULL ASSURANCE** • Appropriate acknowledgement and clarification of issues • Formal response letter was sent within 3 months.	**SIGNIFICANT ASSURANCE** • Issues were general, which made it difficult to look into/provide specific details. • Additional information from GCC would have been helpful but not critical to response	**FULL ASSURANCE** • Letter addressed the individual issues raised and attempted conciliatory tone. • Appropriate apologies were offered.	**FULL ASSURANCE** • Learning was identified and actions agreed, however, specific time scales would have made this more robust.	• Patient is vulnerable adult who has previously provided coerced consent. Agreed request for consent could distress patient, so provided limited response. • Patient discussed with Safeguarding team for assurance. • Complaint was not upheld
Complaint 2 Patient's wife unhappy with being excluded from discussions by staff about the patient's care and the decision to do a home visit.	**FULL ASSURANCE** • Complaint acknowledged but then short delay (within 3 day target) before telephone contact made due to liaison with Safeguarding/Legal teams • Response letter was sent within 3 months.	**SIGNIFICANT ASSURANCE** • Comprehensive investigation, although more detail about specific events may have provided greater assurance. • A lot of work ongoing around the investigation (with legal and safeguarding teams)	**FULL ASSURANCE** • A difficult letter to write due to the challenging family dynamics but measured and considered in tone. • Letter addressed the issues raised in an objective way. • Appropriate apologies were offered.	**SIGNIFICANT ASSURANCE** • Learning was identified but not clear who is accountable for the action	• Safeguarding team alerted and advice sought from legal team regarding LPA • Complaint was not upheld
Complaint 3 Patient complained that nurse was rude, abrupt and dismissive and said the nurse is ignoring and/or bullying her.	**FULL ASSURANCE** • Significant PCET assurance when complaint first raised. • Concerns shared with Ward Manager who met with patient the same day • POhWER leaflet also shared same day • Response letter sent within 3 months	**SIGNIFICANT ASSURANCE** • Comprehensive investigation and matter dealt with appropriately • Further detail about the incident would have been helpful but assured that the investigator was assured with the nurse's version of events	**SIGNIFICANT ASSURANCE** • Letter was deliberately brief to prevent escalation, however, more detail would have been helpful (including signposting if patient feels unsafe in the future).	**FULL ASSURANCE** • Local actions agreed (no learning).	• Patient reported feeling unsafe on the ward, which PCET immediately addressed with ward and advocacy staff. • Complaint was not upheld

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

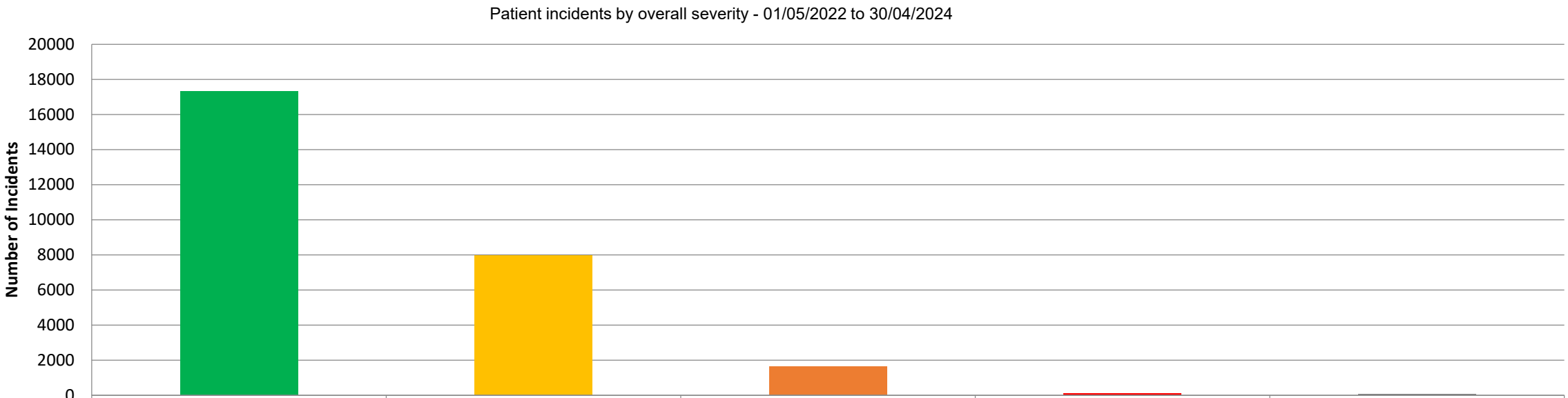
CQC DOMAIN - ARE SERVICES SAFE? INCIDENTS (Whole Trust data)

	Reporting Level	Threshold	23-24 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2024-25 YTD	R / A / G	Exception Report?	Benchmarking Report
Number of Never Events	N - T	0	0	0												0			N/A
Number of Serious Incidents Requiring Investigation (SIRI)	N - R		22	4												4			N/A
No of overdue SI actions (incomplete by more than I month)	L - R		0	0												0			N/A
No of unallocated SI investigations (waiting more than 1 month for allocation).	L - R		3	0												0			N/A
Number of Serious Incidents Requiring Investigation (SIRI) regarding self harm or attempted suicide	N - R		1	0												0			N/A
Number of Learning and Engagement Sessions meetings taking place	L - R		168	19												19			N/A
Total number of Patient Safety Incidents	L - R		14101	1035												1035			N/A
Number of incidents reported as resulting in low or no harm	L - R		13140	952												952			N/A
Number of incidents reported as resulting in moderate harm, severe harm or death	L - R		962	83												83			N/A
Total number of patient falls (hospitals and inpatient units) reported as resulting in moderate harm, severe harm or death	L - R		14	5												5			N/A
Total number of medication errors reported as resulting in moderate harm, severe harm or death	L - R		5	1												1			N/A
Total number of sexual safety incidents	L- R		112	12												12			N/A
Total number of Rapid Tranquilisations (RT)	N - R		564	83												83			N/A

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

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

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



None (no harm caused by the incident)	Low (minor harm, e.g. takes up to 1 month to rectify)	Moderate (significant but not permanent harm e.g. takes up to 1 year to rectify)	Severe (permanent or long term harm caused)	Death
17323	7960	1623	92	67

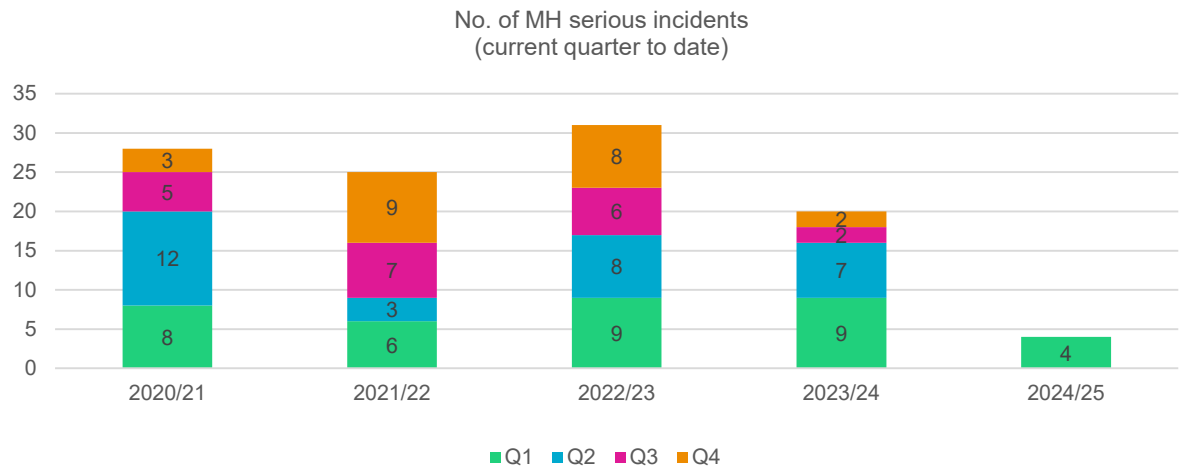
Key highlights:

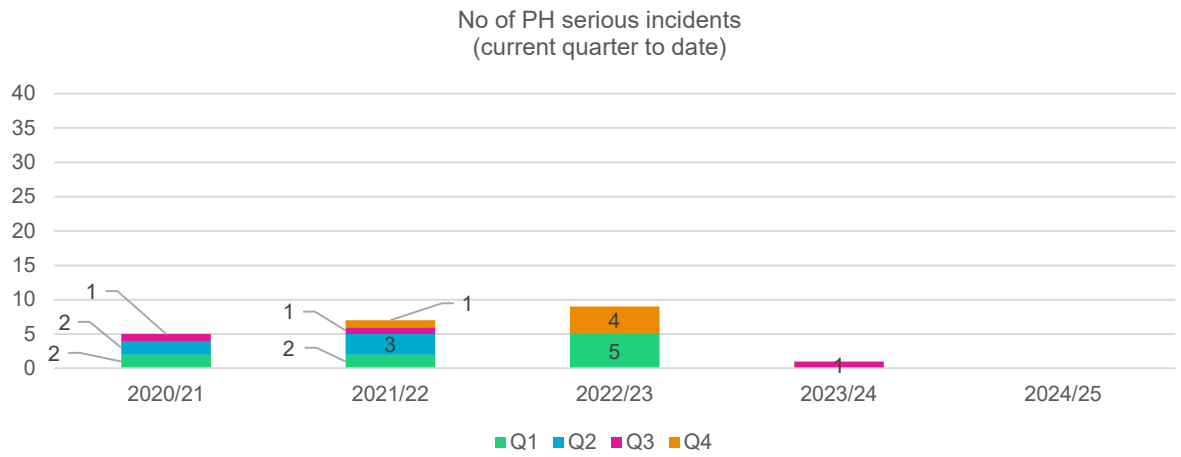
We have included in this dashboard a summary of patient safety incidents reported over the last 2 years and seek to present data that can identify patterns requiring deeper analysis.

In April 2024 there were 1035 patient incidents reported on Datix, 33 fewer than March (1068). 952 were reported as No and Low harm incidents, 38 fewer than March (990) and 83 as Moderate or Severe harm or Death, 5 more than March (78).

The PST continues to review incidents in teams with reporting anomalies and shares comprehensive reports with service level Ops and Governance meetings to support the development of insights into patient care.

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





Key Highlights

4 Patient Safety Incident Investigations / Care Review Reports were undertaken in April 2024, all related to mental health incidents.

8 After Action Reviews (AAR) were undertaken in April 2024. These are reported in Datix and shared with the clinical team and governance forums. AAR reports form part of the Trusts Duty of Candour response to patients and families. The Team works with clinical teams following AAR's to identify any learning and develop and prioritise safety actions that align with the principles of the Patient Safety Incident response Framework (PSIRF)

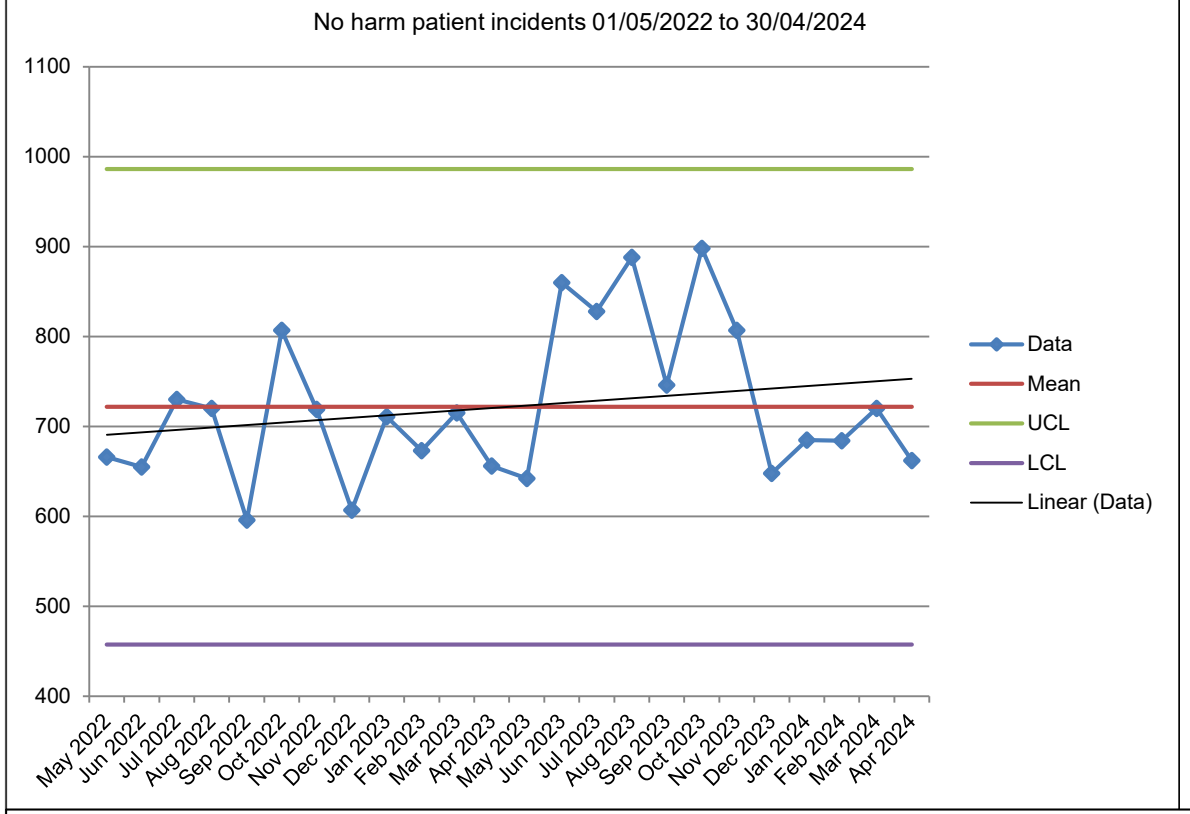
Learning Assurance activity

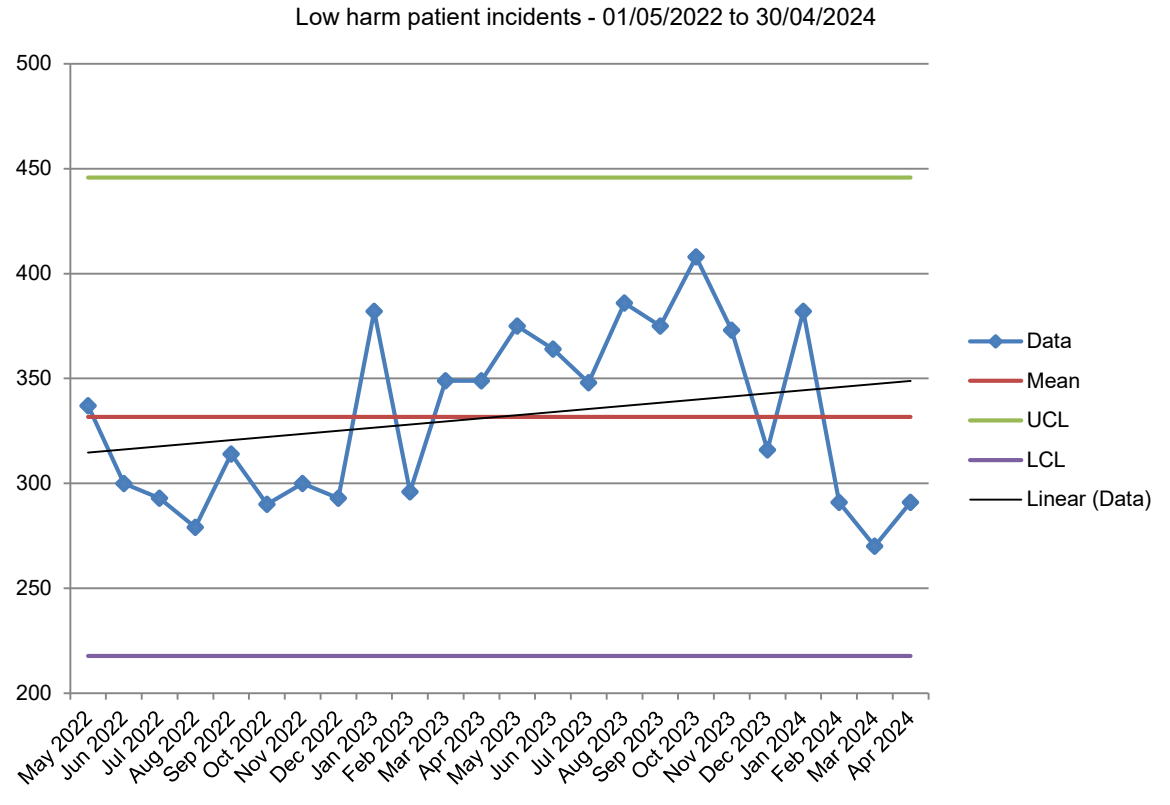
The Team has continued to work with clinical teams, following AAR's, to develop and prioritise actions and are in the process of planning site visits for May. These visits are an opportunity to meet front-line colleagues in different teams, talk about general and specific themes from incidents, learn about good practice and answer any questions. The visits also provide a means of gaining assurance that learning has been embedded. Quality Managers attend for some or all of the day to support this longer-term assurance work. Teaching at the University of Gloucestershire about 'Reporting near misses and critical incidents', to include Learning Assurance, is also taking place in May.

Ongoing learning assurance was supported through:

- Learning was disseminated via Medical and Dental Staffing Committee meeting, Patient Safety and Quality of Care Noticeboards and the Learning Opportunities Group (bi-weekly). The next edition of the online patient safety bulletin, Insight, has been completed and shared via the intranet. Monthly summaries of clinical incidents for directorates, to support information cascade, have continued in April and feedback is being reviewed.
- The Team attended one internal review meeting, the Learning from Case Reviews meeting, a joint GHC/GHT Risk Governance meeting and the Mental Health Mortality Review Group meeting
- Regular meetings with Matrons at Wotton Lawn and Charlton Lane Hospitals (the Clinical Development Manager and Duty of Candour Lead also attend) and Quality Managers
- The homicide action plan working group
- A meeting with the ICB

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



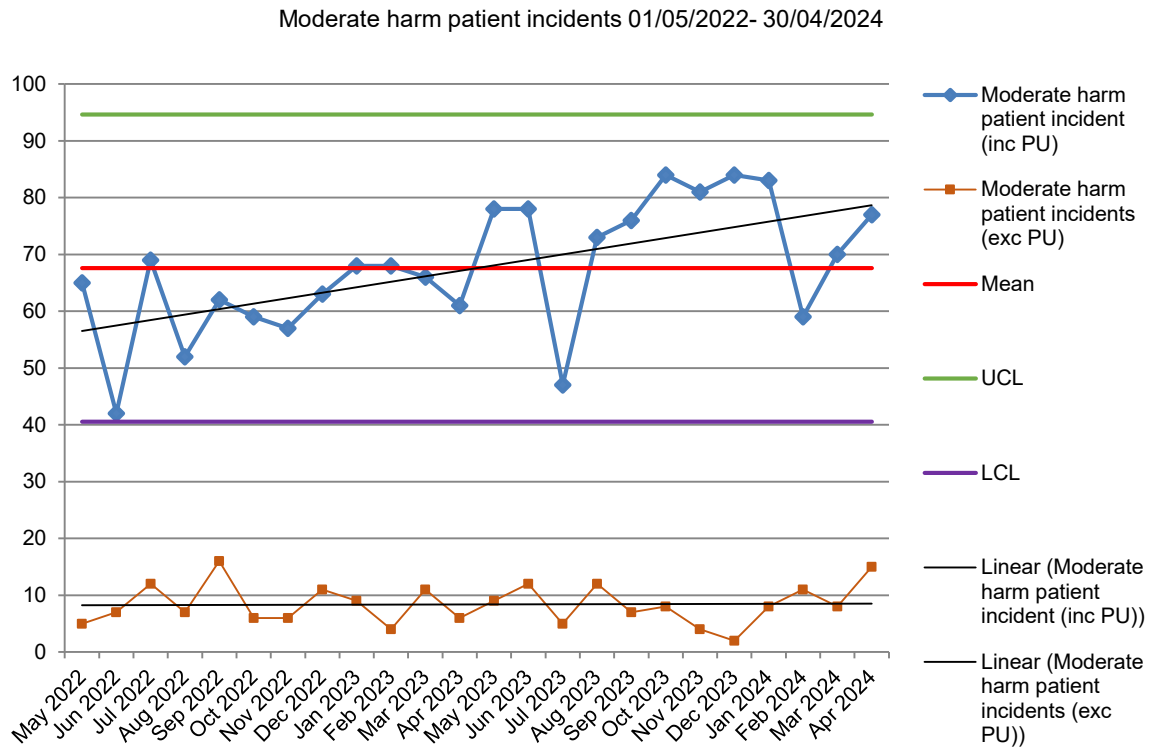


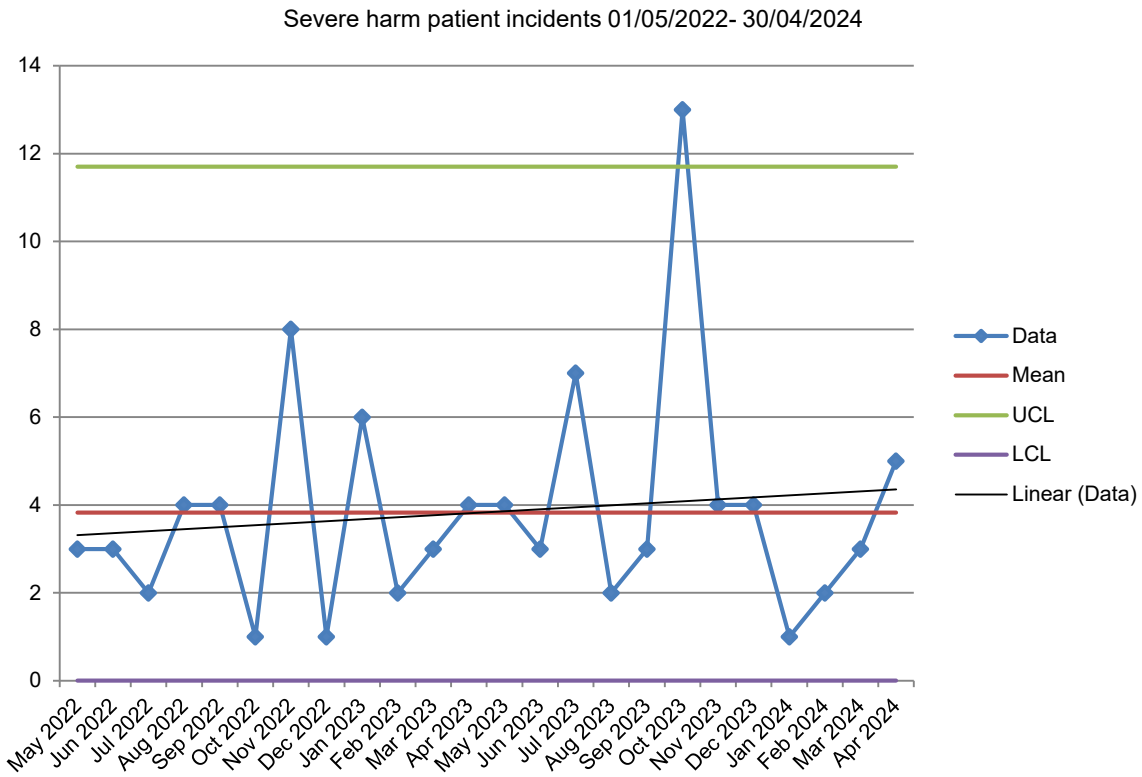
Key Highlights:

- **No Harm Incidents** – The increase from May to October 2024 can be attributed to no harm restraints at Berkley House to prevent harm to self or harm to others. There has been little variation in the reporting of no harm patient safety incidents since December. The current data point remains under the mean.
- **Low Harm Incidents** - There was a statistically significant increase in low harm patient incidents reported, with 9 data points above the mean between March 2023 and November 2023. There have subsequently been 3 data points below the mean since February 2024. Although this is still well within the lower control limits, this will be monitored.

A high level of incident reporting is positive and patterns observed will be monitored and reported through operational governance forums and QAG.

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

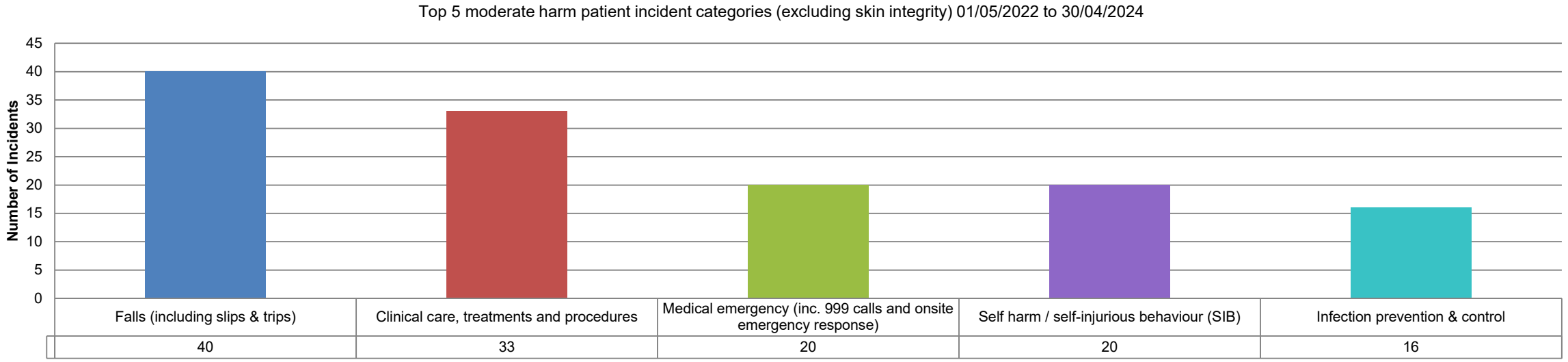




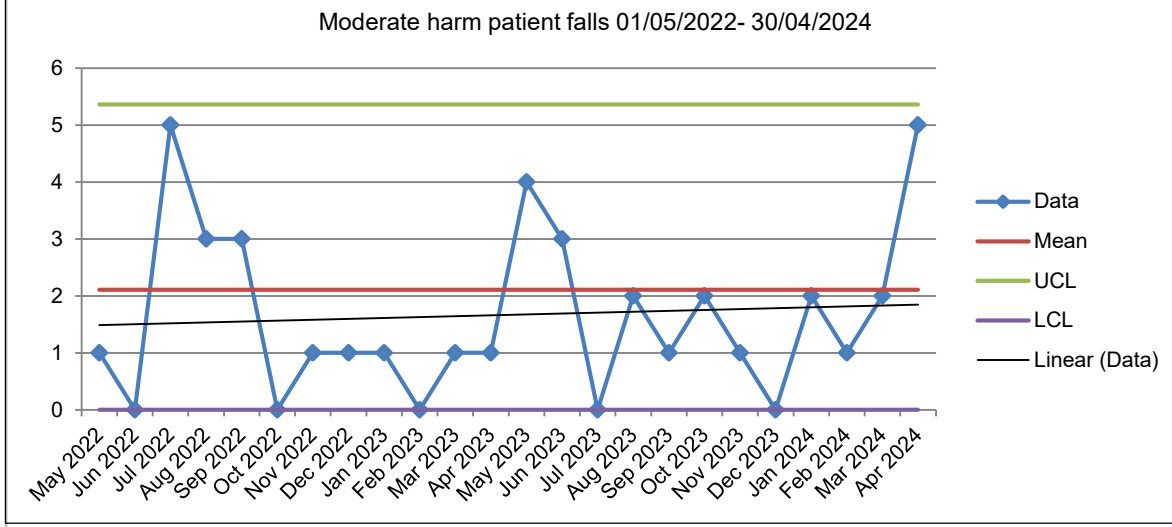
Moderate Harm Incidents - There has been a slight increase in Moderate harm incidents (including PU) in April (77 incidents) compared to March (70 incidents). The majority (6 out of 7 incidents) were not PU related incidents

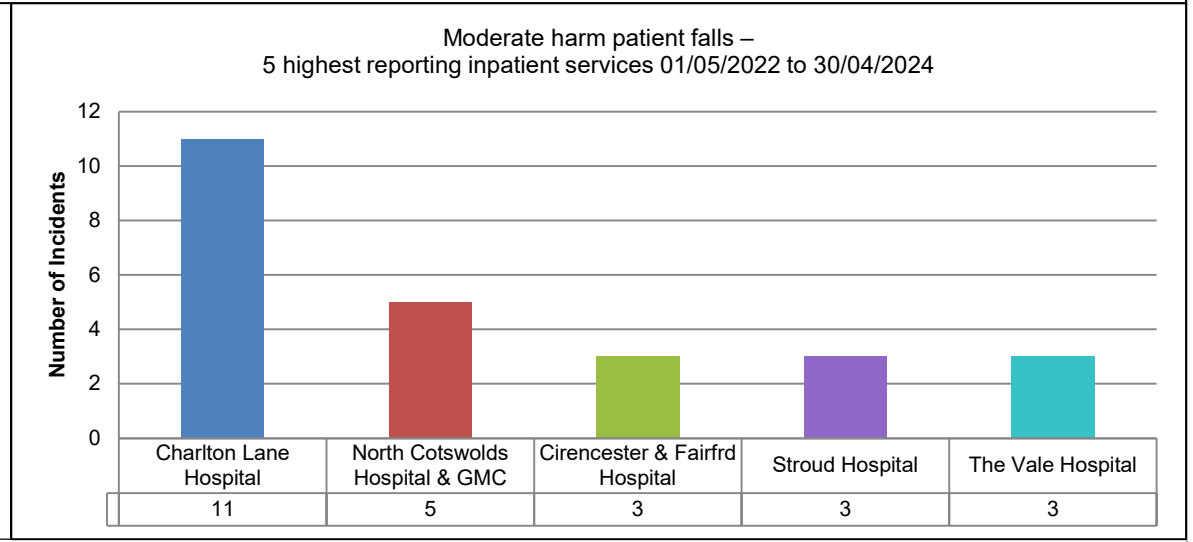
Severe Harm Incidents - 5 severe patient harm incidents were reported in April, an increase of 2 compared to March (1 incident affected a member of the public).

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



Moderate harm patient incidents (excluding skin integrity)
The chart above shows the 5 highest categories of moderate harm patient incidents (excluding skin integrity) over 24 months. The charts below provide a breakdown of moderate harm patient falls over the same period.





Quality Dashboard

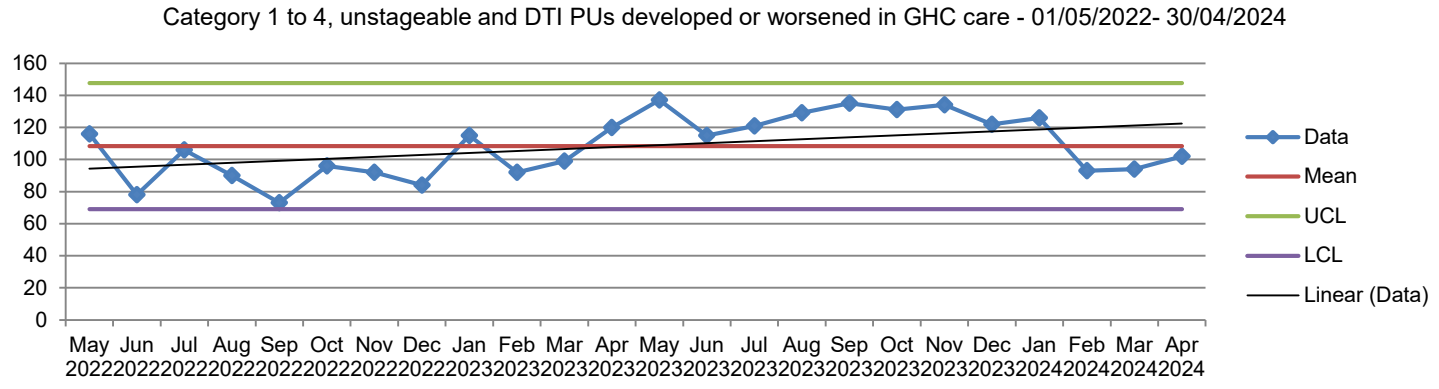
Gloucestershire Health and Care NHS Foundation Trust

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

	Reporting Level	Threshold	2023/24 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2024/25 YTD	R A G	Exception Report?	Benchmarking Report
VTE Risk Assessment - % of inpatients with assessment completed	N - T	95%	99%	98.5%												98.5%	G		
Number of HODA Clostridium Difficile Infections (C Diff)	N	16	5	1												1	G		
Number of C Diff cases (days of admission plus 2 days = 72 hrs) - avoidable	N	0	1	0												0	N/A		
Number of MRSA Bacteraemia	N	0	0	0												0	N/A		
PU Data threshold removed therefore no longer RAG rated – in line with revised national guidance.																			
Total number of pressure ulcers developed or worsened within our care.	L - R		1457	102*												102			
Number of Category 1 & 2 pressure ulcers developed or worsened within our care.	L - R		927	75*												75			
Number of Category 3 pressure ulcers developed or worsened within our care.	L - R		47	7*												7			
Number of Category 4 pressure ulcers developed or worsened within our care.	L - R		17	3*												3			
Number of unstageable and deep tissue injury (DTI) pressure ulcers developed or worsened within our care.	L - R		466	17*												17			

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

HCAI: There was 1 post 48-hour Clostridium Difficile (C.diff) and no MRSA infections recorded in April. Awaiting C.diff threshold for 2024/25 from ICB.



Pressure Ulcers:

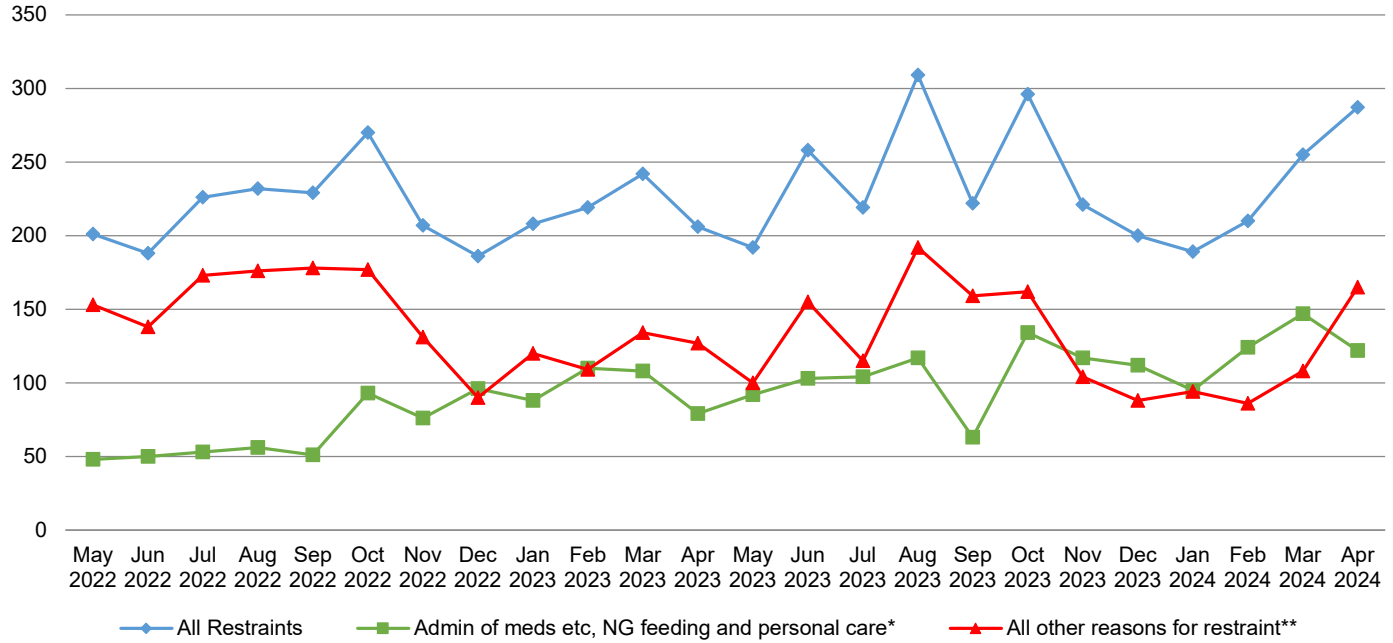
All cat 3, 4 & unstageable pressure ulcers each month are subject to senior clinical review as part of our validation process.

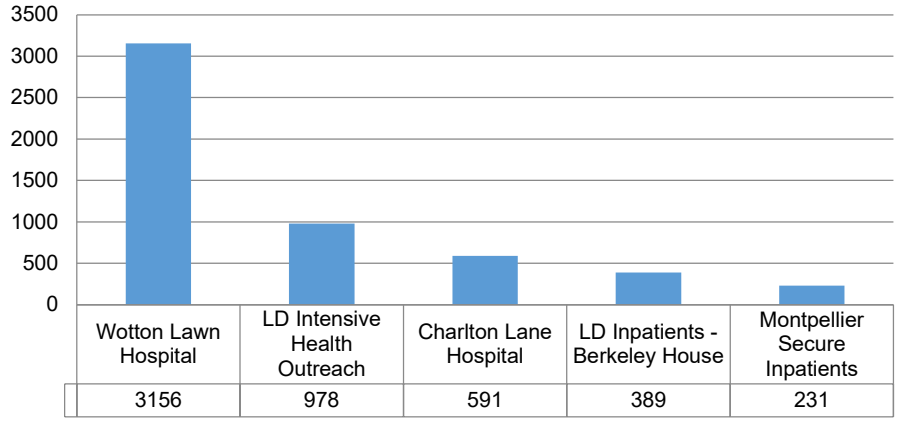
*April 2024 data has not been fully validated so PU classification is likely to alter due to duplication of reporting etc. 59% of skin integrity incidents from April 2024 had been reviewed and closed by 13/05/2024.

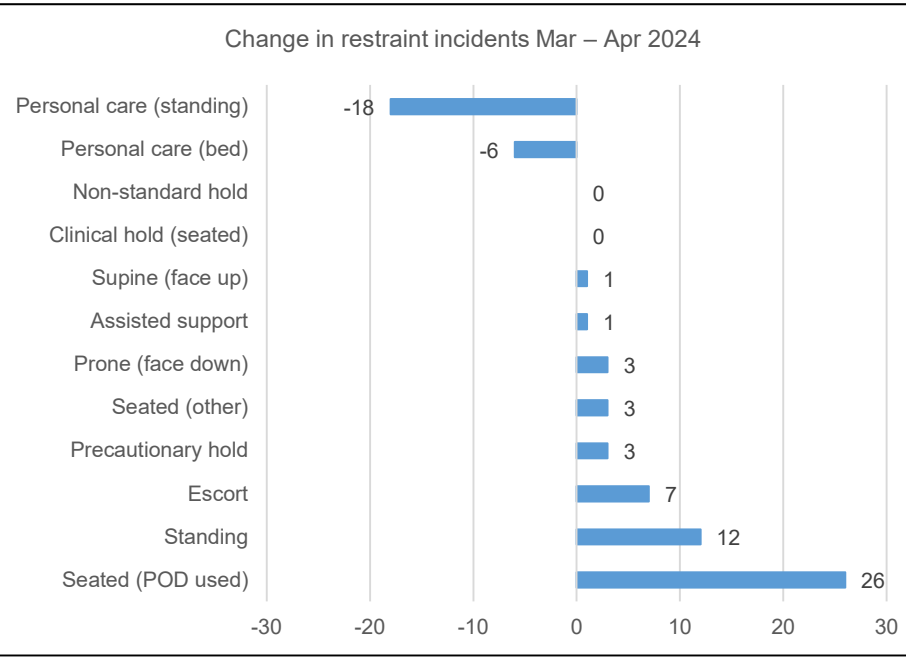
There has been a slight decrease in unstageable and deep tissue injury, from 24 in March to 17 in April, keeping the data below the mean.

The chart to the left demonstrates that moderate harm pressure ulcers, that developed or worsened in our care, were a key driver in the overall increase in moderate harm incidents from May 2023 to January 2024. Since February 2024 there have subsequently been 3 data points below the mean in the number of moderate harm pressure ulcers developed or worsened in our care.

Incidents involving restraint





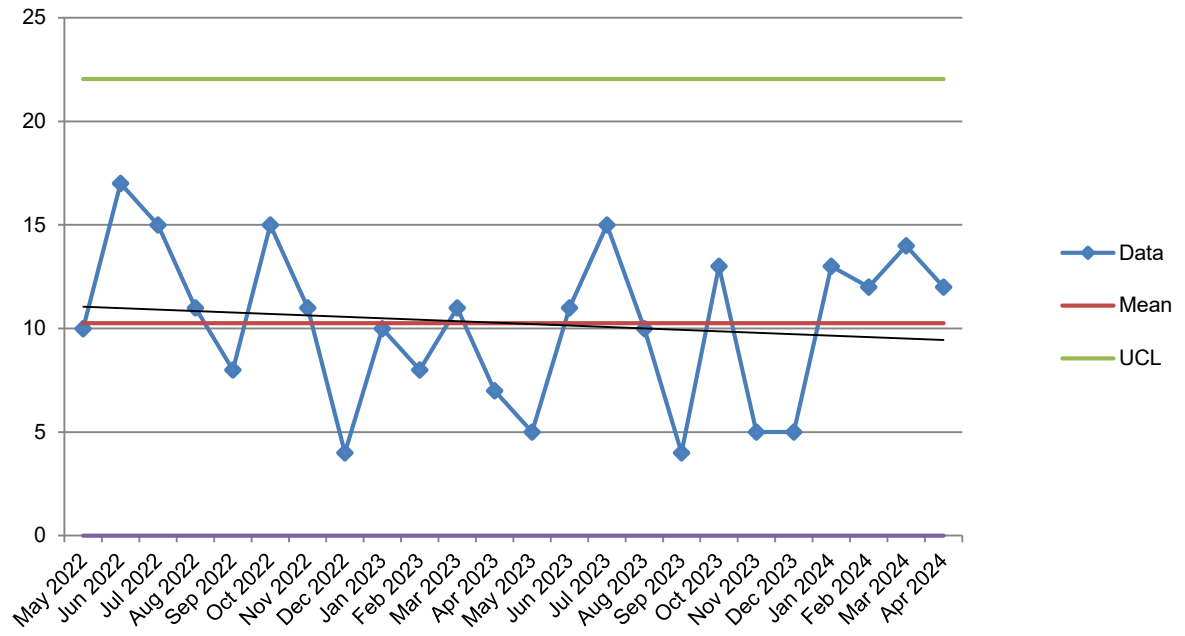


*Lawfully administer medicines or other medical treatment, Facilitate nasogastric (NG) feeding & Facilitate personal care
**Prevent a patient being violent to others, Prevent a patient causing serious intentional harm to themselves, Prevent a patient causing serious physical injury to themselves by accident, Prevent the patient exhibiting extreme and prolonged over-activity, Prevent the patient exhibiting otherwise dangerous behaviour, Undertake a search of the patient's clothing or property to ensure the safety of others, Prevent the patient absconding from lawful custody & Other/Not Known.

The Positive and Safe meeting continues to review all activity on a monthly basis. A weekly summary is provided to all team managers which gives regular oversight of restraint and ensures managers can take action to support teams. The "seated" category accounts for interventions supported on a sofa, bed or on a Safety Pod and this is now widely used as an alternative to the more restrictive supine or prone positions. The "seated" category is the most frequently used intervention, accounting for 31% of interventions, prone and supine restraint accounted for 0% and 4% of interventions respectively. These interventions are carried out within the appropriate legal framework (MHA & MCA) with appropriate debriefs being completed with the patient and team. No episodes of restraint resulted in physical harm to patients.

The numbers of interventions during April remain elevated and can be attributed to a small number of patients requiring high frequency interventions and a continued raised acuity at Wotton Lawn. However, the last week in April saw a 74% decrease in the total number of recorded physical interventions at Wotton Lawn (14 restrictive physical interventions in this week, compared to 54 the previous week) and during this period no rapid tranquillisation was administered. IHOT interventions continue to be utilised for clinical procedures, phlebotomy and vaccinations.

Sexual Safety Incidents

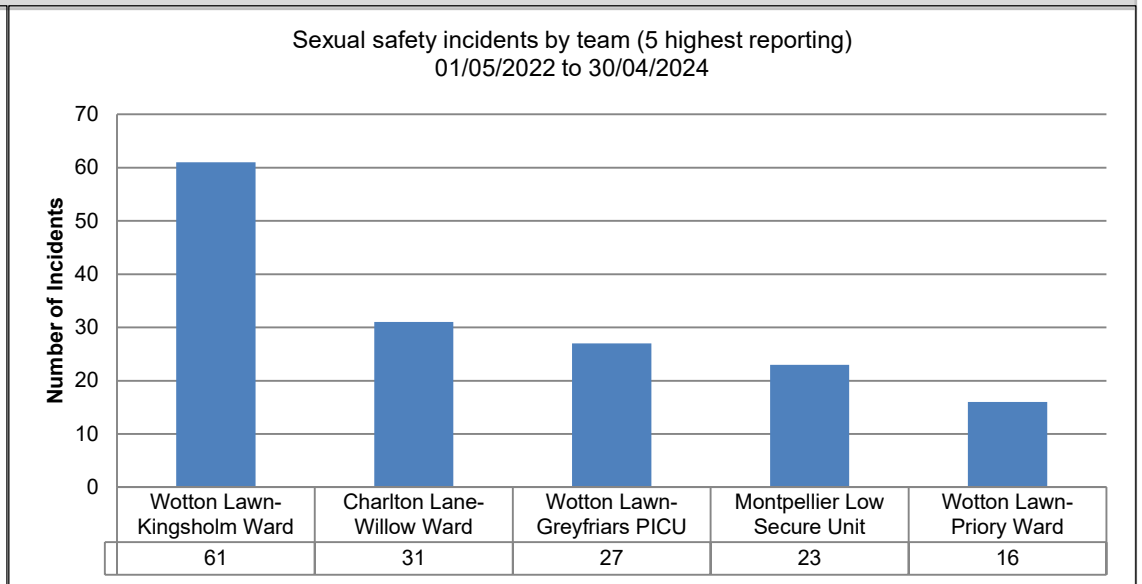


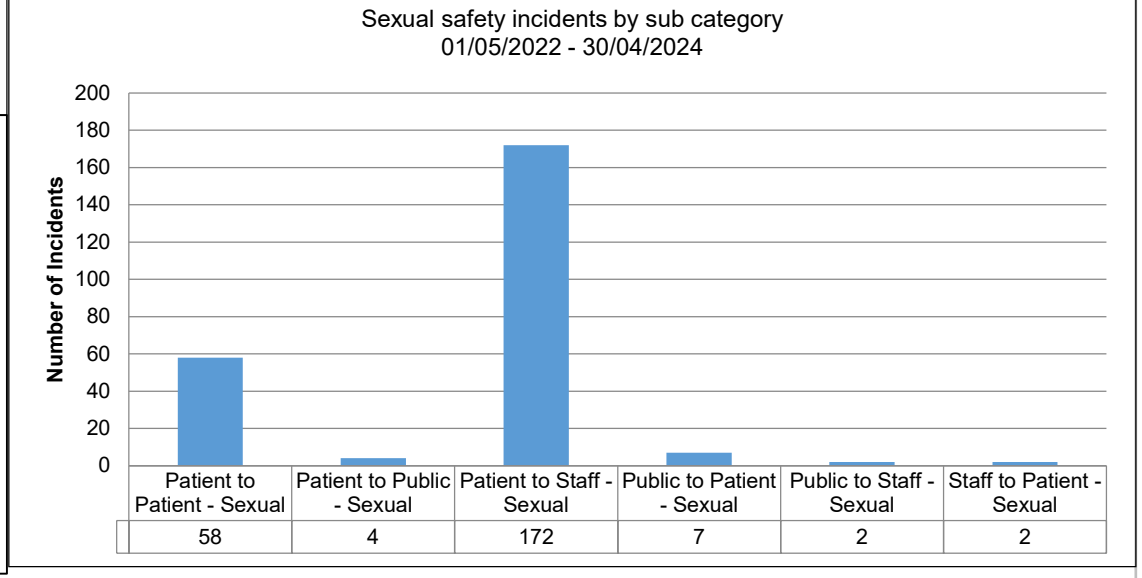
NHS England have developed a toolkit designed to support colleagues to discuss and tackle unwanted, inappropriate and/or harmful sexual behaviour in the workplace. The Trust has a local plan, ongoing work continues regarding reducing sexual behaviour harms and incidents and data collection is more robust due to improved sexual safety incident reporting. Policy alignment has taken place to strengthen sexual safety and connect practices.

The number of incidents decreased in April 2024, with the majority of sexual safety incidents continuing to occur in mental health inpatient services. There were 2 lone worker incidents involving the same service user, reported from a physical health community, and 1 incident from a community hospital. Male service users targeting female employees in a sexually inappropriate manner continues to be a theme over time (90% of reported incidents in April). This is being addressed via an OD/HR project to promote the Sexual Safety Charter through the Violence and Harm Reduction workstream.

Some lone workers are using the Hollie Guard App but further discussion is required of the benefits and costs of investing in the Zecure app (which is the Hollie Guard App for organisations)

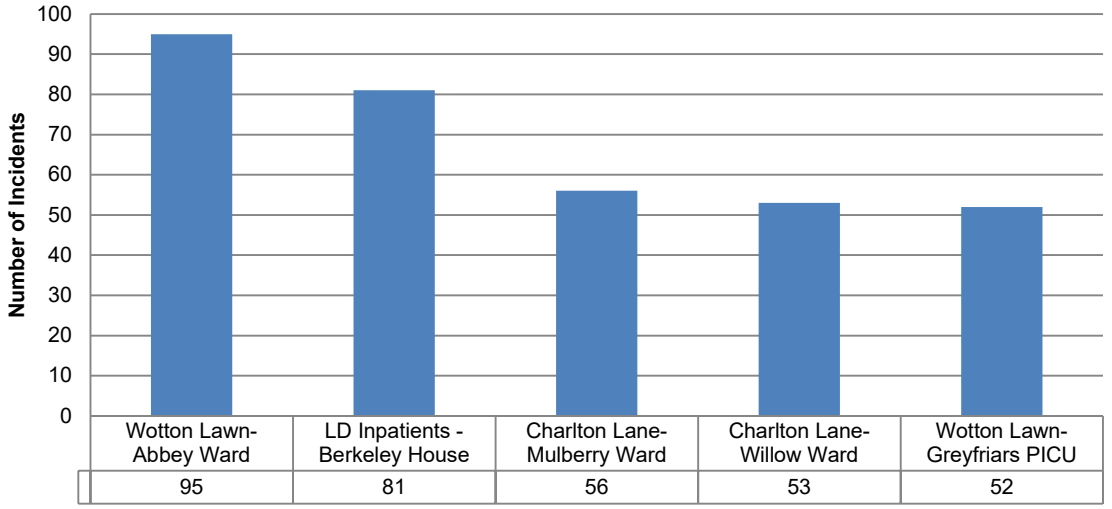
PICU Greyfriars, Kingsholm and Priory Wards at Wotton Lawn Hospital were the most frequent reporters of sexual assault, sexual disinhibition and sexual harassment. All of the reported incidents resulted in zero harm. Sexual Violence Awareness Training offered by SARC is planned with WLH teams for May/June 2024



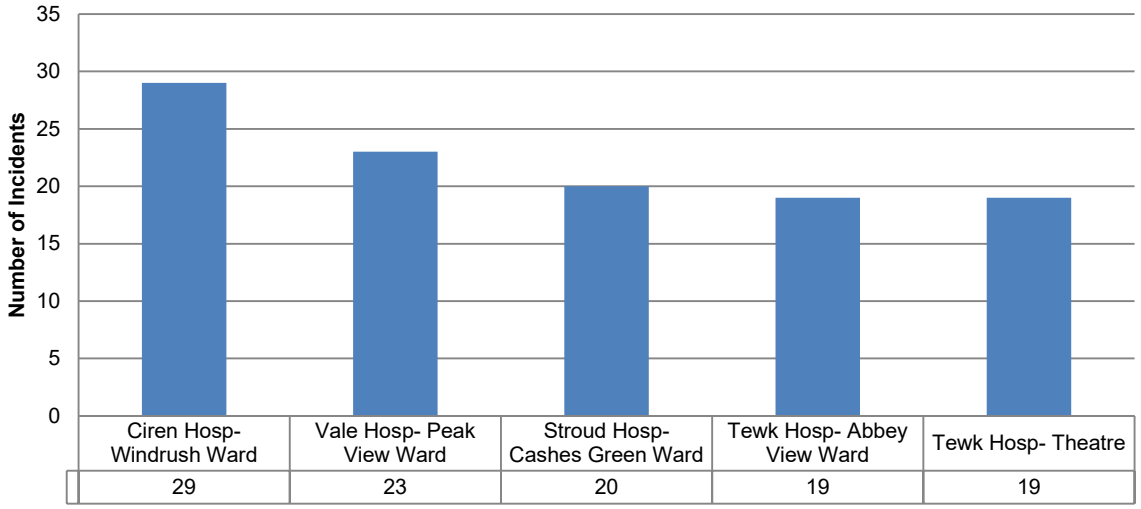


Incidents awaiting review and confirmation of level of harm: data priority areas and actions underway

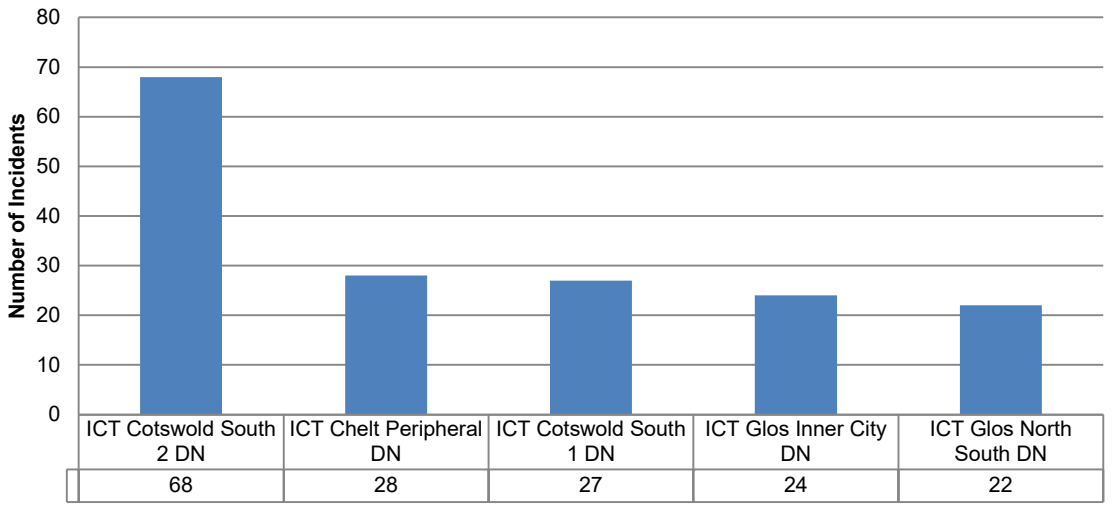
MH/LD inpatient wards/units (Top 5) –
Open incidents (awaiting review / being reviewed) as of 13/05/2024



Community hospitals (Top 5) –
Open incidents (awaiting review / being reviewed) as of 13/05/2024



ICT teams (Top 5) –
Open incidents (awaiting review / being reviewed) as of 13/05/2024



The Datix incident reporting system captures reported incidents and requires managers to review the incident and allocate the correct level of harm and overall severity.

The total number of open incidents (awaiting review/being reviewed) that have yet to be closed was 1818 as of 13/05/2024.

The Patient Safety Team continue to monitor the number of incidents (awaiting review/being reviewed) and working with operational colleagues to ensure timely review and closure of incidents.

National incident reporting changed from NRLS to LFPSE within GHC Datix from 9 January 2024. Any moderate/severe harm or death patient incidents that occurred before 9 January, but remained open at that time, needed to be reported nationally via LFPSE, with the mandatory LFPSE questions completed retrospectively. 68 such incidents remain open as of 13/05/2024.

Quality Dashboard

NHS Gloucestershire Health and Care

CQC DOMAIN: Patient Safety – Closed Cultures: eliminating the risk of our patients experiencing abuse

Closed cultures – identification and risk factors (April 24)

The CQC closed culture-related work applies to services that can be described as locked environments or areas where open access is restricted. Alongside these areas, services that deliver care to people that have communication or significant cognitive challenges are also considered at risk of becoming a closed culture. We have identified the following settings in the Trust as *potentially* having a raised risk of a closed culture; these are the focus of increased monitoring and support to eliminate this risk.

- **Berkeley House: Learning disabilities assessment and treatment**
- **Montpellier Ward: Mental health forensic low secure**
- **Willow Ward: Dementia unit**
- **Greyfriars Ward: Psychiatric intensive care unit**

Objectively, however, all our Trust inpatient services are potentially vulnerable to delivering poor care due to a complex range of organisational and individual factors, ranging from staffing issues, frail/vulnerable patients, organisational mandated tasks that divert staff from care giving through to an individual's personal values and behaviours that, in turn, can lead to poor care.

We are using the recent substantial governance review of the Manchester Edenfield Unit, published by the Good Governance Institute (2023), to develop an improved governance approach and implement anti-closed culture interventions. We are planning a Board development session on the report's findings and will update on outputs from this work.

Ward narratives

Montpellier Unit

Staffing: Two WTE Band 5 staff nurses are due to start summer 2024. One WTE Band 3 HCA is undergoing recruitment checks. 0.2 WTE Band 6 outstanding – we are planning to skill mix. Similarly, we are planning to skill mix for 1 WTE Band 3 HCA and 0.6 WTE Band 4 Admin roles. The current establishment is meeting the needs of the patients, although plans to skill mix the establishment will optimise this further.

Incidents: All 10 incidents occurring in April were consistent with expectations within a low secure unit. Two incidents involved restrictive interventions that were considered necessary to maintain the safety of staff and other patients. The principles of least restriction were followed.

Training: Training figures are at an all time high. Funding has been approved by SWPC for clinical staff to completed the Association for Psychological Therapies ADDRESS course for working with personality disorder. OT has completed additional training in ASI Wise sensory integration training. The team are struggling to improve PMVA compliance and are anticipating a drop in safeguarding compliance due to limited availability of training dates.

Other: None to report this month.

Greyfriars Ward

Staffing: We currently have 3 vacant Band 6 posts. Interviews were completed on 8 May 24 but we did not recruit as it was felt that the applicants did not have enough experience. We have now put out some Band 5-6 development posts, which will hopefully offer a more structured programme to support Band 5s to gain relevant experience as a development pathway to Band 6. We are fully recruited at Band 5 and Band 4 levels. We have 3 vacant Band 3 posts, which will be re-advertised.

Incidents: We have seen an **o**verall reduction in Datixes this month which is felt to correlate with significant improvements in some of our patients' mental health and a subsequent reduction in behavioural disturbance.

Training: Ongoing, with notable increases in compliance in most areas. Our biggest deficit has been the Oliver McGowan training because of lack of training dates – new dates are now available and most of the team are booked on.

Issues: Ongoing challenges with bed management/PICU beds being used for acute patients. This has impacted on patients moving to acute wards when they have met their PICU goals of admission which in turn impacts on the ability to consolidate patients' recovery in a less restrictive environment. This is due to significant pressures for beds locally and nationally.

Berkeley House

Staffing: Awaiting start dates for two newly recruited Band 5 RNLD Nurses and the newly qualified RNLD Nurse is progressing through her preceptorship. Our OT posts will soon become vacant, these posts will be put out to advert. Clinical Psychologist position is being advertised and in the interim we are having support from the Clinical Psychologist with South CLDT. 0.4WTE. Band 6 S&LT has commenced. Physiotherapy assessment and treatment are happening on a referral basis with Lead Physio for LD.

Incidents: No major incidents of note. Low level self-harming and damage to the environment are the most frequent incidents.

Training and supervision: No issues to report.

Issues: Estates continue to provide support managing issues that arise with our estate. Works have been carried out to Eagle flat to repair doors, flooring and walls during the month. Harrier flat works continue.

Charlton Lane Hospital (incl Willow Ward)

Staffing: We have a 3.4% vacancy rate across the hospital. Willow Ward is fully recruited with the exception of one HCA position. However, a candidate has been identified and is currently going through the recruitment process.

Incidents: No issues to report.

Training: The compliance with statutory and mandatory training across the hospital is 96.2%, with Willow Ward compliance at 95.5%.

Issues: None to report this month.

Promoting an open culture

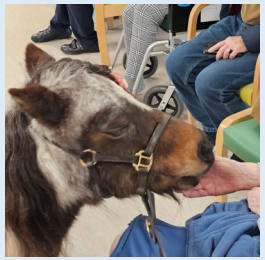
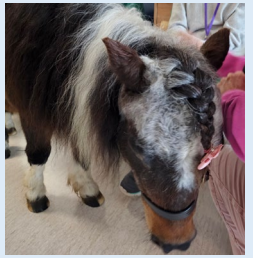
Charlton Lane Hospital (incl Willow Ward)
'Dinky Ponies' visited 10th April 2024, attended by carers and families.
Music in hospital event on Tuesday 7th May.
Casa carers event on Tuesday 7th May.

Greyfriars Ward
Greyfriars is starting work with the QI team to create a project looking at interventions that support the reduction of restrictive intentions. The ward has chosen to focus on blanket restrictions and work is currently being conducted to look at the views of staff and patients on blanket restrictions that are currently in place on the ward.

Montpellier Unit
No events this month.

Berkeley House
Daily activities including trips out occur on most days. These are tailored to the individual needs of each patient.

All vehicles are repaired and functioning.

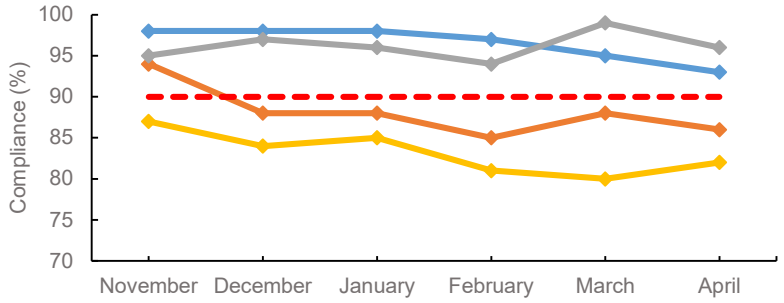

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

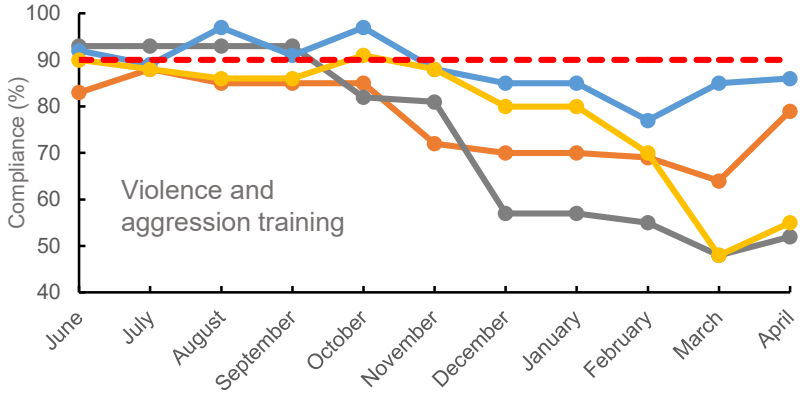
CQC DOMAIN: Patient Safety – Closed Cultures: eliminating the risk of our patients experiencing abuse

Closed cultures – Trust safeguards against risks

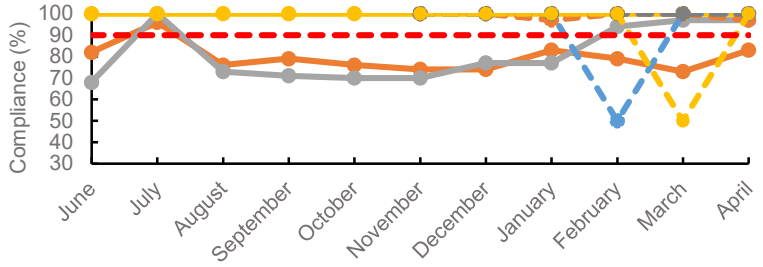
Safeguarding training



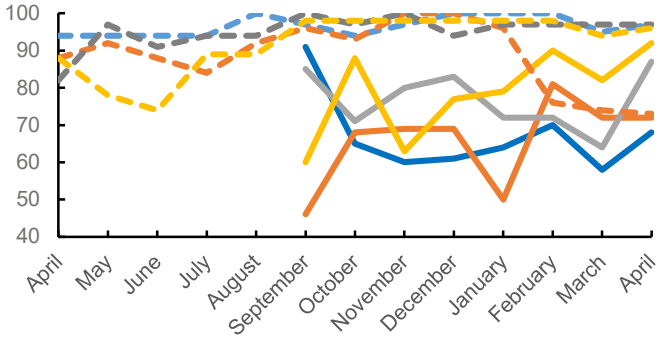
Violence and aggression training



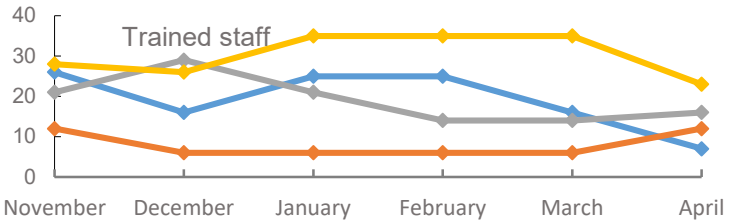
Conflict resolution and breakaway training

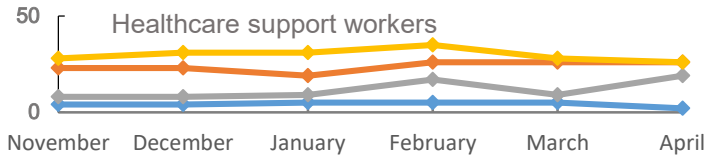


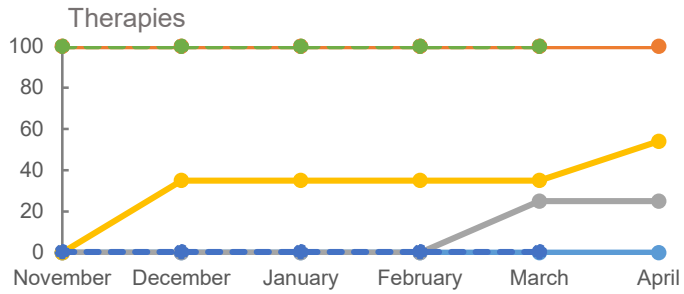
Supervision and appraisals



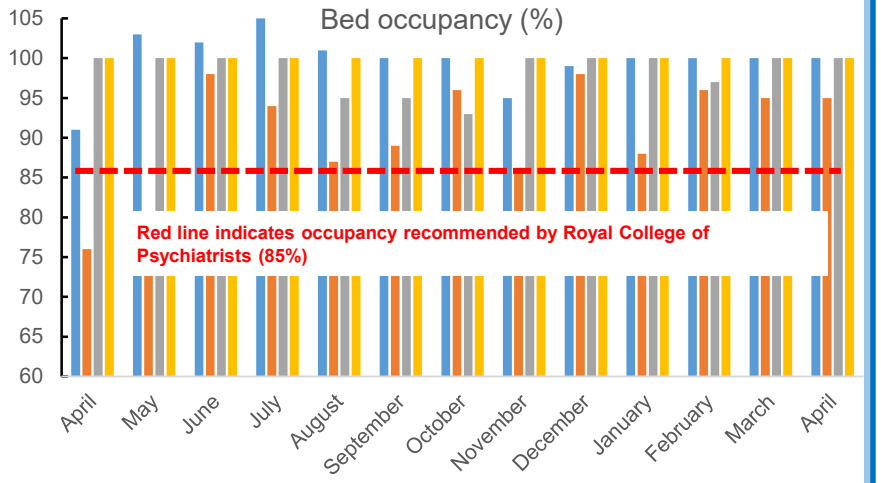
Staff vacancies (%)







Bed occupancy (%)



Key

Blue, Willow Ward
Orange, Greyfriars
Grey, Montpellier
Yellow, Berkeley House

For conflict resolution and breakaway training, dashed lines indicate conflict resolution

For supervision and appraisals compliance, dashed lines show appraisals

For therapies vacancies:

- blue line shows CLH occupational therapy
- blue dashed line shows CLH physiotherapy
- green line shows CLH speech and language therapy (no data available for April)

Dashed red lines show target/recommended levels

Areas that fall below recommended compliance are noted and highlighted to ops and training. Plans are put in place to rectify

These measures support safeguards against a closed culture: training and staff engagement. Datasets are collated at different timepoints as incidents are validated; numbers may not align with other reports.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

CQC DOMAIN: Patient Safety – Closed Cultures: eliminating the risk of our patients experiencing abuse

Closed cultures – Trust safeguards against risks

Patient to patient incidents

		April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April
Attempted assault	Willow W	0	2	2	5	1	2	0	4	3	3	4	1	4
	Greyfriars	0	0	0	0	4	0	1	0	0	0	1	2	0
	Montpellier	1	0	0	0	1	1	0	0	0	1	0	0	3
	Berkeley H	0	0	0	0	0	0	0	0	0	0	0	0	0
Physical	Willow W	2	11	17	15	11	17	5	8	3	3	7	8	1
	Greyfriars	0	1	8	1	2	0	4	3	2	2	3	2	13
	Montpellier	1	2	1	0	0	0	0	0	0	0	0	0	1
	Berkeley H	1	1	1	1	0	0	0	2	0	0	0	0	0
Verbal	Willow W	2	0	1	0	0	0	0	0	1	0	0	2	1
	Greyfriars	0	1	0	0	1	0	0	2	0	0	1	0	0
	Montpellier	1	0	0	0	0	0	0	0	0	1	1	1	1
	Berkeley H	0	0	0	0	0	0	0	0	0	0	0	0	0
Racial abuse	Willow W	0	0	0	0	0	0	0	0	0	0	0	0	0
	Greyfriars	0	0	0	0	0	0	0	1	0	0	0	0	0
	Montpellier	0	0	0	0	0	0	0	0	0	1	1	2	0
	Berkeley H	0	0	0	0	0	0	0	0	0	0	0	0	0

Patient to staff incidents

		April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April
Attempted assault	Willow W	0	0	2	3	1	2	1	0	1	3	0	2	0
	Greyfriars	0	0	1	1	5	1	5	2	3	5	2	1	4
	Montpellier	8	0	1	4	40	23	2	1	0	0	1	1	0
	Berkeley H	19	20	15	14	11	16	15	8	8	1	5	3	11
Physical	Willow W	13	9	8	6	14	9	10	17	6	7	3	6	4
	Greyfriars	4		7	2	8	1	18	6	15	18	6	5	22
	Montpellier	4	0	0	4	5	10	2	2	0	2	1	3	0
	Berkeley H	46	48	46	63	72	56	61	46	29	15	11	14	30
Verbal	Willow W	1	0	0	1	0	0	0	0	0	3	0	0	0
	Greyfriars	0	0	1	0	2	0	0	1	4	6	4	1	0
	Montpellier	1	1	0	1	3	0	3	1	3	1	2	3	2
	Berkeley H	0	1	1	2	3	2	2	3	2	0	1	0	0
Racial abuse	Willow W	1	0	0	2	0	0	0	1	0	1	2	0	0
	Greyfriars	0	0	1	0	2	0	1	3	1	1	0	1	11
	Montpellier	2	1	1	1	1	1	0	2	2	0	2	0	2
	Berkeley H	0	0	0	0	0	0	0	0	0	0	0	0	0

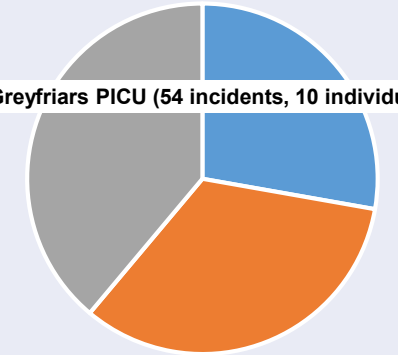
PALS, Patient Advice and Liaison Service; PCET, Patient and Carer Experience Team; PI, physical intervention; resn, resolution; RT, rapid tranquilisation.

Datasets are collated at different timepoints as incidents are validated; numbers may not align with other reports.

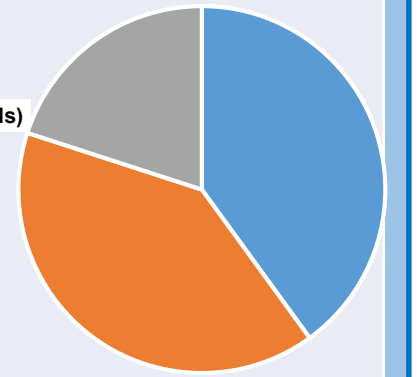
		April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April
RT (RT only + PI and/or RT)	Willow W	10	15	14	20	10	6	9	8	6	7	28	56	5
	Greyfriars	1	9	10	5	25	5	28	9	27	26	31	18	54
	Montpellier	11	0	0	7	56	53	4	1	0	2	1	1	2
	Berkeley H	23	15	25	29	23	25	31	33	6	5	11	20	16
Total sexual safety incidents	Willow W	0	0	0	4	2	0	1	0	2	6	2	0	1
	Greyfriars	1	2	0	2	3	0	2	0	0	0	3	3	2
	Montpellier	1	0	1	1	0	0	0	0	0	0	0	0	0
	Berkeley H	0	0	0	0	0	0	0	0	0	0	0	0	0
PALS visits (no. patients giving feedback, 2 visits every month)	Willow W	1	2	4	3	2	1	5	2	4	4	6	0	3
	Greyfriars	2	2	4	4	2	0	0	4	3	1	1	1	2
	Montpellier	7	4	2	1	2	0	2	5	1	2	3	0	2
	Berkeley H	Visits starting												
PCET activity (0 for units/wards not shown): Enq/comment	Willow Ward	0	0	0	1	0	0	0	0	0	0		0	0
	Greyfriars	0	1	0	0	1	1	1	0	1	1	2	1	0
	Montpellier	0	0	0	0	0	2	0	1	0	0	0	0	0
	Berkeley House	0	0	0	0	0	1	0	0	0	0	0	0	0
Early resn	Willow Ward	1	0	0	0	0	0	0	0	0	0	0	0	0

Berkeley House (16 incidents, 2 residents)

Greyfriars PICU (54 incidents, 10 individuals)



Willow Ward, 5 incidents, 3 individuals



Reported incidents of physical intervention and/or rapid tranquilisation in April, by individual; Montpellier Unit had only 2 reported incidents

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

CQC DOMAIN - ARE SERVICES SAFE?- Statutory and Mandatory and Essential to Role Training

Service – data as at 07/05/24	Resus Level 3	PBM/PMVA	Clozapine	Rapid Tranquilisation	Mental Capacity Act	Clinical Risk Assessment	Observation and Engagement
Cirencester & Fairford Hospital	82.5%	N/A	N/A	N/A	96.2%	N/A	N/A
Dilke Hospital	92.5%	N/A	N/A	N/A	100%	N/A	N/A
Lydney Hospital	100%	N/A	N/A	N/A	100%	N/A	N/A
MIIU's	88.7%	N/A	N/A	N/A	93.4%	N/A	N/A
North Cotswold Hospital	93.4%	N/A	N/A	N/A	94.6%	N/A	N/A
Stroud Hospital	85.8%	N/A	N/A	N/A	92.1%	N/A	N/A
Tewkesbury Hospital	95.3%	N/A	N/A	N/A	98.7%	N/A	N/A
The Vale Hospital	93%	N/A	N/A	N/A	96.6%	N/A	N/A
Community Physical Health	N/A	N/A	N/A	N/A	99.1%	N/A	N/A
AMHP	100%	N/A	N/A	N/A	94.4%	100%	N/A
Charlton lane Hospital	95.7%	85.2%	100%	100%	99.1%	95.3%	96.5%
Community Forensics	N/A	N/A	100%	N/A	92.8%	100%	N/A
Criminal Justice Liaison	N/A	N/A	90.9%	N/A	87.5%	90.9%	N/A
Crisis Resolution HT	100%	N/A	97.9%	N/A	84.4%	92.4%	N/A
Honeybourne	81.2%	N/A	100%	N/A	100%	87.5%	93.7%
Laurel	100%	N/A	100%	N/A	95.8%	84.6%	94.7%
Berkeley House	82.5%	55%	N/A	85.7%	90.9%	90%	78.9%
Psychiatric Liaison	N/A	N/A	100%	N/A	85.7%	92.5%	N/A
Wotton Lawn Hospital	86.8%	67%	97.1%	67%	95.6%	86.2%	85%
Community Mental Health	N/A	N/A	%	N/A	96.3%	88.4%	N/A

Additional information

Statutory and Mandatory training - is included on the slide where there are 5 or more teams not reaching the threshold for compliance. Some Essential to Role (E2R) training is included this month (mainly MH), more will be included this year when they become E2R on Care2Learn. PMVA/PBM compliance rates are being impacted by access to courses (they are fully booked over the next few months). Staff are booking onto courses where they are available. This does not impede the hospitals ability to provide safe management of distress.

Appraisal - The April figure is 87%, a slight increase on last month. **Clinical Supervision** – The April figure is 39.77% Trust-wide which is a slight increase on last month. There is new guidance for teams to support recording of clinical supervision, with a requirement for 8 sessions per year with no more than 40 days in-between sessions. Supervision compliance for MH IPU is 69.47%, PH IPU is 33.84% and Adult Community MH, PH and LD is 29.78%.

Supervision - April 2024

Childrens: Group Supervision Compliance	60%

Integrated Group Supervision Sessions: **25**

One to One Supervision Sessions: **0**

Adults Group Supervision Sessions	0

Training

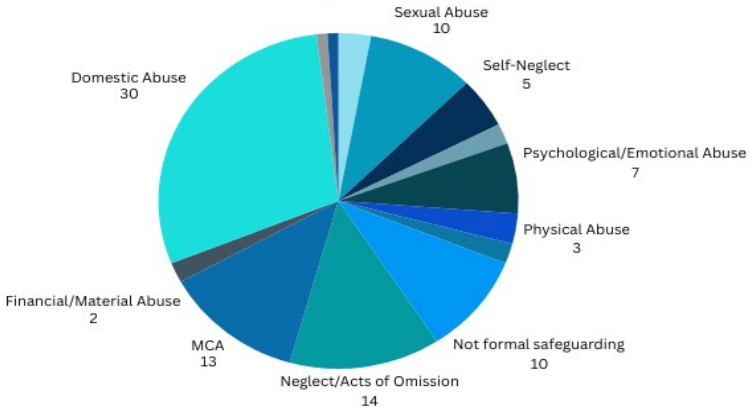
LEVEL 1: INDUCTION	LEVEL 2: THINK FAMILY	LEVEL 3: CHILD PROTECTION	LEVEL 3: ADULT PROTECTION	LEVEL 4: ADULT PROTECTION
97%	88%	82%	88%	88%
Apr 24: 97%	Apr 24: 88%	Apr 24: 82%	Apr 24: 82%	Apr 24: 88%
Mar 24: 97%	Mar 24: 89%	Mar 24: 84%	Mar 24: 89%	Mar 24: 91%
Feb 24: 97%	Feb 24: 89%	Feb 24: 88%	Feb 24: 89%	Feb 24: 93%
Jan 24: 97%	Jan 24: 90%	Jan 24: 90%	Jan 24: 88%	Jan 24: 87%

Referrals and Advice Line

116 APR 24 — Contacts to Advice Line (adults and children combined)
Jan 24: 124 Feb 24: 120 Mar 24: 119 Apr 24:116

23 APR 24 — Referrals made to GCC (adults and children combined)
Jan 24: 30 Feb 24: 26 Mar 24: 19 Apr 24: 23

Referral Themes - April 24



Summary information

The Safeguarding Dashboard provides assurance that:

- Safeguarding activity is a Trust priority function that is closely monitored
- Safeguarding is being delivered as per the requirements of the Gloucestershire

Safeguarding Adults Board (GSAB), the Safeguarding Children Partnership (GSCP), commissioning expectations, and national guidance and legislation. Safeguarding children and adults is a key element of the assessment and care management processes for staff. There are arrangements in place to ensure that staff are appropriately trained, supervised and supported in their safeguarding related work. The Trust's Safeguarding Group monitors safeguarding activity and reports quarterly into the Quality Assurance Group.

The Safeguarding Dashboard is presented in 3 sections:

1. Safeguarding Children Activity
2. Safeguarding Adults Activity
3. Safeguarding Training Compliance and Safeguarding Supervision

Summary

Highlights

- The B7 children practitioner secondment post has been offered to two experienced nurses who currently work in MASH to job share, a twelve month secondment for MASH is currently being advertised.
- The new children's supervision model is being finalised ready to share with GHC practitioners to provide more choice and opportunities to access supervision.
- The Adult Safeguarding template was introduced to SystmOne on 22nd April, and work is continuing towards the introduction of the Children's template (scheduled for September 2024).
- Adult Safeguarding referral data will be obtained from the local authority from this month which will enable us to make meaningful progress towards risk 298 'Capturing and Quality Assuring Safeguarding Referrals made to the Local Authority'.
- We have also identified a way to obtain data on Children's referrals, although we're not entirely certain exactly what this will look like yet.

Challenges/Risks

- The introduction of the Adult Safeguarding template to SystmOne is a positive, as is the promise of Safeguarding referral data from the local authority but there remains work to be done to turn this into measurable progress. Further work will be required to strengthen reporting across other clinical systems.
- Risk 109, recording of household members – while we are making steady progress with our review of this risk, we are some way off being able to effect front-line practice.

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

Long Length of Stay Patients – Community Hospitals

The information presents a summary of data relating to long length of stay in our Community Hospitals. For assurance, both Operational and Nursing, Therapies and Quality senior colleagues have good visibility of the data and attend appropriate system groups that identifies the impact of a long length of stay together with system meetings that seek to address the challenges. The detrimental effect that a prolonged hospital admission has upon a patient is well evidenced. When a patient is deemed to ' *no longer meet the criteria to reside'* (nCTR), timely and effective discharge plans should be in place to enable a discharge. Unfortunately due to the flow and capacity challenges across the system, we often see patients delayed. We are keen to ensure our 'super stranded' patients (over 50 days nCTR) have a continued focus and support in escalation with system partner working to expedite their discharge pathway. It is imperative we learn and shape services around the needs of the population, by collecting data and identifying themes of the delays, we can support discharge pathways that meet the needs of the patients, and also target our approach to escalation and requests of support. At system request, the focus is now on over 30 days not meeting the criteria to reside (nCTR).

Headline Data - April 2024

- There has been an average of 38 patients that have Not Met the Criteria to Reside (nCTR) in a community hospital in April 2024
- There has been an average of 2 patients in total Not Meeting the Criteria to Reside (nCTR) for over 30 days in April 2024

- Overall, there has been a slight increase in the number of patients that have not met the Criteria to Reside in a Community Hospital. The average number of patients who do not meet criteria to reside for > 30 days remains low.
- There has been a reduction in the delays for Pathway 1 discharges.
- There is sufficient evidence available highlighting the increased risk to individuals whose discharge is delayed. A review of all Datix recorded for each of the individuals delayed for mare than 30 days did not highlight any acquired harms, as a result of their extended stay.

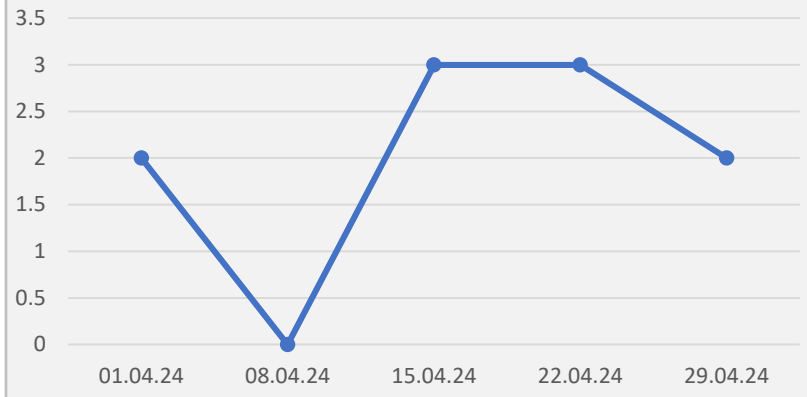
Pathway Zero – 'Simple Discharge' 0
No formal care arranged but could include follow up appt, district nurse or community and voluntary sector input

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

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

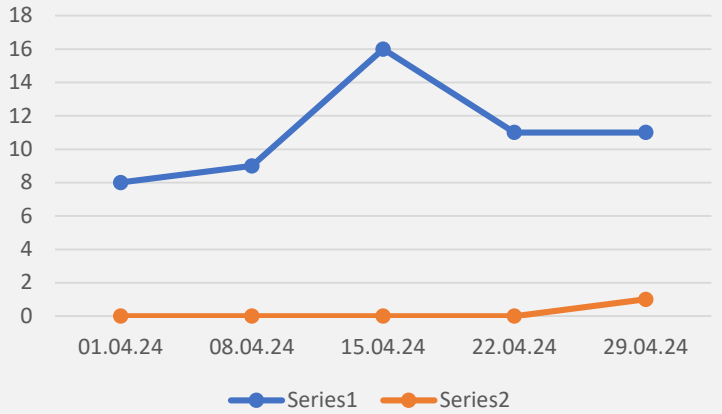
Pathway Three – Longer Term Setting 3
Short Term Residential/Nursing Respite after recognised ongoing needs, which lead to long term nursing or residential placements if not home

Number of patients not meeting Criteria to Reside for over 30 days in a Community Hospital



Showing the number of patients that do not meet the Criteria to Reside for > 30 days. Date ranges week commencing 1/04/24 – 29/04/24.

Discharges on Pathway 1



Showing the number of patients **discharges** on Pathway 1 who did not meet the criteria to reside for > 30 days. Date range: week commencing 1/04//24 – 29/04//24. Pathway 1 can be defined as discharge home with support from Home first, a self-funding care package or a care package sourced by Social Care.

Discharges on Pathway 3

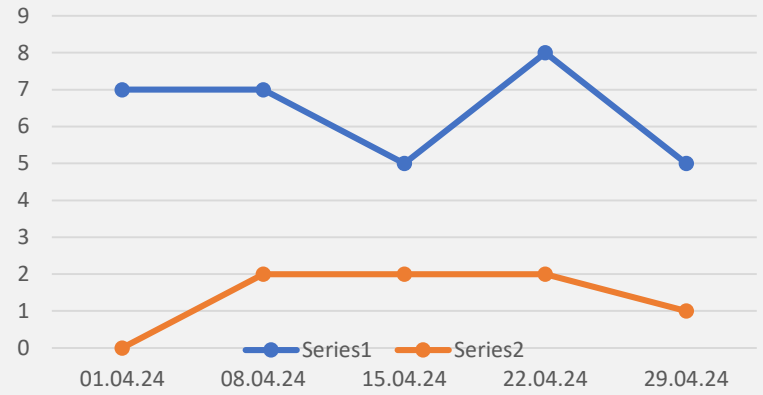


Chart 3 - Showing the number of patients delayed on Pathway 3 for over 30 days. Date range: week commencing 01/04//24 – 29/04//24. Pathway 3 is defined as discharge to a Care home, either funded by the individual or through Social Care funding.

CQC DOMAIN - ARE SERVICES EFFECTIVE? – Mental Health Hospital Delayed Patients

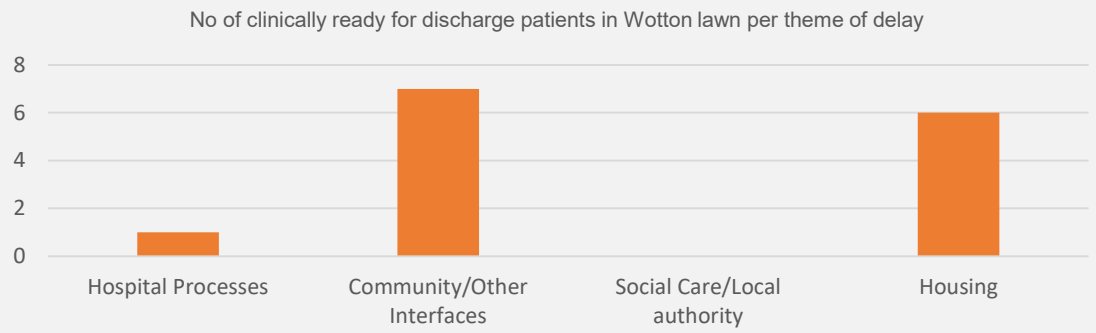
Long Length of Stay Patients- MH Hospitals.

Clinically Ready for Discharge, formally known as DTOC, is the new terminology for reporting delays in MH since January 2023. "Clinically Ready" does not indicate complete recovery, it is the point at which a person could be safely assessed, cared for and treated at home or in a less restrictive setting. Being "Clinically Ready for Discharge" (CRfD) is an indication that a person could continue their recovery outside of a hospital setting – with adequate support/services in place.

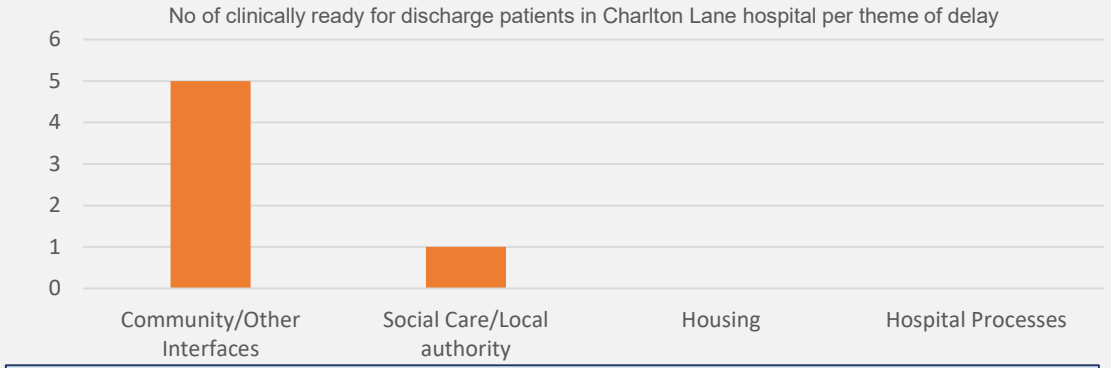
For reporting and descriptive purposes four high level sub-categories have been developed and these categories describe the reasons that a persons discharge is delayed.

- **Hospital Processes** - defined as any process that is the responsibility of the inpatient service that is related to the delay.
- **Community/other interfaces** – defined as any team or service (excluding social care/local authority or housing partners) that are responsible for/related to the delay.
- **Social Care/Local Authority** – defined as any factors that are due to social care provision or are the responsibility of social care/local authority partners, related to the delay.
- **Housing /accommodation** – defined as any factors that are due to housing provision or are the responsibility of housing partners/teams, related to the delay.

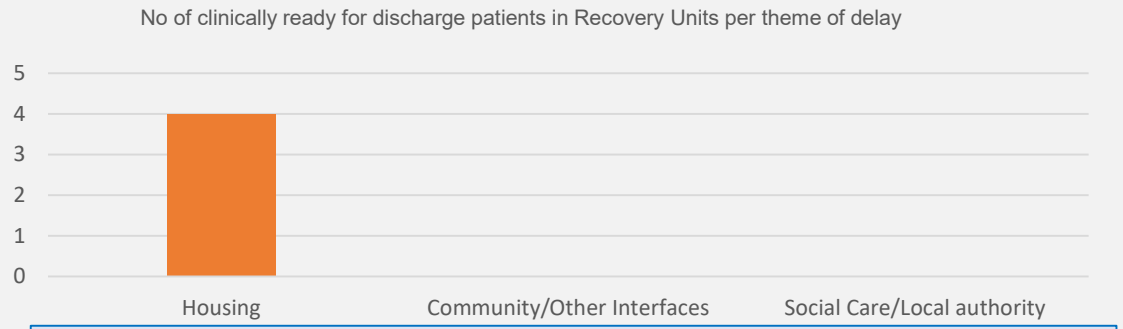
Headline Data - April 2024: Total of patients across WLH, CLH, Recovery, LD = 25 WLH = 14 CLH = 6 Recovery Units = 4 Learning Disability = **1**



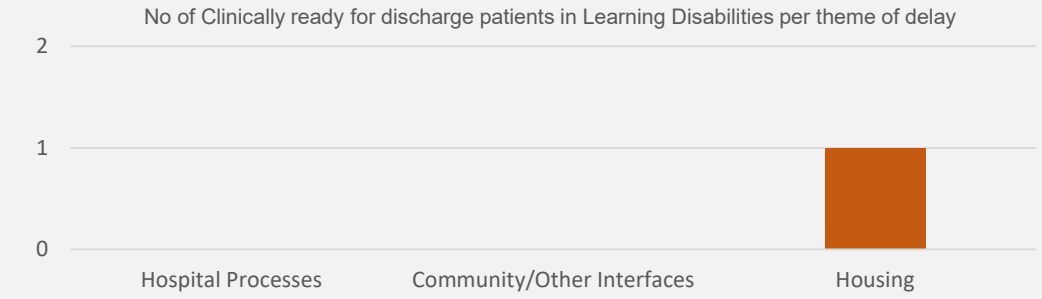
Themes related to delays:-
Community/Other Interfaces – lack of specialist health care provision.
Social Care/Local Authority – lack of social care provision to support assessment/discharge
Housing – homelessness, lack of appropriate supported accommodation



Themes related to delays:-
Hospital Processes – patient/family choice regarding care home placement
Community/Other Interfaces – awaiting care home placement (under care of hospital social work team)
Social Care/Local Authority – Awaiting care home through brokerage



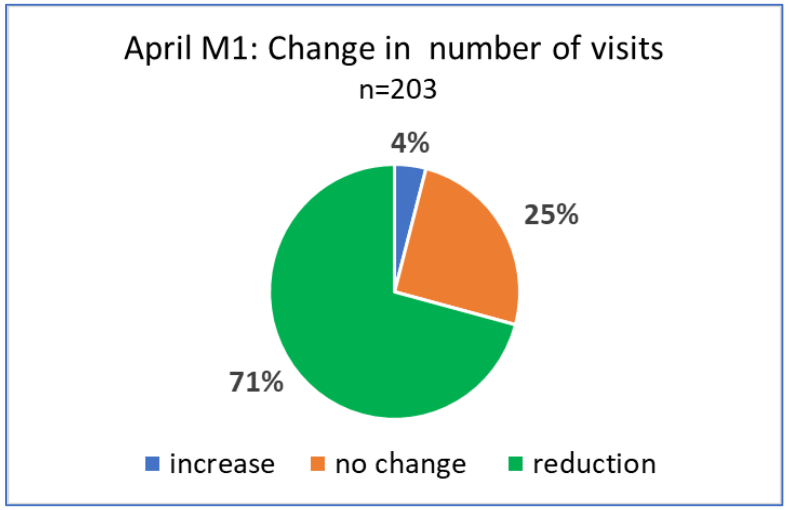
Themes related to delays:-
Community/Other Interfaces – awaiting public funding, await outcome of legal requirements e.g. awaiting mental capacity assessment

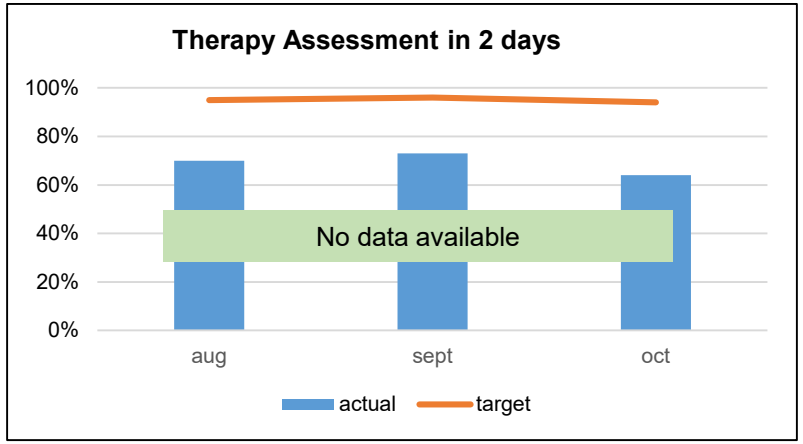


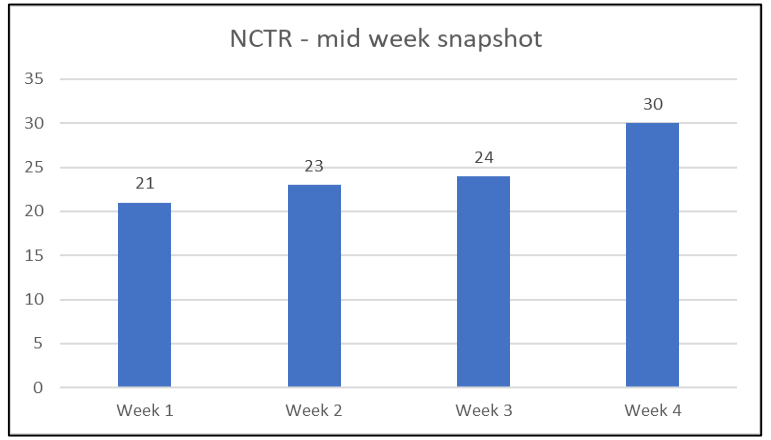
Themes related to delays:-
Lack of appropriate housing

Quality Dashboard

CQC DOMAIN - ARE SERVICES EFFECTIVE ? – Home First & Reablement April 24

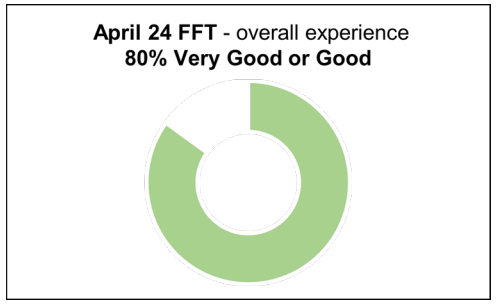






Newton Europe Effectiveness score	Feb	Mar	Apr
All cases closed in month	36.6%	38.7%	53.4%
Home First only	18.8%	42.6%	46.0%
HF + R & Reablement only	55.1%	61.6%	61.2%

	Feb	Mar	Apr
AvLoS (Mean)	21	22	24
AvLoS (Median)	17	18	20
Longest LoS	74	81	89
AvLoS - R only	30	26	33
AvLoS - HF only	14	16	15



Goal Plans	
Place holder	%

MyCaw Outcomes	
Placeholder	

Patient experience	
Compliments	14
Concerns	0
Compliments	0

Change in visits: The number of people with a reduction in visits improved from 60% in March to 71% this month
Therapy Assessment in 2 days: BI reporting for the service is still in development and is also dependent upon S1 changes
Friends and Family: There were 5 respondents in April.100% reported being involved in decisions about their care and treatment and that the service was delivered safely and protected their welfare.
Goal Plans: BI reporting for the service is still in development
MyCaw: The roll out of this outcome measure is dependent upon One Gloucestershire decisions
AvLoS & NE Effectiveness score - manual data extract. Outstanding Clinical Systems development work necessary before this can be accurately reported via BI

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

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

Quality Improvement Hub Support along the Improvement Lifecycle

1. New improvement opportunity/concept/idea

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

- = Dental Services – medical history form
- + SMI pathway
- + Therapy Review in mental health hospitals
- + Internationally Educated Nurses Project
- = IPS project
- = Inappropriate referrals into therapies (OT) from care homes
- =DBT outcomes
- +Supporting the testing and learning of acute care pathway in LD
- +Clinical System Team Model
- +Trauma Informed Care

2. Improvement idea scoping

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

- = QUITT - reducing inpatient smoking in MH
- = On Call medical staffing review at Charlton Lane Hospital
- + Improving number of infections for people with catheters in Gloucestershire community
- = (s) Psychological Services Research
- = (s) Homeward Assessment Team and ICT pathway
- = Improving Working Environment in Stroud Recovery Team
- = Gloves off - reducing PPE glove waste

3. Improvement idea initiated

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

- ↑ Reducing restrictive practice in Greyfriars, WLH
- + MH inpatient and urgent care flow pathway mapping
- = School nursing - Supporting Primary Schools with High Health Needs
- = (s) CYPS SLT Selective Mutism Project
- = Health checks for those with SMI
- = (s) Improve communication and liaison between maternity service and health visiting service
- = Improving access to ECT in WLH and community
- = School nursing mental health pathway and resources
- = (s) CYPS SLT waiting list
- = Temporary access card use for RIO by agency workers WLH
- = CYPS Public Health Liaison Nursing
- = Staff retention - itchy feet
- =(s) Retire and return HR project
- ↑ Improving the number of patients receiving their depots in primary care
- +Weight management in SMI project

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

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

- ↑ Increasing percentage of successful home visits in Home O2 Service
- +Improving self-referral form for MSK physiotherapy
- ↑ Sexual health specimen mis-labelling
- + Measuring effectiveness of new OATS service
- =(s) Paired ROMs compliance – CAMHS
- = (s) Creating a sustainable placement offer for AHP Students in GHC
- = (s) Improving mouthcare standards in inpatient areas
- = (s) Improving the nutritional pathway
- = Single handed personalised care approach
- = School nursing duty system
- = Substance misuse in CAMHS
- = (s) Leadership opportunities for AHP students
- = Reducing medication errors in CLH
- = Patchwork project Infection Prevention Control
- = Increasing the time between incidents of severe constipation needing a proactive response in CLH
- = Reducing restrictive practice in Dean Ward, WLH
- = Developing a FCP Occupational therapist in Primary Care
- + Stroud HV pre-SCAAS
- ↑ Toilet training - improving outcomes for children

5. Improvement idea sustained & implemented

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

- = Antipsychotic monitoring CAMHS
- ↑ (s) How do we provide services for lung cancer patients
- = Optimising flow in community hospitals

Directorate	No of Projects
Countywide	7
MH Hospitals and UC	14
PH Hospitals and UC	2
Adult MH/PH/LD Community	14
CYPs	11
Corporate	8
Total: 56	

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

Training data April 2024:
28 Silver – 0.6% workforce
571 Bronze (C2L) - 12.3% workforce
835 Pocket QI – 18% workforce

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

CQC DOMAIN - ARE SERVICES SAFE

Safe Staffing Inpatient data April 2024

Dean	15	2	37.5	5	0	0	0	0	0	0
Abbey	67.5	9	115	14	0	0	0	0	0	0
Priory	75	10	0	0	0	0	0	0	0	0
Kingsholm	0	0	0	0	0	0	0	0	0	0
Montpellier	80	10	15	2	0	0	0	0	0	0
Greyfriars	60	8	15	2	0	0	0	0	0	0
Willow	0	0	30	4	0	0	0	0	0	0
Chestnut	0	0	32.5	4	0	0	0	0	0	0
Mulberry	15	2	0	0	0	0	0	0	0	0
Laurel	142.5	19	30	4	0	0	0	0	0	0
Honeybourne	7.5	1	0	0	0	0	0	0	0	0
Berkeley House	15	2	140	17	0	0	0	0	0	0
Total In Hours/Exceptions	477.5	63	415	52	0	0	0	0	0	0

The Acting Director of NTQ reviews safe staffing reports every month ahead of submission to NHSE, this acts as a rolling review of safe staffing and is informing a detailed Trustwide safe staffing review in line with NHSE guidance. This paper was taken to Execs in Feb, plans are in place to develop the business case. We have cross referenced highest exceptions with patient safety and experience data. Laurel have reported the highest code 1 exception levels, followed by Priory ward and Montpellier. The Matrons report no adverse impact on care delivery or patient experience. Code 1 exceptions at Laurel House were attributable to HCA vacancies on early and late shifts. Code 2 exceptions at Berkeley were attributable to all shifts (RN and HCA) apart from RN nights.

Mental Health & LD			
Ward	**Average Fill Rate %**	**Sickness %**	**Vacancy %**
Dean Ward	129.38%	3.8	14.7
Abbey Ward	96.40%	13.5	-4.9
Priory Ward	148.72%	7.4	-2.8
Kingsholm Ward	108.91%	5.5	-0.4
Montpellier	98.92%	4.4	12.2
PICU Greyfriars Ward	131.39%	9.5	16.7
Willow Ward	100.30%	5.2	3.5
Chestnut Ward	99.80%	6.8	1.5
Mulberry Ward	109.83%	2.7	0.0
Laurel House	107.78%	9.9	0.8
Honeybourne Unit	103.06%	5.5	15.5
Berkeley House	99.88%	5.0	26.0
MHH Totals Avg (Apr 2024)	**106.65%**	**5.2**	**12.2**
Previous Month Totals	104.14%	6.6	9.4

Physical Health			
Ward	**Average Fill Rate %**	**Sickness %**	**Vacancy %**
Coln (Cirencester)	99.35%	7.0	9.9
Windrush (Cirencester)	99.23%	2.6	8.4
The Dilke	113.52%	In compilation	In compilation
FOD hospital	127.91%	In compilation	In compilation
North Cotswolds	97.57%	5.5	5.7
Cashes Green (Stroud)	95.73%	2.6	19.0
Jubilee (Stroud)	91.70%	7.0	13.5
Abbey View (Tewkesbury)	96.29%	6.2	4.3
Peak View (Vale)	98.02%	4.4	14.0
PHH Totals Avg (Apr 2024)	**102.15%**	**4.9**	**7.9**
Previous Month Totals	95.58%	5.8	13.0

NHSE Zero HCSW Vacancy Commitment Inc. bank – 3 month report	
Feb	82.84
Mar	74.45
Apri	70.59

Row Labels	FTE Budgeted	FTE Actual	FTE Variance
Grand Total	600.29	529.7	-70.59
327 E11850 LD Inpatients - Berkeley House	49	35.2	-13.8
327 D11602 Wotton Lawn- Dean Ward	12.5	7.2	-5.3
327 B11200 Ciren Hosp- Windrush Ward	17.06	12.47	-4.59
327 E11700 Stroud Hosp- Cashes Green Ward	17.52	13.53	-3.99
327 E11701 Stroud Hosp- Jubilee Ward	14.34	10.87	-3.47
327 B11201 Ciren Hosp- Coln Ward	20.16	16.76	-3.4
327 G12200 CAMHS MH Outreach	4.4	1	-3.4
327 D11604 Wotton Lawn- Greyfriars PICU	12.8	9.6	-3.2

NHSE Zero HCSW Vacancy Commitment: The workstream continues with 5 main strands - Attraction, Innovative Recruitment, Learning and Development, Recognition and Value and Retention. There are 27 people in recruitment pipeline and in April there were 11 new recruits and 7 leavers. The table opposite is a breakdown of the current HCSW vacancy hotspots.**IR/Recruitment**: 0 International Educated Nurses (IEN) arrived in April 2024 however there are a further 2 in the pipeline. 98 international colleagues have been recruited (from Jan 2021). The project continues to strive to recruit new staff and then to provide pastoral care to support recruits through the process and smooth their transition into employment. The views of the IR nurses are particularly welcomed in the most recent new staff survey results The Home Office has announced that employers will no longer need to renew their sponsorship licence from Saturday 6 April. This will apply to all routes, including study and work.

Appendix One

Safeguarding Information - April 2024

with you, for you

Summary
Trust Safeguarding Data

NHS
Gloucestershire Health and Care
NHS Foundation Trust

Summary information:

The Safeguarding Dashboard provides assurance that:

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

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

The Safeguarding Dashboard is presented in 3 sections:
1. Safeguarding Children Activity
2. Safeguarding Adults Activity
3. Safeguarding Training Compliance and Safeguarding Supervision

Highlights:

- The B7 children practitioner secondment post has been offered to two experienced nurses who currently work in MASH to job share, a twelve month secondment for MASH is currently being advertised.
- The new children's supervision model is being finalised ready to share with GHC practitioners to provide more choice and opportunities to access supervision.
- The Adult Safeguarding template was introduced to SystmOne on 22nd April, and work is continuing towards the introduction of the Children's template (scheduled for September 2024).
- Adult Safeguarding referral data will be obtained from the local authority from this month which will enable us to make meaningful progress towards risk 298 'Capturing and Quality Assuring Safeguarding Referrals made to the Local Authority'

Challenges/risks:
- The introduction of the Adult Safeguarding template to SystmOne is a positive, as is the promise of Safeguarding referral data from the local authority but there remains work to be done to turn this into measurable progress. Further work will be required to strengthen reporting across other clinical systems.
- Risk 109, recording of household members – while we are making steady progress with our review of this risk, we are some way off being able to effect front-line practice, however robust mitigations are in place.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

GHC - Safeguarding Dashboard 2024/25 Children's Safeguarding Data

	Q4	Apr-24	May-24	Jun-24	Additional Information
SAFEGUARDING ACTIVITY					
Advice Line Calls	161	41			Good use of the Safeguarding Advice Line continues for April.
Multi-Agency Request for Service Forms submitted to MASH	47	13			We are still unable to gain an accurate number of the MARFS completed by the Local Authority. This is a documented risk – 298. The children's safeguarding template which will be placed onto System One will go some way to address this however, we will still not known how many referrals are sent from mental health (RiO). We have been in contact with the Local Authority directly to try to gain this information and this work is still on going.
Number of Safeguarding Escalations	1	0			This information is currently obtained from our Safeguarding Advice Line data. It does not give an accurate picture of the number of escalations made to partner agencies. Further work is underway with Clinical Systems/Business Intelligence Teams to accurately identify the number of escalations made to partner agencies. Original target date of Nov 2023 has not been met however, work on the template has increased and good progress is being made.
CHILD DEATH NOTIFICATIONS					
Expected	1	1			Expected deaths are infants with known life limiting conditions or cases of extreme neonatal prematurity.
Unexpected	1	0			Gloucestershire Child Death Overview Process is followed for each unexpected death.
RAPID REVIEWS/LCSPR'S					
Number of Serious Incident notifications made by LA	0	0			There have been no Serious Incident Notifications.
Number of Rapid Reviews attended	0	0			There have been no Rapid Reviews
Number of LCSPR's in progress	1	0			There are currently no LCSPR underway.
MASH HEALTH TEAM ACTIVITY					
Children researched/info shared	4,125	1,498			
Adults researched/info shared	306	105			The introduction of the PDVM has placed significant pressure on the MASH team, increasing it's workload significantly, the MASH team are only researching adults where there is a clear need to do so. This is not a negative thing, in fact demonstrated appropriate information sharing.
MASH strategy meetings attended	79	10			The new strategy process within MASH is working well and MASH health have attended all.
Demographic information sharing	570	188			MASH health are frequently asked for demographic data from multiagency partners - this is due to referral data quality and incomplete data.
AUDITS					
Single Agency	3	2			The GHC internal safeguarding audit is due to be signed off and one audit about a young person is about to be started.
Multi-Agency sub group activity	6	2			MASH health attend an audit with MASH multiagency partners once a week to look at good practice and identify any areas of learning.
UNDER 18'S ADMISSIONS					
Number of under 18's admitted to Adult MH Wards	0	0			0 children admitted in April.
Number of under 18's assessed under S.136 of the MHA 83/07	5	2			2 children assessed in April.
OTHER WORKSTREAMS					
Allegations management – number of referrals to/from the LADO	0	0			0 referral made to the LADO in April.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

GHC - Safeguarding Dashboard 2024/25 Adults safeguarding Data	Q4	Apr-24	May-24	Jun-24	Additional Information
SAFEGUARDING ACTIVITY					
Contacts to GHC advice Line	202	75			Calls to the GHC advice line re. adult safeguarding enquiries - may or may not proceed to a referral to the Local Authority. Continued good use of the Advice Line.
Safeguarding Referrals made to GCC	25	10			This data is currently obtained from the Safeguarding Team Notifications Inbox. In addition to the work underway with Clinical Systems and Business Intelligence to identify mechanisms across our clinical systems which capture this data accurately, we are also shortly going to receive details of referrals direct from the local authority.
MH/LD Household Member Form Compliance	56%	57%			Linked to Risk 109 – recording of household members. Household & Family form completion (MH/ LD Current caseload) – added as new 2023/24 Performance indicator - Threshold: 100%
CASE REVIEWS					
New Safeguarding Adult Reviews/Domestic Homicide Reviews	1	2			2 new reviews in April.
Number of Reviews ongoing	36	13			Consistently high number of safeguarding reviews relating to adults (DHR's DARDR's and SARs). Several reviews are in the final stages of sign off.
Action Plans Ongoing	18	7			This includes single and multi agency action plans
MAPPA					
Level 2 Meetings Held	15	*	*	*	Data reported quarterly.
Level 2 Meetings Attended	15	*	*	*	Data reported quarterly.
Level 3 Meetings Held	4	*	*	*	Data reported quarterly.
Level 3 Meetings Attended	4	*	*	*	Data reported quarterly.
PREVENT					
Number of Prevent Referrals Made	0	0			0 Prevent concern raised with the police.
Information requests received & completed from Police/Channel	8	0			100% response to all police and channel panel information sharing requests, supportive effective planning and decision making.
MARAC					
Families screened/researched	507	169			Continued high level of MARAC activity. Minor variation in month.
No.of children open to MH Services	41	7			Number of children open to mental health service highlights the emotional impact of domestic abuse on children. Expected minor variation in month.
No.of victims open to MH Services	86	22			Highlights the link between the impact of domestic abuse on victims mental health. Expected minor variation in month.
No.of perpetrators open to MH Services	86	27			Identifies the number of perpetrators open to MH services. Expected minor variation in month.
Un-uploaded MARAC Action Plans	0	0			MARAC Action Plans are uploaded to clinical records of all related parties. They contain detail of the Domestic Abuse incident and agreed multi agency action plan.
DOLS - No. of referrals for standard authorisation from:					
Mental Health Services Total	10	5			Continued pattern of DOLS applications
Mental Health Services Authorised	1	0			4 are awaiting assessment and 1 closed (death).
Physical Health Services Total	62	22			Physical health urgent applications (not requiring LA authorisation)
Physical Health Services Authorised	0	0			21 awaiting assessment and 1 closed (1 death).
AUDITS					
Single Agency - Safeguarding Related	1	0			
Multi Agency Sub - Group Related	2	0			
OTHER WORKSTREAMS					
Allegations management - use of PiPoT guidance	1	0			0 new allegations relating to a member of GHC staff in April.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

GHC - Safeguarding Dashboard 2024/25 Training and Supervision Data

	Q4	Apr-24	May-24	Jun-24	Additional Information
TRAINING					
Level 1 – Induction	97%	97%			Consistent month on month compliance level
Level 2 – Think Family	89%	88%			Overall a minor variation in month
Level 3 – Multi-Agency Child Protection	87%	82%			Overall a minor variation in month. Training compliance review being undertaken to identify specific Teams to target to improve compliance.
Level 3 Adult Protection	87%	88%			Overall a minor variation in month. Training compliance review being undertaken to identify specific Teams to target to improve compliance.
Level 4 Adult Protection	90%	88%			Overall a minor variation in month. Training compliance review being undertaken to identify specific Teams to target to improve compliance.
PREVENT:					
Level 1	97%	98%			Continued high level of compliance with Level 1 Prevent Training
Level 2	94%	93%			Training compliance review being undertaken to identify specific Teams to target to improve compliance.
Level 3	97%	95%			Improving picture of compliance with Level 3 PREVENT training
MENTAL CAPACITY ACT:					
Level 1	96%	96%			New item to the dashboard. Level 1 MCA training is an online package, mandatory for all clinical staff who work with adults.
Level 2	71%	82%			New item to dashboard. During the Covid 19 Pandemic, Level 2 MCA training was put on hold. Training recommenced in July 2022.
Bespoke MCA Training	24	8			3x Mental Capacity Assessment/Best Interest Training, 2x DoLS Training, 2x Preceptorship MCA Training and 1x Level 2 MCA Training.
SAFEGUARDING SUPERVISION					
CHILDREN:					
Group Supervision Sessions	64	25			Clinical staff working with children need to attend this supervision 3x per year. 5 x sessions are delivered per week. Attendance at sessions is excellent, with a maximum of 8 participants per session. Feedback is sought and captured following every session via a Snap Survey – feedback helps to shape future sessions.
Group Supervision Compliance	59%	60%			In April 22 Safeguarding Group Supervision was added as an 'essential to role requirement' on staff Care to Learn Training Profiles. Operational line managers are responsible for monitoring individual staff member compliance. A piece of work is underway to breakdown compliance at team level for targeted work to address low compliance rates. Alongside this a scoping activity is underway to consider developing a new model of Safeguarding Supervision, development will include consultation with operational teams and a review of the different supervision needs of the target audience.
One to One Supervision Sessions	4	0			121 Supervision is available to all upon request. The uptake for 121 supervision is poor. Practitioners are made aware of this facility in their Group supervision sessions, in training and on the advice line.
ADULTS:					
Group Supervision Sessions	2	0			A new offer/model of Adult Safeguarding Supervision has been developed to address poor attendance and engagement with supervision. This is now beginning to be rolled out across teams and localities
Number of Staff who attended Supervision	11	0			
One to One Supervision Sessions	0	0			121 Supervision is available to all upon request.

Appendix Two
Organisational Quality Priorities 2023-2025

QUALITY PRIORITIES 2023-2025

Standard	**Tissue Viability (TVN) - with a focus on the recognition, reporting and clinical management of chronic wounds using quality improvement methodology and educational resources**
Performance	**Target** – To include recognition of the importance of prevention which has received wide coverage within clinical areas and to align workstreams with the national Wound Care Strategy.
Commentary	

Work Stream	Q1	Q2	Q3	Q4
Implementation of the National Wound Care Strategy (2 year initiative)	Link with TVN colleagues across nearby Community Trusts: Oxford & Bristol	Review learning content on NWCS platform	Scope strategy requirements	Set SMART objectives and achievable timelines
Refresh and evaluate the delivery of training education and support available.	Meet with TVN colleagues, noting current vacancy in CLWS/TVN Professional Lead role will delay progress.	HOP & Operational Lead for Wound and lower limb services to map current education offer from GHC. Identify any gaps; produce an action plan.	Allocate identified gaps in training to clinical specialists to progress. (Professional Lead role commencing mid Oct.)	Update Care to learn with new training. Ensure colleagues are aware of complete TV training offer using professional & operational managerial cascade routes. Publicise using the Trust's weekly communications update: Indigo.
Evaluate and produce business case for the implementation of a wound care app.	Contact companies approved by NWC strategy and identify the ap most suited to community care	Invite community based clinicians & TVN colleagues to review the ap & comment on its application to supporting patient care.	Identify a community nurse team to trial the use of the ap. Request a quote from the company. Identify business planning colleagues to progress on a "go no go basis "	Identify if funding is available to proceed on a go no go basis.
Evaluate and strengthen links with dietetic services other services both within GHC and across the system to improve holistic support to patients..	Identify colleagues within GHC	Meet with colleagues and invite comment on the production of improvement and collaboration work.	Participate in systemwide approach to wound care strategy led by ICB.	In partnership with system colleagues scope how to strengthen links to support improved patient care and outcomes

Lead NF

QUALITY PRIORITIES 2023-2025

Standard	**Tissue Viability (TVN) - with a focus on the recognition, reporting and clinical management of chronic wounds using quality improvement methodology and educational resources**	
Performance	**Target** – To include recognition of the importance of prevention which has received wide coverage within clinical areas and to align workstreams with the national Wound Care Strategy.	
Commentary	**Work Stream**	**H2 update**
	Implementation of the National Wound Care Strategy (2 year initiative)	Links with TVN colleagues across Gloucestershire (GHFT) and nearby Community Trusts have been established: (Oxford and Bristol). Across Gloucestershire colleagues from acute, community and commissioning are meeting regularly. TVN's and ICT Clinical Nursing leads are also sighted on this strategy which will continue to be shared across the Trust. Review of the latest guidance/standards published on the NWCSP website has been completed. Links to the NWCSP videos and training/learning resources have been shared and key messages fed back to clinicians.
	Refresh and evaluate the delivery of training education and support available.	A successful appointment to the Professional Lead for Tissue Viability was made in October. Discussion and initial agreement has been reached with colleagues to scope a countywide role out of a standardised risk assessment for pressure Ulcers (Purpose T). Resources to support organisations to do this is expected to be included with the NWCSP this year. A blended model of training is being formulated encompassing both Face to Face training and Webinars. Face to Face offers are available all around the county at multiple locations , not just in centralised training facilities, to enable more staff to be able to attend. Training materials are being developed and current material reviewed in line with the National Wound Care Strategy Programme.
	Evaluate and produce business case for the implementation of a wound care app.	Evaluation of Aps has taken place and the most suitable one has been identified as Healthy I.0. which been presented to and reviewed by clinicians. Colleagues from operations are in discussion with the company with next steps to prepare a business case and undertake trial when/if suitable funding is secured.
	Evaluate and strengthen links with dietetic services other services both within GHC and across the system to improve holistic support to patients.	Links have been established and colleagues from Dietetics have been approached to be involved and actively contribute to training offers, materials and policy. Colleagues have been invited to system meetings initially focused on inpatient CQUIN requirements around pressure ulcers. These meetings will be the vehicle to discuss and agree NWCSP implementation moving towards true system working.
Lead NF		

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

QUALITY PRIORITIES 2023-2025

Standard	**Dementia Education - with focus on Increasing staff awareness of dementia through training and education, to improve the care and support that is delivered to people living with dementia and their supporters across Gloucestershire.**
Performance	**Target** – To achieve all elements of each quarter by the end of year 2.

Commentary

Work Stream Plans	Q1	Q2	Q3	Q4
• **Training** • Establish the baseline for T1, T2 and T3 dementia training and Undertake evaluation of future requirements. • Plan and facilitate the implementation of Essential to Role Training at Charlton Lane Hospital, including plan profile and journey updates.	Scoping	• Gather baseline training data providing a breakdown across services / teams. • Identify training audience and agree training thresholds	• Q3 training data will be reported at the next ICS Dementia Training and Education Strategy Network (1st Feb) • Dementia Lead Lou from Tewkesbury COHO won an award at NHSE SWIPC Awards (CARE document)	• Q3 data to be reported to the ICS Dementia Training and Education Strategy Network.
• **Gloucestershire 5 Step approach.** • Progress across Community Hospitals.	Scoping	• Establish network with Training and Development Sisters across Community Hospital's and aim to share and evidence distribution of training resources. Add to GCC Dementia Education website for use across ICS. • Develop training targets	• Report training uptake of GHC staff via Care2Learn. • Train the Trainer delivered to T&D Sisters across COHO with plan and support in place by DET	• Ensure training module is uploaded to Care2Learn. • Report training uptake of GHC staff via Care2learn. • Report upon how many GHC staff the Training and Development Sisters have trained.
• **Patient /Carer Experience** • To establish and evaluate any themes and trends relating to dementia arising from complaints and compliments received via the Patient Experience Team and to ensure learning from these events is shared throughout the organisation.	Scoping		• To meet with Patient Experience Team in order to identify themes and trends from compliments and complaints and begin evaluation. • Complete evaluation and report on these findings via Improving Care Group, evaluate how these can feed into workstreams .	• Share learning
• **System working with GP practices** • Targeted work within GP practice staff to include ARRS roles around early onset dementia and identification.	Scoping	• Evaluate ARRS team training needs. • Develop education session along side EBE.	• Finalise education session with EBE and deliver with EBE. Consider session for social prescribers (non-GHC colleagues). Discuss best way to engage with GP's	• Develop GP session – (video resource – Webinar)
• **Communication** • Develop Comms plan with a profile of workstream to be on current agendas and team meetings	Scoping	• NA	• NA	• Update Complete comms and add to Bitesize

Lead	SSK

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

QUALITY PRIORITIES 2023-2025

Standard	**Dementia Education - with focus on Increasing staff awareness of dementia through training and education, to improve the care and support that is delivered to people living with dementia and their supporters across Gloucestershire.**
Performance	**Target** – To achieve all elements of each quarter by the end of year 2.

Commentary

Workstream	Detail Q4 Update	Next Steps
• **Training** • Establish the baseline for T1, T2 and T3 dementia training and Undertake evaluation of future requirements. • Plan and facilitate the implementation of Essential to Role Training at Charlton Lane Hospital, including plan profile and journey updates.	ICS Dementia Training and Education Quarterly report just under development and will be presented at the next network meeting (2nd May) Building up team of Dementia Link Workers and Dementia Leads on Willow Ward Charge Nurse on Willow Ward completing her Dementia Care Mapping (DCM) course to support Trust wide DCM plans SSK presenting at GHLL conference in June, to encourage more PHSE teachers to use the dementia resources across the county in schools No current significant increase in GHC colleagues completing Tier 1, 2 or 3 training.	Workstreams to continue into 24-25
• **Gloucestershire 5 Step approach.** • Progress across Community Hospitals.	This online resource is available on the GCC website. Colleagues across the ICS are directed there to complete. Currently seeking feedback from ICS on the session and how effective this is for colleagues Increase in staff completing Tier 2 and Tier 3 dementia training Currently reviewing the PLACE assessment for the dementia and disability domain and overall % has decreased this year First DCM session took place at Cirencester Community Hospital (5th April) and report currently underway (overall positive).	
• **Patient /Carer Experience** • To establish and evaluate any themes and trends relating to dementia arising from complaints and compliments received via the Patient Experience Team and to ensure learning from these events is shared throughout the organisation.	16 concerns raised to the Trust relating to a person living with dementia between April 2020 – September 2023 have been reviewed. These were made predominantly during the Pandemic and some of the concerns raised relate to families not being able to see their relative in hospital or appointments being cancelled due change in service delivery during that period. Some of the overarching themes relate to poor communication and daily assessment / input.	
• **System working with GP practices** • Targeted work within GP practice staff to include ARRS roles around early onset dementia and identification.	Primary Care Dementia Education Event currently in planning stage, will include local and national speakers. Plan to arrange and deliver dementia awareness sessions for the MH ARRS workers across surgeries, specifically focused on YOD. Gloucestershire Dementia Strategy should be published in January / February 2024. Session for MH ARRS work booked for quarter 2, particularly around young Onset Dementia. Education session developed and arranged for 15th May (during Dementia Action Week) for primary care facing staff. Targeted comms going out through ICB on Dementia Diagnosis Rate and highlighting need for this to be improved and how we can help.	
• **Communication** • Develop Comms plan with a profile of workstream to be on current agendas and team meetings	Ongoing reminders / promotion of dementia training that is available to colleagues across the trust. Dementia Action Week takes place on 13th - 18th May – this years theme is 'reducing your risk' and we would welcome guests at any of the events that we have planned. **ICS Dementia Action Week, 13th – 19th May - Plans for the week:** **Theme for the week –** Reducing your risk of getting dementia	

Lead	SSK

SAFE : QUALITY PRIORITIES 2023-2025	
Standard	**Falls prevention with a focus on reduction in medium to high harm falls based on 2021/22 data**
Performance	**Target** – an overall reduction in the number of medium and high harm falls within inpatient units.

Commentary	• The Trust wide Falls group ensures consistency of practice, and strong focus on evidence based falls prevention in all areas of GHC. The group is looking to produce and implement a framework with the ambition of:
	  • A reduction in the number, and impact of falls in both **community and inpatient** settings, (hence widening the reach of the indicator)
	  • Improving both staff **and patient awareness** of falls risks,
	  • Reduce the variation of practice in falls prevention.
	• The focus is to promote a culture in which falls prevention, risk assessments and interventions are everybody's business.

Lead	HW

Workstream - Plans	Q1	Q2	Q3	Q4
Community falls Establish a baseline for falls at home to measure improvements made. Inpatient Falls To produce a countywide Falls Reduction Action Plan for Inpatient Units	Scoping Scoping –Decision made to trial at CLH	Data gathering and process map to be produced. Roll out Falls reduction plan at CLH	Review data and depending on results, decide how and if these falls can be reduced Review data and plan. Share best practice with CoHo's to implement where appropriate Introduce an inpatient Falls Reduction Awareness Training programme for Inpatient Staff. Target 80%	Evaluation and plan of roll out Audit number of falls within inpatient units since introduction of action plan Audit number of staff who have attended Falls awareness training
Falls Policy Revise and refresh policy to meet NICE standards for both Community and Inpatient	Scoping	Draft policy to be produced and circulated to Trust Falls group for comment.	New Trust wide Policy to be ratified by GHC Policy Group. Undertake Roll out Trust wide and implement changes.	Audit compliance with revised policy.
Trust wide Inpatient falls leaflet to be produced.	Scoping	Draft version to be produced and circulated within Falls Group	New Falls Prevention Leaflet to be agreed and circulated to Inpatients Trust wide	Ask for staff/patient feedback on Leaflet, make changes if needed

SAFE : QUALITY PRIORITIES 2023-2025	
Standard	**Falls prevention with a focus on reduction in medium to high harm falls based on 2021/22 data**
Performance	**Target** – an overall reduction in the number of medium and high harm falls within inpatient units.

Commentary	• The Trust wide Falls group ensures consistency of practice, and strong focus on evidence based falls prevention in all areas of GHC. The group is looking to produce and implement a framework with the ambition of:
	  • A reduction in the number, and impact of falls in both **community and inpatient** settings, (hence widening the reach of the indicator)
	  • Improving both staff **and patient awareness** of falls risks,
	  • Reduce the variation of practice in falls prevention.
	• The focus is to promote a culture in which falls prevention, risk assessments and interventions are everybody's business.

Lead	HW

Workstream - Plans	H2 update
Community falls Establish a baseline for falls at home to measure improvements made. Inpatient Falls To produce a countywide Falls Reduction Action Plan for Inpatient Units	There were issues found with data collection with regard to falls at home as it is known that the majority of these type of falls are unrecorded and unknown to the Trust. The data may be held by ED or Ambulance Services (if they were in attendance) with regards to injurious falls, however, the majority of non-injurious falls at home will not be recorded. This prompted a change in approach and links were made with the Falls Assessment Education Service who provide a "Strong and Steady Service" to evaluate any alternative courses of action and the availability/coverage of the service. Successful trial undertaken at CLH with data/presentation available to demonstrate that there were lower numbers of injurious falls evidenced post initiative.
Falls Policy Revise and refresh policy to meet NICE standards for both Community and Inpatient	Falls policy has been refreshed and ratified and is compliant with NICE guidelines.
Trust wide Inpatient falls leaflet to be produced.	Leaflets have been produced and are available to inpatient units, community hospitals and doctors surgeries .with the ambition of reaching out to members of the community who may have experienced falls at home but are unknown to services.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

SAFE : QUALITY PRIORITIES 2023-2025

Standard	**End of Life Care (EoLC) – with a focus on patient centered decision, including the extent by which the patient, their carers and families, wish to be involved in the End of Life Care decisions.**				
Performance	**Target** – To be fully assured that patients, their carers and families, are being involved as much as they want to be in end of life care decisions. To Be fully assured that all appropriate staff are identified and have received essential to role training with systems in place for ongoing compliance and monitoring of training provision. To maximise training availability, and ensure identification of additional resource where required.				
	Quality Priority Plan	**Q1**	**Q2**	**Q3**	**Q4**
Commentary	**GHC EoLc priorities align with NICE Quality Standards for care at the end of life and NHSE personalised care approach. Our aim is to enable all our staff to be compassionate, confident and competent in delivering personalised end of life care in our hospitals and in the community.**	• Identify training needs baseline across the organisation – (Essential to Role) including which staff are trained to what level. • Identify targets • Devise training plan • Audits to evidence personalised care	• Evidence 90% or better attendance at Essential to Role Masterclass sessions • Identify the number/% of instances where care was/was not personalised (identified through Datix, concerns, compliments, case reviews, bereavement surveys)	• Evidence 90% or better attendance at Essential to Role Masterclass sessions • NICE QS144 (Care of Dying Adults in Last Few Days of Life) Audit on care at end of life for community and in-patients • Identify number/%of instances where care was/was not personalised (identified through Datix, concerns, compliments, case reviews, bereavement surveys)	• Evidence 90% or better attendance at Essential to Role Masterclass sessions • Number/% of instances where care was/was not personalised (identified through Datix, concerns, compliments, case reviews, bereavement surveys) • Undertake review of documentation (Shared Care Plan for Expected Last Few Days of Life/S1 template)
Lead	DW				

To be fully assured that patients, their carers and families, are being involved as much as they want to be in end of life care decisions.	H2 – Q4 NACEL Audit 2024 commenced, 20 case notes audited, results due July. H1 - NACEL 2023 Pilot Audit in Sept 2023 (20 case notes reviewed). Evidence of good compliance that patients, their carers and families are being involved in end of life care decisions as much as they wanted to be. H2 – Community EoL Audit results poor (53% overall) due to poor documentation. Action Plan with short, medium and long-term plans developed with community nurses. Immediate issue is to improve documentation and, to support, first assessment visits will now be 2 hours. H1 - Community Nursing Care at EoL Audit in October is being analysed currently. Community Hospital Bereavement Surveys to next of kin ask "During the last few days, how involved were you with the decisions about their care and treatment?" H2 – 24 surveys returned, 18 (75%) responded "As involved as I needed or wanted to be (only 4% wanted to be involved more). H1 – 19 surveys returned, 18 (95%) responded "As involved as I needed or wanted to be" Complaints raised. H2 – 0 complaints. H1 – 3 complaints. For a patient who died in the community there was a learning point around ensuring next of kin are as informed about care and decisions as the patient. Datix reported. H2 – 107 Datix (excl. falls and skin integrity) Work in Q3 successfully reduced the number of CHC fast-track applications that were declined. SCP review has been moved to 2024/25. H1 – 98 Datix (excl. falls and skin integrity). Communication and lack of accurate documentation about care at end of life are a common theme. There will be a review of Shared Care Plan and templates used to document end of life care on S1 and RIO n H2 to better capture personalised care at end of life	**Next steps - To re evaluate the training needs baseline and match to available resource/ increase resource.**
To Be fully assured that staff are identified and receive E2R training with systems in place for ongoing compliance monitoring.	A training needs baseline has been identified and 13 Masterclasses have been assigned as Essential to Role for certain staff groups. Work undertaken has shown that the trajectories for staff completing E2R training are not realistic or achievable during the 2 years expected in the End of Life Quality Priority. Further work is required to refine what is E2R and the End of Life Lead is looking at what the mandatory end of life training offer is in other NHS Trusts. The number of Masterclasses that are classed as E2R and/or staff groups needs to reduce and/or a different way of delivering the training needs to be introduced in order to deliver within the 2 years.	
To maximise training availability, and ensure identification of additional resource where required.	30 spaces are available at Masterclass (with the exception of Having Difficult Conversations which is face to face and 15 max). H2 – Q3 – 39% and Q4 – 50% of available Masterclass spaces were taken up. Overall H2 – 45% take-up of Masterclasses. H1 - Q1 – 69% and Q2 – 58% of available Masterclass spaces were taken up. Overall H1 64% take-up of Masterclasses. We allow these sessions to be overbooked on C2L as there are always No Shows on the day. (In total, Q1 – 125 staff trained, Q2 – 95 staff trained, Q3 – 70 staff trained, Q4 – 104 staff trained). We are increasing the number of places that can be overbooked for the next run of Masterclasses. Need identified for Difficult Conversations at End of Life training for call handlers/ward clerks in hospitals, ICT Referral Centres etc. H2 -2 sessions in October (20 attendees). H1 - 1 session in September (17 attendees). Training aimed at HCA's has been rolled out to Training and Development sisters at Community Hospitals, Charlton Lane Hospital and Professional Leads in ICT's for them to train HCA's in their hospitals/localities. H2 – 55 attendees. H1 - 47 attendees. 2 face to face Masterclasses regarding Dementia in EOL care have been arranged to encourage attendance in addition to 2 MS teams sessions	

QUALITY PRIORITIES 2023-2025	
Standard	**1. Increasing the visibility of the Friends and Family Test (FFT) feedback to staff and patients and their families** **2. Embedding the actions of the 2022 CQC Adult Community Mental Health Survey action plan**
Performance	**Target** **To deliver greater value for the data collected through patient surveys and demonstrate increased awareness of patient and carer feedback**

Commentary

Work Stream	Q1	Q2	Q3	Q4
Silver QI FFT project	Complete Silver QI training / Project scoping/ Development	Work with services to implement agreed changes and scoping further developments within remit of project. Draft FFT toolkit with QI project group	DELAYED: Finalise FFT toolkit and distribute to services – undertake implementation training with services where required (delayed to Q4) Progress work on the FFT toolkit	Finalise FFT toolkit and distribute to services – undertake implementation training with services where required. COMPLETE Evaluate project success and potential further development
CQC Community MH Survey Action Plan	Agree actions from 2022 MH Community Survey	Work with services to implement agreed actions	DELAYED: Evaluate action outcomes Interim update on 2022 survey actions	Evaluate action outcomes and share final report on 2022 survey/actions. Report on 2023 MH Community Survey and develop action plan (Q1 2024/25 in progress.

Lead KB

Action	Update Q3
Silver QI project	Community services are now using a variety of methods for collecting FFT responses, including electronic, paper and QR codes. This has resulted in an increased number of responses across most areas. Staff are encouraging patients to complete the FFT using these new methods. The project team have considered different options on how to share the outcomes more widely with staff and patients through the use of feedback boards in clinical settings and social media. New 'You said, we did' feedback boards have been installed in three services in Q4. An evaluation of their success will be undertaken in 6 months time in the way of feedback analysis.
CQC Community MH Survey Action Plan 2022	We asked both the services how we could best help the address the action areas and both agreed that a review of the information currently provided to patients via leaflets and websites would be a helpful start. **Crisis Care:** ensuring people have access to crisis care at the time of need and they receive the help they need when contacting the Crisis Team. Action: reviewing patient information regarding access to the service through a review of the Service specific website and patient information leaflet Q4 Update: Website – reviewed to make it simpler and include what people can expect when they call. External links to VCSE providers added. COMPLETE. Leaflet – reviewed to make it simple and clearer and changed some of the language. Q4 report on progress to Board. **Talking Therapies:** ensuring talking therapies is explained in an understandable way and service users are involved in decision making. Action: reviewing patient information regarding access to the service through a review of the Service specific website and patient information leaflet Q4 Update: Website – reviewed and updated to reflect the feedback provided by the survey group. COMPLETE. Leaflet – reviewed and changed the way in which the service was explained, including what it has to offer. IN PROGRESS. Leaflet has been completed but with Comms for printing, so not available to the public yet

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

QUALITY PRIORITIES 2023-2025

Standard	**Suicide Prevention – with a focus on incorporating the NHS Zero Suicide Initiative, developing strategies to improve awareness, support, and timely access to services.**
Performance	**Target** – To Reduce Restrictive Interventions within Mental Health & Learning Disability Inpatient Services.

Progress will be measured through the implementation of 4 key elements

	Priority	Q2 23/24	Q3 23/24	Q4 23/24	Q1 24/25	Q2 24/25	Q3 24/25	Q4 24/25
Commentary								
1.	MHC Project Reducing the incidence of reactive restrictive practice in inpatient mental health and learning disability services by 10% by March 2025	Refresh project objectives & support for participating wards	Engage with hospital/unit managers. Identify participating wards & establish new baseline.	Wards/units to run PDSA Cycles Data collection ongoing. Monitor impact via SPC charts	Wards/units to run PDSA Cycles Data collection ongoing. Monitor impact via SPC charts. Extend Project to March 2025	Wards/units to run PDSA Cycles Data collection ongoing. Monitor impact via SPC charts	Wards/units to run PDSA Cycles	Wards/units to run PDSA Cycles
2.	CQUIN 17 Achieving 90% of restrictive interventions in adult and older adult inpatient mental health settings recorded with all mandatory and required data fields completed.	Business Intelligence to develop the event lines that can be used to monitor the records reportable as Restrictive Interventions in the MHSDS.	Report on compliance, establish baseline & promote improvements in reporting where identified.	Monitor compliance – target 90%	IMPLEMENT NEXT PHASE OF CQUIN – details awaited			
3.	Reduce Blanket Restrictions	Agree template for identifying restrictions	Pilot draft template on identified ward.	Evaluate Pilot and agree process for spread.	Implement template across all wards WLH	Implement trust wide across relevant sites	Trust wide register of blanket restrictions to be established	Embed ongoing review of blanket restrictions throughout relevant GHC sites
4.	Develop Post Restraint Debrief Process	Map out current practice	Establish potential options and framework for debrief	Pilot draft model on identified ward	Evaluate Pilot	Draft Standard Operating Procedure (SOP) and consult	Approve & Implement SOP	Embed SOP in practice

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

QUALITY PRIORITIES 2023-2025			
Standard	**Suicide Prevention – with a focus on incorporating the NHS Zero Suicide Initiative, developing strategies to improve awareness, support, and timely access to services.**		
Performance	**Target** – To Reduce Restrictive Interventions within Mental Health & Learning Disability Inpatient Services.		
Commentary	Progress will be measured through the implementation of 4 key elements **Quarter 4 Updates**		
	1.	MHC Project Reducing the incidence of reactive restrictive practice in inpatient mental health and learning disability services by 10% by March 2025	Dean Ward identified as initial pilot site. Baseline data for Q1 & Q2 2023/24 unplanned restrictive interventions and rapid tranquillisation established including incidents by days of week, time of day, type of intervention, reason for intervention. Ward away day held in November 2023 supported by GHC QI Team, data reviewed and initial ideas for PDSA cycles discussed. Kata Boards to be used as visual reference and Life QI run charts set up. PDSA cycles were due to run from January 2024 with a focus on provision of therapeutic engagement/activity at the times of day where the most unplanned restrictive interventions occur (evenings). This, however, was not able to be progressed as the ward needed to focus on embedding the Self Harm Pathway. During Q1 2024/25 the team will consider the overlap between embedding the Self Harm Pathway and restraint reduction and establish if these can complement each other from a safety and quality perspective. Greyfriars PICU identified as next ward to engage with the project and 'set up' meeting held on 15/01/2024. Blanket restriction template confirmed as fit for purpose during Q4 2023/24 so will be utilised by Greyfriars throughout 2024/25.
	2.	CQUIN 17 Achieving 90% of restrictive interventions in adult and older adult inpatient mental health settings recorded with all mandatory and required data fields completed.	BI have established an indicator within the Performance Dashboard to broadly monitor this (N31 – Event ID 1073). However, more detailed development was required to actively progress phase 2 of the KPI portfolio development process. This did not occur during Q4 and BI are not progressing. Interrogation of the Datix System (post LFPSE configuration) did establish compliance data relating to mandatory data fields as follows: • 2443 restrictive intervention incidents 2023/24 took place in MH/LD units (including S136 suite). • MHS505 data was not fully completed on 685 of 2443 incidents, giving us a compliance percentage of **71.96%** The primary reason for non-compliance with MHS505 is failure to record whether post incident reviews took place (not recorded on 661 of 685 records where data for MHS505 not fully completed) • MHS515 data was not fully completed on 573 of 2443 incidents, giving us a compliance percentage of **76.54%** The primary reason for non-compliance with MHS515 was onset and offset times not being completed (not recorded on 535 of 573 records where data for MHS515 not fully completed) These aspects of non-compliance will a priority during 2024/25
	3.	Reduce Blanket Restrictions	Montpellier Unit have piloted the blanket restrictions template during Q3 focusing on identification of 2 restrictions. 1) Relating to items that patients have 'in possession' e.g. razors/lighters etc which must be returned for secure storage after use and 2) the unit garden being closed between midnight and 06:30hrs. These were piloted with input from service users. Feedback from use of the forms was evaluated during Q4 and the form was approved as being fit for purpose. Greyfriars PICU will focus on reduction of blanket restrictions as their restraint reduction project during 2024/25. Other wards will commence establishing a log of blanket restrictions in place.
	4.	Develop Post Restraint Debrief Process	Current practice, regarding both patient and staff debrief and support mechanisms, has been mapped out. Following an incident three broad elements have been identified. 1) Ward based support (includes access to the individual MDT professions, managerial and clinical supervision, and handovers). 2) Support external to the ward (includes advocacy, PALS, PCET, matron, investigative processes, Working Well, Freedom to Speak Up, Let's Talk and Behaviour Support and Training Team). 3) Reporting and recording (RiO, Datix and investigative process where indicated). A Standard Operating Procedure remains in the process of development ahead of being piloted. It is envisaged that this will be ready to trial by Q2 2024/25
	Gordon Benson, Quality Lead (Mortality, Engagement & Development)		

QUALITY PRIORITIES 2023-2025

Standard	**Suicide Prevention– with a focus on incorporating the NHS Zero Suicide Initiative, developing strategies to improve awareness, support, and timely access to services.**
Performance	**Target** – To Improve The Safety Of Mental Health Services Through Implementing Measures Known to Reduce Patient Suicide

Commentary

The National Confidential Inquiry into Suicide & Safety In Mental Health (NCISH) identifies 10 key elements for safer care of patients

- NCISH have produced a toolkit (revised March 23) intended to be used as a basis for annual self-assessment by mental health care providers. NCISH | Resources (manchester.ac.uk)
- The Trust will review its practice and performance against each element of the self-assessment toolkit and implement improvements where there is an identified need.
- This activity will be supported by findings from ongoing activity such as ligature audits, the clinical audit programme, KPIs and feedback from service users, carers and families.

	Priority	Q2 23/24	Q3 23/24	Q4 23/24	Q1 24/25	Q2 24/25	Q3 24/25	Q4 24/25
5.	Suicide Prevention Implementation of the NCISH self-audit Toolkit for mental health services.	Identify Leads for each of the 10 key elements for safer care	Leads to complete the self-audit	Develop and implement action plan where improvements have been identified.	Establish compliance with action plans.	Annual cycle of re-audit against the toolkit to recommence.	Develop and implement action plan where improvements have been identified.	Establish compliance with action plans.

Lead	Gordon Benson, Quality Lead (Mortality, Engagement & Development)

Update Q4 progress

Implementation of the NCISH self-audit Toolkit for mental health services.	Self-assessment against the 10 key elements of the suicide prevention toolkit was completed during 2023/24. GHC has the majority of systems and processes in place and the recommended operational configuration. The areas for focus in 2024/25 include staff turnover, family involvement in learning lessons, and multi-agency working by CAMHS health and social care, specialist drug and alcohol services and services for self-harm. The Safety Scorecard compiled by NCISH in November 2023 identified that the suicide rate for people in contact with GHC secondary mental health services was **3.72** (per 10,000 people under mental health care) compared to the national median of **4.83.** This benchmark can be viewed positively notwithstanding our aspiration to achieve the lowest possible rate.

QUALITY PRIORITIES 2023-2025

Standard	**Learning disabilities – with a focus on developing a consistent approach to training and delivering *trauma informed* Positive Behavioral Support (PBS) Plans in line with National Learning Disability Improvement Standards. This includes training all learning disability staff in PBS by April 2025.**
Performance	**Target** – To **train all GHC Learning Disability staff in PBS by April 2025.**

Commentary

Workstream Plans	Q1	Q2	Q3	Q4
• Develop training matrix to identify the baseline no of staff who require a consistent approach to training.	• Scoping	• Establish and report upon the identified staff numbers who require training at team level. • Develop training plan		
• Develop a bespoke Trauma Informed Positive Behaviour Support Training Pack (TIPBSTP) to form core foundation of the delivery of this programme.	• Scoping	• Collaboratively produce training pack.	• Training pack to be available .	
• Deliver Trauma Informed Positive Behaviour Support Training to ALL staff working in learning disability services			• Pilot training pack	• Commence delivery of training

Lead KA

Q3 Progress Update

Matrix and Training Pack/day	A comprehensive training pack is now available, having been piloted both internally and externally with a group of local Positive Behaviour Support (PBS) practitioners. The training day covers an introduction to PBS and the role that staff within our different services play in promoting and delivering the approach. It also provides an overview of trauma informed care, sharing both the evidence base and also the principles that underpin trauma informed practice. It ends by bringing the two together, encouraging staff to fully embed trauma informed approaches within all of their PBS work. We have run one training session and now have dates booked until March 2025. This includes over 50 staff from both community and inpatient settings, offering mixed sessions across the community teams to encourage multi-disciplinary discussion and networking across teams. There are smaller, more focussed, training days for staff working at Berkeley House to allow time for more patient-specific discussion in order to increase awareness of the unique needs of each individual. The Berkeley House training days will initially target staff who have not yet received formal PBS training and the community days will be open access, with the aim of reaching all staff across all services. Work is currently ongoing regarding the identification / development of an evaluation tool to monitor the impact this training will hopefully have on practice.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

QUALITY PRIORITIES 2023-2025

Narrative	**The KPI will be further enhanced by the continuation of the separate Oliver McGowan Training with the ambition that all staff will have an increased awareness of the unique needs of people with a learning disability and autistic people, with a focus on reasonable adjustments, diagnostic overshadowing and tackling health inequalities with the baseline from 2022-23 being evaluated and increases delivered.**
Performance	**Target** – To **continue the roll out of the Oliver McGowan Mandatory Training in Learning Disabilities and Autism across the Trust and monitoring it's impact.**

Commentary

Workstream Plans	Q1	Q2	Q3	Q4
• Tier One of The Oliver McGowan Mandatory Training package co-designed by GHC, Inclusion Gloucestershire and Family Partnership Solutions in Gloucestershire was chosen last year to be the national training package to be s rolled out nationally. • Plan further roll out organisationally at tier 1 and 2 with the ambition of improving last years figures of 82.15% T1 and 355 members of staff T2.	• Re-commence delivery of T1 webinars • ICB to lead on training needs analysis	• ICB to lead on developing work plan for rollout of the training • Review T2 materials and train trainers for T2. • T1 webinars available	• Pilot T2 locally • T1 webinars available	• T1 webinars and T2 training available across the Trust & ICB
• Develop measures to assess impact of training		Report upon levels of training achieved H2	• Collaboratively Identify and document measures to assess direct and indirect outcomes from training that can be shared.	• Establish and report upon the effectiveness of Oliver McGowan Mandatory Training.

Lead

H2 Update

Tier One Training	Tier 1 Webinars, facilitated by Inclusion Gloucestershire (IG), are now available to staff across Gloucestershire for staff working in both health and social care. The capacity of IG to deliver training is restricted by the number of Experts with Lived Experience available to help co-deliver the Webinars, but IG continues to recruit and train people so numbers are increasing. They have also recruited a Training Co-Ordinator who is overseeing this training which is helping to improve the booking procedures. There are currently 8 webinars being delivered each month, with 30 places available on each course, although there are often a number of people who do not attend the training. Work is still underway to assess the total number of staff across the ICS who need training for Tier 1 and to ensure all organisations have fair access to the finite number of places available.
Roll out	GHC has trained nine facilitating trainers (mostly staff from within GHC learning disability services) as well as appointing a half-time, fixed term trainer dedicated to Tier 2 delivery. Tier 2 training sessions started in March 2024 and dates are currently planned through to August 2024. There are currently two Tier 2 training days being offer each month although the hope is to be able to increase this to one every month, when possible. We are still awaiting guidance from the national steering group with regard to how the training will be evaluated at a national level. However, we are conducting local evaluation and the feedback has been encouraging. Positives include: Informative and engaging content: Personal experiences and interactive sessions appreciated: Knowledgeable and well-delivered by facilitators. Areas for Improvement: Length and repetition led to loss of concentration for some: Need for more tailored content based on prior experience: More interactive activities, especially in the afternoon: Examples more relevant across different settings. Here's just one quote: "I really like this training because its not just theory we get videos in between and group discussions. Its really nice."

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

SAFE : QUALITY PRIORITIES 2023-2025

Standard	**Children's services – with a focus on the implementation of the SEND and alternative provision improvement plan.**				
Performance	**Target** – To improve the outcomes and experiences of children with SEND by developing system relationships and the knowledge and skills of healthcare staff supporting these children and their families.				
Commentary	**Quality Priority Plan**	**Q1**	**Q2**	**Q3**	**Q4**
	Digital reporting Implement performance reporting of SEND related data to inform service provision by reviewing the SystmOne modules and RiO data capturing capabilities by 1st October 2023	• Take a proposal/request paper to the relevant clinical system working group, highlighting the needs and the recording/ reporting capabilities required. • To have an agreed plan to develop digital reporting for SEND.	• Work with CST to build recording capability within the clinical systems.	• Work with BI to ensure data flows through the data warehouse and performance reports and dashboards can be developed.	• To have robust reporting capability that demonstrates activity, demand and compliance against statutory EHCP timeframes.
	Training Develop a SEND Training Assurance Framework by 1st April 2024 to enhance knowledge and understanding of the SEND process focusing on inclusion co-production, participation, engagement, personalisation and advocacy. This will include CPD opportunities for all patient facing staff in CYPS to complete the Council for Disabled Children SEND Basic Awareness E-Learning Level 1 and Level 2.	• Work with the Learning & Development Team to get SEND Basic Awareness Training Levels 1 & 2 added to Care2Learn. • Early adopters in CYPS leadership to start completing training to ensure it works.	• For all CYPS staff to have completed Level 1 & 2 SEND Basic Awareness Training on Care2Learn. This training is delivered by the Council for Disabled Children (CDC).	• SEND Leads and Training Team to develop EHCP Contents Awareness Training that is informed by the outcome of the audits.	• To have a SEND Training Assurance Framework ratified by CYPS Governance forums by April 2024.
	Feedback Complete survey of CYP who have transitioned to adult care in order to improve the experiences of young people and inform future practice. This will include 3 patient cohorts (MH/PH and LD)and their carer/family's.	• Scope engagement opportunities with service users and young people with SEND to better understand needs, hear their voices and coproduce development work.	• SEND Leads to engage with the Engagement Officer for Future Me Gloucestershire (GCC). • SEND Leads to join the ICB-led Transition to Adulthood group that is reviewing transition processes, tools and frameworks across health services and the wider system.	• SEND Leads to join Future Me Glos forums to work alongside young people.	• Work with Communications team to develop transition surveys that can be shared with parent/ carers and young people to understand their experience and quality of transition. • Work with the Young Adults Team and Adult services to share this survey with young people and families who have recently transitioned from children's services to adulthood.
	Electronic EHCP Portal For all new referrals received through the electronic portal to be actioned electronically in the portal by 1st August 2023 in CYPS Physical health services, and by 1st January 2024 for CYPS Mental Health Services.	• SEND Leads to work with the Portal development team to get health services set up on the new platform. • Offer teaching and training for CYPS staff on how to use the portal.	• All CYPS PH services to be using the EHCP portal by the end of Q1.	• CAMHS and LD Services to prepare to use the EHCP portal – set up, training sessions and testing.	• For all CYPS Services will be using the EHCP portal.

Q4 Updates (Year 1)

Gloucestershire Health and Care NHS Foundation Trust

Digital Reporting Q4 Update	**Visibility of SEND**: • EHCP High Priority Reminders are now being added to SystmOne for all children and young people with a new confirmed EHCP. The SOP for this has been agreed at governance forums. **Next steps:** Review reporting for new process. Once reporting has been quality assured, work will commence to share the SOP with all CYPS staff so EHCP reminders can be added to all records of CYPs with a EHCP. This will inform demand and capacity planning, evaluation of referral trends and distribution of SEND across the services. • The Health Visitors continue to use the Purple Square icon for children with SEN. This is reportable and is shared with GCC. This figure informs resource planning in early years. • There are no options for these to be used on RiO. **Next steps**: The CAMHS/ LD SEND Lead will pick up discussion with Clinical Systems about options available on this system. **SEND Performance:** • SEND activity on SystmOne and on RiO cannot be reported upon within specialist services because it is included in holistic delivery and not able to be differentiated. • There is no way of reporting via the clinical systems whether EHCP assessments are completed and returned within statutory timeframes. **Next Steps:** The EHCP Portal is now in use across all agencies and it is hoped that this will provide rich data around assessment timelines. It is noted, however, that there are still issues with this platform and it is not yet fit for purpose. • New SEND Advisor roles are being established in the School Nursing Service. They will provide assessment and recommendations for CYPs not known to specialist health services as part of the EHCP assessment process. **Next Steps:** When this service is operational, there will be record and reporting for SEND assessment timeliness, as well as activity. **SEND Demand:** • EHCP demand is captured manually across CYPS and provides an indication of demand trends. • Tribunal demand is provided by the GHC legal team – there has been a significant increase in EHCP tribunals over the last 2 years. This reflects the national picture. RAG at end of Yr 1 - Amber - some elements have progressed, but further development is required across all areas to provide a satisfactory position.
Training Q4 Update	**GHC SEND Training:** • SEND Basic Awareness Training Level 1 - 62% compliance across CYPS. • SEND Basic Awareness Training Level 2 - 77% compliance across CYPS. It is worth noting that is ongoing data quality issues with the compliance reporting, with many staff groups reporting completion of the training, but this is not pulling through on the reporting system. The training team continue to support with reporting as CYPS strive towards improved compliance across the directorate. **Next Steps:** Establish reporting for adult services supporting young adults with SEND, including CLDT. • SEND Leads in GHC attend external training provided by the wider system, Council for Disabled Children and SEND Networks. **GHC EHCP Training:** • The EHCP handbook has not been produced yet due to operational pressures in all areas, but CYPS have now commissioned a SEND Handbook to be produced - as part of this there will be EHCP information and action cards for all staff. It is anticipated that this handbook will be completed by end Q2 24/25. • Once the handbook is available the SEND Leads for PH and MH/ LD Services will launch and share it across the CYPS directorate and offer 'SEND Training Clinics' for staff. **GHC Tribunal Training:** The GHC Legal Team offer tribunal readiness and information training to leads and managers who may be required to attend hearings. RAG – Green for year one. A whole SEND Training Assurance Framework has not yet been established, but with the fundamental training offers are now in place across CYPS, so there is opportunity to produce this in year 2.
Feedback Q4 Update	**Service Users/ Experts:** • SEND Leads are working with the Engagement Officer for Future Me Glos at the County Council - they are attending some forums with young people with SEND to capture their voice and hear their thoughts and contributions. • **Next Steps**: SEND Leads hope to work with Experts by Experience to audit the quality of EHCPs health assessment and reports in 24/25. **System Partners:** • The Head of Service for CYPs Learning Disabilities attends and supports the Preparing for Adulthood working group. • The partnership's Preparing for Adulthood strategy is now outdated and requires review – this will be driven by the ICB. It was noted though that data to inform the review of the strategy is limited across all areas. **GHC:** • A CYPS Directorate PfA group has been established and will plans to work in work in partnership with the ICB to review the PfA strategy. The group also recognises that there is a requirement for GHC to review its internal transition processes, tools and outcomes for service users – this is a large scale piece of work and may require additional resource to complete alongside other SEND priorities. • The Transition of Care Policy requires review.
EHCP Portal Q4 Update	CYPS Physical Health Services all use the EHCP Portal. However, there have been numerous and ongoing issues with the Portal itself, which have hindered uptake. Health services are still receiving paper and electronic referrals, as well as portal referrals. GHC have produced a SBAR which was shared with the ICB and EHCP Portal team outlining the ongoing issues so these can be addressed. 50 Due to the ongoing portal issues, CAMHS and LD services have been advised by the ICB DCO not to start using the portal until these have been resolved.

QUALITY PRIORITIES 2023-2025

Standard	**Embedding learning following patient safety incidents – with a focus on the implementation of the Patient Safety Incident Response Framework**				
Performance	**Target** – To develop a framework which details how the trust will support the development of clear, measurable actions from areas for improvement, how we will schedule longer-term monitoring, define markers of benefit for patients/service users, families and carers and disseminate learning across services and professions.				
Commentary: The approach of the PSIRF seeks to shift our response away from individuals and root cause analysis to exploring and understanding systemic issues. **There will be renewed focus upon the impact of and the part that psychological safety plays in learning from incidents in enabling staff to speak up, participate and learn.**	**Workstream Actions**	**Q1**	**Q2**	**Q3**	**Q4**
	Review Incident Reporting Policy	Scoping	Policy draft	Policy published on Intranet	
	Development and Implementation of Learning Assurance Framework	Scoping	Draft Framework to be produced which details how the trust will support the development of clear, measurable actions from areas for improvement, how we will schedule longer-term monitoring, define markers of benefit for patients/service users, families and carers and disseminate learning across services and professions.	The framework will be completed and agreed in Q3 .	Implementation of framework
	Fidelity Testing	Scoping	Fidelity testing template , process and tracker to be developed.	Review of results and learning	
	Civility saves lives.	This is an Ongoing workstream: Harm from disrespect has been identified as a key element in patient safety efforts and fostering a culture of civility and respect within our Trust further supports the delivery of our values and behaviours. Civility and respect sit behind a positive workplace culture and our Trust values. **Civility** describes a behaviour: treating someone politely or with courtesy. **Respect** involves valuing other people's experience and feelings. The two are closely linked, as people show their respect for someone by acting with civility. In health and care, civility and respect involve supporting, valuing and respecting each other for what we do and showing kindness, compassion and professionalism towards our colleagues, patients and service users. It also means ensuring that people are civil in their digital communications, avoiding sharp, harsh or insulting comments on email or social media. Civility saves lives is intended to be entwined into all that we do and we have a four module course available on C2L which we aim to report uptake of over the 2 years.			
Lead PBM and SP					

H2 Update	
LAF Framework and Incidents Policy and fidelity Testing **Fidelity Testing:**	The Learning Assurance Team has continued to explore channels for dissemination of learning and this is now done via various means, such as learning videos, sharing of information on the Patient Safety and Quality noticeboards, via the Patient Safety Bulletin 'Insight', site visits alongside the Quality Managers, monthly Quality meetings with hospital matrons, attendance at governance / directorate meetings, monthly meetings with the ICB and joint working meetings. Monthly slides are now produced for each directorate which summarise incidents and the sharing of learning. We have also started developing safety actions with clinical teams following 'After Action Reviews' (AAR's). Fidelity Testing is now imbedded in quality Culture and occurring on a routine basis with positive feedback received.
Civility Saves Lives	Ongoing workstream, highlights in H2 include webinars from external prominent speakers which were well attended and received

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

Standard	**Carers –** with a focus on achieving and maintaining the Triangle of Care Stage 3 accreditation.
Performance	**Target** – To revalidate the organisational Stage 2 accreditation in 2023/24 and then achieve Stage 3 accreditation in 2024/25.
Commentary	• As a Trust we need to feel confident that the principles held within the Triangle of Care mirror our Organisational values and beliefs, and should be undertaken and embraced by teams as part of their core activities forming business as usual. Prior to merger, 2gether NHS Foundation Trust was accredited at Level 2 having established Triangle of Care within both the Mental Health inpatient and community teams, and therefore prior to undertaking assessment enabling our journey to Level 3 to progress we are required to demonstrate that the merged organisation retains and can evidence competency with each requirement of the accreditation.
Lead	CN

QUALITY PRIORITIES 2023-2025

Workstream	Q1	Q2	Q3	Q4
Mission and vison Develop and launch an Organisational plan that communicates the mission and vision of the project.	Scoping	Work to re-engage connections with all Mental Health and Learning Disability Community and Inpatient teams, to review their position within the Triangle of Care Self Assessments and develop plans to progress RAG ratings as a result	Work continuing to re-engage remainder of all Mental Health and Learning Disability Community and Inpatient teams who have yet to review their position with Triangle of Care Self Assessments and to define their progress accordingly	Work to finalise engagement with the remaining teams within Mental Health and Learning Disability Community and Inpatient teams who have yet to undertake or complete a review of their position with Triangle of Care Self Assessments
Mapping Develop a map of all teams and establish their current compliance status with level 2 requirements by using a self assessment methodology.	Scoping	Development of a matrix map to begin detailing the Trusts current position with teams self assessment within the Triangle of Care covering all Mental Health, Learning Disability Community and Inpatient teams	Continuing progressing the matrix detailing all teams self assessment compliance with Triangle of Care	Work to finalise the self assessments within all MH & LD teams and to have this detailed within the matrix thus providing clear and succinct position within all MH & LD inpatient and community teams
Engagement Engage with stakeholders	Scoping	Engagement with teams and carer champions to work towards completion of the Triangle of Care self assessment. Carer Ambassador undertakes work alongside to support teams	To continue process and encourage Team Managers and Carer Champions to advance any remedial work required to positively progress the RAG ratings within the Self assessment	Trust is assured that 80% of its MH and LD teams (both community and inpatient) are complaint with the Triangle of Care Self assessment process and teams remain positively engaged to continue to make progress within their RAG ratings
Planning Develop plan on a page and project control methodology.	Scoping	Team Managers and Carer Champions are enabled to become positively engaged within this process	Evidence that Team Managers and Carer Champions are enabled to become constructively engaged with the Carer Ambassador to positively progress the Triangle of Care self assessment	Teams are able to successfully take ownership of their onward progression within the Triangle of Care self assessment process

ToC 2 star status is granted for our Mental Health inpatient and community teams and crisis teams.
All these teams need onward annual review of their Self-assessment and annual reporting. This is scrutinised by the Carers Trust to ensure progressive implementation of ToC across our MH teams and recommendations are made to continue best practice.
The journey for physical heath is in its infancy but when we have introduced this across all PH sites (the 2 year plan) and they are conducting their self-assessments, then we will have all Trust teams on board. We will then be in the position where we can formally apply for 3rd and final star status to be granted. Again the Carers Trust will scrutinise the overall report submitted (based upon all the individual teams reporting), review the findings and make recommendations accordingly.

REPORT TO: **TRUST BOARD PUBLIC SESSION – 30th MAY 2024**

PRESENTED BY: Graham Russell, Chair

AUTHOR: Graham Russell, Chair

SUBJECT: **REPORT FROM THE CHAIR**

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

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

The purpose of this report is to

Update the Board and members of the public on my thoughts moving forward and my activities and those of the Non-Executive Directors to demonstrate the processes we have in place to inform our scrutiny and challenge of the Executive and support effective Board working.

Recommendations and decisions required

The Trust Board is asked to:

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

Executive summary

As my first report as Chair, I considered that it would be useful to set out some of my thoughts moving forward based upon a number of conversations and some respectful listening with colleagues, partners, and service users.

Risks associated with meeting the Trust's values
None.

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

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

Appendices:	**Appendix 1** Non-Executive Director Summary of Activity March and April 2024

Report authorised by: Graham Russell	**Title:** Chair

REPORT FROM THE CHAIR

1.0 INTRODUCTION AND PURPOSE

In my first few weeks as Chair, I have been out and about meeting colleagues and service users. I have also met with stakeholders and partner organisations and these are included in the appendix of visits and meetings.

Given that this is my first report as Chair I considered that it would be useful to set out some of my thoughts moving forward based upon a number of conversations and some respectful listening with colleagues, partners and service users.

2.0 THOUGHTS MOVING FORWARD

The values of the organisation provide us with the platform to be ambitious and impactful both for the benefit of the people and communities we serve and also for all of us in the Trust. We are a well performing Trust. We can take the energy from that position to continue to improve and innovate.

Clearly the Trust has a forward Strategy and an Annual Business Plan and so my intention would be to bring emphasis and renewed focus to what we are already committed to and passionate about providing.

- Since the formation of the Trust the Board has seen little change in its membership. We are now about to enter a period during which we shall welcome 3 new Non-Executives and 3 new Executives over a 6-month period. This is significant change for any team and will bring new experience, insights, and perspectives to the Board which is exciting. That said we need to ensure that we place a real emphasis upon building the new Board team - getting to know each other and valuing the contribution which each Board member can make.

- Be well led and have really effective Governance. The role of Governors is the democratic foundation for the Trust. We need to ensure that Governors are enabled to be a key agent in the way in which we both engage with our constituencies and also improve through the benefit of useful insights and also the challenge from our members and communities.

- From my early conversations there is also an appetite to focus the Board level discussions and decisions on what really matters. How we assure the performance and quality of our services is of particular importance. Our data analytics are taking significant steps forward towards helping us to even better understand how we are performing and how we can be better.

- Equity, Equality, Diversity and Inclusion are fundamental in everything we do together as colleagues and how we serve our service users and communities. I would like the Trust to challenge itself to be the best in terms of how we understand, regard, respect, and benefit from the diversity in the Trust which is one of our real strengths. The Board itself needs to walk the talk.

- The Trust is a great place to work as demonstrated, amongst other ways, by our staff surveys. The challenge now is to continue improving. We need every insight, every idea, every concern, every voice from every colleague to be listened to and heard in order to help make that be the case.

- Lived experience provides invaluable insights and perspective and is already an important dynamic in how we co-design many of our services. The opportunity now is for the co-design of both policy and practice with those with lived experience to be our norm. Let us also be ambitious in how we employ more people with lived experience.

- We are committed to tackling health inequalities. But improving deep seated inequalities is not easy nor is it a quick fix. Neither is tackling inequalities a programme nor an initiative – rather it should be part of everything we do and how we do it. As our evidence base gets more useful so shall we be able to focus more clearly on what we can and must do in order to provide effective health and care for those more disadvantaged individuals and communities.

- There are further opportunities to develop the ways in which we provide services in the local community and at a neighbourhood level. Alongside inter alia primary care, social services, and the voluntary sector we are, and must continue to be, part of transforming how we integrate the many services into a personalised offer which meet the needs of the individual. We merged 2g and Gloucestershire Care Services Trusts in order to bring physical and mental health together. With that experience we are well placed to be an active and driven player alongside other health and care providers through collaboration, partnering, and alliance building – our value of working together.

- Increasingly we are operating in the One Gloucestershire Health and Care System and are members of the Integrated Care Board. One Gloucestershire is a c£1.3bn investment in the health and care of the residents in Gloucestershire. In addition to being a respected provider of services we are demonstrating our ability to design and shape services e.g. through our lead role in the Community Mental Health Framework. There is an imperative for system change and to transform the way in which One Gloucestershire meets the health and care needs of Gloucestershire residents. Our Trust has a key and important role in that system change and making a transformational difference.

3.0 BOARD UPDATES

3.1 The recruitment for two new Non-Executive Directors concluded on 12th April. Following a rigorous recruitment process overseen by our Governors' Nominations and Remuneration Committee, I am delighted to advise that Jason Makepeace and Bilal Lala have been appointed. I am sure you will all join me in welcoming Jason and Bilal to the Trust, with both commencing in post on 20th May 2024.

Profiles for Jason and Bilal are below.

Profile: Jason Makepeace

Jason is a director at Ginkgo Bioworks, a US-based company seeking to make biology easier to engineer. He is also a non-executive director of the Royal Agricultural University, and sits on both the Audit and Risk Committee and the Remuneration Committee there. Before joining Ginkgo, Jason worked as a senior civil servant, including as both director of products and director for community services at the UK Health Security Agency (formerly NHS Test & Trace) during the Covid-19 pandemic, and as chief digital, data and technology officer at Barnardo's. Jason has strong interests in ensuring public services are designed around the needs of people and communities, in improving equity of access to health and care, and in helping Government put emerging technology to use in tackling the greatest challenges of our age. Location: Stroud, Gloucestershire.

Profile: Bilal Lala

Bilal is a qualified accountant who has held non-executive roles with large acute NHS Foundation Trusts, and broader Chair and Trustee positions. Up until June 2023, he worked as Finance Director for Equans UK & Ireland (he has recently gone back there to work for a short period of time); he was also Interim Finance Director of the Transport & Cleaning Division for ISS UK & Ireland. Bilal has held Finance Director roles for the last 23 years in various organisations and industries. His personal interest in the NHS stems from his children, all of whom have pursued careers in medicine; and most of whom are now working for the NHS. Having developed many of the skills needed to make a rounded contribution as a non-executive, he believes he can combine all of his strengths to the Trust's benefit. Location: Gloucester

With sadness, May will be the last Trust Board meeting for **Marcia Gallagher, Non-Executive Director and Senior Independent Director who will be stepping down from 30 June**. I would like to personally thank Marcia for all of her hard work and dedication to the Trust and I wish her well for the future.

3.2 **Trust Board Meetings:**

- Due to the level of transition at Board level and recruitment to key Board positions, much of the Board's time over the last quarter and been engaged in supporting the recruitment processes through the participation in focus groups and interview panels. A more intensive programme of Board development, focussed on ways of working to include new Board colleagues will commence later in the year.

- On 30th April an **Extraordinary Board** meeting took place where Board colleagues discussed the System Operating Plan submission and the system finance position.

4.0 GOVERNOR UPDATES

- I continue to meet on a regular basis with the **Lead Governor Chris Witham**, Director of Corporate Governance & Trust Secretary, Lavinia Rowsell and Anna Hilditch, Assistant Trust Secretary where matters relating

to our Council of Governors including agenda planning, governor elections and matters relating to membership engagement.

- An Extraordinary meeting of the **Nominations and Remuneration Committee** took place on 16th April. The Committee considered and endorsed the appointment of two new Non-Executive Directors, following the interviews that had taken place on Friday 12th April. An Extraordinary Council of Governors meeting subsequently took place on 17th April and these new appointments were approved.

- On 15th May we held our **Council of Governors meeting** via MS Teams. At the meeting I facilitated a discussion with Governors on future ways of working and optimising the contribution and value of Governors.

5.0 CHAIR ACTIVITY

Since coming into post on 1st May, I have met with colleagues, partners and service users and a summary of my activity from 1st – 31st May is below.

Meetings with Executives, colleagues, External Partners	GHC Board / Committee meetings
Meetings with Douglas Blair, Chief Executive Meetings with Lavinia Rowsell, Director of Corporate Governance and Trust Secretary Visit to Stroud General Hospital, Weavers Croft, Park House and the Health visiting Team Gloucestershire ICS: System Resources Committee Meeting with Mary Morgan, Senior Commissioning Manager, ICB Visit to the Forest of Dean Community Hospital 1:1 with Chris Witham, Lead Governor Introduction meeting with Deborah Evans, Chair of Gloucestershire Hospitals NHS Foundation Trust Introduction meeting with Bob Lloyd-Smith, Healthwatch Gloucestershire Gloucestershire Neighbourhood Transformation Steering Group Meeting with Marcia Gallagher, Non-Executive Director and Senior Independent Director Council of Governors Meeting Visit to Cirencester Hospital with Governors Peter Gardner and Jenny Hinks	Quality Committee Trust Board: Public Trust Board: Private

Meetings with Executives, colleagues, External Partners	GHC Board / Committee meetings
1:1 with Nicola de Iongh, Non-Executive Director Gloucestershire County Council Health Overview and Scrutiny Committee Meeting with Nic Matthews, Union Lead Representative Video recording for inclusion in the Trust New Starter Induction Introduction meeting with Bilal Lala and Jason Makepeace, new Non-Executive Directors Non-Executive Directors Meeting Introduction meeting with Lucy Elliott and Juliette Richardson, Deputy Service Directors for Community Hospitals Meeting with Lavinia Rowsell and Hannah Williams, interim Director of Nursing, Therapies & Quality to discuss quality visits and future arrangements Property schemes update meeting with Kevin Adams, Associate Director of Estates, Facilities and Medical Equipment	

6.0 NED ACTIVITY

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

See **Appendix 1** for the summary of the Non-Executive Directors activity for March and April 2024.

7.0 CONCLUSION AND RECOMMENDATIONS

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

Appendix 1

Non-Executive Director – Summary of Activity 1st March – 30th April 2024

NED Name	Meetings with Executives, Colleagues, External Partners	GHC Board / Committee meetings
Graham Russell	Appraisal with Chair Better Care Awards Ceremony Chair Farewell Council of Governors Agenda Planning Meeting Council of Governors Meeting Council of Governors Meeting Hospital League of Friends ICB Board Development Meeting ICB Neighbourhood Transformation Working Group Incoming Chair Preparation Meeting Meeting with Elizabeth O'Mahony, Regional Director Meeting with Margaret Greaves, interim Chair of Stroud Non-Executive Director Interviews Non-Executive Director Meeting Non-Executive Director Shortlisting 1:1 with Lavinia Rowsell, Director of Corporate Governance & Trust Secretary 1:1 with Sumita Hutchison, Non-Executive Director	ATOS Committee Board Development Session Extraordinary ATOS Committee Extraordinary Trust Board Meeting Extraordinary Trust Board Meeting Lessons Learned Board Development Nomination and Remuneration Committee
Dr Stephen Alvis	Appraisal with Chair Chair Focus Groups Council of Governors Meeting GGI Webinar - The Hewitt Review 'One Year On' ICS Non-Executive Director Network Meeting Mental Health Act Manager's Forum Mental Health Act Manager's Personal Development Review MHLS Committee Pre-meeting with Medical Director Non-Executive Director Meeting Non-Executive Director Meeting	Extraordinary ATOS Committee Extraordinary Trust Board Meeting Extraordinary Trust Board Meeting Lessons Learned Board Development MHLS Committee Quality Committee Resources Committee Trust Board: Private Trust Board: Public

Marcia Gallagher	Appraisal with Chair Chair Focus Group Feedback Chair Interviews Feedback following Chair Candidates Psychometric Test Lunch with Chair Focus Group attendees Meeting with Chair Candidate Meeting with Chair External Assessor, Andy Willis Meeting with Gloucestershire Hospitals NHS Foundation Trust Chair re Chair Candidates Meeting with Head of Counter Fraud Pre-interview Chair Panel Meeting	ATOS Committee Extraordinary ATOS Committee Extraordinary Trust Board Meeting Extraordinary Trust Board Meeting Nomination and Remuneration Committee Quality Committee
Sumita Hutchison	1:1 with Neil Savage, director of HR & Organisational Development 1:1 with Nic Matthews 1:1 with Nic Matthews Appraisal with Chair Chair Farewell Chair Recruitment Focus Group Council of Governors Meeting Diversity Network Agenda Planning Diversity Network Meeting Gloucestershire ICS NEDs Network Meeting Great Place to Work Committee Pre-Meet Non-Executive Director Interviews Non-Executive Director Meeting Non-Executive Director Shortlisting Meeting	Board Development Session Board Development Session Extraordinary ATOS Committee Extraordinary Trust Board Meeting GPTW Committee MHLS Committee Trust Board: Private Trust Board: Public
Nicola de longh	6 x Non-Executive Director role discussions with candidates Appraisal with Chair Chair Farewell Chair Focus Group Feedback Chair Focus Groups Council of Governors Meeting Meeting with Kate Bowden re PCET Complaints Process Mentoring Meeting following staff story at GPTW Committee Non-Executive Director Meeting Non-Executive Director Meeting Non-Executive Director Recruitment Meeting	ATOS Committee Board Development Session Extraordinary ATOS Committee Extraordinary Board Meeting Extraordinary Trust Board Meeting Great Place to Work Committee Nomination and Remuneration Committee Resources Committee Trust Board: Private Trust Board: Public

Jan Marriott	1:1 w Sarah Birmingham, Chief Allied Health Professional re AHP Strategy 1:1 with Derek Hammond, Service Director, Specialist Services 1:1 with Julie Mackie, Head of Partnerships re Coproduction Conference 1:1 with staff member 1:1s with Interim Director of Nursing Therapies & Quality Appraisal with Chair Chair Farewell Council of Governors Meeting Director of Nursing, therapies & Quality Appointment Panel Meeting Focus Group for Chair's appointment Freedom to Speak Up Champions Meeting Freedom to Speak Up National Conference Good Governance Institute Webinar – Quality Committees ICB Non-Executive Director Network ICB System Quality Committee – Public and Private Non-Executive Director Meeting Non-Executive Director meeting with Chair Quality Assurance Group Quality Assurance Group	ATOS Committee Board Development Session Extraordinary ATOS Committee Extraordinary Board Meeting Extraordinary Trust Board Extraordinary Trust Board Meeting Lessons Learned Board Development Quality Committee Trust Board: Private Trust Board: Public Working Together Advisory Committee
Vicci Livingstone-Thompson	1:1 with Chair 1:1 with Mo Rashid, Insight Programme Placement Appraisal with Chair Council of Governors Meeting Disability Awareness Network Meeting Meeting with Amy Aitken following GPTW presentation Non-Executive Director Meeting Single Point of Access Quality Visit	Board Development Session Extraordinary ATOS Committee Extraordinary Trust Board Meeting Extraordinary Trust Board Meeting Great Place to Work Committee Lessons Learned Board Development Trust Board: Private Trust Board: Public

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Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 11/0524

REPORT TO: **TRUST BOARD PUBLIC SESSION – 30 May 2024**

PRESENTED BY: Douglas Blair, Chief Executive Officer

AUTHOR: Douglas Blair, Chief Executive Officer

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

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

This report is provided for:

Decision ☐ Endorsement ☐ Assurance ☒ Information ☒

The purpose of this report is to

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

Recommendations and decisions required

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

Executive Summary

The report summarises the activities of the Chief Executive (CEO) and the Executive Team and the key areas of focus since the last Board meeting, including:

- Chief Executive Overview
- System updates
- Achievements / Awards
- Regional and National Updates

Risks associated with meeting the Trust's values

None identified.

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

Where has this issue been discussed before?
N/A

Appendices:	

Report authorised by:	Title:
Douglas Blair	Chief Executive Officer

CHIEF EXECUTIVE OFFICER AND EXECUTIVE TEAM REPORT

1.0 CHIEF EXECUTIVE OVERVIEW

1.1 Integrated Urgent Care Service

On behalf of the Board, I am pleased to announce that the Trust has been awarded the contract to provide an **Integrated Urgent Care Service (IUCS)** for people across Gloucestershire. The IUCS includes NHS 111 (telephone and online), a local Clinical Assessment Service offering patients access to general and specialist advice from clinicians where appropriate and the Primary Care Out of Hours service.

The service will be provided by the Trust in a partnership with social enterprise organisation Integrated Care 24 (IC24), who currently deliver services such as 111 in other areas of England.

This is a new area of work for the Trust, but it will blend well with some of our existing services and help us work more closely with primary care colleagues.

Mobilising the contract to go live in November 2024 will be a significant undertaking for the Trust. A dedicated Programme Director has been identified to lead and coordinate this task and our work programme will be prioritised to ensure that this can be delivered.

Gloucestershire Health and Care and IC24 will work alongside system partners to ensure the service is responsive and provides high quality care when needed. The overall aim is to improve patient experience and to ensure there is high quality, responsive advice and treatment available for the people of Gloucestershire, preventing the need to use ambulance services and Emergency Departments unnecessarily.

1.2 Chief Executive – Service/Team Visits

I have continued to carry out service visits, team meetings and to 'hot desk' from different sites. I have welcomed the opportunity to meet with colleagues, learn about their roles and understand any of the challenges facing their service areas. My visits since the last Board meeting have included:

- Honeybourne Rehabilitation Centre
- Laurel House
- St Paul's Medical Centre
- Avon House, Tewkesbury
- Kings Street (Five Valleys)
- Forest of Dean Hospital, Cinderford

1.3 New Director of Nursing, Therapies and Quality

I am pleased to update that we have appointed Nicola Hazle as our new Director of Nursing, Therapies and Quality. Nicola will start substantively with the Trust from 1st July, having completed her induction two-days a week during

June, which will include getting to meet as many services and colleagues as possible.

Nicola has 23 years of experience as a registered mental health nurse and is joining the Trust from her current role as Health and Care Professional Director within Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board. In her current role she is responsible for the strategic direction and implementation of health and care professional leadership across the Integrated Care System. She also supports and leads key priority areas of quality, effectiveness and clinical practice. Nicola is currently a Bank Mental Health Inspector for the Care Quality Commission and a Lay Advisory Panel Member (voluntary) with the College of Optometrists. Prior to this she was Clinical Director, BANES Swindon & Wiltshire Division, within Avon & Wiltshire Mental Health Partnership NHS Trust. Before this Nicola worked in a range of nursing, senior nursing and management roles in mental health and community organisations across the NHS.

In the meantime, Hannah Williams has kindly agreed to continue providing interim leadership as our Acting Director of Nursing, Quality and Therapies.

1.4 New Deputy Medical Director

Dr Olesya Atkinson has been appointed as Deputy Medical Director, Community Health Services, and will start with the Trust on 12th June.

Olesya is a highly experienced GP with an extensive background in teaching and training, as well as working collaboratively to deliver holistic care in a joined up and sustainable way in local communities. We are delighted she is joining our medical leadership team and very much looking forward to working alongside her to deliver high quality care to the communities we serve.

Her appointment means she will combine the role with her current role as GP Partner at Berkeley Place surgery, Clinical Director of Cheltenham Central PCN and Vice Chair of Cheltenham ILP.

Olesya qualified as a doctor from the University of Cambridge in 2002, working as a medical doctor in Nottingham until she made the move to General Practice in 2006. She is a GP partner at Berkeley Place Surgery in Cheltenham, which she joined ten years ago. She became actively involved in Primary Care Networks (groups of GP practices working together) at their onset, seeing them as an opportunity to enhance primary care workforce, the range of services, reduce health inequalities and increase resilience of GP surgeries. Olesya has represented Primary Care Networks on the Gloucestershire Integrated Care Board since July 2022.

1.5 Stakeholder Engagement

I continue to participate in regular discussions with MPs and other key stakeholders on matters affecting the Trust and our local communities. Further information on specific engagements, including with the Health Overview and Scrutiny Committee are detailed at **Section 2.0** of this report.

2.0 SYSTEM UPDATES

2.1 Gloucestershire Coalition for the Wellbeing of Children & Young People

On 8th May I attended the Gloucestershire Coalition for the Wellbeing of Children & Young People, held at the Social Work Academy, Quayside House. The meeting focused mainly on the One Plan for Children and Young People in Gloucestershire and the recent SEND Ofsted Inspection report. I welcomed the opportunity to speak with colleagues and learn more about the important children's agenda in Gloucestershire.

2.2 Health Overview Scrutiny Committee

On 21st May the Chair, Graham Russell, and I attended the meeting of the Health Overview and Scrutiny Committee. The meeting primarily focused on an update on access to General Practice in Gloucestershire, Maternity Services, and the Gloucestershire Integrated Care System Performance Report. Reports were also received from the NHS Gloucestershire Integrated Care Board.

An NHS Reference Group is due to be scheduled in the near future to receive a briefing from the Trust on various items of interest, including the Children and Adolescent Mental Health Service and the autism assessment service.

2.3 Community Mental Health Transformation

Embedding the Locality Community Partnership (LCP) model continues as we start to shift the focus onto the alignment with the internal GHC locality teams. The programme budget is in the final stages of sign-off for 24/25 and we are pleased to report that this should include a further allocation of monies for Voluntary, Community & Social Enterprise (VCSE) Small Grants following the successful rounds offered last year. Recruitment to the final roles has also been on hold pending budget sign-off and it is therefore hoped that this will be able to proceed shortly.

Annual physical health checks continue to be a priority with the system achieving over 55% overall, with GHC recording 77% compliance for those within the secondary care setting.

2.4 ICB Board Meetings

The NHS Gloucestershire ICB Confidential and Public Board Meetings were held on 29th May. The papers for the Public Board meetings can be located on their website - Board Meetings : NHS Gloucestershire ICB (nhsglos.nhs.uk)

Gloucestershire ICB also held a Board Development day on 11th April which was attended by David Noyes, Chief Operating Officer, and Neil Savage, Director of HR and OD, on behalf of the Executive team. The session focussed on the review and consideration of the ICB's strategic priorities for 2024/25 and to provide an opportunity for attendees to feedback on progress and challenges across a range of issues that remain priorities for the whole system.

There was a further Development session on 24th April, which was attended by the Trust Chair, Graham Russell.

2.5 Visit to the Three Counties Medical School, University of Worcester

On 22nd April, I visited the University of Worcester and the medical school, along with Dr Joe Stratford, Director of Medical Education. We met with the Vice Chancellor and the senior team and it provided a welcome opportunity to discuss our workforce requirements and to further develop our partnership working.

This year the Medical School has 20 home funded students (funded from the three counties of Herefordshire, Worcestershire, and Gloucestershire), and 24 self-funded international students, making a cohort of 44 in total. The NHS Workforce Long Term Plan cites increasing medical training places and the school have been successful in securing 50 government funded places with a September 2024 start. Work is ongoing to secure the allocation for 2025. The Trust will be part of offering training placements for a proportion of these students, largely in their third year of training.

2.6 Forest of Dean Hospital Community Hospital Update

I am pleased to report that the new Forest of Dean Community Hospital has been completed and is now fully operational and was delivered to budget with only minor delays to overall timescales.

Throughout April, colleagues at the Dilke and Lydney hospitals prepared for the moves to take place with the inpatients team being the first to move, moving 16 patients in one day. The team are now operating at full capacity with 24 patients. Outpatients, Diagnostics, CYPS (Children and Young People's Services), Adult MSK (Musculoskeletal), and Dental services, moved in during the following weeks with the final services being MIIU (Minor Injury and Illness Units) and the Complex Leg and Wound Service taking place once the new x-ray machine

was operational over the 16/17th May. Teams are settling in well to the new hospital and positive feedback has been received from both colleagues and patients on the new site.

As with any project of this size and complexity, there will be a period of final snagging works and minor adjustments as teams settle into their new facilities. We remain in discussions with the Highways Agency for obtaining the final approvals for the installation of the speed calming measures on the road adjacent to the site and recognise that this may take a little while to be completed as the Highways Agency need to complete their own consultation processes.

The official opening of the new hospital is scheduled for Friday 7th June, performed by HRH The Princess Royal.

3.0 ACHIEVEMENTS / AWARDS

3.1 Apprenticeships

Congratulations on the achievements of our apprentices who have recently successfully completed their apprenticeships:

- Ruby Coleman – Level 3 Business Administrator
- Donna Hooper – Level 3 Business Administrator
- Bethany Jackson – Level 3 Senior Health Care Support Worker

3.2 Quality Improvement Celebration Event

Our annual Quality Improvement Celebration event took place at University of Gloucestershire on 13th May. The event was well attended and provided an opporuntity to showcase the variety of quality improvement work taking place across the Trust, and the way in which colleagues are making improvement a part of their every day work. Awards were presented for the folllowing categories:

- Involving experts by experience in QI work
- Sustainability in QI
- Best use of QI tools and/or data
- Improvement team/service/directorate of the year
- Improver of the year

Quality Improvement is integral to the culture of our Trust and enabling improvement work leads to deliving better care to the communities we service. Congratulations to everyone who was nominated and to all our winners.

3.3 National recognition for Infection Control Quality Improvement Project

Infection Control Nurse Amy Barnes has been selected to present her Quality Improvement Patchwork Project to the Queens Nursing Institute, who will then present the project to NHS England.

This Patchwork Project aims to repair Trust furniture such as plinths and couches with minor defects, which our Infection Control team regularly find on audits or walkarounds. The aim is to make the furniture last longer by using a patch which meets all requirements for Infection Prevention Control, health and safety and fire safety. Re-upholstery repair can take up to four months, is expensive and needs to be stored until it can be repaired, so often teams dispose of it and buy another. The Patchwork project aims to save funds and support our commitment to sustainability.

Amy was recently a finalist for the Regional Chief Nursing Officer Sustainability Nurse and Midwife Award, where she presented her project and was a runner up.

4.0 REGIONAL AND NATIONAL UPDATES

4.1 South West Mental Health CEOs Meeting

On the 17th May, I attended a regional meeting of the Mental Health Chief Executive's meeting in Somerset. This was a long-planned opportunity to meet face to face to share thinking on our collective challenges and learn from each other about positive things happening in different areas of the region. It provided a welcome opportunity to network with colleagues to ensure we are learning from others and more importantly, telling other people about the great work going on in Gloucestershire.

4.2 NHS Leadership Event

On the 1st May I attended the NHS Leadership Event in London, which was hosted by Amanda Pritchard, NHS Chief Executive. The day opened with reflections from NHS England on the previous six-months, before a series of breakout groups, exploring a variety of topics including approach to improvement, metrics/benchmarking tools and supporting the NHS workforce to thrive. There was an opportunity at the end of the day to consider the Oversight and Assessment Framework and the Digital Transformation priorities for 2024/25.

5.0 CONCLUSION AND RECOMMENDATIONS

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

REPORT TO: **TRUST BOARD PUBLIC SESSION – 30 MAY 2024**

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

AUTHOR: Lavinia Rowsell, Director of Governance & Trust Secretary

SUBJECT: **BOARD ASSURANCE FRAMEWORK (BAF)**

If this report cannot be discussed at a public Board meeting, please explain why.	The report has been redacted to remove commercially sensitive information

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

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

Recommendations and decisions required

The Board is asked to:
- **Receive** and **consider** the BAF (Q4 year-end review)
- **Note** the overarching risk profile for the Trust (Page 1, **Appendix 1** BAF)
- **Note** progress towards mitigating strategic risks

Executive summary

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

The Board Assurance Framework (BAF) for 2023/25 reflects the Trust's Strategic Aims and Objectives. For the assurance of the Board, throughout the year, the BAF has been reviewed and updated in line with Trust policy with the regular governance touchpoints (Executive risk owners, Executive Team and Governance Committees) as set out on page 2 of **Appendix 1 (BAF).** The BAF is a dynamic in nature as demonstrated by the changes set out below.

<u>Key changes during 2023/2024:</u>

a) Four strategic risks have been **added** in year:
- Risk 10 – System Operation

- Risk 11 – Closed Culture
- Risk 12 – Workforce Transformation
- Risk 13 – Board Stability

b) Four risks have reached their target scores and as such will be **closed**:

- Risk 5 – Partnership Culture
- Risk 7 – Sustainability
- Risk 9 – Strategic Focus
- Risk 10 – System Operation

c) **Movements** in risk ratings over the year can be seen in the dashboard on page 1 of the BAF with rationale contained within the main document. Changes to risk scores are reviewed by the relevant governance committee.

Board development

It is proposed that in light of the recent changes at Board level, a board development session be held to review current and identify new strategic risks.

Risks associated with meeting the Trust's values

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

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

Where has this issue been discussed before?
▪ Governance Committees, Executive Team, Board / Seminar

Appendices:	Board Assurance Framework Q4 Review

Report authorised by: Lavinia Rowsell	**Title:** Director of Corporate Governance & Trust Secretary

AGENDA ITEM: 12.1/0524

APPENDIX 1

BOARD ASSURANCE FRAMEWORK

November 2023- March 2025

Risk No	Strategic Risk Description	Strategic Aim				Risk Type(s)							Lead Committee	Tolerance	Initial Risk Score	Target Risk Score	Risk Score					Lead Exec	Last Exec Review	Last Comm Review	Issue to be raised By Exec /Comm.(Y/N)
		High Quality Care	Better Health	Great Place to Work	Sustainability	Quality/Outcomes	Compliance / Regulatory	Reputational	Innovation	Partnerships	Workforce	Finance Inc. VFM					Target Date Aim By When	Qtr 1	Qtr 2	Qtr 3	Qtr 4				
1	Quality Standards	✓	✓			✓	✓	✓					Qual.	10	12	8	April 2025	12	12	12	12	Dir NTQ	April 24	May 24	N
2	Services Not meet Pop Need	✓	✓			✓	✓	✓	✓	✓		✓	Res.	10	16	12	April 2025	16	16	12	12	COO	April 24	May 24	N
3	Recruitment & Retention	✓	✓	✓		✓	✓	✓			✓	✓	GPTW	12	12	12	April 2025	16	16	16	16	DIR HR& OD	April 24	May 24	N
4	Inclusive Culture (Internal)		✓	✓				✓					GPTW	6	9	4	April 2025	6	6	6	9	DIR HR& OD	April 24	May 24	Y
5	Partnership Culture		✓			✓		✓		✓			Board	12	9	6	April 2025	9	9	9	6	Dir S&P	April 24	May 24	N
6	Level & Prioritisation of Funding	✓	✓			✓	✓	✓	✓			✓	Board	10	16	8	April 2025	12	12	9	12	DoF	April 24	May 24	N
7	Sustainability (environment)				✓		✓		✓	✓			Res.	6	12	6	April 2025	12	9	9	6	Dir S&P	April 24	May 24	N
8	Cyber	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	Audit	6	20	8	April 2025	12	12	12	12	DoF	April 24	May 24	N
9	Strategic Focus	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Board	10	9	6	April 2025	9	9	9	6	Dir S&P / COO	April 24	May 24	N
10	System Operation	✓	✓	✓		✓	✓	✓			✓	✓	Audit	6	12	6	April 2025		9	6	6	DoF/ CEO	April 24	May 24	N
11	Closed Culture	✓	✓	✓		✓	✓	✓		✓	✓		Board	6	12	6	April 2025		12	12	12	DNTQ /DHR	April 24	May 24	N
12	Workforce Transformation	✓	✓	✓	✓	✓		✓		✓	✓	✓	GPTW	10	12	12	April 2025		9	9	9	COO/ DHR	April 24	May 24	N

13	Board Stability	✓	✓	✓	✓								Board		12	8	March 2025				**12**	CEO	April 24	May 24	N

<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="3">High Quality Care
Better Health</td><td>Exec Risk Owner</td><td>Dir NTQ</td><td>Date of review:</td><td>April 24</td></tr>
<tr><td>Risk ID:</td><td>01</td><td>Description:</td><td colspan="3" rowspan="2">Quality Standards:

There is a risk that failure to:
(i) monitor & meet consistent quality standards for care and support;
(ii) address variability across quality standards;
(iii) embed learning when things go wrong;
(iv) monitor and respond to trends in complaints and concerns, serious clinical incidents and mortality;
(v) ensure continuous learning and improvement,
(vi) ensure the appropriate timings of interventions

will result in poorer outcomes for patients / service user and carers and poorer patient safety and experience.</td><td>Lead Committee</td><td>Quality</td><td>Date of next review:</td><td>June 24</td></tr>
<tr><td colspan="3">Risk Rating:
(Consequence x Likelihood):</td><td colspan="4">Relevant Key Performance Indicators:
(taken from the Performance Report/ Quality Dashboard)
• Number of Complaints (and trends – including by site and service)
• Number of concerns and trends including by site & service)
• Timeliness of reviews into Concerns
• Patient Safety Incidents
• Friends & Family Test measures
• Safe Staffing Levels
• Embedding learning /Quality Improvement activity reporting
• Waiting times
• Vacancy rates – aggregate position</td></tr>
<tr><td colspan="3">Date Risk Identified/confirmed</td><td colspan="3">Updated Oct 2023 (Ongoing BAF Risk from 2019)</td><td colspan="4" rowspan="5"></td></tr>
<tr><td></td><td colspan="2">Likelihood</td><td>Impact</td><td>Overall</td></tr>
<tr><td colspan="2">Inherent Risk Score:</td><td>3</td><td>4</td><td>12</td></tr>
<tr><td colspan="2">Current Risk Score:</td><td>3</td><td>4</td><td>12</td></tr>
<tr><td colspan="2">Target Score</td><td>2</td><td>4</td><td>8</td></tr>
<tr><td colspan="2">Date to Achieve Target Score</td><td>1st April 2025</td><td>Tolerance</td><td>10</td><td colspan="4"></td></tr>
<tr><td colspan="5">Potential or actual origin of the risk:</td><td colspan="5">Recognising its core importance to the work of the Trust this has been confirmed as an area for ongoing monitoring on the BAF since 2019, confirmed 2023.</td></tr>
<tr><td colspan="10">Rationale for current score:
(What is the justification for the current risk score)</td></tr>
<tr><td colspan="10">The work of the Quality Committee and their reviews of the Quality Indicators provides ongoing assurance. The development, implementation and monitoring of the Quality Strategy/Framework, approved by the Board in July 2021, ensure this risk is effectively managed and continues to be central to our ways of working. The majority of KPIs identified to inform the scoring of this risk are within agreed parameters excluding waiting times/access. Safe staffing levels are improving, with an improvement in the rate of Healthcare Support Workers (HCSW), noting that Berkeley House is still recording the highest HCSW rate. Increased focus on inpatient settings including WL Assurance Group. Anti-closed culture activity progressing such as reducing restrictive practice, improving clinical supervision and independent advocacy reporting to Quality Committee. Trust has received a down-grade of rating at Berkeley House. Work has been completed to provide assurance on immediate safety and standards and the Trust continues to provide monthly reports to CQC and remains on enhanced surveillance with ICB.</td></tr>
<tr><td colspan="10">Links to Risk Register</td></tr>
<tr><td colspan="10">273: Eating Disorders, 165/320: Core CAMHS Waiting List/Medical Vacancies, 196 Demand and Capacity MH Inpatient Beds. 109 Safeguarding. 107: Ligatures, 160: Patient Doc Storage, 247: Agency and Bank Reliance,</td></tr>
</table>

232: CAMHS Neurodevelopmental Assessment Delivery, 280: Out of Area Placements, ~~326: Social work capacity~~; 346: Estate Berkeley House, ~~355 LFPSE~~, 295 VOIP Infrastructure {Telephony] 372 Building works for accreditation, 3~~23 General Anaesthetic Provision for Community Dental Services referrals~~, 354 Estate Maxwell Centre, 194 Non-NIHR Research and Development Funding, 412 Forest of Dean Hospital - Endoscopy, 405 Continuing Professional development (CPD) - Funding, 73 Data Quality, 324 Young person residing in an Adult LD Inpatient flat, 152 Health and Safety - Compliance, 421 - CSSD - contaminated sets

Controls: (What do we currently have in place to control the risk?)		Last Review Date:	Next Review Date:	Reviewed by:	Gaps in Controls: (What additional controls should we seek?)
1.	Quality Dashboard	Monthly	2023/24	Dir NTQ/ Quality Committee / Board	Implementation and embedding of Quality Strategy. Work in progress on embedding this
2.	Patient Safety Controls – including Freedom to Speak Up mechanisms	As above	As above	Dir NTQ	Quality Dashboard and patient safety, experience and Freedom to speak up reports consistently produced – to maintain.
3.	Patient Experience Controls	As above	As above	As above	As above
4.	Workforce Controls	As above	As above	Dir NTQ	Community services staffing data being developed.

Sources of Assurance: (How do we know if the things we are doing are having an impact?)		Lines of assurance: L1 - Operational L2 - Board oversight L3 – Independent	Last Received	Received by	Assurance Rating	Gaps in Assurance: (What additional assurances should we seek?)
1	Reports on Quality Standards/Performance	L2	Rec'd each Mtg	Qual/Res Comm or Board	Satisfactory	KPIs within Monthly reports and regularly review to ensure measures being used are the most appropriate and timely.
2	Reports on Service User Experience	Includes L3	monthly reports	Qual Comm/Board	Satisfactory	Complaints waiting times closely monitored and improving To date 93% complaints have been closed within 6 months, this compares to 87% last year (Sept 23)
3	Internal Audit Reports on Freedom to Speak Up	L3	Aug 2023	Audit Committee	Satisfactory	Outcome of FTSU internal audit – substantial assurance
4	Reports on Freedom to Speak up actions & issues raised	L2	6 monthly Reports	Board	Satisfactory	None highlighted since recommendations within Internal Audit Report implemented.
5	Service Experience Stories to Board	L3	Every other month	Board	Satisfactory	Feedback loop from service user stories built into Quality Committee agenda cycle.

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions:	Action Owner:	Deadline [revised deadline] Complete / In Progress / Delayed / Not Started
1	Freedom to Speak Up revised Policy - 2024 requirement	To be discussed at Board.	FSUG	Completed
2	Measuring What Matters Work Phase 2 to be progressed	Ongoing – Board Dev Session Aug 23	DoF	Priorities & focus to be agreed
3	Quality Strategy/Framework implementation to be reviewed	Biannual implementation update to Quality Comm – 09 22, 09 24	DoNTQ	Ongoing
4	Quality mechanism processes KPIs to be kept under review	Quality Committee to Monitor for timeliness of actions	DoNTQ	Dashboard being updated
5	CQC action-planning & review in response to improvement plans	Quality Committee review in Jan. Monthly assurance meetings with CQC/ICB and NHSE.	DoNTQ	Ongoing
6	Ongoing review and prioritisation for recruitment focus of safer staffing hotspots	See Risk 3 (Colleague Recruitment and Retention) – progressing well international nursing, safe staffing position improving (WL/Physical Health), trust wide work ongoing. Continuing review of hotspots (currently ICTs).	DoNTQ / DHR&OD	Ongoing
7	Development of service heat maps, triangulating data and scoring mechanism as early warning and detection.	Rec. arising from well led review and considered further at quality seminar. Further development required.	DoNTQ / MD	Delayed 24/25 review
8	Anti-closed culture activity and action plan in response to BDO internal audit	Progress in activities such as reducing restrictive practice, improving clinical supervision and independent advocacy reporting to Quality Committee. See Risk 11. Dedicated closed culture slides in Quality Report. Quality Committee action plan review March/May.	DoNTQ	In progress – June 2024

<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="3">High Quality Care

Better Health</td><td>Exec Risk Owner</td><td>David Noyes, COO</td><td>Date of review:</td><td>April 24</td></tr>
<tr><td>Risk ID:</td><td>2</td><td>Description:</td><td colspan="3" rowspan="2">Services not Meeting Population Need

There is a risk of demand out stripping supply for services and/or that services operate in a way which does not meet the needs of the population, potentially reinforcing health inequalities.</td><td>Lead Committee</td><td>Resources</td><td>Date of next review:</td><td>June 24</td></tr>
<tr><td colspan="3">Risk Rating:
(Consequence x Likelihood):</td><td colspan="4" rowspan="2">Relevant Key Performance Indicators:
(taken from the Performance Report)

• Waiting times
• Referral and Access Reports
• Length of Stay
• No. Complaints and Compliments (also Trends – access, timeliness, E&D focus)
• Out of Area Placements
• Increased number of individuals with long term conditions – once available
• Health Inequalities key metrics
• User Satisfaction – by service, E&D characteristics
• Quality Data</td></tr>
<tr><td colspan="3">Date Risk Identified/ confirmed</td><td colspan="3">Oct 2023 (Refocused from 2022 BAF risk)</td></tr>
<tr><td colspan="3"></td><td>Likelihood</td><td>Impact</td><td>Overall</td><td colspan="4" rowspan="5"></td></tr>
<tr><td colspan="3">Inherent Risk Score:</td><td>5</td><td>4</td><td>20</td></tr>
<tr><td colspan="3">Current Risk Score:</td><td>3</td><td>4</td><td>12</td></tr>
<tr><td colspan="3">Target Score:</td><td>2</td><td>4</td><td>8</td></tr>
<tr><td colspan="2">Target Date</td><td>1st April 2025</td><td>Tolerance</td><td colspan="2">10</td></tr>
<tr><td colspan="3">Potential or actual origin of the risk:</td><td colspan="7">Oct 2023 – Demand for Services Risk substantially revised and refocused to reinforce link to health inequalities and ensure reflects on way services delivered as well as demand.</td></tr>
<tr><td colspan="10">Rationale for current score: (What is the justification for the current risk score)
Demand for our services remains high and monitoring to reflect service operation meets the needs of the population continues to be in development. The Working as One diagnostic intervention identified areas for improvement which are currently being prioritised; the next phase of implementation was mobilised at system level in qtr2/3 2023 (actions under our direct control are being taken forward and monitored through physical health transformation board). There has been a pause in activity for winter with further trails being mobilised in q1 24/25. To date relationships with Commissioners remain supportive, but we need to ensure clear understanding of the volumes we are dealing with and how we are supporting Health & Care across the County through different services and different communities. We maintain a full suite of service improvement plans which are regularly reviewed at operational and governance level. We have developed a plan to reconfigure service around local partnerships considered by Board August 2023. Data monitoring of services against diversity characteristics to ensure needs of different communities being met requires further development. This quarter has seen an improvement on key KPIs including average length of stay, out of area placement and agency and bank reliance resulting in a reduction of the overarching risk score. However, it is acknowledged that improvements are not universal across all services and this will be kept under review.</td></tr>
<tr><td colspan="10">Links to Risk Register
273: Eating Disorders, 165/320: Core CAMHS Waiting List/Medical Vacancies, 196 Demand and Capacity MH Inpatient Beds. 109 Safeguarding. 107: Ligatures, 160: Patient Doc Storage, 247: Agency and Bank Reliance, 232/243: CYPS. 280: Out of Area Placements, ~~326: Social work capacity~~; 346: Estate Berkeley House, ~~355 LFPSE~~, 295 VOIP Infrastructure {Telephony] 372 Building works for accreditation, ~~323 General Anaesthetic Provision for Community Dental Services referrals~~, 354 Estate Maxwell Centre, 194 Non-NIHR Research and Development Funding, 412 Forest of Dean Hospital - Endoscopy, 405 Continuing Professional development (CPD) - Funding, 73 Data Quality, 324 Young person residing in an Adult LD Inpatient flat, 152 Health and Safety - Compliance, 303 - SARC Nursing & Medical staffing</td></tr>
</table>

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

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

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions:	Action Owner:	Deadline [revised deadline] Complete / In Progress / Delayed / Not Started
1.	Continue work to build capacity and understanding of self-care and develop more admission avoidance schemes.	To be built into service reviews & developments. Focus on co-production for service developments to continue	COO DS&P	In progress –incremental adoption in conjunction with ILPs
2	Continue work to improve joined up working across the county to make best use of Gloucestershire pound	Ongoing work across ICS	Exec	Ongoing
3	Continue performance report monitoring & deep dives to focus on patient outcomes.	Established within agenda cycles	COO	Ongoing
4	Consider further how health inequalities can be measured and targeted as a system (links to item 6).	Localisation discussed by Board. PLICS project targeting HE data from next iteration. Operationalisation of localisation plan with increased focus as a result. 24/25 business objectives with increased focus on localisation.	Exec/ICS	In progress. Progress Report end 24/25
5	Integrated reporting in newly configured performance report	Executive objective for 23/24. Service profile reports in the interim.	Exec	In progress
6	Quality Improvement Hub operation to be further developed to enable project consideration in relation to services meeting population needs	Resource and focus of QIH to be considered in line with meeting population needs.	DSP	In progress
7	Further work to develop integration of Working Together Advisory Committee within quality improvement processes	Regular meeting cycle to be put in place	DSP	In progress

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<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="3">Great place to work
Better Health
High Quality Care</td><td>Exec Risk Owner</td><td>N Savage D of HR & OD</td><td>Date of review:</td><td>April 24</td></tr>
<tr><td>Risk ID:</td><td>3</td><td>Description:</td><td colspan="3" rowspan="2">Colleague Recruitment & Retention

There is a risk that we fail to recruit, retain and plan for a sustainable workforce to deliver services in line with our strategic objectives.</td><td>Lead Committee</td><td>GPTW</td><td>Date of next review:</td><td>June 24</td></tr>
<tr><td colspan="3">Risk Rating:
(Consequence x Likelihood):</td><td colspan="4" rowspan="8">Relevant Key Performance Indicators:

• Staff Turnover– inc wellbeing metrics
• Annual Staff and Pulse Surveys
• Staff FFT scores
• Vacancy Rates
• Bank and Agency Usage
• Recruitment & Retention Report – exit trends
• Education & Development Report
• Appraisals
• Probationary periods
• Stat & Man Training Update
• Sickness Absence KPI
• Health & Wellbeing Report</td></tr>
<tr><td colspan="3">Date Risk Identified/confirmed</td><td colspan="3">October 23 (Updated from 2022)</td></tr>
<tr><td colspan="3"></td><td>Likelihood</td><td>Impact</td><td>Overall</td></tr>
<tr><td colspan="3">Inherent Risk Score:</td><td>4</td><td>4</td><td>16</td></tr>
<tr><td colspan="3">Current Risk Score:</td><td>4</td><td>4</td><td>16</td></tr>
<tr><td colspan="3">Target Score:</td><td>3</td><td>4</td><td>12</td></tr>
<tr><td colspan="2">Date to Achieve Target Score</td><td>1st April 2025</td><td colspan="2">Tolerance</td><td>12</td></tr>
<tr><td colspan="4">Potential or actual origin of the risk:</td><td colspan="6">Confirmed to be retained 2033-2025 BAF, now broadened to include workforce wellbeing.</td></tr>
<tr><td colspan="10">Rationale for current score: (What is the justification for the current risk score)
A range of revised processes have been developed and are being embedded and further developed. This work is now overseen by the Great Place to Work Committee, Executive Team Meeting and the Sustainable Staffing Oversight Group. The risk has been refocused to incorporate workforce and wellbeing metrics to ensure holistic oversight of recruitment and retention. It is recognised that many aspects of supply, terms, conditions and competitive remuneration remain outside the Trust's immediate control. There is a continuing national shortage of staff, and timescales to resolve are long term, (for example the workforce supply pipeline for degree level registered medical, AHP and nursing roles has between a 3 and 10 year tenure with, our local RNLD degree programme only having commenced in September 2022 and the 3 Counties Medical School only opened in Sept 2023, which initially is not able to enrol UK students). NHSE has ceased funding internationally educated nursing under EHP initiatives. Quarter 4 has seen a further improvement on bank and agency usage however, vacancy factor remains high at 9.9%. Due to these factors recruitment and retention will remain a significant risk, with delays in the current registered staff pipeline continuing to significantly impact our ability to reduce this risk in the short or medium term.</td></tr>
<tr><td colspan="10">Links to Risk Register
165: Core CAMHS Waiting List, 247: Agency and Bank Reliance, 232: CYPS, 280: Out of Area Placements, 320 CAMHS – Medical Workforce Vacancies,</td></tr>
</table>

Controls: (What do we currently have in place to control the risk?)		Last Review Date:	Next Review Date:	Reviewed by:	Gaps in Controls: (What additional controls should we seek?)
1.	International Recruitment Programme for RMN, RGN and AHP	July 23	July 24	Exec	Future national funding withdrawn (Nov 23) combined with ongoing pressure to support sponsorship renewal.
2.	Relationships with a number of universities to build supply New Programmes developed Uni of Glos – LD Nursing, Established RGN, RMN & Physiotherapy Degrees and student placement UoG. Three Counties Medical School – local medical supply line	Ongoing	Quarterly	Exec	Lead time for RN LD degree training to complete i.e 2025. There were insufficient applicants for UWE and UoG to run LD degree programmes in October 23.
3.	Recruitment Policy and SOPs in place to fast track recruitment and reduce 'time to hire'	1/9/23	1/1/24	Exec	Impact of changes to be reviewed.
4.	ICS Workforce Steering Group	01/09/23	Quarterly	Exec	ICS people strategy and recruitment and retention plan agreed.
5.	Health Care Support Worker Recruitment and Retention Project	ongoing	Quarterly	Exec	Retention focus through targeting Health Care Support Worker interventions. Pilot of new HCSW entry pathway (CoHos) in train)
6.	Recruitment and Retention Framework Impact Review	01/06/23	01/04/24	Exec and GPTW	To include consideration of how we recruit from under represented communities (geographic, demographic, & protected characteristics) and potential links to voluntary sector.
7.	Health & Wellbeing Strategic Framework & Budget Funding in place	Quarterly	Quarterly	Exec and GPTW	

Sources of Assurance: (How do we know if the things we are doing are having an impact?)		Lines of assurance: L1 - Operational L2 - Board oversight L3 – Independent	Last Received	Received by	Assurance Rating	Gaps in Assurance: (What additional assurances should we seek?)
1	Monthly Recruitment Activity Reports to SSOG	L1	Monthly	Exec	Work in progress	To consider recruitment from underrepresented communities.
2	Staff Survey and Staff FFT	Ls 1,2 and 3	August 2022	GPTW	Satisfactory	Includes wellbeing metrics
3	Retention Data	Ls 1 and 2	Ongoing	GPTW	Satisfactory	
4	Sickness Data	Ls 1 and 2	Ongoing	GPTW	Work in progress	Concern level remains above target
4	Turnover Data	Ls 1 and 2	Ongoing	GPTW	Satisfactory	
5	Annual Working Well Assurance Report	L2	June 2023	GPTW	Satisfactory	

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions:	Action Owner:	Deadline [revised deadline] Complete / In Progress / Delayed / Not Started
1	International Recruitment – additional partnering for RMNs	11 RMNs arrived in early 2024. Pathway for international recruits to our ICT teams has been developed. Philippines licence application in progress to support a wider search for suitably experienced IENs. Consideration of visa sponsorship and IEN business case by Exec in April.	D HR&OD	In progress
2	Return to practice	Review opportunities to increase RTP recruits for 2023, 2024 cohort	D HR&OD	In progress -Sept 24
3	Remuneration Review	2022 pay review paid at end Sept. Work to calculate the implications of paying the Living Wage underway. Will require ICS and regional consultation. Band 2-3 transition programme - implemented from end April.	D HR&OD	In progress - Q1 24/25

4	ICS Providers Cost of Living Support review	ICS wide Cost of Living support review commended in July 22, with further recommendations expected in year.	D HR&OD	In progress
5	Launch International AHP Recruitment	1 Physio & 1 OT joined through this pathway. AHP secondment created within ICT's to focus on recruitment and retention, including international opportunities.	DHR&OD/DNTQ	
6	Improved long term nursing workforce supply modelling	Health Education England have facilitated 2 "Supply Scenario Modelling (Optioneering) Tool Scoping Workshop" that we have participated in. Further NHSE sessions are underway to review the aims of the Long Term Workforce Plan and how we work as a SW region to implement this.	DHR&OD	In progress
7	Implementation of the Nursing and Midwifery Self-Assessment Tool and action plan	New work stream commenced in Q3. Quarterly updates provided to GPTW. Latest update to GPTW – Oct 23, ICS Nov 2023.	DHR&OD	In Progress – Q1 24/25
8.	Review Recruitment & Retention Framework impact	To include consideration of how we recruit from under represented communities (geographic, demographic, & protected characteristics) and potential links to voluntary sector. Further work with the ICS volunteer network seeking to improve opportunities for under-represented communities. 2 cohorts of the NHS Cadets programme launched in Jan 24 to attract young people who may be at particular risk of not continuing with training or education.	DHR&OD	
9	Increase careers, widening access and apprenticeship engagement	GHC Careers and Engagement Officer connecting with schools, DQP, communities and diversity groups including recruitment to apprenticeship talent pool	DHR&OD	In Progress
10	Agreement for use of Section 256 monies to run a series of 2023/24 ICS wide recruitment campaigns	Initial work to develop a campaign to attract more GPs to work in Gloucs complete. Attention will now focus on recruitment to careers with C&YP within health and social care in Gloucestershire.	DHRD&OD	Launch Q4
11	Submission of a bid to NHSE to support IR recruitment for social care in GCC and GHC	After a successful bid, campaign underway to increase IR into unregistered Adult social care positions in Gloucs. GHC is supporting this with expert pastoral care and onboarding advice.	DHRD&OD	**Complete**
12	Launch International Educated Nurse Council	Launched Sept 2023	DDHR&OD	**Complete**
13	Renewal of funding for the system-wide Mental Health and Wellbeing service (The Wellbeing Line - TWBL), (which is funded through the ICS until March 24) to be identified as priority with ICS.	Funding agreed 24/25	DDHR&OD	**Complete**
14	Retention within Trust – facilitation of movement between Teams/services opportunities to be supported.	Consideration of how to equip staff to move between teams	DDHR&OD	In Progress
15	Violence and Aggression Strategic Plan	V&A Strategic Framework stakeholder engagement sessions ran through Nov 2023 (summary to GPTW Dec 2023) and work is underway to build the themes into the strategic framework.	DDHROD	Delayed – deputy direct HR now in post
16	Industrial Relations /Staff Engagement Activities	Comms processes to be reviewed	Exec	Not started
17	New Agency rate cards and cessation of off framework agency use.	Implementation across the South West may encourage further uptake of substantive recruitment.	DDHROD	In progress

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

Better Health</td><td>Exec Risk Owner</td><td>N Savage, DHR&OD</td><td>Date of review:</td><td>April 24</td></tr>
<tr><td>Risk ID:</td><td>4</td><td>Description:</td><td colspan="3" rowspan="6">Inclusive Culture (Internal)

There is a risk that we fail to deliver our commitment to having a fully inclusive and engaging culture with kind and compassionate leadership, strong values and behaviours which negatively impacts on retention and recruitment, colleagues experience and engagement and on our ability to address inequalities in service delivery (access, experience and outcomes).</td><td>Lead Committee</td><td>GPTW</td><td>Date of next review:</td><td>June 24</td></tr>
<tr><td colspan="3">Risk Rating:
(Consequence x Likelihood):</td><td colspan="4">Relevant Key Performance Indicators:</td></tr>
<tr><td colspan="2">Date Risk Identified/confirmed</td><td>Oct 2023 (Updated from 2022)</td><td colspan="4" rowspan="5">• Staff Survey and Pulse Surveys
• HR Formal Casework report
• Just & Learning Culture e-learning
• Diversity levels at Band 8 and above – area of ongoing work
• Freedom to Speaking up Data
• WRES Data
• WDES Data
• Gender Pay Gap Data
• Service User Equality Access Data – when available
• Recruitment metrics from underrepresented communities</td></tr>
<tr><td></td><td>Likelihood</td><td>Impact</td><td>Overall</td></tr>
<tr><td colspan="2">Inherent Risk Score:</td><td>3</td><td>3</td><td>9</td></tr>
<tr><td colspan="2">Current Risk Score:</td><td>3</td><td>~~23~~</td><td>9</td></tr>
<tr><td colspan="2">Target Score:</td><td>3</td><td>2</td><td>6</td></tr>
<tr><td>Date to Achieve Target Score</td><td>1st April 2025</td><td colspan="2">Tolerance</td><td>6</td><td colspan="4"></td></tr>
<tr><td colspan="5">Potential or actual origin of the risk:</td><td colspan="5">Updated format for 2023-25 BAF (previously in 2021 BAF)</td></tr>
<tr><td colspan="10">Rationale for current score: (What is the justification for the current risk score)</td></tr>
<tr><td colspan="10">The organisation Values & Behaviours work was co-developed, agreed and is now embedded within key policies, reward/award process, recruitment, inductions and appraisals to help ensure the culture reflects Trust and Board commitments. The Speaking Up at Work and Freedom to Speak Up Policies plus the developing Diversity Networks are used to inform and develop practice provide assurance that the values and behaviours are being lived throughout the organisation. The Civility Saves Lives programme is now implemented alongside a Restorative, Just & Learning Culture approach. A new Freedom To Speak Up Policy in place following a new national template policy. The 2023 Staff Survey indicators for ‘compassionate and inclusive culture’ place our Trust above the average score for all trust wide indicators, with 73.9% of colleagues stating they would recommend the organisation as a place to work. However feedback indicators continue to show less good experience for some colleagues related to protected characteristics so this remains an area of ongoing focus. The survey reports a 9% increase in discrimination on the grounds of ethnicity, combined with feedback from IEN Council in Quarter 4, it is recommended that the score of this risk be increased. A programme of work is in place to address this including the launch of the anti-discrimination abuse road map and toolkit in March.</td></tr>
<tr><td colspan="10">Links to Risk Register</td></tr>
<tr><td colspan="10"></td></tr>
</table>

Controls: (What do we currently have in place to control the risk?)		**Last Review Date:**	**Next Review Date:**	**Reviewed by:**	**Gaps in Controls:** (What additional controls should we seek?)
1	Co-developed Values & Behaviours organisational values	01/06/23	01/11/23	Board	
2	Just culture and appreciative enquiry processes included in performance management & Disciplinary Processes	01/09/23	01/12/23	Executive	Learning from HR casework event and wider benchmarking
3	Valuing Difference Leadership Strategy in place	1/06/23	01/12/23	Executive	
4	Freedom to Speak Up, Speaking up at work policies	01/06/23	01/12/23	Board	
5	Co-production commitment to service design	Ongoing		Board	
6	Learning and Development Strategic Framework	01/06/23	01/12/23	GPTW	

Sources of Assurance: (How do we know if the things we are doing are having an impact?)		**Lines of assurance:** L1 – Operational L2 – Board oversight L3 – Independent	**Last Received**	**Received by**	**Assurance Rating**	**Gaps in Assurance:** (What additional assurances should we seek?)
1	Feedback from appraisals and reward award processes	L1	Ongoing	Exec	Satisfactory	Gap between colleagues reported uptake and internal ESR records. Reported usefulness.
2	Disability Confident Leader Accreditation	L3	Aug 2023	Exec	Satisfactory	
3	Annual Workforce Race Equality Scheme & Action Plan	Ls 2 and 3	July 2023	Board	Satisfactory	
4	Annual Disability Equality Scheme & Action Plan	Ls 2 and 3	July 2023	Board	Satisfactory	
5	Patient & Staff Surveys	Ls 1,2 and 3	Mar 2024	Board	Satisfactory	
6	Freedom to Speak Up 6 monthly report	Ls 1,2 and L3	May 2024	Board	Satisfactory	
7	Diversity Networks with Lead NED in place	L2	Ongoing	Board/Exec	Satisfactory	Evaluation of impact and outcomes of networks - co-production with members, exit interviews
8	Gender Pay Gap Reporting	Ls 2 and 3	Mar 2024	Board	Satisfactory	
9	Internal Audit on EDI	L3	May 2023	Comm	Satisfactory	

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		**Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions:**	**Action Owner:**	**Deadline** [revised deadline] Complete / In Progress / Delayed / Not Started
1.	Senior management diversity – Bands 8 and above to be developed.	Reciprocal Mentoring and Flourish Leadership Development programmes in place and ongoing. Flourish review scheduled.	D HR&OD	In progress
2	Equality &Diversity Training to be updated.	New ED focussed 'safer recruitment' training implemented. Updated E&D Training to be implemented to reflect "Dignity at Work practice review - Just and Learning Culture". EDI recruitment / interviewer programme in place for Board-level appointments	D HR&OD	In progress
3	Annual EDI action plan formalised, which includes key statutory requirements and stretch milestones.	Work towards a single EDI action plan continues against priorities raised through the staff surveys, and 6 'high impact actions' specified by NHSE. Board seminar April 24 to ensure that Board member actions are clearly defined and aligned to these priorities	D HR&OD	In Progress – Seminar postponed
4	Values and Behaviours Review survey	Scoping work with UoG commenced delivery through Qs 3 and 4.	D HR & OD	In progress
5	Review of Apprenticeship (widening access) policy and pay	Commenced Q4 – delayed due to prioritisation of b2/3 project	ADELD	In progress
6	Recruitment metrics to be reviewed	Focus on underrepresented communities – geography, demographics & protected characteristics	D HR&OD	Not Started to be considered
7	External Culture review commissioned	Expert review to be commissioned in targeted in-patient areas.	DHR&OD	Q1
8	Anti-racism campaign	Launch of campaign and roll out. Roadmap, resources, video and training workshops	DHR&OD	In progress

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<table>
<tr><td colspan="4">Strategic Aim:</td><td>Better Health</td><td>Exec Risk Owner</td><td>Angela Potter, Dir of Strategy & Partnerships</td><td>Date of review:</td><td>April 24</td></tr>
<tr><td>Risk ID:</td><td>5</td><td colspan="2">Description:</td><td rowspan="3">Partnership Culture

There is a risk that the Trust is not seen as, and does not maintain focus on being, an organisation which actively engages with its patients, staff and wider community partners impacting on our ability to deliver co-produced, personalised, high-quality services and address inequalities in health service delivery (access, experience and outcomes).</td><td>Lead Committee</td><td>Board</td><td>Date of next review:</td><td>June 24</td></tr>
<tr><td colspan="4">Risk Rating:
(Consequence x Likelihood):</td><td colspan="4" rowspan="2">Relevant Key Performance Indicators:
(taken from the Performance Report)
• Number of Engagement Partners
• Number of services redesigned using co production
• Number and breadth of services covered by Experts by Experience?
• Staff Diversity data reflects our community
• Patient Diversity Data reflects our community – available but needs to be more widely promoted and used
• Working Together Advisory Committee feedback</td></tr>
<tr><td colspan="2">Date Risk Identified/confirmed</td><td colspan="2">Oct 2023 (updated from 2022)</td></tr>
<tr><td colspan="2"></td><td>Likelihood</td><td>Impact</td><td>Overall</td><td colspan="4"></td></tr>
<tr><td colspan="2">Inherent Risk Score:</td><td>3</td><td>3</td><td>9</td><td colspan="4"></td></tr>
<tr><td colspan="2">Current Risk Score:</td><td><s>3</s> 2</td><td>3</td><td><s>9</s> 6</td><td colspan="4"></td></tr>
<tr><td colspan="2">Target Score:</td><td>2</td><td>3</td><td>6</td><td colspan="4"></td></tr>
<tr><td>Date to Achieve Target Score</td><td>1st April 2024</td><td>Tolerance</td><td>12</td><td colspan="5"></td></tr>
<tr><td colspan="4">Potential or actual origin of the risk:</td><td colspan="5">Similar risk on BAF since 2019. Refined Oct 2023.</td></tr>
<tr><td colspan="9">Rationale for current score: (What is the justification for the current risk score)</td></tr>
<tr><td colspan="9">Partnership working, co-production and personalised care are central to the Trust's ways of working. There is clear leadership around the personalisation agenda through the Quality Improvement Team and the Partnership Team providing a consistent approach to how the Trust is taking forward co-production and working with stakeholders to achieve this. The Working Together Advisory Committee is in place, providing strong oversight, and engagement with system partners. CMHT programme has strong partner engagement throughout and an evaluation will take place to review all aspects including engagement. All actions proposed have now been completed and the experts by experience cohort is growing. Work is ongoing to further embed co-production & personalisation within the organisation with clear work plans in place.</td></tr>
<tr><td colspan="9">Links to Risk Register</td></tr>
<tr><td colspan="9"></td></tr>
</table>

Controls: (What do we currently have in place to control the risk?)		**Last Review Date:**	**Next Review Date:**	**Reviewed by:**	**Gaps in Controls:** (What additional controls should we seek?)
1	Directorate for Strategy and Partnership with engaged team embedded in the communities we serve	Agreed as part merger	-	Board	
2	Joint Director with GCCG to support working with GP Network	Agreed as part merger	-	Board	
3	Expert by Experience Programme	21/22	22/23	D S&P	
4	Governor Membership & Engagement Strategy	31/3/21	June 23	Council of Governors/Board	Action Plan to be implemented

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

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		**Update since last reviewed (this should be high-level actions – the detail of the actions part of regular committee discussions:**	**Action Owner:**	**Deadline** [revised deadline] Complete / In Progress / Delayed / Not Started
1	Personalisation of Care to be a confirmed element of co-production and service review	A clear work plan is now in place with a focus on 'What Matters to Me' folders being piloted and a roll out plan is being taken forward to expand across IP wards and community hospitals. Updates to SLN (last in Feb 24). S117 work plan in place with resources co-produced with EBE via Inclusion Glos.	D S&P	In progress
2	Experts by Experience Review	EBE numbers continue to increase – focus on recruiting young experts and those with physical health conditions. Policy review underway.	D S&P	In progress
3	Governor Membership & Engagement Action Plan	To be implemented – partners and members to be put in place. Action plan review by Governors by end June 24.	Dir CG	In Progress – June 24
4	Walk in My Shoes Programme	To be reviewed for impact – application to Charity Commission to register WIMS as a CIO submitted. Discussions with ICB ongoing.	CEO	Delayed
5	Patient Access and Involvement Data to be developed	BI have developed a range of data tools to enable understanding of our cohorts at team and patient level and demographic data is being introduced into reporting. Building into Measuring What Matters Phase 2 to raise profile and utilisation across ops teams. Plan for roll out to be developed.	DD of BI	In Progress

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<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="3">High Quality Care
Better Health
Great Place to Work</td><td>Exec Risk Owner</td><td>Sandra Betney D of F</td><td>Date of review:</td><td>April 24</td></tr>
<tr><td>Risk ID:</td><td>6</td><td>Description:</td><td colspan="3" rowspan="6">Level & Prioritisation of Funding
There is a risk that National and System Funding is insufficient, and does not effectively balance and prioritise the breadth and range of NHS provision, resulting in an inability to meet demand and delays in individuals being seen.</td><td>Lead Committee</td><td>Board</td><td>Date of next review:</td><td>June 24</td></tr>
<tr><td colspan="3">Risk Rating:
(Consequence x Likelihood):</td><td colspan="4" rowspan="2">Relevant Key Performance Indicators:
• NHS Funding Settlement
• ICS Funding Settlement
• Access waiting times</td></tr>
<tr><td colspan="3">Date Risk Identified/confirmed</td><td colspan="3">2023</td></tr>
<tr><td colspan="3"></td><td>Likelihood</td><td>Impact</td><td>Overall</td></tr>
<tr><td colspan="3">Inherent Risk Score:</td><td>4</td><td>4</td><td>16</td></tr>
<tr><td colspan="3">Current Risk Score:</td><td>3</td><td>4</td><td>~~9~~ 12</td></tr>
<tr><td colspan="3">Target Risk:</td><td>3</td><td>3</td><td>9</td></tr>
<tr><td colspan="2">Date to Achieve Target Score</td><td>March 2025</td><td colspan="2">Tolerance</td><td>10</td></tr>
<tr><td colspan="4">Potential or actual origin of the risk:</td><td colspan="7">2023 (national and system funding risks brought together from 2022 BAF)</td></tr>
<tr><td colspan="11">Rationale for current score:
(What is the justification for the current risk score)</td></tr>
<tr><td colspan="11">The Trust's ability to directly impact on national funding is limited, but the Trust is active nationally in NHS Providers, the ICS and in community and mental health networks to support understanding of the roles of these services in supporting the population of the community and recognition of the need for their distinct funding. Gloucestershire submitted a balanced plan for 23/24. During 23/24 the System has had to deal with the inflationary pressures and underfunded pay award and deliver efficiency. The System is still delivering on the plan as originally submitted. It does not appear as if the national economic position has had a disproportionate effect on NHS funding. The 24/25 financial outlook for the system and the Trust is however challenging with a current projected deficit of £28m (following review, proposal to revise risk wording to There is a risk that financial constraints will impact the ability of commissioners to commit to long term transformation of services to meet the needs of the populations we serve).</td></tr>
<tr><td colspan="11">Links to Risk Register</td></tr>
<tr><td colspan="11"></td></tr>
</table>

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

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

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions:	Action Owner:	Deadline [revised deadline] Complete / In Progress / Delayed / Not Started
1	Continue to provide information to NHS Providers to demonstrate wider impact of the NHS settlement in keeping individuals able to return to work/self-care.	Ongoing	CEO/DoF	Ongoing
2	Continue to work with community and mental health networks	Ongoing	CEO/COO	Ongoing
3	Continue to be active ICS Partner making best use of Gloucestershire pound	Ongoing	CEO/DoF	Ongoing

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<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="3">Sustainability</td><td>Exec Risk Owner</td><td>Angela Potter, Director of S&P</td><td>Date of review:</td><td>April 24</td></tr>
<tr><td>Risk ID:</td><td>7</td><td>Description:</td><td colspan="3" rowspan="8">Sustainability (environment)

There is a risk that responding to the climate emergency is not prioritised resulting in the failure to transform and deliver the Green Plan.</td><td>Lead Committee</td><td>Resources</td><td>Date of next review:</td><td>June 24</td></tr>
<tr><td colspan="3">Risk Rating:
(Consequence x Likelihood):</td><td colspan="4">Relevant Key Performance Indicators:</td></tr>
<tr><td colspan="3">Date Risk Identified/confirmed</td><td colspan="4">2023 Reviewed & 2022 Risk maintained</td></tr>
<tr><td colspan="3"></td><td>Likelihood</td><td>Impact</td><td>Overall</td><td colspan="4" rowspan="4">• Green Plan in Place on track
• Green Plan Targets/KPIs</td></tr>
<tr><td colspan="3">Inherent Risk Score:</td><td>4</td><td>3</td><td>12</td></tr>
<tr><td colspan="3">Current Risk Score:</td><td><s>3</s> 2</td><td>3</td><td><s>9</s> 6</td></tr>
<tr><td colspan="3">Target Score:</td><td>2</td><td>3</td><td>6</td></tr>
<tr><td>Date to Achieve Target Score</td><td>March 2025</td><td>Tolerance</td><td colspan="3">TBC</td><td colspan="4"></td></tr>
<tr><td colspan="4">Potential or actual origin of the risk:</td><td colspan="6">Recognition of need to keep a holistic oversight on Trust's approach to sustainability which helps drive change.</td></tr>
<tr><td colspan="10">Rationale for current score:
(What is the justification for the current risk score)</td></tr>
<tr><td colspan="10">Sustainability (environment) has been identified as an area of ongoing focus for the Trust. A Green Plan, with Board input, was developed to support this work. (Green Plan Guidance (A three-year strategy towards net zero) has been issued by NHSE/I with Trust plans required by January 2022 and system-wide plans by end March 2022). The focus of the risk has moved from set up to taking forward of breadth of actions. Progress is being made in overall carbon reduction and the Sustainability Steering Group in place to bring together a wider Trust wide focus to the broader issues of sustainability development including workforce, procurement, anchor institution work. External funding bid for the works to upgrade the Charlton Lane boilers has now been secured and work is now being scheduled which means we are now on line to deliver the key net zero activities.</td></tr>
<tr><td colspan="10">Links to Risk Register</td></tr>
<tr><td colspan="10"></td></tr>
</table>

Controls: (What do we currently have in place to control the risk?)		Last Review Date:	Next Review Date:	Reviewed by:	Gaps in Controls: (What additional controls should we seek?)
1	Estates Environment Measures monitoring	Ongoing	Mar 24	Head of Sustainability	Annual Monitoring in Place
2	Management structure to support sustainability in place – Directorate responsibility DSP and Head of Resources in Place	Nov 2020	-	DSP	
3	Relationships in place to support joint working on this issue	Ongoing	-	DSP	
4	Commitment to sustainability within Trust Business Plan	Mar 22	Mar 24	Board	Need to embed the sustainability culture further
5	Commitment to sustainability within Trust Strategy	Mar 22	Mar 24	Board	

Sources of Assurance: (How do we know if the things we are doing are having an impact?)		Lines of assurance: L1 - Operational L2 - Board oversight L3 – Independent	Last Received	Received by	Assurance Rating	Gaps in Assurance: (What additional assurances should we seek?)
1	Estates Reporting on environmental measures within annual report	L2	May 23	Board	Satisfactory	Reporting in progress for 2024 report
2	Procurement processes in place which include high level consideration of sustainability	L1	2023	Resources	Satisfactory	Embed sustainability within procurement at all levels.
3	Sustainability Annual Report at Board level to contextualise this work.	L2	Nov 2023	Board	Satisfactory	
4	Resources Committee Review	L2	April 2024	Resources	Satisfactory	
5	Sustainability Maturity Internal Audit	L3	2023	Resources	Satisfactory	Environmental maturity assessment completed – 1 domain assessed as mature, 3 as defined and 1 Amber – all actions being taken forward

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions:	Action Owner:	Deadline [revised deadline] Complete / In Progress / Delayed / Not Started
1	Embed sustainability considerations into Trust Procurement processes	Work ongoing to further develop sustainability considerations into Trust wide procurement processes – beyond estates procurement. Key sustainability projects taking place.	DSP	**In progress**
2	Consider future reporting mechanisms for sustainability to ensure impact is recognised and built upon	Dashboard has been developed for wider monitoring of sustainability to be considered as part of the green plan development	H of Sustainability	**In progress** – discussions with BI
3	Explore external funding sources and grant applications	Government PSDS funding bid successful for Charlton lane boiler replacement.	DSP	**Complete**
4	Improve awareness of sustainability agenda across organisation	Successful Better Care Together Event on 20th March with over 80 attendees from the Trust & local system. A number of key projects commencing including a focus on food waste, and the Gloves-Off campaign to reduce non-sterile glove use and a patchwork project to repair and reduce the disposal of expensive medical equipment	DSP	Ongoing

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<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="3">High Quality Care
Better Health</td><td>Exec Risk Owner</td><td>Sandra Betney DoF</td><td>Date of review:</td><td>April 24</td></tr>
<tr><td>Risk ID:</td><td>8</td><td>Description:</td><td colspan="3" rowspan="6">Cyber
There is a risk that we do not adequately maintain and protect the breadth of our IT infrastructure and software resulting in a failure to protect continuity/ quality of patient care, safeguard the integrity of service user and colleague data and performance/monitoring data.

]</td><td>Lead Committee</td><td>Audit</td><td>Date of next review:</td><td>June 24</td></tr>
<tr><td colspan="3">Risk Rating:
(Consequence x Likelihood):</td><td colspan="4" rowspan="5">Relevant Key Performance Indicators:
(taken from the Performance Report/ Quality Dashboard)

Cyber Essentials Plus Certification
Colleague Cyber Training</td></tr>
<tr><td colspan="2">Date Risk
Identified/confirmed</td><td colspan="2">2023 (originated 2022)</td></tr>
<tr><td colspan="2"></td><td>Likelihood</td><td>Impact</td><td>Overall</td></tr>
<tr><td colspan="2">Inherent Risk Score:</td><td>4</td><td>5</td><td>20</td></tr>
<tr><td colspan="2">Current Risk Score:</td><td>3</td><td>4</td><td>12</td></tr>
<tr><td colspan="2">Target Score:</td><td>2</td><td>4</td><td>6</td></tr>
<tr><td>Date to Achieve Target Score</td><td>1 April 2025</td><td>Tolerance</td><td colspan="2">6</td></tr>
<tr><td colspan="3">Potential or actual origin of the risk:</td><td colspan="7">Risk identified at Board Risk Seminar March 2022, informed by the growing risks in the corporate risk register relating to cyber security. Confirmed ongoing 2023 with additional recognition of risks to service user and colleague data and performance monitoring data.</td></tr>
<tr><td colspan="10">Rationale for current score: (What is the justification for the current risk score)</td></tr>
<tr><td colspan="10">(Redacted – full review by Audit and Assurance Committee May 2024).</td></tr>
<tr><td colspan="10">Links to Risk Register</td></tr>
<tr><td colspan="10"></td></tr>
</table>

<table>
<tr><td>Risk ID:</td><td>9</td><td colspan="2">Description:</td><td colspan="2" rowspan="6">Strategic Focus
There is a risk that operational challenges and the constrained financial challenges to meet system imperatives mean that Board and Executive focus is not sufficiently strategic and holistic, resulting in a failure to achieve transformation and the agreed Board Strategic Aims.</td><td>Lead Committee</td><td>Board</td><td>Date of next review:</td><td>June 24</td></tr>
<tr><td colspan="4">Risk Rating:
(Consequence x Likelihood):</td><td colspan="4">Relevant Key Performance Indicators:
(taken from the Performance Report/ Quality Dashboard)</td></tr>
<tr><td colspan="2">Date Risk
Identified/confirmed</td><td colspan="2">2023</td><td colspan="4" rowspan="4">It is recognised that there is an inter relation of this risk and risks 5 – Partnership Culture, Risk 3 Colleague Recruitment and Retention and that if risk 9 increases in likelihood that risks 3 and 5 are also likely to increase.</td></tr>
<tr><td colspan="2"></td><td>Likelihood</td><td>Impact</td><td>Overall</td></tr>
<tr><td colspan="2">Inherent Risk Score:</td><td>3</td><td>4</td><td>12</td></tr>
<tr><td colspan="2">Current Risk Score:</td><td>3</td><td>3</td><td><s>9</s> 6</td></tr>
<tr><td colspan="2">Target Risk:</td><td>3</td><td>2</td><td>6</td><td colspan="4"></td></tr>
<tr><td>Date to Achieve Target Score</td><td>March 2025</td><td>Tolerance</td><td>10</td><td colspan="6"></td></tr>
<tr><td colspan="4">Potential or actual origin of the risk:</td><td colspan="6">Builds on previous risk relating to diversion of time due to system demands.</td></tr>
<tr><td colspan="10">Rationale for current score:
(What is the justification for the current risk score)</td></tr>
<tr><td colspan="10">Recognition that ongoing operational demands, at both Trust and system level can divert time and focus from transformational activity. There is a need to invest adequately to fund transformation.</td></tr>
<tr><td colspan="10">Links to Risk Register</td></tr>
<tr><td colspan="10"></td></tr>
</table>

Controls: (What do we currently have in place to control the risk?)			**Last Review Date:**	**Next Review Date:**	**Reviewed by:**	**Gaps in Controls:** (What additional controls should we seek?)
1.	Executive Review of Transformation Programme		Bi monthly	Jan 24	Exec	
2.	Exec Prioritisation of transformation Programme		Annually	Feb 24	Exec	
3.	Strategic Oversight Group		Ongoing	Ongoing	Exec/Board	
4.	Board Development Time – review of Strategy Progress		March	Annual	Board	
Sources of Assurance: (How do we know if the things we are doing are having an impact?)		**Lines of assurance:** L1 - Operational L2 - Board oversight L3 – Independent	**Last Received**	**Received by**	**Assurance Rating**	**Gaps in Assurance:** (What additional assurances should we seek?)
1	Board Strategy Reporting	L2	Every other month	Board	Satisfactory	Incorporated into the CEO report as BAU
2	Enabling Strategies Reporting	L2	6 monthly	Relevant Committees	Satisfactory	
3	Overarching Board Strategy Reviews	L2	Annual (July 23)	Board	Satisfactory	
4	Core Strategies Reviews	L2	6 monthly	Relevant Committees	Satisfactory	
5	Urgent care transformation programme	L1	Monthly	Board/Comm	Satisfactory	Clear governance and reporting process for the system wide urgent care transformation is in development. COO us a member of the programme delivery group.

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		**Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions:**	**Action Owner:**	**Deadline** [revised deadline] Complete / In Progress / Delayed / Not Started
1	Ensure that performance reporting is considered against impact on achieving long term strategic goals	Ongoing	Exec	Ongoing
2	Ensure that overarching Strategy achievement progress is considered to identify if performance is impacting on this risk and remedial action considered.	Strategic oversight group mapping the organisational programmes of work with the ICS clinical programme groups and ensuring alignment and attendance.	Execs	**In progress**
3	Annual strategy review took place to reconfirm overarching direction of travel and impacts of ICS strategy	Board Development session took place January & July 2023 and further sessions planned for 2024	DS&P	**In progress**
4	Full participation in the urgent care transformation programme	Working as One update to Trust Board – Jan 24. Trust input into the delivery and governance structure now clearer.	Execs	**Ongoing**
5	Ensure Board Development Programme – sessions and seminars has long term strategic as well as operational focus.	Board Seminar and Development Programme Cycle for 2023/24 to be finalised and outline for 2024-25 to be developed.	DoG	**In progress**
6	Development of Service Frameworks	Scope of work developed		**In progress**

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<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="3">High Quality Care
Better Health
Great Place to Work</td><td>Exec Risk Owner</td><td>DoF/ CEO</td><td>Date of review:</td><td>April 24</td></tr>
<tr><td>Risk ID:</td><td>10</td><td>Description:</td><td colspan="3" rowspan="6">System Operation
There is a risk that controls, practices and processes are inconsistent across the ICS resulting in the Trust being impacted by risks which are not within its direct control.</td><td>Lead Committee</td><td>Board</td><td>Date of next review:</td><td>June 24</td></tr>
<tr><td colspan="3">Risk Rating:
(Consequence x Likelihood):</td><td colspan="4">Relevant Key Performance Indicators:
(taken from the Performance Report/ Quality Dashboard)</td></tr>
<tr><td colspan="2">Date Risk
Identified/confirmed</td><td>2023</td><td colspan="4" rowspan="4">ICS Updates to Board.</td></tr>
<tr><td></td><td>Likelihood</td><td>Impact</td><td>Overall</td></tr>
<tr><td colspan="2">Inherent Risk Score:</td><td>3</td><td>4</td><td>12</td></tr>
<tr><td colspan="2">Current Risk Score:</td><td>3</td><td>2</td><td>6 ~~9~~</td></tr>
<tr><td colspan="2">Target Risk:</td><td>3</td><td>2</td><td>6</td><td colspan="4"></td></tr>
<tr><td>Date to Achieve Target Score</td><td>March 2025</td><td>Tolerance</td><td>12</td><td colspan="6"></td></tr>
<tr><td colspan="3">Potential or actual origin of the risk:</td><td colspan="7">2023 – recognises ICS Working requires best practice common systems and practices to be in place.</td></tr>
<tr><td colspan="10">Rationale for current score:
(What is the justification for the current risk score)</td></tr>
<tr><td colspan="10">There is a need for best practice common controls, practices and processes across the ICS. At this stage this is broadly understood but actions have not been put in place to review and implement.</td></tr>
<tr><td colspan="10">Links to Risk Register</td></tr>
<tr><td colspan="10"></td></tr>
</table>

Controls: (What do we currently have in place to control the risk?)		**Last Review Date:**	**Next Review Date:**	**Reviewed by:**	**Gaps in Controls:** (What additional controls should we seek?)
1.	Membership of ICS Board	Every other month	Dec 23	Board	
2.	Membership of ICS Strategic Executive Meetings	Ongoing	Ongoing	Exec	
3.	Finance Directors Meetings	Ongoing	Ongoing	Exec/Board	
4.	ICS Risk Reporting	Every other month	Dec 23	Board	

Sources of Assurance: (How do we know if the things we are doing are having an impact?)		**Lines of assurance:** L1 - Operational L2 - Board oversight L3 – Independent	**Last Received**	**Received by**	**Assurance Rating**	**Gaps in Assurance:** (What additional assurances should we seek?)
1	ICS Reports to Board	L2	Every other month	Board		
2	Common Internal Auditors for system	L3	Ongoing	Audit Comm	Satisfactory	
3	ICS Exec Level Meetings	L1	Ongoing	Exec Level ICS Mtgs		

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		**Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions:**	**Action Owner:**	**Deadline** [revised deadline] Complete / In Progress / Delayed / Not Started
1	Review governance controls, processes and practices for the system to ensure fully compatible	System approach to be reinforced by GHC exec & Board	CEO/DoF	**In progress**
2	Continue to monitor and promote commonality of finance controls for system	All organisations using NHSE Grip and Control checklist, Investment control mechanism in place.	DoF	**Complete**
3	Continue to monitor and promote implementation of cyber controls across the system	Cyber exercise review planned cross system	DoF	**Ongoing**
4	Continue to monitor and promote implementation of system approach to workforce management.	Safer staffing review across ICS commenced. Commonalities across e-rostering and job planning being explored	DHR	**In progress**

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<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="3">High Quality Care
Better Health
Great Place to Work</td><td>Exec Risk Owner</td><td>DNTQ/ DHR</td><td>Date of review:</td><td>April 24</td></tr>
<tr><td>Risk ID:</td><td>11</td><td>Description:</td><td colspan="3" rowspan="6">Closed Culture
There is a risk of closed cultures existing within the organisation, where problems and concerns are not openly shared and acted on, either locally and/or at a Trust level, resulting in vulnerable and isolated patient groups being at risk of harm.</td><td>Lead Committee</td><td>Board</td><td>Date of next review:</td><td>June 24</td></tr>
<tr><td colspan="3">Risk Rating:
(Consequence x Likelihood):</td><td colspan="4">Relevant Key Performance Indicators:
(taken from the Performance Report/ Quality Dashboard)</td></tr>
<tr><td colspan="2">Date Risk
Identified/confirmed</td><td>2023</td><td colspan="4" rowspan="3">Independent advocate activity data (TBC)
Training Compliance
Vacancy rates
Clinical supervision rates
Complaints and compliments
Reported incidents</td></tr>
<tr><td></td><td>Likelihood</td><td>Impact</td><td>Overall</td></tr>
<tr><td>Inherent Risk Score:</td><td>3</td><td>4</td><td>12</td></tr>
<tr><td>Current Risk Score:</td><td>3</td><td>4</td><td>12</td><td colspan="4" rowspan="2"></td></tr>
<tr><td>Target Score:</td><td>2</td><td>3</td><td>6</td></tr>
<tr><td>Date to Achieve Target Score</td><td>March 2025</td><td>Tolerance</td><td>10</td><td colspan="6"></td></tr>
<tr><td colspan="3">Potential or actual origin of the risk:</td><td colspan="7">Identified following reflection on Edenfield case, issues identified within the Trust and at other Trusts.</td></tr>
<tr><td colspan="10">Rationale for current score:
(What is the justification for the current risk score)</td></tr>
<tr><td colspan="10">The Trust has in place a range of processes to support an open culture, such as Freedom to Speak Up, Civility at Work, options to raise concerns confidentiality or via CEO or Board member, however it recognises this is an area where vigilance is required where supporting vulnerable and/or isolated patient groups. Trust internal audit to test Trust's ability to detect concerns has been undertaken. The audit raised some challenging issues and an action plan is in place with progress oversight from the Quality Committee and reports to Audit and Assurance. Reporting on closed culture in higher risk areas being developed, including collation of key metrics with increased granularity for inclusion in the Quality Dashboard. Lesson learned exercise commissioned to strengthen board and organisational assurance in relation to governance and oversight of higher risk service areas in particular those at risk of closed culture has been undertaken.</td></tr>
<tr><td colspan="10">Links to Risk Register</td></tr>
<tr><td colspan="10">387 – Berkeley House Closed Culture</td></tr>
</table>

Controls: (What do we currently have in place to control the risk?)		**Last Review Date:**	**Next Review Date:**	**Reviewed by:**	**Gaps in Controls:** (What additional controls should we seek?)
1.	Quality Report	Aug	Monthly	Qual Comm/Board	Collation and presentation of key metrics relating to closed culture.
2.	Quality Dashboard	Aug	Monthly	Qual Comm/Board	
3.	Freedom to Speak up Policy and Processes	6 Monthly	Dec	Board	
4.	SIRI and Complaint Reporting Processes	Ongoing	Ongoing	Qual Comm/Board	
5.	Leadership Training, including reflection on mechanisms to avoid closed culture	Ongoing	Ongoing	GPTW Comm	

Sources of Assurance: (How do we know if the things we are doing are having an impact?)		**Lines of assurance:** L1 - Operational L2 - Board oversight L3 – Independent	**Last Received**	**Received by**	**Assurance Rating**	**Gaps in Assurance:** (What additional assurances should we seek?)
1	Safeguarding Reports	L1	Annual	Annual	Satisfactory	
2	Safeguarding Internal Audit Report	L1	Ongoing	Ongoing	Satisfactory	
3	Non-Exec Quality Visits	L2	Ongoing	Ongoing	Satisfactory	
4	Internal Audit FSU	L3	Aug 23	Audit Comm/Qual Comm	Satisfactory	
5	Clinical Issues Report	L2	Dec 23	Board	Some Concerns	Further reporting ongoing
6	Internal Audit Closed Culture	L3	Nov 23	Board	Limited	Audit Comm Review in February

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		**Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions:**	**Action Owner**	**Deadline** [revised deadline] Complete / In Progress / Delayed / Not Started
1	Ensure robust processes in place relating to Closed Culture at Wotton Lawn Hospital	Consistent good quality data around mitigating metrics regularly received and reported. No ongoing concerns noted. Evidence of good practice.	DNTQ	**Complete**
2	To expand patient safety data set to include themes related to restrictive practice. Particular attention is being applied to improving recording of rapid tranquilisation and continued focused work in falls reduction	Included in the Quality Dashboard	DNTQ	**Complete**
3	Improvement Plan Berkeley House following management reviews and CQC unannounced inspection Sept 23	Review & Development of improvement plan with focus on culture ongoing. Positive feedback from CQC on progress. Trust to apply to CQC to have s31 notice rescinded. Continuation of ICB enhanced surveillance and monthly catch ups.	DNTQ	**In progress**
4	Reviews of practice ongoing to identify improved ways of working & options to identify & then share good practice.	RCP clinical review scheduled to support findings of CQC inspections – evaluate effectiveness of MDTs at BH.	DNTQ/MD	**In progress**
5	Ensure workforce data: clinical supervision, T&D, appraisal, length of service in one area, staff vacancies and safety incidents and complaints/concerns for areas with vulnerable or isolated patient groups regularly triangulated.	Appropriate frequency and reporting mechanism to Board committee/operational groups to be considered – potential for regular deep dives focused on closed culture risks to be assessed. Closed culture dashboard presented to Quality Committee May 24.	Exec	**In progress**
6	Action plan in place against internal audit recommendations	Action plan in place with review at Quality Committee in May.	DoNTQ	In progress – June 24
7	Lesson learned exercise	External facilitated sessions undertaken with Exec and Board. Report pending	DoG	**Complete – report pending**

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<table>
<tr><td colspan="4">Strategic Aim:</td><td colspan="3">High Quality Care
Better Health
Great Place to Work</td><td>Exec Risk Owner</td><td>COO/ DHR</td><td>Date of review:</td><td>April 24</td></tr>
<tr><td>Risk ID:</td><td>12</td><td colspan="2">Description:</td><td colspan="3" rowspan="6">Workforce Transformation – Skill Mix & New Roles
There is a risk the Trust does not invest strategically and sufficiently in colleague's development, meaning that colleagues do not develop the new skills or have the ability to undertake the transformational roles needed for the future, do not have a long-term relationship with the trust and that productivity is below target.</td><td>Lead Committee</td><td>GPTW</td><td>Date of next review:</td><td>June 24</td></tr>
<tr><td colspan="4">Risk Rating:
(Consequence x Likelihood):</td><td colspan="4">Relevant Key Performance Indicators:
(taken from the Performance Report/ Quality Dashboard)</td></tr>
<tr><td colspan="2">Date Risk
Identified/confirmed</td><td colspan="2">2023</td><td colspan="4" rowspan="4">Staff Development Budget %
Digital Budget % transformation related</td></tr>
<tr><td></td><td>Likelihood</td><td>Impact</td><td>Overall</td></tr>
<tr><td colspan="2">Inherent Risk Score:</td><td>3</td><td>4</td><td>12</td></tr>
<tr><td colspan="2">Current Risk Score:</td><td>3</td><td>3</td><td>9</td></tr>
<tr><td colspan="2">Target Risk:</td><td>3</td><td>2</td><td>6</td><td colspan="4" rowspan="2"></td></tr>
<tr><td>Date to Achieve Target Score</td><td>March 2025</td><td>Tolerance</td><td>12</td></tr>
<tr><td colspan="4">Potential or actual origin of the risk:</td><td colspan="7">Reflection of need to ensure focus on transformation of staffing roles and practice.</td></tr>
<tr><td colspan="11">Rationale for current score:
(What is the justification for the current risk score)</td></tr>
<tr><td colspan="11">Recognition of need to equip colleagues for transformed ways of working to support the Trust's long term operation. Recruitment and retention challenges can potentially reduce the focus on this risk.</td></tr>
<tr><td colspan="11">Links to Risk Register</td></tr>
<tr><td colspan="11"></td></tr>
</table>

Controls: (What do we currently have in place to control the risk?)		Last Review Date:	Next Review Date:	Reviewed by:	Gaps in Controls: (What additional controls should we seek?)
1.	Executive Review of Transformation Programme	Bi monthly	Sept 23	Exec	
2.	Exec Prioritisation of transformation Programme	Annually	Feb 24	Exec	
3.	Strategic Oversight Group	Ongoing	Ongoing	Exec/Board	
4.	Board Development Time – review of Strategy Progress	March	Annual	Board	
5.	Staffing Structure Reporting	Ongoing	Ongoing	GPTW	

Sources of Assurance: (How do we know if the things we are doing are having an impact?)		Lines of assurance: L1 - Operational L2 - Board oversight L3 – Independent	Last Received	Received by	Assurance Rating	Gaps in Assurance: (What additional assurances should we seek?)
1	Board Strategy Reporting	L2	Every other month	Board	Satisfactory	Incorporated into the CEO report as BAU
2	Quality, Finance & Workforce Reporting	L2	Monthly	Board/Related Committee	Satisfactory	Exception Reporting in place and any significant changes in performance to be considered to identify if they are being impacted by this risk.
3	Digital Strategy	L2	Annual	Board	Satisfactory	Ensure colleagues provided with best digital tools.
4						
5						

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions:	Action Owner:	Deadline [revised deadline] Complete / In Progress / Delayed / Not Started
1	Ensure that colleague T&D planning and budget commitment is considered through this lens to ensure there is appropriate balance between funding for statutory training and preparing colleagues for future working practice.	Reports to GPTW Committee	DNTQ DHR&OD	**In progress**
2	Ensure mechanisms in place to identify and fund the best digital tools to future proof practice. – regular best practice review in relation to digital innovation	Consider best mechanism to ensure regular review of innovative practice being developed at similar Trusts.	DNTQ DHR&OD	**Not started**
3	Consider mechanism to ensure supervision and appraisal discussions include reflection on wider opportunities within the Trust and development for future roles		DHR&OD	**Not started**

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Strategic Aim:			**High Quality Care, Sustainability** **Better Health, Great Place to Work**	**Exec Risk Owner**	Dir of Gov.	**Date of review:**	April 24
Risk ID:	**13**	**Description:**	**Board Stability** There is a risk that transition of Board members over the next 12 months, Executive and Non-Executive, leads to loss of board capacity (both executive and non-executive) whilst appointment and induction processes are ongoing, which impacts on strategic focus leading to a failure to deliver strategic objectives within planned timescales.	**Lead Committee**	Board	**Date of next review:**	June 24
Risk Rating: (Consequence x Likelihood):				**Relevant Key Performance Indicators:** (taken from the Performance Report/ Quality Dashboard)			
Date Risk Identified/confirmed	Jan 2024						
	Likelihood	**Impact**	**Overall**				
Inherent Risk Score:	**4**	**4**	**16**				
Current Risk Score:	**4**	**3**	**12**				
Target Risk:	**2**	**4**	**8**				
Target Date to Achieve Target Score	**April 25**	**Tolerance**					
Potential or actual origin of the risk:			Risk considered as potential BAF risk in September 23. Further unscheduled resignations of Executives and Non-Executives meant the risk was reviewed and agreed to be raised to a BAF risk.				

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

Chair is currently transitioning from organisation as part of routine succession planning and comprehensive recruitment processes have been undertaken and induction in place. New Chair has been Vice-Chair so appointment will provide consistency, but will leave vacancy of Vice-Chair and NED. Three of Executive Core Team (of 7) leaving within next 6 months. Executives have provided long notice of intentions to support effective transition and comprehensive planning is ongoing. There is one unscheduled Non-Executive vacancy and two expected due to succession planning (plus the Chair). The change of approximately fifty percent of the overall Board will put additional pressure on ongoing Board members, with them holding additional responsibilities and also additional demands on time, to build the new team once appointments made. It is noted that within the wider system there has also been significant change at GHFT, particularly within the Executive members of their Board, and that their Chair has been in place for c1 year. The ICB membership has therefore also changed and additional relationship building time will be required. By October 2024 corporate memory held prior to April 2023 will continue to be significant, but a number of key roles will be developing knowledge of the Trust, and potentially this region.

Links to Risk Register

Controls: (What do we currently have in place to control the risk?)		**Last Review Date:**	**Next Review Date:**	**Reviewed by:**	**Gaps in Controls:** (What additional controls should we seek?)
1.	Appointment Processes – Chair – comprehensive process supported by NHSE and stakeholder engagement	15/03/24	-	Nom and Rem	
2.	Executive Appointment Processes overseen by ATOS	15/03/24	01/07/24	ATOS	
3.	Planned appointment processes NEDS – timing staggered	15/03/24	15/04/24	Nom and Rem	
4.	Induction Processes for new Executive and Non-Executive members	15/03/24	15/06/24	Chair/ ATOS	Targeted programme required to ensure focuses on key aspects to avoid overload. Use of joint inductions to be considered to maximise benefit of executive time spent.
5.	Board Development Planning	15/03/24	15/06/24	Chair/ ATOS	24/25 development programme in place
6.	Succession Planning process – Deputy Executive Directors	15/03/24	01/11/24	ATOS	Deputy Dir HR in post. Next level of structure confirmed as robust.
7.	Board Relationship Building Planning	15/03/24	01/11/24	ATOS	Targeted programme required to ensure focuses on key aspects to avoid overload
8.	Delivery of Strategic Goals	Board	Board		Monitoring to see if on track

Sources of Assurance: (How do we know if the things we are doing are having an impact?)		**Lines of assurance:** L1 – Operational L2 – Board oversight L3 – Independent	**Last Received**	**Received by**	**Assurance Rating**	**Gaps in Assurance:** (What additional assurances should we seek?)
1	Effective appointments made	L3 – NHSE, stakeholders, ATOS	At appointment	ATOS/ Nom Rem	Satisfactory	Ongoing appointment process
2	NED appraisal feedback	L2	Sept 23	Nom Rem	Satisfactory	
3	Executive appraisal feedback	L2	July 23	ATOS	Satisfactory	
4	Staff survey	L1	March 24	Board	March 25	
5	Retention Board members	L2		ATOS		
6	Strategic Goal Progress	L2	Board	Board	Currently on track	

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		**Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions:**	**Action Owner:**	**Deadline** [revised deadline] Complete / In Progress / Delayed / Not Started
1	Acting Up by Current Deputy Executives	To be part of development programme.	CEO	In progress
2	Executive Development Coaching Programme	Ongoing – targeted to provide support	CEO/Chair	In progress
3	Non-Executive Development & Coaching	Targeted programme to be developed.	Chair/ATOS	In progress
4	New CEO /Chair Coaching	Targeted programme to be developed .	Dir of Gov	In progress
5	Review of Non-Executive activities to ensure for 12 months focused on core business.	Director of Governance assessing frequency of meetings, quality visits etc to ensure best use made of NED and ED time.	Dir of Gov	In progress
6	Refocussed board development programme 24/25	Pending discussion with Chair	Chair	In progress

Agreed Risk Appetite Table for Nov 2023- Mar 2025 BAF (following Risk Seminar)

Risk Theme	Appetite Level	Tolerance	Reporting Impact
Research and Innovation	High (Open)	12	Risks scored 13 and up reported
Partnership and Collaboration	High (Open)	12	Risks scored 13 and up reported
Workforce	High (Open)	12	Risks scored 13 and up reported
Quality of Care and Service User Experience	Moderate (Cautious)	10	Risks scored 11 and up reported
Meeting Population Needs	Moderate (Cautious)	10	Risks scored 11 and up reported
Finance	Moderate (Cautious)	10	Risks scored 11 and up reported
Compliance and Regulation	Low (Minimalist)	6	Risks scored 7 and up reported
Information Security (Cyber and Information Governance)	Low (Minimalist)	6	Risks scored 7 and up reported

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

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

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

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REPORT TO: **TRUST BOARD PUBLIC SESSION – 30 May 2024**

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

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

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

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

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

The purpose of this report is to:

Provide assurance to the Trust Board that:

- Speaking Up processes are in place and remain open for colleagues to speak up, be listened to and follow up action occurs
- Speaking Up processes are in line with national guidance
- Continued progress in raising the bar in embedding our positive speaking up culture.

Recommendations and decisions required:

The Trust Board is asked to **Receive, Review** and **Note** information for assurance relating to Freedom to Speak Up activity in 2023-24.

Executive summary

This six-monthly update report covers 2023-24 and gives an overview of the cases, some national and regional updates and the proactive work undertaken by the Freedom to Speak Up Guardian.

There have been 96 speak up cases raised to the Freedom to Speak Up Guardian in 2023-24. There is a notable increase for this year of 25% compared to 2022-23. Previous years data is 77 cases in 2022-23, compared to 54 cases 2021-22, 120 cases in 2020-21 and 60 in 2019-20.

On a quarterly basis, Freedom to Speak Up Guardians are expected to share non-identifiable information with the National Guardian's Office (NGO) about the speaking up cases raised with them. This information provides invaluable insight into the implementation of Freedom to Speak Up and is available to view on the NGO website. National full year consolidated data for 2023-24 is not currently available for benchmarking.

Our new Freedom to Speak Up in-house application that went live on the 30th October 2023 is being utilised by colleagues.

Feedback continues to be positive from colleagues who have accessed the Freedom to Speak Up Guardian service, to include the growing network of Freedom to Speak Up Champions.

Promise element 3: We each have a voice that counts - Nationally the Freedom to Speak Up (raising concerns) sub-score has remained stable with the national average 6.46 this year. As a Trust we rate favourably at 6.92.

In July 2023, BDO our external auditors report concluded a substantial opinion across both the design and effectiveness of the controls in place. Overall, the Trust has a robust Freedom to Speak Up Service in place. Responses to concerns raised are timely and effective, and there are several proactive measures in place to address barriers and promote a positive speaking up culture across the Trust. All actions are in line with agreed dates.

The Quality Strategy review and BDO closed culture review actions are also on target. These actions link to the above audit and are documented in the improvement section of the reflection tool.

Our Freedom to Speak Up Champion Network continues to grow with 90 colleagues now awareness raising, signposting and promoting a positive speaking up culture by supporting the organisation to welcome and celebrate speaking up.

Since my last update various National reports have been published and as a Trust we have an opportunity to reflect on these and capture some learning. Within the Trust the new Freedom to Speak Up policy has been implemented (in line with NHSE/I requirements), and the Guidance for Boards reflection tool continues to be a working document with improvement plans and evidence to support this. The tool will focus on learning and continual improvement to evaluate how healthy the Trust's speaking up culture is.

Risks associated with meeting the Trust's values

All risks are clearly identified within the paper.

Corporate considerations	
Quality Implications	Processes are aligned to the guidance NHE/I and the National Guardian's Office embedded in the NHS Contract. A positive speaking up culture within our workforce will ensure that patient safety matters are heard and that colleagues are supported.
Resource Implications	Continued monitoring of the workload and demand on the Freedom to Speak Up service.
Equality Implications	No issues identified within this report.

Where has this issue been discussed before?
• PowerPoint presentation to the Workforce Management Group 6th March 2024. • Paper, PowerPoint presentation and reflection and planning tool to the Quality Assurance Group 19th April 2024. • Paper, PowerPoint presentation and reflection and planning tool to the Great Place to Work Committee 25th April 2024.

Appendices:	

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

FREEDOM TO SPEAK UP REPORT

1.0 INTRODUCTION

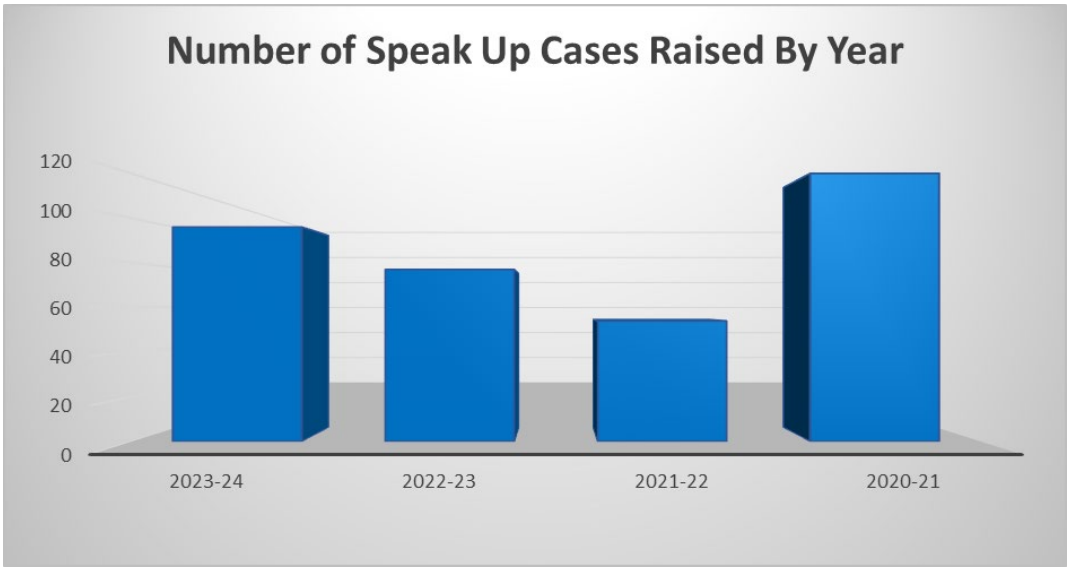
1.1 This bi-annual report is to give assurance to that speaking up processes are in place and remain open for colleagues to speak up, be listened to and follow up action occurs. Colleagues are feedback with outcomes where appropriate.

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

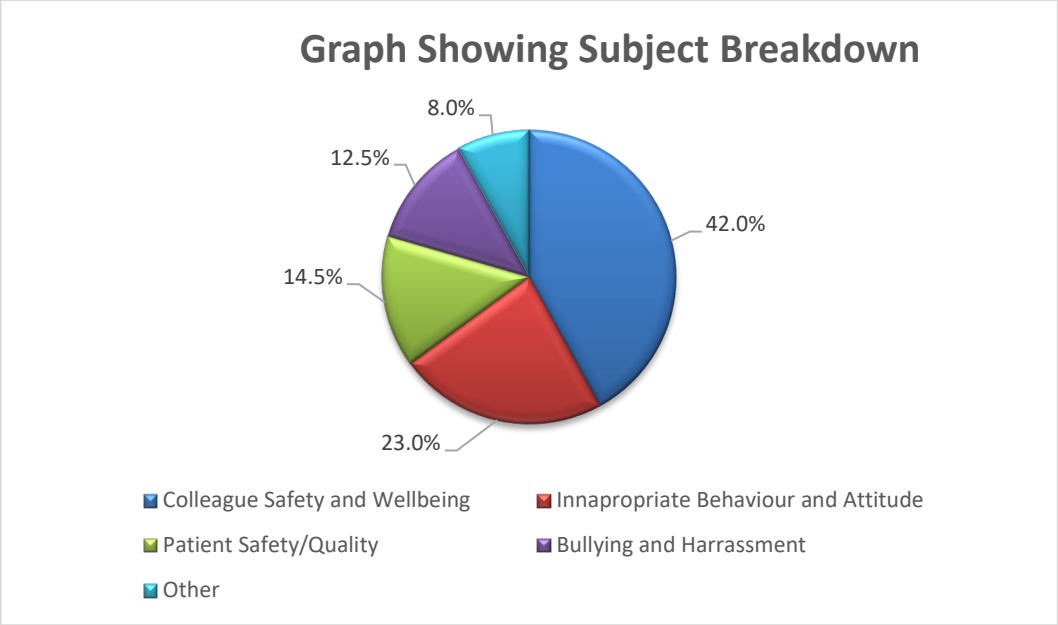
2.0 ASSESSMENT OF FTSU CASES

2.1 This report covers the period of April 2023 - March 2024. It highlights the continued use of Freedom to Speak Up as an as an alternative route for colleagues to speak up either through the Guardian, the Executive and Non-Executive Leads, champions or the in-house application. Data provided are those colleagues that have been supported by the Freedom to Speak Up Guardian.

2.2 There have been 96 speak up cases raised to the Freedom to Speak Up Guardian in 2023-24. There is a notable increase for this year of 25% compared to 2022-23.



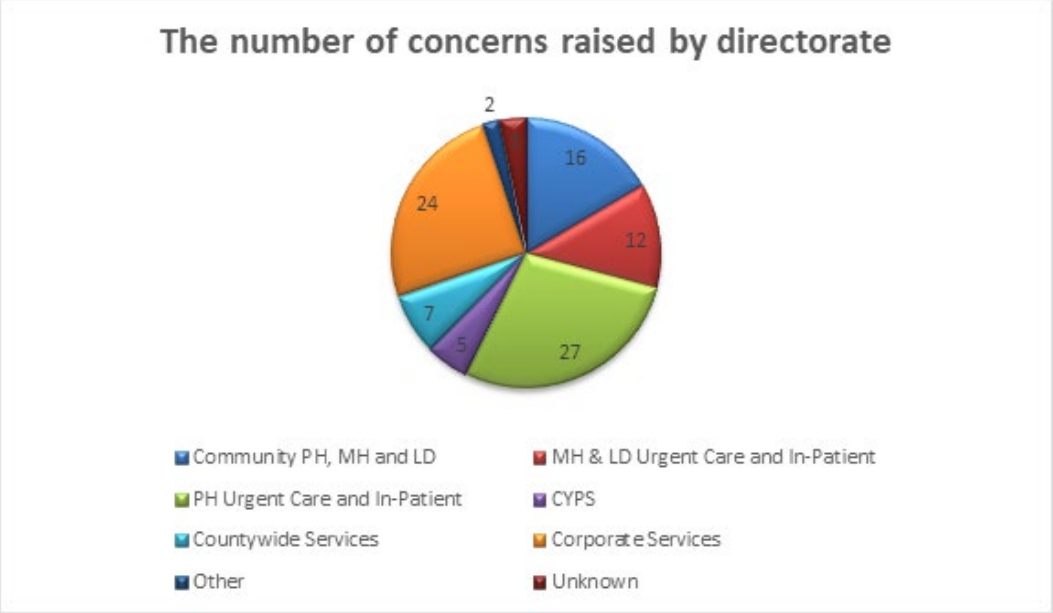
2.3 Nearly half (42%) of themes included an element of colleague safety or wellbeing and 23% with an element of inappropriate behaviours and attitudes (other than bullying and harassment). Patient safety/quality at 14.5% with bullying and harassment reduced at 12.5%.



2.4 There has also been a notable increase in allegations of potential fraud and the GHC Counter Fraud Survey 2023 highlights some further awareness raising that is needed. Overall staff felt comfortable raising concerns about potential fraudulent behaviour, however, the majority would do this via their line manager. Communications were shared to encourage Gloucestershire NHS Counter Fraud Service (GNHSCFS) as the first contact. The Freedom to Speak Up Guardian is working with the Head of GNHSCFS to promote the messaging and improvement work around this.

2.5 Nationally there have been escalating cases of sexual assault and sexual safety of colleagues reported, although non-reported to the Guardian in the Trust. The National Guardian's Office has intelligence from support calls with Freedom to Speak Up Guardians, that that there may be some variation in escalating speak up cases about sexual assault or the sexual safety of a worker to the safeguarding team. Assurance is given that any cases of sexual assault or sexual safety, whether worker or patient, would be escalated to our safeguarding team. Ann Thummler, Specialist Safeguarding Practitioner attended our Champion network in January 2024 where we she supported champions to identify any safeguarding concerns discussed with them and to know where and when to escalate these concerns to. The escalation routes are available to colleagues in the Freedom to Speak Up Policy also.

2.6 From a service directorate perspective, those colleagues working within physical health inpatient and urgent care are the greatest number to speak up to the Freedom to Speak Up Guardian.



2.7 From a professional perspective, Registered Nurses as a group accounted for those speaking up the most at 43 colleagues, followed by administrative and clerical colleagues. Other colleagues as below have also accessed the Freedom to Speak Up Guardian.

2.8 Thirteen colleagues have spoken up to the Freedom to Speak Up Guardian via the new in-house application that went live on the 30th October 2023 and three have chosen to remain anonymous. Anonymous reporting within the

Trust is low compared to benchmarking against other organisations.

2.9 Almost 1 in every 14 cases reported to the Guardian are from colleagues indicating that they have suffered detriment after speaking up. This has been identified as an area of improvement on the reflection tool.

3.0 COLLEAGUE EXPERIENCE FEEDBACK

3.1 Feedback continues to be positive from colleagues who have accessed the Freedom to Speak Up Guardian service, including the growing network of Freedom to Speak Up Champions which now stands at 90 colleagues. Forty-five colleagues provided feedback, 43 said that they would speak up again and 1 maybe and 1 no. Some feedback shared by colleagues is below;

- The Freedom to Speak Up avenue provided a safe impartial space for me to discuss my concerns without worrying too much about what would happen next. Subsequently, I developed the confidence to discuss with my immediate supervisor and then with my team manager which I was nervous to do beforehand. Sometimes, we just need that safe space to sort out our thoughts and have some reassurance that the matter is worth talking about and/or escalating.

- I would absolutely speak up again, as my promise to the NHS was always to do my best and look after the people I care for. Support would always be required as this really has knocked my confidence more than I realised sadly, and I am unsure why, but I still feel I let the patients down as I should have raised things earlier. I am always willing to help you or anyone with anything I can.

- The Freedom to Speak Up avenue provided a safe impartial space for me to discuss my concerns without worrying too much about what would happen next. Subsequently, I developed the confidence to discuss with my immediate supervisor and then with my team manager which I was nervous to do beforehand. Sometimes, we just need that safe space to sort out our thoughts and have some reassurance that the matter is worth talking about and/or escalating.

- Thank you for responding, I would speak up again to resolve issues and knowing the is speak up support.

- I was pleased with your response towards ensuring the situation was resolved and also giving me chance to be heard. Speaking up did give me clear insight on what went wrong and other options to consider to attain positive outcome. I am pleased I found out about such platform in ample time.

- The trust explains always improving and working together. I am not afraid to speak up to make things better. We are all working to make things better for everyone it does not make a different what title you are.

- Yes, I will continue to speak up! I've appreciated the info I've been given, whilst recognising that often issues arise from more subtle aspects of the institutional culture – it's not just about whether Trust policies have been followed. If you get my drift! Thanks again for your help.

4.0 NHS STAFF SURVEY RESULTS 2024

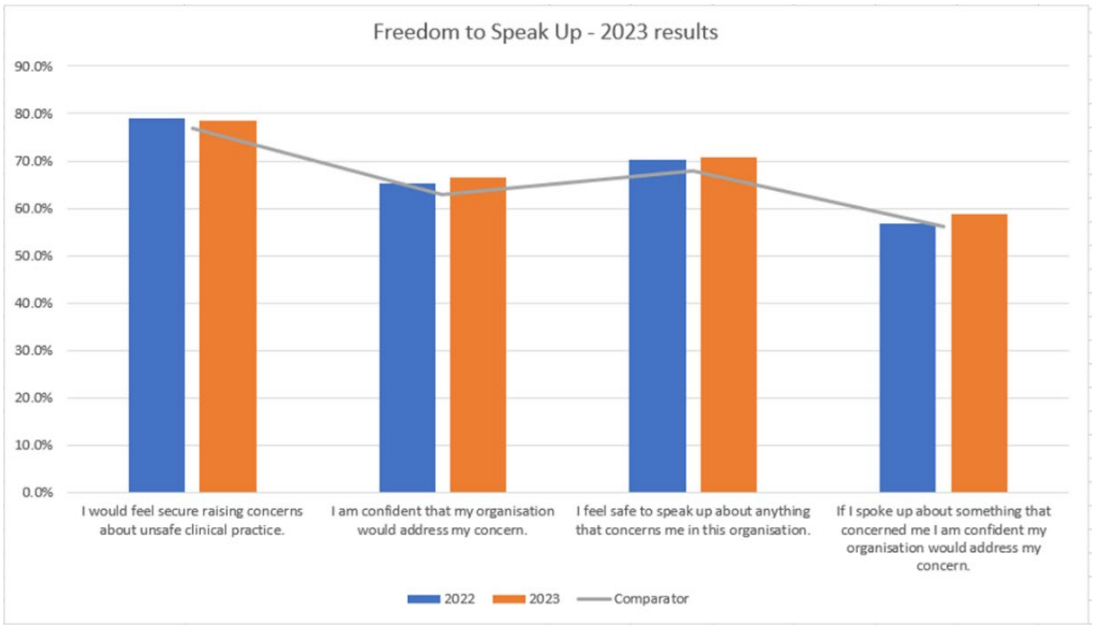
4.1 'We each have a voice that counts' within the NHS Staff Survey 2023 results includes an of focus are the culture of speaking up questions. Nationally the Freedom to Speak Up (raising concerns) sub-score has remained stable with the national average improving from 6.44 in 2022 to 6.46 this year (+0.3% percentage change). There has been an improvement in the national average for three out of the four Freedom to Speak Up questions.

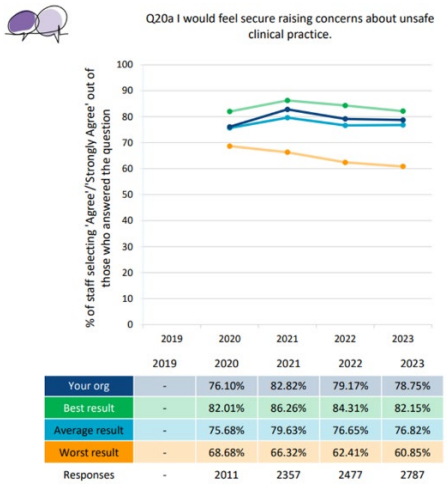
The fear and futility of speaking up, the four questions which make up the Freedom to Speak Up sub-score, can be mapped against two key barriers to speaking up:

1. The fear of detriment, that speaking up is a risky thing to do (questions 20a and 25e);
2. The belief that speaking up is futile - that nothing will happen as a result (questions 20b and 25f).

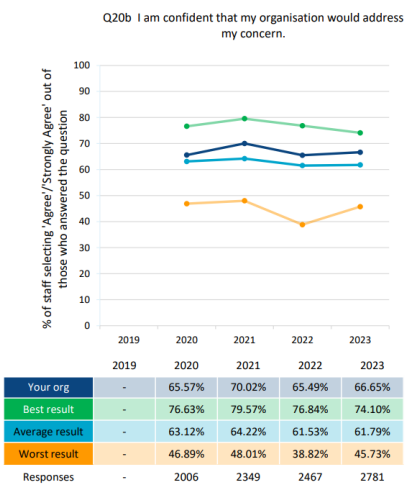
4.2 Within the Trust we rate favourably nationally and against our comparators at 6.92.

People Promise 3, Subscore 2 - Raising concerns	Org.	Sector	Diff.
	6.92	6.79	+0.12 (Not sig.)

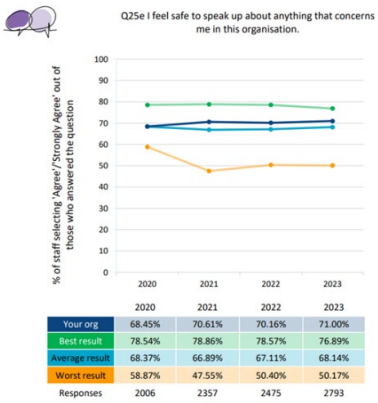




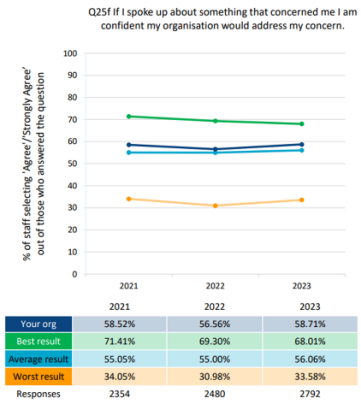
	2019	2020	2021	2022	2023
Your org	-	76.10%	82.82%	79.17%	78.75%
Best result	-	82.01%	86.26%	84.31%	82.15%
Average result	-	75.68%	79.63%	76.65%	76.82%
Worst result	-	68.68%	66.32%	62.41%	60.85%
Responses	-	2011	2357	2477	2787



	2019	2020	2021	2022	2023
Your org	-	65.57%	70.02%	65.49%	66.65%
Best result	-	76.63%	79.57%	76.84%	74.10%
Average result	-	63.12%	64.22%	61.53%	61.79%
Worst result	-	46.89%	48.01%	38.82%	45.73%
Responses	-	2006	2349	2467	2781



	2020	2021	2022	2023
Your org	68.45%	70.61%	70.16%	71.00%
Best result	78.54%	78.86%	78.57%	76.89%
Average result	68.37%	66.89%	67.11%	68.14%
Worst result	58.87%	47.55%	50.40%	50.17%
Responses	2006	2357	2475	2793



	2021	2022	2023
Your org	58.52%	56.56%	58.71%
Best result	71.41%	69.30%	68.01%
Average result	55.05%	55.00%	56.06%
Worst result	34.05%	30.98%	33.58%
Responses	2354	2480	2792

Further analysis of the Staff Survey alongside interventions from our Organisational Development teams has highlighted service areas to focus more visibility, champion development and enhancing the proactive speaking up culture work with in the next 6-12 months. The Freedom to Speak Up Guardian will also work closely with the newly appointed People Promise Manager (NHSE Exemplar programme), priority areas of the people promise one being 'We each have a voice that counts' with particular lens on how we can support people from an ethnic minority background to speak up and be heard. A review has commenced of the people promise self-assessment, within the Trust Freedom to Speak Up assessed as an area of excellence.

5.0 LEARNING AND FURTHER PROACTIVE WORK HIGHLIGHTS

5.1 Our Champion Network continues to grow with 90 colleagues now awareness raising, signposting on and promoting a positive speaking up culture by supporting the organisation to welcome and celebrate speaking up. The network meets on a monthly basis for peer support and development. Some champions attended the National conference in Birmingham face to face and virtually in March, Throughout the day we heard thought-provoking panellists

exploring the barriers to speaking up and one of our colleagues reflected on the day and the learning she will take back to Berkeley House, and how we must all 'Listen to the Silences'.

5.2 The Freedom to Speak Up Guardian continues to deliver bespoke sessions. 'Speaking Up in a Culture of Civility and Respect' reflects on speaking up and the link to patient safety. Alongside organisational development colleagues within our Thrive programme 'Creating Psychological Safety' continues to be delivered with the messaging linking to speaking up and Civility Saves Lives. There is appetite from colleagues to run a part 2 on Civility Saves Lives following Creating Psychological Safety.

Cultural Competence workshops are also part of a series of measures for leaders relating to workplace culture and dealing with bullying and harassment.

5.3 The Freedom to Speak Up Strategic Framework (2024-2026) - An initial draft updated following the BDO audit, is being shared with colleagues through networks and team sessions.

Action: Draft Freedom to Speak Up Strategic Framework to be presented to the Workforce Management Committee in Q2.

5.4 Staff Networks - The Freedom to Speak Up Guardian is an integral member of all the network and offers guidance, support and leadership to the Chair of the Race and Cultural Awareness Network. More recently supporting the Internationally Educated Nurses Council.

5.5 Collaboration continues with the University of Gloucestershire to share Freedom to Speak Up to learners within health.

5.6 National Mentor for Freedom to Speak Up Guardians following stepping down as Chair of the South West Guardian Network in May 2023 (5-year term).

5.7 NHS England have published their cultural review of ambulance trusts following a review by the National Guardian's Office found that the culture in ambulance trusts was having a negative impact on workers' ability to speak up.

Action: Review required to reflect on learning by Q2.

REPORT TO: **TRUST BOARD PUBLIC SESSION – 30 May 2024**

PRESENTED BY: Sandra Betney, Director of Finance & Deputy CEO

AUTHOR: Paul Griffith-Williams, Head of Information Governance & Records

SUBJECT: **SIRO ANNUAL REPORT**

If this report cannot be discussed at a public Board meeting, please explain why.	Content agreed suitable for public board.

This report is provided for:

Decision ☐ Endorsement ☒ Assurance ☒ Information ☐

The purpose of this report is to:

To provide assurance to the Trust Board on the effectiveness of controls for Information Governance, data protection and confidentiality and to document the Trust's compliance with legislative and regulatory requirements.

Recommendations and decisions required

The Trust Board is asked to:

- Take **assurance** that the Trust has effective systems and processes in place to maintain the security of information; and,
- **Endorse** the report.

Executive summary

The Senior Information Risk Owner (SIRO) is responsible for ensuring that organisational information risk is identified and managed across the organisation. This Annual Report provides assurance on practice, progress and developments around Information Governance (IG), Clinical Coding and Records, Data Quality and Cyber/Data Security.

It should be noted that the Trust was able to achieve a DSPT submission (self-assessment) of 'Standards Exceeded' for the 2022/23 year. There were three data breaches that met the threshold for onward reporting to the Information Commissioners Office, two were reported within the 72 hours legal timeframe, the ICO accepted the reason for the one delayed report.

Although we are no longer in a pandemic there continues to be an impact on the IG activity as we continue to move toward new ways of working, embracing more and more within the digital arena. This has continued to increase the demand for advice and support from the

IG team and the IG Group, with the IG Group approving 26 Data Protection Impact Assessments.

This year there has been an increase in Subject Access Requests (SARs) of 4.9%. The number of Freedom of Information Requests received until 3rd April 2024 has also seen an increase of 17%.

Cyber security continues to be a very real risk to the Trust, with IT reviewing cyber threats at weekly meetings. Phishing attacks continue to be a top three cyber risk for the Trust, with the Trust experiencing 1200 phishing email per day. It is worth noting that a system partner's IT systems were compromised by a phishing attack.

Risks associated with meeting the Trust's values

- IG and cyber breaches can result in the disclosure of sensitive patient and staff information;
- IG and cyber breaches can result in significant financial penalties and have a negative impact on the Trust's reputation if breaches occur; and,
- IG and cyber breaches can result in a negative impact on patient care.

Corporate considerations	
Quality Implications	*Ensures the quality of information available to deliver patient care.*
Resource Implications	*Can result in financial penalties if IG breaches occur.*
Equality Implications	*There are none identified*

Where has this issue been discussed before?

The report has been discussed with the SIRO and the Trust's IG Group in April and the Audit and Assurance Committee in May 2024.

Appendices:	NA

Report authorised by: Sandra Betney	**Title:** Director of Finance & Deputy Chief Executive

Annual SIRO Report
2023 – 2024

INTRODUCTION

Welcome to the annual report from the Senior Information Risk Owner (SIRO) for Gloucestershire Health and Care NHS Foundation Trust (GHC). The purpose of the report is to provide assurance to the Board on the effectiveness of controls for Information Governance (IG), data protection and confidentiality. This assurance is provided by the SIRO who has responsibility for information risks and information assets.

The role of SIRO is well established in GHC. The SIRO advocates at Board for relevant control and safety measures to manage and reduce information and security risks in controlling or processing the data the Trust holds. Ensuring effective use of resource, relevant Board commitment, execution of tasks and appropriate communication to all staff of the measures in place. The aim is to create a culture in which information is valued as an asset and information risk is managed in a realistic and effective manner within the legislative frameworks.

During 2023/24 the governance model and structures for IG and Records continue to develop. The IG and records functions for the Trust, have strived to ensure greater resilience and improved governance. There is evidence that IG & records practices are being developed across the organisation, with the conclusion of the SystmOne simplicity programme, and the continued onboarding of an Electronic Management Data System (EMDS) in addition to an increased volume of DPIAs and sharing agreements.

This report provides assurance that robust governance mechanisms are in place to ensure that the Trust remains legally compliant with national guidance and legislation whilst also achieving an ability to ensure operational effectiveness.

Recognising the breadth of the legislation, the SIRO report is divided into four sections:

Section 1: Information Governance

Section 2: Clinical Coding and Health Records

Section 3: Data Quality

Section 4: Cyber / Data Security

Key highlights 2023/2024

- The Information Governance Group met six times and approved 26 Data Protection Impact Assessments to support services;
- The 22/23 final submission for the Data Security and Protection Toolkit was assessed as ‘standards exceeded’ and 23/24 is expected to again meet the standards;
- There has been 3 data breach that met the threshold for onward reporting to the Information Commissioners Office (ICO), alongside one complaint, with a number of changes made as a result;

- The Trust achieved the 95% mandatory compliance target for Data Security and Awareness training, on 9 occasions and maintained an average of 93.6% compliance in the year;
- The Trust achieved Cyber Essential Plus accreditation, one of only two in the South West;
- There have not been any significant health records incidents or losses reported; and,
- The EDMS team (Electronic Document Management System), has now completed a review of all mental health records and they have been ingested into CITO, with a soft go live in March 24.

1.0 INFORMATION GOVERNANCE

The IG Group (IGG) has maintained scrutiny and assurance for the security, integrity and availability of the data utilised. Whilst continuing to review and approve DPIAs (Data Protection Impact Assessments) and sharing agreements.

1.1 Information Governance & Records Team (IG&R)

The IG&R team continues to develop and embed processes and support the recruitment and development of new colleagues within the team. Freedom of Information requests have seen a 17% increase until 3rd April 2024.

Due to recruitment challenges and staff absence Subject Access Requests have not always been returned within the 30-day timeframe and on occasion an extension to 90 days has been required. This has been communicated to the requestor along with the reason for the need to extend.

The IG&R team has delivered operational support, advice, and guidance to colleagues. It also represents the Trust's information governance interests at the ICS level. The Team is an active member of the Gloucestershire Information Governance Group, and the Southwest Strategic Information Governance Network. The Team also delivers the Data Protection role in support of the Trust's compliance with data protection legislation and good practice.

1.2 Information Governance Group (IGG)

The IGG is chaired by the Director of Corporate Governance, with the SIRO, Caldicott Guardian (CG) and Data Protection Officer (DPO) are key members.

IG Group	Apr 23	Jun 23	Aug 23	Oct 23	Dec 23	Feb 24
Chair	✓	✓	✓	✓	✓	✓
SIRO	✓	✓	✓	✓	✓	✓
CG	✓	✓	✓	✓		✓
DPO	✓	✓	✓	✓	✓	✓

(Key member's, or their deputies, attendance)

The IGG's role is to guide the strategic direction of IG within the Trust, ensure IG compliance, support best practice and ensure that all Trust information is:

- Confidential and Secure;
- Of High Quality;
- Relevant and Timely; and,
- Processed Lawfully, Transparently and Fairly.

The IGG met bi-monthly throughout the year.

During 2023/2024, the group has:

- ✓ Set a work plan for the group to formalise and focus activity;
- ✓ Reviewed the asset register and the assigned asset owners;
- ✓ Reviewed the data flows;
- ✓ Reviewed and approved the Data Security & Protection Toolkit (DSPT) interim submission for 23/24 and final submission for 22/23;
- ✓ Reviewed and approved 26 Data Protection Impact Assessments (DPIA);
- ✓ Reviewed and approved 10 data sharing agreements; and,
- ✓ Reviewed and agreed the Trusts training analysis for IG training.

The IGG reports to the Audit and Assurance Committee, a Committee of the Board. This ensures the Board is kept suitably aware of issues and progress being made.

1.3 Data Security and Protection Toolkit (DSPT)

The Trust has submitted both the final submission for 22/23 and the interim baseline submissions for the 23/24 toolkit within the required timescales. The 22/23 final submission was assessed as 'standards exceeded' in June 23. The 23/24 final submission will be made in June 24 and is expected to meet standards.

A mandatory requirement for the submission of the DSPT, is an Independent Assessment of our DSPT submission. The assessment is against a set number of standards set by NHS Digital (NHSD). This was undertaken by the Trust's Internal Auditors BDO, compliant with the NHS audit guidance. The Audit assessed the Trust across all 10 data standards and involved reviewing a total of 13 assertions, with three assertions were rated medium. The overall risk assessment was medium, with an overall high level of confidence in the Trust's DSPT submission.

1.4 Breaches and Near Misses

There have been 373 IG incidents reported in year, of which three were referred to the SIRO and Caldicott Guardian for review and consideration of onward reporting. Three breaches were reported to the ICO (Information Commissioner's Office), within the 72 hours statutory requirement.

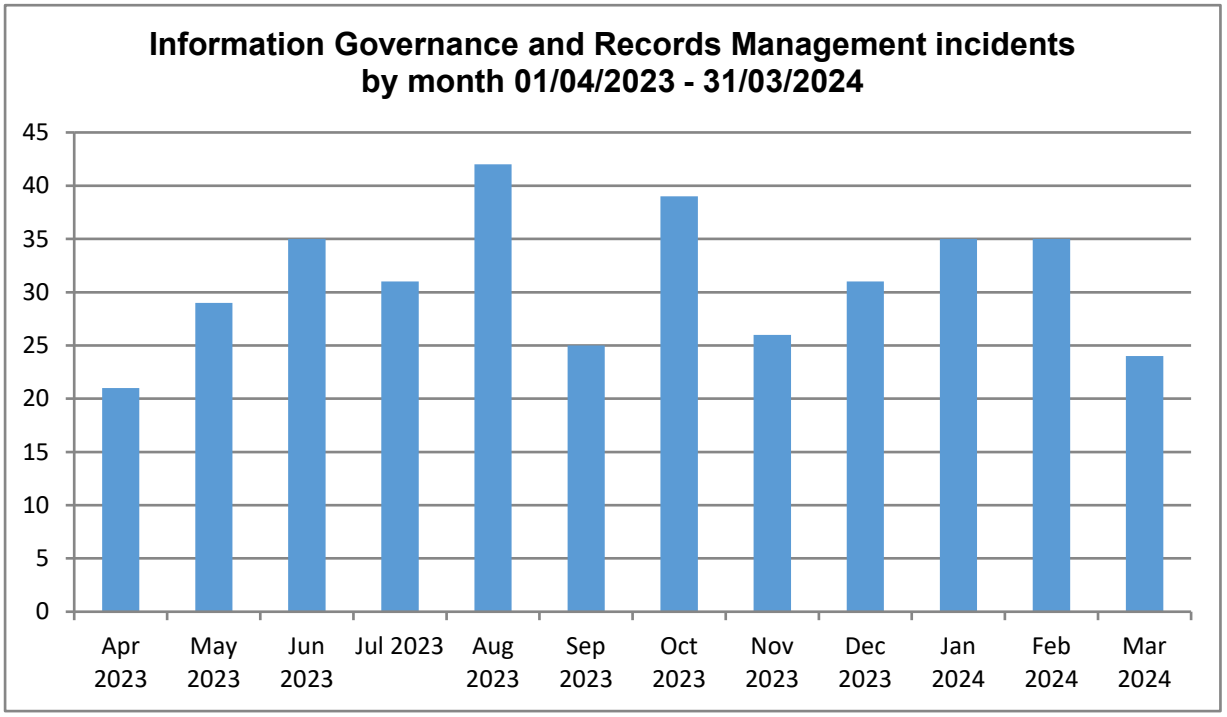
The ICO has advised the Trust they have now concluded their review on two of the breaches, however, they have not yet issued their final report with any enforcement action or recommendations.

As a result of reported breaches for the Trust a number of actions have been

implemented, to prevent or reduce the risks in the future, such as:

- Additional guidance has been provided to clinical teams around the application of the harmfulness test on records to be disclosed and where support is available;
- The SAR team have revised their process to ensure they know where to refer into if they have ongoing concerns about a record to be released; and,
- Information has been provided to clinical teams about marking third part information not to be disclosed.

Below is a report on incidents by month for the last financial year taken from Datix.



There is an increase of 73 incidents from 2022/23, which was 300. The DPO has reviewed the incidents and there does not appear to be any apparent pattern to the incidents or incident type. Although there has been learning for teams and individuals from breaches there has been no organisational learning or trends identified.

1.5 Subject Access Requests (SARs) and Freedom of Information Requests (FOIRs)

Subject Access Requests

The following table sets out activity data for the current and previous years.

	Total requests			Total over time limit		
Request	**2021/22**	**2022/23**	**2023/24**	**2021/22**	**2022/23**	**2023/24**
FOIRs	293	398	466	55	35	164
SARs	968	974	1022	0	7	2

The number of SARs received for 2023/24 have increased by 4.9%.

There may on occasion, where due to size and complexity, SARs can take up to three months to process as per the UK GDPR (General Data Protection Regulation) guidelines. Requestors are kept informed of extensions.

There were 2 SARs over the one-month response time where no extension had been agreed with the requester. One was 22 days over and the other 10 days over the one-month response deadline.

The number of SARs continues to rise, and although there is only limited data, the number of requests appear to peak around specific times of the year;

- Easter holidays;
- Summer holidays; and,
- Christmas holidays.

The reasons for the increase in requests during these periods may be two-fold:

1. People simply have more free time to make requests;
2. Requests are being driven by the economic climate as people look for other ways to supplement income. These times of the year can be the most expensive, particularly for those with young families.

There appears to be a rise in requests from Solicitors for medical records to support 'potential' personal injury claims and clinical injury claims.

SARs vary considerably both in the size of the records and the time involved. A simple request for MIIU records for a specific date / incident could be only 3-4 pages long and take 10 minutes to download, review and send for approval. A more complex request, for example an entire set of Mental Health records dating back several years, which also has paper records that have to be retrieved and scanned, could involve downloading several hundred documents, resulting in a document over 2,000 pages long, taking several days or even weeks to review for redactions of 3rd party information / information considered likely to cause serious harm to the physical or mental health or condition of the patient or any individual lawfully requesting.

It is worthwhile remembering that it is not only the time of the Records Team that is invested in the turnaround of SARs; Clinicians approving records for disclosure also invest considerable time.

Freedom of Information Requests (FOIRs)

The number of FOI requests received up until 3rd April 2024 has increased by 17%. Not all of the FOI requests were answered in the timeframe.

On identifying the overdue FOI requests a structured recovery plan was enacted to understand and rectify the breach and a supported recovery plan in place. Throughout 24/25 a new digital interface is being launched which will flag any requests going over the legislative time frame.

Breakdown of the days over time

Total FOIR requests for April 2023/24: 466		
Days Over time	**Number**	**% of FOIRs**
21 – 25	16	4.23%
26 – 46	57	15.07%
47 +	91	24.07%
Total	164	43.38%
Total FOIs on time	302	64.80%

1.6 IG Training Standard 95%

The Trust achieved the 95% mandatory target for Data Security and Awareness training in compliance with the DSPT. This was achieved this year on a number of occasions, which is a huge improvement from previous years. The IGG, IG&R team and SIRO regularly review training statistics and ways in which to improve compliance to ensure that good IG practices are embedded across the Trust.

The SIRO, Caldicott Guardian and the DPO have undertaken their annual update training specific to their roles in line with the IG training needs analysis. Trust Board Members undertake annual IG training.

The training needs analysis has been updated in line with new guidance and presented to the IGG for reviewed and approval.

1.7 Summary of DPIAs completed and any high risks processing

The IG Group has reviewed and approved 26 DPIAs so far. There have not been any residual high-risk processing issues identified that needed escalation and reporting to the ICO.

1.8 Information Asset Owners & Register

The Trust maintains an information asset register that is reviewed with IT and clinical systems regularly, along with the IGG periodically. As assets are identified they are added accordingly, assets are usually identified through the DPIA review and approval. The asset register also details the Trust assigned Information Asset Owner (IAO) and Information Asset Assistant (IAA).

The IG Group has recognised there is further work required to strengthen the asset register and flow process and embed the role of IAO within the Trust. The Trust engaged the Commissioning Support Unit (CSU) to review the Trust's process, strengthen the current information held, provide assurance on the current position and to consider the development of the asset register, owners and the data flows.

The CSU has fully reviewed the asset register, assigned owners and flows identified. They have linked in with each asset owners and carried out an audit of the register updating the asset register following the returns made by IAOs. They have utilised their knowledge and experience across different NHS organisations to take a view on the Trust's current system. The CSU have concluded that the current system meets the toolkit requirements and the IG Group can take assurance and confidence from it. They

have however made some recommendations to strengthen the system, processes and IAO training to improving the current position.

The IG Group has reviewed the CSU report and agreed to implement a short life working group to consider the recommendations and any changes needed.

1.9 Updated media statement in the event of a data breach

The Trust has a prepared a base media statement that was drafted in conjunction with the Head of Communications, the statement has been shared with the IGG.

1.10 Data Processor update on any issues, contractual updates on compliance with UK GDPR

The IGG has reviewed and approved 10 data sharing agreements in year. There have been no reported issues raised with or by a processor, or UK GDPR compliance concerns.

1.11 Data Flows

The Trust maintains a list of its data flows, the flows are updated by the IG team following DPIA and sharing agreements reviewed and approved in year. The IGG has reviewed the flows register this year and agreed that all known flows were identified and mapped.

The Trust's data flows have been reviewed as part of the CSU's review of the Trust's approach to Information Assets and Asset Owners. The CSU have concluded that the Trust's data flows register meet all requirements of the toolkit and the IG group can take assurance from it.

1.12 IG Risk

IGG manages information governance risks on behalf of the organisations, reporting to the Audit and Assurance Committee. As part of its annual review of Risk Appetite, the Trust Board agreed that it had a 'low risk' appetite for risks relating to information security (cyber and information governance) with an upper risk tolerance score of 6. As a result, all risks rated 7 and above that fall within this category are reported to the Audit and Assurance Committee quarterly for review as the responsible Board Governance Committee.

2.0 CLINICAL CODING AND RECORDS

2.1 Privacy Officer

Privacy officer checks are performed across SystmOne and RIO to ensure staff do not access deducted patient records without a valid reason. At times clinicians and administrators are required to access patient records after the patient has been deduced, on doing so the administrator or clinician will be asked to enter a valid reason on SystmOne or RIO. Privacy reports are run monthly to validate these reasons.

There have been 34,315 SystmOne privacy officer checks performed between April 2023 and February 2024. Of the checks carried out 163 resulted in queries being raised with staff as to why patient records were accessed. Reasons for access have been

queried and responses received. No concerns have been raised following the responses received from staff.

Summary Care Record (SCR) privacy officer checks recommenced in October 2023.

There have been 4,443 SCR privacy officer checks performed between October 2023 and March 2024. Of the checks carried out 96 resulted in queries being raised with staff as to why patient records were accessed. Reasons for access are being considered for any further follow up action.

2.2 Clinical Coding Report Clinical Coding

Finished completed episodes for coding are outsourced to CHKS Limited who review episodes across GHC services and ensure they are coded correctly. All clinical coders are fully trained Accredited Clinical Coders and have attended a clinical coding standards course, regular three yearly refresher training and specialty workshops.

Mental Health

- The coding team rely upon the Nursing/Doctors Summaries to code episodes, followed by accessing the progress notes.
- When Discharge Summaries are not available, the progress notes are used to determine a diagnosis.
- Patient lists are sent to coding on a two-weekly basis.

Sexual health

- Coders access clinic lists on Lillie to code all Sexual Health activity.
- There are issues with coding sexual health episodes, where proformas or sexual reproductive health activity data sets (SRHAD) are not available. Coding reports are sent to Hope House identifying missing documentation, and once rectified the clinical coding for these episodes is completed at a later date.
- There is a longstanding issue regarding clinical codes not being available for use in the Lillie system. The full ICD 10 and OPCS classifications are not available for use by the coder. Episodes are therefore only coded using the codes available and there is a significant risk that episodes are not being coded to national standards.

Rehabilitation

- Episodes that require coding appear on an uncoded report on SystmOne, which the coder can access when needed.
- In the first instance the coding team use the Doctors Discharge Summaries to code, followed by accessing the patient's journal. When a Discharge Summary is not available only information from the patients' journal is used.
- On rare occasions some episodes are unable to be coded. This is due data quality or insufficient data in the patient's journal (the journal is the narrative of the patient's care in the clinical record). On these occasions the episode details are sent to Clinical Systems to rectify.

All the above issues have all been highlighted to the relevant teams in GHC and the coding team continue to work with GHC on improving coding.

2.3 Health Records

Destruction of children's records has been on hold for several years due to the "Independent Inquiry into Child Sexual Abuse (IICSA). In October 2022 the IICSA final report was published. In August 2022 the restriction on the destruction of children's records was removed from the "Records Management Code of Practice 2021, updated August 2022. Children's records that had been held in off-site storage which have reached the retention period are now being destroyed.

There still remains to be a moratorium on the destruction of records in relation to the national infected blood enquiry.

2.4 CITO EDMS Project

Deployment of the CITO Electronic Document Management System (EDMS) to the trust's Mental Health, Physical Health and corporate teams, includes migration of documents from RiO + SystmOne and digitisation of the historical paper health records, currently stored in Crown commercial storage.

The EDMS team now consists of a total of 28 FTE and the rate of work has increased significantly. The team completed processing all mental health records in September 2023. They are now working through the remaining Learning Disabilities and Physical Health records, with a projected end date of May 2024.

One of the biggest challenges in 2024 will be the system, integration work required between CITO and SystmOne. The project team has agreement from TPP the supplier of SystmOne to meet most of the trust's requirements. Some details are yet to be agreed, which may affect the go-live date for physical health services.

<u>Key Milestones Planned for 2024</u>:

- CITO Soft-launch (access to scanned historical mental health records) – March 2024
- CITO eLearning Go-live – TBC
- Full Go-live Mental Health Services – TBC
- Full Go-Live Physical Health Services – Estimate Sept 2024

The EDMS project has made progress in a number of areas during the 2023/24 financial year:

An in-context click-through from the patient record in RiO to CITO has been developed and successfully tested. This will provide a fully integrated view of CITO within the RiO patient record.

A Microsoft Word plugin has been developed by the GHC IT Applications team, in order to save RiO editable letters to CITO. This is currently in the testing phase, due to be signed off in March 2024.

System Configuration and folder structure for Mental and Physical Health Services has been agreed and signed-off by the project board.

2.5 Summary of audits which have Data Privacy/Quality Implications

The clinical audit programme has delivered on a varied programme of audits. There were 154 national and locally agreed clinical audits.

The programme for 23/24 is under review and capacity is being created in the team to support a number of clinical interest audit requests. The outputs of the audits enable us to benchmark a range of quality indicators, share good practice and identify areas for improvement. We monitor the progress of the audit programme through a group of well-established governance and reporting structures which forms part of our Quality Management System. The team reports findings into the Regulatory Compliance Group, Improving Care Group and the Quality Assurance Committee. The audit team have strong links with the Quality Improvement Hub and have supported a number of improvement programmes over the year. The audit team ensure there is a consistent approach to data management and reporting utilising the SNAP digital audit software.

The embedding learning function has been enhanced during the year and the quality team has been testing actions through the fidelity testing process. A structure of assessment using quantitative and qualitative approaches to test the embedded nature of actions arising from a number of learning vehicles has been established. Activity is tracked using the Datix system. Any significant issues that have implications on the Trust's compliance with Data Protection Legislation will be raised with the SIRO, Caldicott Guardian and DPO.

3.0 DATA QUALITY

3.1 Policies

The Trust's IG related policies have all been reviewed and updated accordingly in year. The linked Data Quality policy is under review.

3.2 Business Continuity / Disaster Recovery

The Trust has an incident response policy that forms the backbone of its disaster recovery and business continuity planning. There have been a number of technical incidents this year that have required teams to utilise their business continuity plans including:

- January 2024 – HSCN Network issues for approx. 1hr 30mins all HSCN traffic within Gloucestershire did not flow due to a failed BT firewall upgrade. This impacted on the majority of Trust systems including core clinical system access;
- October 2023 - Legacy 2gether Telephones were unable to make or receive external calls- External calls both incoming and outgoing to former 2g sites stopped due to a routing fault at Gamma from the dedicated telephony circuit at

Rikenel. Charlton Lane telephony circuit was also unavailable due to an ongoing issue. The issue resolved itself after the route to Gamma came back online again;

- October 2023 - Slow Network speeds county wide for several days. The issue was resolved by firewall changes completed by Countywide IT Service (CITS); and,
- August 2023 – External call issues experienced in and out of the former Gloucestershire Care Services Maintel estate.

3.3 Business Intelligence

Since 2019, the Business Intelligence service has been developing its data warehouse to include corporate, as well as clinical data sources. The introduction and ongoing maintenance of these new data tables are offering a new layer of governance and understanding to corporate practice and user habits and will offer further potential as the Trust progresses to align data sets and analyse correlations and understand possible causations. The data warehouse now includes multiple data tables from systems such as workforce, risk, incident management, finance, service experience, training, appraisals, supervision, e-rostering and five clinical systems.

The single Trust Hierarchy underpins the integration of data across all these systems, and the maintenance of this continues to be paramount to the success of the overall product and outputs available. Change control mechanisms to support in-system developments, particularly within SystmOne have become more robust.

For the first time, this aligned warehouse provides the organisation with a single version of the truth with absolute alignment between National, Regional and Local data (external such as ICB agreed, and internal for operational delivery). This is driving operational and management confidence in many areas with Data Quality monitoring reports now reintroduced and a clinical systems audit programme underway.

Although SystmOne Simplicity was closed in 2023, there remains work to improve the physical health community clinical system configuration, record keeping, data quality and associated reporting and further plans in this area are being developed for 2024 now that the Clinical Systems Vision Programme has concluded.

It is recognised that, as with any large organisation, managing multiple corporate and clinical systems, there will be underlying data quality issues, both stemming from business-as-usual data entry errors or user oversights. To mitigate this, data quality reports are published and available to all staff which help feed audit and help monitor operational practice to mitigate this issue. The clinical systems and BI team also run starter and refresher user training to maintain a good level of data recording and report monitoring. BI manage the portfolio of these reports however it is a combination of the Nursing, Quality and Therapies directorate, the Operations Directorate and Clinical Systems that monitor compliance and undertake corporate and clinical audits. A new Data Quality Forum is being established in 2024 by operational services to improve ownership and accountability for data quality within clinical systems.

The Trust currently maintains a full BI reporting suite of information reports that maintains pseudonymised data (through clinical system ID or NHS numbers) with the following exceptions that use patient identifiable information however these are used for direct patient care and clinical monitoring, not research or planning purposes:

- Bed Management Report - Digital Whiteboard (Name and Age) Secure to bed management team, wards and select senior operational managers to manage patient flow which went through a DPIA process;
- Criteria to Reside LoS Reports (Patient Name) Secure to significantly reduced list (from Covid period) of pandemic response leads;
- Covid Lateral Flow Test Results (Patient Name) Secure to significantly reduced list (from Covid period) of pandemic response leads; and,
- There are comparable controls to manage access to corporate reports such as financial budget statements (to budget holders and associated management accountants) and HR Workforce reports (Workforce leads).

There are controls in place to manage access to these reports, and although an automated IT owned, Active Directory solution is still in development, it is currently managed through a locally BI managed list of responsible names that is maintained periodically with the last full review just over 12 months ago. The reports themselves are reviewed annually for use and will be securely archived if no longer required. Access to any of these reports can also be monitored if required.

Although the majority of the Trust's *identifiable* data use is for direct patient care (acceptable) and any planning or development reporting uses *confidential, un-identifiable* data (also acceptable); the Trust does have a technical solution and process in place for instances such as research where future disclosures should have data opt-outs applied. The Trust also handles pseudonymised and anonymised data where appropriate, often for ICS but also GHC management needs.

3.4 ESR

There have not been any system or data security issues in year. Data quality audits and reviews continue to be carried out monthly using system reports. There are no emerging themes or trends following these reviews.

There has been an NHS pension's report highlighting data accuracy issues, that was worked through and resolved with the supplier.

4.0 CYBER / DATA SECURITY

4.1 Access Controls

The Trust follows a well-defined procedure for granting access to our IT and Clinical Systems for new employees and managing access for departing staff. The leaver process is automated, relying on a weekly ESR (Electronic Staff Record) Report from the HR Workforce.

The leaver process disables accounts and archives data.

There have been 1,416 new Active Directory accounts set up, while there have been 906 leavers processed. It is recognised that this process does not suitably cover inter organisational moves as this is reliant on leads notifying IT of the access changes needed.

In line with account segregation guidelines colleagues within the Digital Services team members are issued a separate privileged Active Directory account to complete tasks that require administrative access to GHC devices such as servers, switches, and workstations. Audits also take place every 6-months to ensure the least privilege approach is followed.

Privileged Access Management (PAM) has been purchased to automate secure, authorised access to GHC's back up servers.

There is an ongoing project to deploy an Identity Management system for automating the joiners, leavers, and movers' process. However, the project implementation still faces considerable challenges related to data cleansing.

Various tools are utilised to flag up potential suspicious activity, all GHC Microsoft accounts have Multi-Factor Authentication enforced as an extra layer of protection.

4.2 Cyber Report

The Countywide IT Service (CITS) plays a crucial role in managing the cyber response for the Integrated Care System (ICS). CITS ensures that the ICS Digital Executive Steering Group, which includes the Senior Information Risk Owner (SIRO), receives timely cyber security updates. Weekly meetings hosted by GHC focus on reviewing cyber threats, assigning actions to address potential risks. These threats are identified through various channels, including, Microsoft alerts, Carecert notifications, vendor notifications, and CITS security scans.

GHC also holds responsibility for maintaining accreditation, such as Cyber Essentials Plus. The successful re-certification assessment was completed in October 2023.

CITS conducts monthly penetration testing for GHC, identifying vulnerabilities within the GHC IT Service Management systems. These findings are discussed during weekly GHC Cyber meetings. Additionally, GHC collaborated with an external organisation for penetration testing and a full IT Health check in August 2023. Meanwhile, NHS England performs monthly penetration testing to scan externally facing links, with the infrastructure team addressing any concerns.

4.3 Data Destruction

IT Equipment

There have been no reported issues around data destruction or disposal. The contract is held with Hewlett Packard (HP) and was reviewed July 2021. Devices are collected by HP who in turn issue reports of what has been destroyed, recycled etc. All data is wiped/destroyed to the required standard and a HPEFS Disposal Certificate is provided for each collection.

To date for 2023/2024 GHC have has 14 disposal collections with 4,133 assets returned and processed. 2398 of these assets were recycled.

Print waste

There have been no reported data issues with the print waste contract or supplier. Additionally, the supplier has not highlighted any data issues.

4.4 Cyber Data Security Risks

The Digital Group manages the cyber security risks for the Trust with oversight provided by the Audit and Assurance Committee.

The top three risks are currently:

Risk	Information/Mitigation
Email Phishing	Controls in place are. • Firewalls • Antivirus • ATP There are a number of active work packages to improve the position in this area too.
Servers end of life	Extended support (ESU) is in place to ensure updates will be applied.
Countywide Cyber Security	Gloucestershire health community has a shared cyber resource and tools to protect the environment.

4.5 Phishing

Phishing remains the number one method by which attackers initiate a cyber-attack, this is evidenced within GHC's own environment.

Around 36% of all data breaches involve a phishing attack, with industry research reporting that healthcare and retail workers are more likely to fall victim to a cyber-attack attempt.

The Trust has several technological measures to protect against cyber-attacks. As part of the Trust's response plan and to help protect against phishing attacks we carry out annual phishing campaigns to departments. The results and recommendations falling out of the simulation are reported to and managed through the Digital Group.

4.6 Patching

To minimise risk, GHC has implemented a comprehensive defence-in-depth cyber strategy that includes various solutions to mitigate risks. These solutions encompass firewalls, malware detection and elimination (MDE), the deployment of a Security Information and Event Management (SIEM) solution, and robust antivirus measures.

4.7 Unsupported Software

A review has been carried out of systems, there is an action plan to mitigate risks through the GHT cyber delivery plan:

- Rationalisation of detection and prevention tooling where appropriate. (Security Tools and IT asset Management Projects);
- Introduction of targeted monitoring and alerting across key systems and entry points. (Security tools Project);
- Establishment of comprehensive asset register for devices including medical devices and internet of things. (Security Tools and IT asset Management Projects);
- Review and robust management of third-party suppliers to prevent downstream implications. Meeting requested with Procurement team to take forward; and,
- Removal of all end-of-life software and hardware. (End of life operating systems and legacy Software upgrade projects).

Images, courtesy of Canvas and Getty images

REPORT TO: **TRUST BOARD PUBLIC SESSION – 30 May 2024**

PRESENTED BY: Graham Russell, Trust Chair

AUTHOR: Anna Hilditch, Assistant Trust Secretary

SUBJECT: **APPOINTMENT OF DEPUTY CHAIR AND SENIOR INDEPENDENT DIRECTOR (SID)**

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

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

The purpose of this report is to:

Present the Trust Board with the proposal for the appointment of a new Deputy Trust Chair, and Senior Independent Director (SID).

Recommendations and decisions required

The Trust Board is asked to:

- **Approve** the appointment of Nicola de Iongh as Senior Independent Director, to take effect from 1 July 2024.
- **Note** that the Council of Governors approved the appointment of Nicola de Iongh as Deputy Trust Chair, with effect from 15 May 2024.

Executive Summary

Senior Independent Director
The Board of Directors shall appoint one of the independent Non-Executive Directors (NED) to be the Senior Independent Director (SID), in consultation with the Council of Governors (CoG).

The Board will be aware that the current SID, Marcia Gallagher will be coming to the end of her term on the 30 June 2024. There is therefore a need to nominate a successor to Marcia.

The role description for the SID is included for reference at the end of this paper. This is a Board appointment, taking into account the views of Governors.

Deputy Chair
In line with the Trust's Constitution, *the Council of Governors at a general meeting of the Council shall appoint one of the current non-executive directors as Deputy Chair, on recommendation of the Trust Chair.*

Following the appointment of Graham Russell to the position of Trust Chair, the Deputy Chair position has since become vacant.

The role of the Deputy Chair is to take on responsibilities delegated to them by the Chair and to deputise for them during any absence. They should work closely with the Chair to establish a constructive relationship, share responsibilities and act as a substitute for the Chair whenever required.

PROPOSAL

The Chair, having consulted with Board colleagues, has recommended the appointment of Nicola de longh as both Deputy Chair and Senior Independent Director.

The Trust welcomed Nicola as a NED in July 2022. Nicola is an experienced NED in other sectors and brings great scope to help build stronger relationships with the University of Gloucestershire where she is currently the Chair of Council. Nicola has already made a significant contribution and is a welcome addition to the Board bringing some fresh eyes and experience from outside the NHS. She has very much brought a different skill set, experience, commentary, challenge and helpful opinion to the Board, along with enthusiasm, optimism and humour. Nicola has confirmed that she has the capacity to undertake both roles.

The Code of Governance for NHS Provider Trusts states that the same NED may carry out the role of SID and Deputy Chair. This will help ensure that there is continuity during a period of significant change at Board level and allows for a fuller insight into the Chair's performance when undertaking the annual appraisal.

The role of Deputy Chair carries a responsibility allowance. This will be subject to consideration by the Nominations and Remuneration Committee in June.

Robust discussion took place at the Council of Governors meeting on 15 May about the Deputy Chair and SID appointment, specifically about the capacity of one person to undertake both roles and the experience of the nominated NED to carry out the role of Deputy Chair. Good assurances were received and the Council approved the proposal to appoint Nicola de longh as Deputy Chair and SID.

Corporate considerations	
Quality Implications	
Resource Implications	
Equality Implications	

Where has this issue been discussed before?
Council of Governors and Trust Board.

Report authorised by:	**Title:**
Graham Russell	Trust Chair

Senior Independent Director (SID)
Role Description

1. Eligibility

The Senior Independent Director (SID) is to be a non-executive director (NED) who is considered by the Board of Directors to fulfil the criteria of 'independence' set out by NHSE (NHS England), in the Code of Governance for NHS Provider Trusts. The Chair is not eligible to be the SID. The Deputy Chair is eligible to be the SID.

2. Appointment and Accountability

The SID will be appointed by the Board of Directors, having consulted with the Council of Governors. The Board will review the appointment periodically and may re-appoint or remove the SID from this position; otherwise the appointment of SID will lapse when the holder of this position ceases to hold the position of NED.

The SID will share the general duties of NEDs, and in respect of these duties will be subject to the normal reporting relationships of NEDs.

The SID will have specific duties, defined below, in respect of which the SID will be accountable to the Board of Directors.

3. Specific Duties

a) To undertake and promote Governor engagement on behalf of the Trust Chair and the Board, in order to develop effective working relationships between the Council of Governors and the Board.

b) To attend sufficient meetings of Governors to gain a balanced understanding of the issues which are important to them and any concerns they may have. This should normally be accomplished by attending ordinary meetings of the Council of Governors.

c) To be available to Governors if they have any concerns that contact through the normal channels of Trust Chair, Chief Executive, Finance Director or Trust Secretary has failed to resolve, or for which such contact is inappropriate. This will not replace the formal dispute resolution procedure outlined in the Trust Constitution.

d) To act as a sounding board for the Trust Chair and to serve as an intermediary where necessary

e) To act on behalf of and coordinate views for all Directors, including making him/herself available for confidential discussions if necessary, and ensure that any issues raised are communicated to the Chair or, where appropriate, to the Board as a whole.

f) Be available to Governors as a source of advice and guidance in circumstances where it may be inappropriate to involve the Chair.

g) To facilitate and oversee the performance evaluation of the Chair. This process is set out in the Trust's framework for conducting annual appraisals of the Chair.

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 16/0524

REPORT TO: **TRUST BOARD PUBLIC SESSION – 30 May 2024**

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

AUTHOR: Anna Hilditch, Assistant Trust Secretary

SUBJECT: **USE OF THE TRUST SEAL 2023-2024**

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

The purpose of this report is to:

To provide information to the Trust Board on the use of the Trust Seal, as required by the Trust's Standing Orders, reference section 7.3.

Recommendations and decisions required

The Board is asked to **NOTE** the use of the Trust seal for the period 2023/24 (1st April 2023 – 31st March 2024).

Executive summary

The Trust's Standing Orders require that use of the Trust's Seal be reported to the Trust Board at regular intervals. The common Seal of the Trust is primarily used to seal legal documents such as transfers of land and lease agreements. Up to the 31 March 2024, the seal has been used **19 times (16 x Documents, 3 x Plans).**

Risks associated with meeting the Trust's values

All actions have been taken in accordance with the Trust Board's Scheme of Delegation and no inherent risks are to be reported to the Trust Board in the application of the Corporate Seal.

Corporate considerations	
Quality Implications	Nil
Resource Implications	Nil
Equality Implications	Nil

Where has this issue been discussed before?
Bi-annual reporting to Trust Board

Appendices:	Appendix 1: Register of Seals (1 April 2023 – 31 March 2024)

Report authorised by: Lavinia Rowsell	**Title:** Director of Corporate Governance/Trust Secretary

APPENDIX 1

Gloucestershire Health and Care NHS Foundation Trust

Register of Seals – 1st April 2023 – 31st March 2024

- Q1 & Q2 – 1st April 2023 to 30th September 2023 – **5** x documents signed/sealed
- Q3 & Q4 – 1st October 2023 – 31st March 2024 – **11** x documents & **3** Plans signed/sealed

Seal No.	Date of Sealing	Document Description	No. of Copies	Document Signatory (1)	Document Signatory (2)	Attested by	Attested Date
34/2023	25/04/23	**Deed of Surrender of Part and Variation** Between Invista Textiles (UK) Ltd and GHCNHSFT ***Background:*** *The deed refers to GHC's occupancy of Invista management block where the trust has agreed to surrender part of its demise. The lease will continue on mostly the same terms as those agreed in August 2019*	1	David Noyes COO	Angela Potter Director of Strategy and Partnerships	Lavinia Rowsell Trust Secretary	25 April 2023
35/2023	09 May 2023	**Underlease** Between MD Morgan, SW Heginbotham, AP Gillett & CA Fisher and GHCNHSFT *relating to part second floor, St Paul's Medical Centre, 121 Swindon Rd, Cheltenham, GL50 4DP*	1	Douglas Blair CEO	Angela Potter Director of Strategy & Partnerships	Lavinia Rowsell Trust Secretary	09 May 2023
36/2023	09 May 2023	**Licence to carry out Alterations** Between Assura Properties UK Ltd and GHCNHSFT *Ref: St Paul's Medical Centre, 121 Swindon Rd, Cheltenham, GL50 4DP re installation of new LED lighting*	1	Douglas Blair CEO	Angela Potter Director of Strategy & Partnerships	Lavinia Rowsell Trust Secretary	09 May 2023
37/2023	15 May 2023	**Lease** between Cheltenham Borough Council and GHCNHSFT. *Ref: Oakley Community Resource Centre, Clyde Crescent, Whaddon, Cheltenham*	1	David Noyes COO	Neil Savage Director of HR & OD	Anna Hilditch Deputy Trust Sec	15 August 2023

Seal No.	Date of Sealing	Document Description	No. of Copies	Document Signatory (1)	Document Signatory (2)	Attested by	Attested Date
38/2023	08 Sept 2023	**HM Land Registry TP1** – Title No. GR154951 Engrossment SOSH Transfer 168520 *Ref: Land at West Lodge Drive, Gloucester being part of the former Coney Hill Hospital Site (Holly House).*	1	Douglas Blair CEO	John Trevains Director of Nursing, Quality & Therapies	Louise Moss Deputy Head of Corporate Governance	
39/2023	24 Oct 2023	**Agreement** Between GHCNHSFT and Gloucestershire County Council *Application for Planning Permission re Highways Act 1980 re Playing Field, Steam Mills Road, Cinderford, GL14 3HY – FoD Community Hospital*	1	Douglas Blair CEO	Angela Potter Director of Strategy & Partnerships	Lavinia Rowsell Trust Secretary	24 October 2023
40/2023	13 Nov 2023	**Lease (GR179172) / Plan** between the Landlord, GHCNHSFT and Tenant, South Western Ambulance Services NHS FT *Ref: land, Cleeve House, Horton Road, Gloucester Term 5 yeedge://restart 2023 – 2028. Use as CAP (Community Ambulance Point)*	1	Douglas Blair CEO	Angela Potter Director of Strategy & Partnerships	Lavinia Rowsell Trust Secretary	13 Nov 2023
41/2024	05 March 2024	**MWD 2016 Minor Works Building Contract with contractors Design** Between GHCNHSFT and Keitone Building Ltd *Ref: Rikenel External Wall Rebuild*	1	Douglas Blair CEO	Angela Potter Director of Strategy & Partnerships	Lavinia Rowsell Trust Secretary	05 March 2024
42/2024	18 March 2024	**Lease – GR242721** – Expiry Date 23 May 2034 Between GHCNHSFT and Industrial Sales Ltd *Ref: Avon House, Green Lane Business Park, Tewkesbury, GL20 2SJ*	1	Douglas Blair CEO	Sandra Betney Finance Director	Lavinia Rowsell Trust Secretary	18 March 2024

Seal No.	Date of Sealing	Document Description	No. of Copies	Document Signatory (1)	Document Signatory (2)	Attested by	Attested Date
43/2024	18 March 2024	**Licence to Underlet** Between GHCNHSFT and Assura Properties UK Ltd and Tenants M Morgan, S Heginbotham, A Gillett and C Fisher *Ref: shared space – St Pauls Medical Centre, 121 Swindon Rd, Cheltenham, GL50 4DP*	1	Douglas Blair CEO	Sandra Betney Finance Director	Lavinia Rowsell Trust Secretary	18 March 2024
44/2024	18 March 2024	**Retrospective Licence** for Undertenant to carry out works relating to a shared space / Plan A Between GHCNHSFT and Assura Properties UK Ltd and Tenants M Morgan, S Heginbotham, A Gillett and C Fisher *Ref: shared space – St Pauls Medical Centre, 121 Swindon Rd, Cheltenham, GL50 4DP*	1	Douglas Blair CEO	Sandra Betney Finance Director	Lavinia Rowsell Trust Secretary	18 March 2024
45/2024	18 March 2024	**Underlease / 2 x Plans** Between GHCNHSFT and Tenants M Morgan, S Heginbotham, A Gillett and C Fisher *Ref: shared space part 2nd floor – St Pauls Medical Centre, 121 Swindon Rd, Cheltenham, GL50 4DP*	1	Douglas Blair CEO	Sandra Betney Finance Director	Lavinia Rowsell Trust Secretary	18 March 2024
46/2024	25 March 2024	**Overage Deed** Between GHCNHSFT (seller) and Berkhampstead School (Cheltenham) Trust Ltd (buyer) *Ref: Lexham Lodge, Copt Elm Rd, Charlton Kings, Cheltenham, GL43 8AG*	1	Douglas Blair CEO	David Noyes COO	Lavinia Rowsell Trust Secretary	25 March 2024
47/2024	28 March 2024	**Deed of Covenant** – GR358018 Between GHCNHSFT and NHS Property Services Ltd re Disposal *Ref: Cinderford Health Centre, Dockham Rd, Cinderford, GL14 2AN*	1	Douglas Blair CEO	Angela Potter Director of Strategy & Partnerships	Anna Hilditch Deputy Trust Secretary	28 March 2024

Seal No.	Date of Sealing	Document Description	No. of Copies	Document Signatory (1)	Document Signatory (2)	Attested by	Attested Date
48/2024	28 March 2024	**Underlease** – GR358018 Between GHCNHSFT and Forest Voluntary Action Forum (Charity) (Landlord) *Ref: Cinderford Health Centre, Dockham Road, Cinderford, GL14 2AN*	1	Douglas Blair CEO	Angela Potter Director of Strategy & Partnerships	Anna Hilditch Deputy Trust Secretary	28 March 2024
49/2024	28 March 2024	**Underlease plus Plan** Between GHCNHSFT and English Braids Ltd *Ref: Hangar SE36, Gloucestershire Airport, Staverton, Gloucester*	1	Douglas Blair CEO	Angela Potter Director of Strategy & Partnerships	Anna Hilditch Deputy Trust Secretary	28 March 2024

GLOUCESTERSHIRE HEALTH AND CARE NHS FOUNDATION TRUST
COUNCIL OF GOVERNORS MEETING

Wednesday 13 March 2024
Oxstalls Indoor Tennis Centre, Plock Court, Gloucester

PRESENT:	Ingrid Barker (Chair)	Chris Witham	Kizzy Kukreja
	Mick Gibbons	Bob Lloyd-Smith	Sarah Nicholson
	Steve Lydon	Cath Fern	Paul Winterbottom
	Peter Gardner	David Summers	Andrew Cotterill
	Laura Bailey	Alicia Wynn	Nic Matthews

IN ATTENDANCE:
Steve Alvis, Non-Executive Director
Douglas Blair, Chief Executive
Anna Hilditch, Assistant Trust Secretary
Sumita Hutchison, Non-Executive Director
Nicola de Iongh, Non-Executive Director
Vicci Livingstone-Thompson, Associate Non-Executive Director
Jan Marriott, Non-Executive Director
Lavinia Rowsell, Director of Corporate Governance / Trust Secretary
Graham Russell, Non-Executive Director/Deputy Chair
Neil Savage, Director of Human Resources and OD

1. WELCOMES AND APOLOGIES

1.1 Ingrid Barker welcomed colleagues to the meeting.

1.2 Apologies had been received from the following Governors: Jenny Hincks, Rebecca Halifax, Ismail Surty, Alison Hartless, Erin Murray and Lisa Crooks. Apologies had also been received from Marcia Gallagher, Non-Executive Director.

2. DECLARATIONS OF INTEREST

2.1 There were no new declarations of interest.

3. MINUTES OF THE PREVIOUS MEETING

3.1 The minutes from the previous meetings held on 22 November 2023 and 17 January 2024 were both agreed as a correct record.

4. MATTERS ARISING AND ACTION POINTS

4.1 The actions from the previous meetings were all complete or progressing to plan. There were no other matters arising.

5. GOVERNOR PRE-MEETING UPDATE

5.1 The main points covered at the pre-meeting would be picked up as part of other items on the agenda for the meeting.

6. APPOINTMENT OF TRUST CHAIR

Graham Russell left the meeting at this point

6.1 The purpose of this report was to present the recommendation from the Nominations and Remuneration Committee to the Council of Governors for the appointment of a new Trust Chair.

6.2 The Council of Governors appoints the Trust's Chair and Non-Executive Directors (NEDs). The Council's Nominations and Remuneration Committee has delegated authority from the Council of Governors to undertake the related recruitment process. The Chair recruitment process was agreed by the Nominations and Remuneration Committee at their meeting held on 6 September. Updates on the process have been presented at the full Council meeting via the N&R Committee summary report. Advertising for the post commenced on 17 October, with a closing date of 19 November 2023.

6.3 After the initial search, 4 candidates were shortlisted. However, the circumstances for recruitment had shifted and the decision was taken, in discussion with Governors, to reopen the recruitment to seek additional candidates for the shortlist. An additional 4 weeks recruitment commenced on 22 January. Shortlisting took place and an additional 2 candidates were added to the shortlist.

6.4 Discussion groups (Governors/Experts By Experience, Board Members and External Partners & Stakeholders) took place on Tuesday 5th March. Five candidates took part, noting that one candidate had withdrawn from the process the previous week.

6.5 The formal interviews took place on Friday 8th March. The Governor interview panel was supported by the Senior Independent Director (SID). The Chair of Gloucestershire ICB and the Chair of Devon Partnership Trust also participated in the interview in an advisory capacity.

6.6 The interview panel, having considered feedback from the focus groups and performance at interview, recommended that Graham Russell be appointed as Chair of the Trust. Chris Witham advised that the Nominations and Remuneration Committee endorsed this recommendation at its meeting on Tuesday 12th March, for onward presentation to the full Council of Governors for approval.

6.8 The Council of Governors **approved** the appointment of Graham Russell as the new Trust Chair for a term of 3 years, commencing on 1 May 2024 at a remuneration rate of £47,100k per annum.

6.9 Vicci Livingstone-Thompson asked whether there was a plan in place to replace the NED vacancy that would arise from Graham Russell's new appointment. Lavinia Rowsell advised that recruitment was currently underway for two NEDs and a further round of recruitment to include this new vacancy was planned for later in May. The Nominations and Remuneration Committee would be presented with a report at its May meeting setting out the proposals, to include

a review of the NED skill mix given the departure of Ingrid Barker. She said that work would also be carried out over the coming weeks to agree the process for nominating a new Deputy Chair.

6.10 David Summers suggested that it would be helpful for the Governors to have a session with Graham Russell to discuss plans and ambitions for the Council of Governors going forward. It was agreed that this would be considered further, with the timing and format of such a session to be agreed. **ACTION**

6.11 Paul Winterbottom said that the Trust would be losing a huge amount of organisational memory and intelligence with the upcoming Chair and NED changes and said that the handover period would be extremely important. Ingrid Barker reassured the Council that Graham Russell was already up to speed with key business in his role as Deputy Chair, and he had also been in the Gloucestershire Health system, first with GCS and then GHC since 2016. Graham remaining as Chair would ensure that this memory was retained.

Graham Russell rejoined the meeting at this point

7. NOMINATIONS AND REMUNERATION COMMITTEE SUMMARY REPORT

7.1 The purpose of this report was to provide a summary to the Council of Governors of the business conducted at the Nominations and Remuneration (N&R) Committee, held on 12 March 2024. Chris Witham presented this item.

7.2 It was noted that the key item of business for the Committee's consideration and endorsement was the Chair appointment.

7.3 The Nominations and Remuneration Committee also received a proposal for the completion of the NED and Chair appraisals for 2023/24. Chris Witham said that given the level of turnover and change taking place, a lighter touch approach to appraisals had been proposed. All NEDs would have a 1:1 with Ingrid Barker in advance of her departure at the end of April and the key elements of the appraisal would be covered off, to include NED self-reflection and compliance with the Fit and Proper Person regulations. A mid-year review with all NEDs, to include objective setting would take place later in the year with the new Chair. Colleagues at NHSE had been advised of this years' process.

8. CHAIR'S REPORT

8.1 The Council received the Chair's Report, which outlined the key activities of the Trust Chair and Non-Executive Directors up to the end of January 2024. It was noted that this report had been presented in full to the Trust Board at its meeting on 25 January.

8.2 The Council noted that it continued to be a very busy time, but the Chair's report demonstrated that some great work was taking place, both within GHC and with wider system partners. Ingrid Barker provided the Council with an update on some more recent developments.

8.3 The report provided an update on the upcoming NED changes and an updated NED portfolio document was included for reference, with some changes to

committee membership and Chairing arrangements. Ingrid Barker took this opportunity to thank her non-executive colleagues, noting that the Board was below capacity so everyone was stretched; however, nothing was being dropped and all NED work continued, including quality visits, complaints audits etc.

8.4 Ingrid Barker had attended the NHS Confederation Chairs Meeting in December, and it was noted that the focus of the meeting was productivity. Colleagues were joined by May Li, Interim Director of Efficiency from NHS England and Ed Jones, Senior Policy Advisor, ICS Network from the NHS Confederation. NHS England will start reporting against new productivity metrics regularly from the second half of 2024-25, at a national, integrated care board (ICB) and trust level. New incentives will be introduced to reward providers that deliver productivity improvement at a local level, including through effective investment helping to deliver better outcomes. It was noted that further detail would be set out in the summer.

8.5 Ingrid Barker had participated in the judging panel for the Better Care Together Awards on 18th January. There were 170 nominations across the eight categories, and the panel carefully considered a shortlist of 3 entries per category. The panel felt that the standard of nominations was incredibly high and reflected the breadth and depth of our services. The awards event itself took place on 7th March at Hatherley Manor Hotel and Ingrid said that this had been a truly uplifting event.

8.6 The Council noted the range of meetings that had taken place over the period with local partners and stakeholders, including local MPs and a meeting the Gloucestershire HOSC.

8.7 Chris Witham said that the Governors had carried out a number of discussions at their pre-meeting, and there had been a request for an updated list of locality NED and Governor pairings. This link also included the relevant locality representative from the Partnership and Inclusion Team. It was noted that the NED portfolios were all under review given the changes and new NEDs coming on board, however, once this review had taken place a new listing would be made available to all Governors and NEDs. **ACTION**

8.8 The Council received and noted the content of this report.

9. CHIEF EXECUTIVE'S REPORT

9.1 Douglas Blair provided a written report to the Council which sought to provide an update on various publications and matters of interest. On this occasion it was agreed that a written report would be sensible as it would enable Governors to digest the large quantity of information that would be presented.

Care Quality Commission Inspection Outcome – Berkeley House, Stroud

9.2 On 1st March, the Care Quality Commission (CQC) published a report following an unannounced inspection of Berkeley House, in Stroud. Berkeley House is a six-bedded inpatient unit for people with learning disabilities. The inspection took place

on 10th and 11th October 2023 and the report confirmed the rating for the service has been downgraded from 'good' to 'inadequate'. While the report does detail some positive elements of care and treatment and positive feedback from families and carers, there were, unfortunately, a number of elements highlighted that fall below the standards we aspire to. We had already identified specific quality of care concerns at the unit in summer 2023, through feedback from Trust colleagues and had informed CQC. Unfortunately, actions to establish and resolve issues had not gained sufficient progress ahead of the unannounced CQC inspection.

9.3 We have been working with NHS Gloucestershire as well as Gloucestershire County Council and the NHS England Specialist Learning Disability support team to carry out further reviews and seek additional support on improvements being made. The majority of CQC recommendations have already been partially or completely resolved. The inspection outcome and downgrading of the unit is clearly deeply regrettable but we are grateful to the CQC for the independent scrutiny they have given our service. Our overall priority will always be the health and wellbeing of the people in our care. We are in regular contact with the families of the six people being cared for at Berkeley House and we are supporting them throughout.

9.4 Douglas Blair informed the Council that the Trust had been working with our partners for several years now to address limitations to the environment at Berkeley House which can make it challenging at times to care for those with a high level of need. Over recent months and years, system partners have been working hard to enable individuals to be discharged to more suitable environments as soon as and wherever possible. This work continues, and significant progress is being made, alongside work to redesign the wider support on offer for people with a similar level of need within Gloucestershire over the longer term.

9.5 Paul Winterbottom, Staff Governor and Lead Consultant Psychiatrist at Berkeley House informed the Council that good progress was being made at Berkeley House and said that it would be helpful to have clarity on the future strategic direction for the service.

9.6 Nic Matthews made reference to communications and engagement with colleagues at Berkeley House around the future of the service, noting that there was some concern that staff would not have a job. Douglas Blair said that the next steps were still being worked through with system partners but confirmed that there would be full and proper engagement with all colleagues once in a position to do so.

9.7 David Summers said that the Council needed more assurance from the Trust around Berkeley House. Chas Townley said that this was a tragic position, however, he said that the Trust had been transparent and had acted correctly and had reported its initial concerns to the CQC. The Trust was closely monitoring and reporting on progress against the recommendations. Chas Townley said that it was the Governor's role to provide critical challenge to the Non-Executive Directors.

Forest of Dean Community Hospital Update

9.8 Douglas Blair presented the Council with the proposed dates for the handover and moves of different services to the new community hospital. It was noted that the Trust had experienced some delays, and the reasons for this were set out within the report. Building inspector sign off was due to take place week commencing 15th April. All inpatient activity had now moved across to the Dilke Hospital and as planned we have closed the Lydney inpatient unit. We expect to be in a position to begin moving teams into the new hospital building, beginning on Monday 22nd April.

9.9 Penelope Brown asked about bus routes in the Forest, and specifically buses to and from the new hospital. Douglas Blair said that government funding had been received for a change in bus routes to include the new Hospital, and an improved service across the Forest.

9.10 Chris Witham asked about the Trust's communications plan around the new Forest hospital, noting that he had received some concern from Forest residents at a recent meeting. Douglas Blair said that a communication plan was in place which would become more prominent now that we were in the final stages of the development, but noted that there had been reticence on the level of public communication to be carried out due to delays and changes in dates. Sarah Nicholson said that she had spoken to colleagues in the Forest and they had reported that they felt very well briefed on the transition plans, and had been well engaged.

National Staff Survey Results

9.11 The Trust participated in the National Staff Survey between September and November, giving us feedback on who we are as a Trust, how we treat others and what colleagues would like to see improved. Douglas Blair reported that overall, we have had an improved response rate and the results we can compare showed improvements in many areas. We also continue to compare favourably to other, similar Trusts which is very encouraging. In particular, the proportion of colleagues recommending the Trust as a place to work (73.4%) was one of the highest in the country.

9.12 Some of the key headlines include:

- Year on year improvements in response rates, 58% for 2023 compared with 55% in 2022 and 53% in 2021
- Increases across all Seven People Promises scores
- In the themed additional categories for Staff Engagement and Morale, results improved from 2022 and remained above sector average
- Decreases in the number of colleagues looking for another job in next 12 months and thinking about leaving
- Increases in Friends and Family test questions, now 10% above comparator
- An increase of over 4% of respondents recommending the Trust to work, nearly three quarters of our workforce

9.13 Douglas Blair said that the Trust should be proud of these results, which placed GHC as joint first performer in the South West region. However, in line with the

Trust's values, it was important to look at "always improving", and some specific areas had already been identified for further action. These included colleagues experiencing racial discrimination, wellbeing and further work to hear from those colleagues in certain clinical areas or services.

9.14 David Summers asked who received the Staff Survey and whether individuals were selected to complete it. Douglas Blair advised that all Trust colleagues received a copy of the Staff Survey and were encouraged to complete this each year. The survey was the same for all colleagues and all responses and returns were strictly confidential.

9.15 Vicci Livingstone-Thompson noted the results for colleagues experiencing racial discrimination and made reference to a Global email that had been sent out the previous week addressing this. She said that she welcomed this. Bob Lloyd-Smith said that he had also seen this email and suggested that it be circulated to all Governors for information. **ACTION**

9.16 Chris Witham noted that further work would take place to drill down into the results of the survey and an action plan would be developed over the coming months. However, he wished to congratulate the Trust on the excellent results received, noting that this was a real team effort.

Senior Team Recruitment Update

9.17 Douglas Blair informed the Council that the interviews for the new Director of Nursing, Therapies and Quality had taken place and an extraordinary Appointments and Terms of Service Committee meeting would be taking place later in the week to approve the appointment. He thanked those Governors who had participated on the Focus groups as part of the recruitment process.

9.18 Governors had already been made aware of 2 more Executive Director resignations over the next 6 months, with Angela Potter (Director of Strategy & Partnerships) leaving at the end of May, and David Noyes (Chief Operating Officer) retiring in the autumn. Douglas Blair said that discussions had been taking place and recruitment processes for both positions had been agreed. It was noted that Angela Potter's role and portfolio had been updated slightly, and the role renamed to Director of Improvement and Partnerships.

9.19 Steve Lydon asked whether anything was in place to consider joint Board positions with system partners and the ICB. Douglas Blair said that the Trust already had one joint Director position, Helen Goodey who was the Joint Director of Primary Care and Locality Development. He added that consideration of a joint post had taken place; however, a key role of the Director of Improvement and Partnerships post was to focus on service change and if it was a joint role it was possible to lose focus on that and what was important for GHC. Neil Savage added that the Trust did have a number of joint services with system partners, including payroll services and Working Well Occupational Health.

9.20 The Council of Governors thanked Douglas for his report.

10. MEMBERSHIP ACTVITY AND STATISTICS REPORT

10.1 The Council received this report which provided an update on Trust membership activity and statistics for the period up to 7 March 2024. As of, the Trust had 3179 Public members.

10.2 An overview of Trust membership was presented and included a breakdown of public members by constituency, ethnicity, disability and age profile. As of 7 March, the Trust had 3179 Public members. Of these, 2824 receive communication from the Trust via Email.

10.3 Anna Hilditch advised that a request had been made to the Communications Team to ensure that one page of the Membership Magazine was dedicated to the Council of Governors, and moving forward Governors would be consulted on the content for future editions.

10.4 The Council noted that the team had managed to secure a dedicated Governor & Membership stand at the Trust's upcoming Big Health Day, taking place on Friday 14th June at Oxstalls Tennis Centre. Further discussions would be taking place to plan and coordinate our stand and Governors were invited to help plan for the event, and to attend on the day and help manage the stand. It was noted that this would be a good opportunity to recruit new members, but also for colleagues to engage with both the public and other staff colleagues attending the event.

10.5 On reviewing the current public membership statistics, there was a real interest in drilling down further into areas such as ethnicity, age and rural geography. It was proposed that a meeting of the Governors' Membership & Engagement Committee be scheduled in the coming months and all Governors would be invited to attend this and have the opportunity to learn more about the statistics and focus for membership. **ACTION**

10.6 The Council received and noted the content of this report.

11. GOVERNOR DASHBOARD

11.1 The Governors received the Governor Dashboard, presenting data up to 31 January 2024. The dashboard provides a high-level snapshot to ensure governors have an ongoing sense of how the Trust is performing. This includes key Trust statistics, and the achievement of Trust targets, focussing on the patient experience and quality indicators and workforce targets. It was important to note that information was already available to Governors via public Board papers on the full range of Quality and Performance measures reported by the Trust, so this dashboard was not designed to duplicate this information, simply to highlight some of the key measures that Governors may wish to take assurance from.

11.2 The Governors received and noted the dashboard, which this month had a specific focus on how the Trust receives and reports on compliments and patient feedback.

11.3 It was noted that the dashboard had changed this month and no longer included the full Board Committee summary reports. The summaries were available to all Governors via the Public Board papers and were a few months out of date by the time they were presented at the Council meeting. Discussions had therefore taken place to look at developing this as part of the Governor responsibility of holding the Non-Executive Directors to account, and it was agreed that the NEDs in attendance at the Council meeting would highlight 2 or 3 key areas of interest from the most recent Committee meetings. A table setting out the Committee meetings that had taken place, alongside the key agenda items received, discussed, and noted at these meetings were included for Governor information and reference.

11.4 Audit & Assurance Committee – Graham Russell, Deputy Chair of the A&A Committee informed the Council that the Committee had received the BDO Internal Auditor report on Barriers to Raising Concerns. This audit was requested by the Trust Director of Nursing, Therapies and Quality to independently test current safeguards and provide additional information that can be utilised to improve existing procedures or implement new safeguards to provide strong and sustained assurance regarding eliminating closed culture related risks. This audit reported a moderate opinion on the design and a limited opinion on the operational effectiveness of the controls in place. Graham Russell said that it was the Audit & Assurance Committee role to scrutinise the reports, their findings and to seek assurance on the Trust's next steps with developing appropriate action plans and monitoring arrangements. He said that the Committee received a number of Internal Audit reports at each of its meetings, with the February meeting also receiving a report on Cyber Security, EPRR (Emergency Preparedness, Resilience and Response) and Sickness Absence Management. These reports were highly valued by GHC as they assisted the Trust in looking at internal controls and assurance process, and provided evidence-based ways to improve.

11.5 Great Place to Work Committee – Sumita Hutchison, Chair of the GPTW Committee informed the Council that a great Staff Story had been received at the previous meeting which looked at a colleague's barrier to progression due to disability. A deep dive also took place on the Staff Survey results. Sumita said that the Committee ensured that it focused on those areas where the results may have deteriorated, or newly reported areas such race discrimination. Discussion also took place about appraisals, both in terms of uptake and the value of appraisals and how more guidance was required for managers.

11.6 Quality Committee – Jan Marriott, Chair of the Quality Committee advised that the Committee had also received the BDO Internal Audit report on Barriers to Raising Concerns. It was important for the Governors to see the triangulation between the different committees. The areas identified for action were shared and the Committee received the action plan which had been developed to address the recommendations. The Committee had also received the Medical Education Annual Report 2022/23 and noted that Gloucestershire Health and Care NHS Foundation Trust (GHC), had been ranked the 6th highest NHS Trust in England and Wales in relation to Trainee Satisfaction/Trainer Satisfaction, which was very positive. The Committee discussed the cost implication of

supporting medical trainees, noting that due to financial pressures, GHC have had to decline the offer of additional trainees who were due to start in 2024. In order to preserve, maintain and develop our status as a high-quality provider of training, these ongoing costs need to be prioritised. The greater the number of high-quality trainees we have, will have a positive impact on recruitment in the future and will also reduce our reliance on agency/locum staff. It was agreed that this issue would be escalated for further consideration by the Executive.

11.7 Resources Committee – Graham Russell, Chair of Resources Committee noted that the Committee received and noted the Finance Report for month 10, and also received the Budget Setting Update 2024/25, which highlighted the budget setting process for both the Trust and the System. A breakdown of the underlying position for the Trust for 2024/25 was shared, noting a total deficit for Gloucestershire Health and Care NHS Foundation Trust of £2.3m. The 2024/25 indictive Cost Improvement Plan (CIP) requirements were also shared, which showed a total CIP of £8,859m. The Committee noted and discussed the cost pressures that had been identified, including additional inflationary pressures.

11.8 Governors were supportive of this format going forward, noting that it was helpful to hear directly from the NEDs, however, it was suggested that more time be allocated on the meeting agendas to allow for further discussion and questions. Governors were invited to email through any specific questions that they wished to ask of the NEDs, to Anna Hilditch. **ACTION**

12. QUALITY STRATEGY, ACCOUNT AND PRIORITIES (Pressure Ulcers/TV)

12.1 The Council welcomed Jane Stewart, CQC Compliance Manager, and Nancy Farr, Professional Head of Community Nursing to the meeting. The purpose of this item was to seek Governor agreement to the proposed timeline for this year's Quality Account sign off and to provide information and detail in relation to the Quality Account and how the related Quality Priorities are established and agreed, and how progress is monitored. A detailed deep dive into Quality Priority one (Tissue Viability) and an overview of the Pressure Ulcer workstream would also be presented for Governor information and interest purposes.

12.2 Jane Stewart presented the headline detail regarding the Trust's Quality Priorities and advised that the Quality Priorities originate from the Quality Strategy. Our Quality Strategy sets out our quality ambitions, strategic goals, priorities, and the approaches we will take to measure our progress. It does not sit in isolation but is one of six integrated enabling strategies delivering Gloucestershire Health and Care NHS Foundation Trust's (GHC) strategy: 'Our Strategy for the Future 2021-2026'. By developing this Quality Strategy, we are making clear our commitment and approach to empower the people at the heart of our services. Our colleagues will have the freedom, skills, tools and resources to work in partnership with the people we serve to improve and innovate safely towards defined quality goals.

12.3 Each year the Trust must produce and publish on our website the organisational Quality Account by 30th June. The Quality Priorities and their progress towards targets form the backbone of the Quality Account and as such are used as a

template for the preparation of this document which is a requirement of the Health and Social Care Act 2012. This year the timeline for the quality priorities has been extended to cover a two-year time frame with the ambition that all aspects of each indicator will be in place by the end of Q8 (March 2025). The Council noted and approved the proposed timeline, as follows:

- 2nd May - Quality Committee – Receive Draft Quality Account
- 15th May - Council of Governors – Receive a presentation on the Draft Quality Account and have opportunity to comment.
- 30th May - Trust Board (Private session) – Receive Final Draft

12.4 The Council welcomed Nancy Farr who provided a helpful and informative presentation on Pressure Ulcers. The presentation set out the definition of what a pressure ulcer was and included some pictorial examples to aid Governor understanding on the different levels and categories of wound. The presentation explored the reasons why we may be seeing a rise in pressure ulcer incidence, national guidance, current levels of reporting and the timeline of GHC QI work, education & governance.

12.5 The Council noted that Acute and Community Trusts are caring for more complex patients often with multiple co-morbidities and an increasingly frail and elderly demographic, one which includes covid-19 survivors. All are risk factors for pressure ulcers. The majority of our pressure ulcer incidents are reported in our ICT and community in-reach teams who give advice and prescribe care & equipment; but we are not with patients every day as clinical colleagues are in inpatient settings. Many patients are admitted to our trust with existing PU's which we must again report as a harm. The terms "acquired and inherited" have been replaced, with: "present before admission to the trust" and by "developed or worsened during care by the trust". The Trust is therefore now counting and reporting nationally all PU's regardless of where they originally occurred. These requirements to change how our PU data is reported nationally and locally has resulted in increases in incidence data. Clinicians are also becoming more aware of the need to report and are reporting smaller wounds which may/may not be caused by pressure or shear.

12.6 The Council thanked Jane Stewart and Nancy Farr for their presentations and for sharing this information. A further presentation of the draft Quality Account would be received at the next Council of Governors meeting in May.

13. COUNCIL OF GOVERNOR MEMBERSHIP AND ELECTION UPDATE

13.1 The Council received and noted this report which provided an update on changes to the membership of the Council of Governors and an update on progress with any upcoming Governor elections.

13.2 As of 7 March, the Council has 2 vacant Public Governor positions – one in Cheltenham and one in the Forest of Dean. The next vacancy will arise from 1 June when Nic Matthews (Staff Governor) will come to the end of his second term, and therefore be ineligible for further reappointment having served a full 6-year term. There are no elections currently underway. Looking at all upcoming end of term dates, it is noted that 2 Staff Governor positions will come up for reappointment in September 2024 (end of first term). It was proposed

that the Trust wait and start a nomination / election process to cover all known vacancies and reappointments in late June/early July, with start dates of 22 September 2024.

13.3 It was reported at our November 2023 Council of Governors meeting that Jacob Arnold, Public Governor for the Forest and also Deputy Lead Governor had resigned. An email was sent out on 31 January 2024 inviting all existing Governors to consider putting themselves forward to stand as our new Deputy Lead Governor. Completed nomination forms were requested to be returned to the Assistant Trust Secretary by Friday, 16th February 2024. One nomination was received from Peter Gardner, Public Governor (Cotswolds), and his supporting statement was presented to the Council. The Council of Governors endorsed the appointment of Peter Gardner as Deputy Lead Governor from 13 March 2024.

14. GOVERNOR QUESTIONS LOG

14.1 The Governor Questions Log is presented at each Council meeting, and any questions received between meetings are presented in full, alongside the response for Governors' information.

14.2 It was noted that four new questions had been received since the last meeting, and these were presented to the Council as follows:

01/2024	Virtual Wards
02/2024	Community MH Transformation
03/2024	Forest Hospital Communications
04/2024	Support for Overseas Recruits and Family

15. ANY OTHER BUSINESS

15.1 Andrew Cotterill informed the Council that this was Neurodiversity celebration week.

15.2 The Council agreed that the venue for this meeting had not been appropriate in terms of sound quality, and it had been difficult to hear colleagues speaking and presenting due to background noise and distractions. Alternative accessible venues would be sourced for future face to face Council meetings. Governors were asked to forward any suggestions for suitable venues to Anna Hilditch to explore further. **ACTION**

15.3 On behalf of the Council of Governors, Chris Witham expressed his thanks to Ingrid Barker, as this would be her final Council meeting before leaving at the end of April. Chris Witham said that it had been a pleasure to work with Ingrid over the past 3 years. She had been a huge advocate for the engagement and involvement of Governors, and her support had been invaluable.

16. DATE OF NEXT MEETING

16.1 The next meeting would take place on Wednesday 15th May 2024 at 2.30 – 5.00pm via MS Teams.

ACTION LOG

Date	Item	Action	Lead	Status
13 March	6.10	Governors to have a session with Graham Russell to discuss plans and ambitions for the Council of Governors going forward.	Graham Russell / Trust Secretariat	**Complete.** Session scheduled to take place at 15 May CoG Meeting
	8.7	Updated list of locality NED and Governor pairings to be circulated	Trust Secretariat	**On track.** Updated list to be circulated once new NEDs have been onboarded and portfolios agreed. Scheduled June 2024
	9.15	Global email focusing on colleagues experiencing racial discrimination to be circulated to all Governors	Trust Secretariat	**Complete.** Email sent out to Governors on 15 March 2024
	10.5	Governors' Membership & Engagement Committee be scheduled in the coming months and all Governors would be invited to attend.	Trust Secretariat	**Complete.** M&E Committee scheduled for Tuesday 25th June at 3 – 4.30pm
	11.8	More time to be allocated on future meeting agendas for the Governor Dashboard report to allow for further discussion and questions.	Trust Secretariat	**Complete.**
	15.2	Alternative accessible venues would be sourced for future face to face Council meetings. Governors were asked to forward any suggestions for suitable venues to Anna Hilditch to explore further.	Governors	**Ongoing.**

FOREST OF DEAN ASSURANCE COMMITTEE

SUMMARY REPORT

DATE OF MEETING: **21 MAY 2024**

(BY CORRESPONDENCE)

COMMITTEE GOVERNANCE	Committee Chair: Steve Alvis, Non-Executive Director

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

PROGRAMME AND FINANCE UPDATE

The Committee **received** by correspondence an update on the final commissioning and handover phase of the new hospital and assurance regarding the initial mobilisation of services and the proposed approach to oversight of the post completion aspects of the programme. This update is available to all Board members in the *Diligent Reading Room*.

The Committee:

- **Noted** the successful completion of the construction and commissioning phase of the hospital and that all services are now operational from the new site.
- **Approved** that the Forest of Dean Assurance Committee is now stood down and that oversight of the post project stages of activity as outlined in this paper (including oversight of the disposal of both Dilke and Lydney hospital sites) are passed to the Resources Committee.
- **Note**d that the retention sums will be released in April 2025 and post project evaluation will be completed by February 2025 with oversight proposed to be via the Resources Committee

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **NOTE** the contents of the report
- **APPROVE** the closure of the Committee with all remaining assurance and governance duties being transferred to the Resources Committee as of 30 May 2024.

DATE OF NEXT MEETING:	N/A

WORKING TOGETHER ADVISORY (WTAC) COMMITTEE

SUMMARY REPORT

DATE OF MEETING: **10 APRIL 2024**

COMMITTEE GOVERNANCE	Committee Chair: Jan Marriott, Non-Executive Director

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

WORKING TOGETHER PLAN AND MATURITY MATRIX UPDATE

The Committee received an update on work carried out on the Working Together Plan. The language had been further simplified and aligned. The Ten Steps process would be added alongside the Principles.

The purpose of the Maturity Matrix would be to help services assess themselves. This process was felt to have an important part to play in RAG rating (red, amber, green) people's experiences and thus identifying needs. It was proposed to adopt a rating to accompany the matrix for example: bronze award for assessment carried out within the service only; silver award for completing their assessment in co-production and Gold award if the process is completed independently by experts by experience feedback. It was suggested that NED feedback from their quality visits could contribute to a rating of that service which could be considered moving forward.

PATIENT AND CARER RACE EQUALITY FRAMEWORK (PCREF) UPDATE

The Committee received an update on progress so far with the PCREF, which seeks to address the mental health inequalities experienced by different racial groups and had been adopted nationally in 2023.

The University of Gloucestershire have been appointed to take forward some participatory research through the Integrated Care Board (ICB), looking at gathering views specifically from marginalised communities and there could be some learning from them in terms of how the Trust could adopt the framework.

It was proposed that a focused workshop take place to produce an action plan. It would be useful to explore what anti-racist engagement might look like. Membership could usefully include governors, GHC colleagues and representation from experts by experience.

It was proposed that collection, monitoring and the development of a work plan should be assigned to a formal Trust Board Committee, with this possibly sitting at Resources Committee, with its performance lens. This would be highlighted for consideration in the update to the Trust Board.

CARERS DISCUSSION

The Committee received an overview of the Carer's programme which is currently working towards a Grade Three standard, to include physical health, for the Triangle of Care process. This will take place over two years.

The service works with the Gloucestershire Carers Hub, so that any newly registered carers details are passed by the service so it can monitor the referrals coming through. Working together helps to contribute to a One Gloucestershire Vision.

Discussion took place about if the Trust understands the barriers and challenges for carers; that a myth busting campaign around the carer assessment purpose would be useful; the development of guidance for line managers to support working carers. It was agreed that the voice of carers at the system level should be more visible.

The Trust had previously invested in a range of training that is available to help colleagues take forward more personalised conversations and this also applied to carers.

PERSONALISATION UPDATE

The Committee received an update on Personalisation and those areas where there had been further involvement and developments.

The Orange Folder 'What Matters to Me' pilot scheme is ongoing and being adopted across various services in Gloucestershire. A digital prototype phase of 'One Plan' is now being piloted.

Work is ongoing with one-off Physical Wellbeing Budgets along with Physical Health budgets with a leaflet produced to promote staff and public knowledge.

Following the success of the Enhanced Pathway 2 project at Stroud Hospital, one off funds have been made available for Personalised Care competency training to support community hospital staff.

The new joint OneGlos S.117 Aftercare policy is now live on the GHC staff intranet. It is the legal responsibility of the ICB and local social services to provide the person with aftercare services, or to arrange for them to be provided. GHC provides part of the s.117 Aftercare Personal Health Budget (PHB) funding if it is related to a health need as a result of a person's mental health condition. The Joint Policy emphasises the legal duty to work in partnership and prevent readmission.

A working group will be set up to improve staff knowledge of PHB's and the application process.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to **NOTE** the contents of the report and **CONSIDER** the future reporting options for the PCREF through to a formal Board Committee.

DATE OF NEXT MEETING:	11 July 2024

MENTAL HEALTH LEGISLATION SCRUTINY (MHLS) COMMITTEE

SUMMARY REPORT

DATE OF MEETING: **24 APRIL 2024**

COMMITTEE GOVERNANCE	Committee Chair: Steve Alvis, Non-Executive Director

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

REVIEW OF CQC MONITORING VISITS

The Committee **received** the Review of Care Quality Commission (CQC) Monitoring Visits update. An update was received on Berkeley House. Work was underway to have the Section 31 removed due to the extensive work and improvements within the unit. A Quality-of-Life tool has been developed to test the progress internally and reassure that improvements have been embedded. It was noted that staff at Berkeley House had reported they are seeing the positive difference in working life and care they are able to provide.

Chestnut Ward at Charlton Lane had received a Mental Health Act visit in February and the actions and feedback from this visit were shared and noted.

MENTAL HEALTH ACT MANAGERS (MHAM) FORUM UPDATE

The Committee was **informed** that three Mental Health Act Managers had been appointed and were currently in the induction phase. It had been approved that existing managers were now able to extend their terms of service.

APPROVED MENTAL HEALTH PROFESSIONAL (AMHP) SERVICE ANNUAL REPORT

The Committee **received** the AMHP Service Annual Report which provided an annual overview on the AMHP service activity for the financial year 2023/2024.

June saw the highest demand in 2023 with 127 Mental Health Act Assessments (MHAA). It was reported there had been an increase in CTOs in 2023, from 66 (in the previous year) to 72. A lower number of patients were detained or admitted following MHAA 509 from 531. The total number of admissions was reported lower in 2023, from 703 (in the previous year) to 627.

The assessment by age and gender data was shared, and it was reported that during September 2023 there was an increase in female's over 65 being assessed, and a surge in both working age females and males in June 2023.

Between April 2023 – March 2024 there were a total of 280 instances where patients needed to be conveyed to hospital following a MHA assessment. The majority of instances (27%) private transport had been used. Second to this is the use of SWASFT (21%). The other majority seems to be in order AMHP's using their own vehicles (14%), Police transport (11%), Crisis and other trust staff (8%), and family/friends/informal carers (9%).

The Committee **noted** this report for assurance, and thanked James Green and AMHP colleagues for the work taking place. Regular reports would continue to be presented at the MHLS Committee.

MHA POLICIES – REVISED ALLOCATION OF RESPONSIBLE CLINICIANS POLICY

The Committee **received** the revised Allocation of Responsible Clinicians Policy, for endorsement.

All patients detained in hospital under the Mental Health Act (except for short-term holding powers) must have a Responsible Clinician, who has overall responsibility for the patient's case and who makes key decisions, such as granting section 17 leave and discharge. The Code of Practice states that hospital managers should have local protocols in place for allocating responsible clinicians to patients.

The Committee **received** and **endorsed** the revised policy.

MENTAL CAPACITY ACT (MCA) PRACTICE AND LIBERTY PROTECTION SAFEGUARDS (LPS) UPDATE REPORT

The Committee **received** the MCA Practice and Liberty Protection Safeguards (LPS) Update Report, which provided an update in relation to activities being undertaken within the Trust to ensure that practice in relation to the Mental Capacity Act 2005 is of a required standard.

Bespoke face to face training in relation to the completion of mental capacity assessments and best interest decisions continued to be delivered across the Trust. A new MCA disputes policy had been created and ratified, which supported decisions made in relation to mental capacity. The Committee discussed the MCA training available to band 6 and 7 colleagues and a query was raised as to when this would be available to band 5 colleagues. It was noted that it was necessary to ensure staff were not overloaded with training, and focus would be given to colleagues working within mental health areas first. Further discussions would be held to determine when this could be rolled out further.

The Committee **noted** the work being undertaken to improve MCA practice across the Trust and how this will mitigate the risk outlined on the risk register.

OTHER ITEMS RECEIVED

The Committee **RECEIVED** and **NOTED** the following reports:

- Corporate Risk Register and Board Assurance Framework
- MHLOG Update Report

ACTIONS REQUIRED BY THE BOARD

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

DATE OF NEXT MEETING:	17 July 2024

RESOURCES COMMITTEE

SUMMARY REPORT

DATE OF MEETING: **25 APRIL 2024**

COMMITTEE GOVERNANCE	Committee Chair: Graham Russell, Non-Executive Director

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

FINANCE REPORT – MONTH 12

The Committee **received** the Finance Report for month 12, which provided an update of the financial position of the Trust. The draft final accounts had been submitted and the full audited accounts would be submitted 20 June 2024. The draft year end position was a surplus of £984k. The Cost Improvement Programme delivered £5,026m of recurring savings against the target of £5,445m. The £418k which was unidentified had been carried forward. Agency expenditure had significantly reduced throughout the year, and the Trust had spent £7,449m on agency staff, which equated to 3.33% of total pay; which was below the agency expenditure celling of 3.7%. The Trust had paid 97% of invoices due within 30 days against the national target of 95%. The cash position at the end of month 12 was £51,445m.

The Committee also **received** a verbal update on the System Finance Position.

PERFORMANCE REPORT – MONTH 12

The Committee **received** the Performance Report, which provided a high-level view of the key performance indicators in exception across the organisation. The highlights from the Business Intelligence (BI) Service were shared and it was reported that the Statistical Process Control (SPC) methodology had been reviewed for the new financial year. Learning would be used to update the Performance Dashboard escalation approach for 2024/25, and revise the thresholds for internal domains. This would then lead to an update of the Performance Management Framework in Q1. The Committee **received** and **noted** those indicators currently in exception. The positive performance in the Podiatry service was highlighted, and it was reported performance against 18-week RTT target of 95% had achieved 96.3%.

The Committee **received** an update on the transition timeline for the new Forest of Dean hospital The Committee **acknowledged** the hard work and support of Angela Potter, Director of Strategy and Partnerships, in leading the development of the new hospital.

OVERARCHING TRUST STRATEGY – REVIEW OF MILESTONES 2024/25

The Committee **received** the Overarching Trust Strategy – Review of Milestones 2024/25, which provided an update on the Trust's progress in the delivery of the strategic aims outlined in its 5-year strategy. The report provided an update on the strategic work progressed across the Trust's four domains; High Quality Care, Better Health, Great Place to Work and Sustainability, and a review of the milestones achieved in the Overarching

Trust Strategy. The Committee was **assured** on the delivery of the overall strategic direction from the progress against our Trust strategic objectives.

GREEN PLAN STRATEGY – DELIVERY PROGRESS

The Committee **received** the Green Plan Strategy – Delivery Progress Report, which provided an update on the delivery against the plan to date. The Green Plan was the Trust's three-year sustainability strategy to deliver on national Net Zero requirements, as well as recognising the wider role we play in enabling sustainability across the Trust, as well as the Integrated Care Board and wider system. The Green Plan Linked Goals Dashboard was shared, and it was reported all objectives were on track for Net Zero and ahead of the target for carbon footprint. New objectives had been set within the Green Plan and an update was provided on the various projects across the Trust which were being undertaken as part of the Green Plan. The target for the NHS single-use plastic pledge had been achieved and exceeded, and further focus would be on single use plastics in clinical consumables. The Committee **noted** the positive progress with the delivery of key Green Plan targets and assurance updates on components of the underlying delivery plan.

TRANSFORMING CARE DIGITALLY

The Committee **received** the Transforming Care Digitally Report, which provided an update on the Trust's Transforming Care Digitally (TCD) programme. The key areas of focus within the report were highlighted, with the overarching goal to create a more efficient, user-friendly, and patient-centred Clinical Systems that focused on delivering safe, quality care to Users. The Committee was **informed** that there would be four underpinning core projects, which would address the key weaknesses and development needs to underpin the programme and were the basis on which other developments would depend. The four core projects were; the Clinical System Team Support Model, Technical Architecture Enhanced, Integrated Identity Management and the Reduction of Clinical Systems key risks. The TCD Programme would also be comprised of several transformation projects, which would support specific developments that contribute to transforming clinical care to meet changing needs and to take advantage of new technology. The initial financial envelope for the programme was highlighted within the report, alongside the key management risks identified. The Committee **signed off** the programme to proceed based on the information presented and confirmed the timescales for regular updates to the Committee.

OTHER ITEMS RECEIVED

The Committee **received** and **noted** the following reports:

- Business Planning Report
- Corporate Risk Register and Board Assurance Framework
- National Cost Collection Methodology 2023/24
- Service Development Report
- Summary Reports from: Digital Group, Capital Management Group, Business Intelligence Management Group, Strategic Oversight Group, Community Mental Health Transformation Programme

ACTIONS REQUIRED BY THE BOARD

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

DATE OF NEXT MEETING:	27 June 2024

GPTW COMMITTEE

SUMMARY REPORT

DATE OF MEETING: **25 APRIL 2024**

COMMITTEE GOVERNANCE	Committee Chair: Sumita Hutchison, Non-Executive Director

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

COLLEAGUE STORY

The Committee welcomed Tom to the meeting who shared his career journey in the Trust, from apprentice to management accountant. Tom had begun working with the legacy 2gether Trust on a level 2 AT apprenticeship, which was similar to an accounting technician qualification. He had been working in the NHS and for the same team within the finance department for over six years and was in the final stages of achieving his level 7 qualification to become a chartered management accountant. As well as his accountant role within the Trust, he was a Freedom To Speak Up (FTSU) champion and was also involved with clinical safety. Tom shared that he had received valuable support from his mentor and that the support received allowed him to progress and grow within his role, and in confidence. Tom shared his aspirations for the future and noted that he was currently studying for an advanced diploma in healthcare management. The Committee thanked Tom for sharing his career story, and a request was a made that a report be presented to a future Committee meeting looking again at the Trusts apprenticeship offer.

DEEP DIVE: 2023 STAFF SURVEY UPDATE

The Committee **received** the 2023 Staff Survey Update and was invited to discuss and consider areas of focus. The presentation highlighted the Staff Survey results and the timeline for the delivery and engagement of the survey and action plan. The headline results for substantive staff were shared and showed a comparison of the People Promise themes in 2022 and 2023. The results had either improved or remained in line with the results of the previous year (2022), and also reflected the same trend with comparator organisations. The substantive staff scores also focused on scores which were not low, but that had still received negative responses, including colleagues who had experienced physical violence and discrimination. The Staff Survey action planning had been divided into four areas of focus:

1. Harassment and Bullying
2. Health and Wellbeing
3. Flexible working
4. Internationally Educated Nurses

The Committee shared areas of focus for consideration and raised that more awareness was required for colleagues to understand flexible working. The Committee also discussed whether a sharper focus on race was required and whether there should be a broader focus on Equality, Diversity and Inclusion (EDI) and also protected characteristics.

FREEDOM TO SPEAK UP REPORT

The Committee **received** the Freedom to Speak Up (FTSU) Report. There had been 96 speaking up cases raised to the FTSU Guardian in 2023-24, which was an increase of 25% compared to 2022-23. An increase in allegations of potential fraud was reported, and the GHC Counter Fraud Survey 2023 had highlighted further awareness was required. However, it was reported that staff felt comfortable raising concerns about potential fraudulent behaviour, via their line manager.

In partnership with NHS England, the National Guardian's Office published new and updated FTSU guidance and a FTSU reflection and planning tool. This tool was included in a call to action with the Trust Board at their Development session in November 2022, and all trust Boards were required to evidence this by the end of January 2024.

PERFORMANCE REPORT – WORKFORCE KPIs (Key Performance Indicators)

The Committee **received** the Performance Report – Workforce KPIs, which provided a high-level view of key people performance indicators (KPIs) across the organisation. The Committee **received** and **noted** the current data for workforce establishment, vacancies, turnover, temporary staffing, sickness absence and appraisals. The Trustwide training compliance data was shared, and it was noted that the Trust had achieved 94.10% training compliance against a target of 90%.

EQUALITY DELIVERY SYSTEM

The Committee **received** the Equality Delivery System (EDS) Report, which provided assurance on the Trust's submission for its annual return on the EDS by end of March 2024 in accordance with meeting the Equality Act 2010 and our Public Sector Equality Duty (PSED). The EDS was a framework designed to help facilitate NHS organisations to assess and improve the services they provide for their local communities and to provide better working environments, free of discrimination, whilst meeting the requirements of the Equality Act 2010. The EDS was comprised of eleven outcomes, spread across three domains; commissioned or provided services, workforce health and wellbeing and leadership. The Committee reviewed and agreed the provisional ratings and approved the publication of this report and the Trust's submission template.

OTHER ITEMS RECEIVED

The Committee **received** and **noted** the following reports:

- Corporate Risk Register and Board Assurance Framework
- HR Policy Manual Update Report
- Summary Reports from:
  - ICS People Function
  - Joint Negotiating and Consultative Forum
  - Sustainable Staffing Oversight Group
  - Workforce Management Group

ACTIONS REQUIRED BY THE BOARD

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

DATE OF NEXT MEETING:	27 June 2024

QUALITY COMMITTEE

SUMMARY REPORT

DATE OF MEETING: **2 MAY 2024**

COMMITTEE GOVERNANCE	Committee Chair: Jan Marriott, Non-Executive Director

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

QUALITY DASHBOARD REPORT

The Committee **received** the Quality Dashboard Report, which provided a summary assurance update on the progress and achievement of quality priorities and indicators across Trust's physical health, mental health and learning disability services.

The areas showing quality improvement were shared, and it was highlighted the internal MARAC process had been reviewed and reported there were no backlogs of action plans awaiting administrative uploading to records for the second successive month; it was also shared that PALs visits had been re-introduced at Berkeley House.

Areas showing quality issues for priority development were shared with the Committee, and it was reported that focus continued on the recording of observations post rapid tranquilisation, and improvements had been made and would go through further fidelity testing to ensure whether they were sustainable.

The Committee was informed that that the new safeguarding templates had been launched, which would allow for an improved recording of household contacts.

Confirmation was **received** that the works around the emergency call system at Charlton Lane had been completed.

CELEBRATING IMPROVEMENT IN COMMUNITY HOSPITALS

The Committee **received** the Celebrating Improvement in Community Hospitals Report, which provided an overview of the innovations and improvements which had happened in the last 12 months, and the plans for how the directorate continued to nurture and develop this culture of continuous improvement and innovation to create a space for reflection and learning.

The Committee was informed of twelve different QI projects which had taken place throughout the year, and the learning and outcomes of these were shared within the report.

The Committee welcomed the positive report and congratulated the teams involved.

The Committee **noted** the report of work completed to date and the ongoing Quality Improvement work in Community Hospitals.

QUALITY STRATEGY 2021 – 2026 – BI-ANNUAL UPDATE REPORT

The Committee **received** the Quality Strategy 2021/26 Bi-Annual Update Report, which provided an overview of the progress made in implementing the Trusts Quality Strategy. The Quality Strategy set out the Trust's ambitions and goals up until the end of 2026. The Trust pledged to place quality at the heart of everything it does for the population served and to deliver the best possible care at all times. The Committee **received, noted** and **discussed** for assurance the progress on the plans and the areas still to be developed.

CQC COMMUNITY MENTAL HEALTH SURVEY 2023/24

The Committee **received** the Care Quality Commission (CQC) Community Mental Health Survey 2023/24, which provided a summary of the results of the 2023 CQC National Community Mental Health survey, and **noted** that this was the first year the survey was able to be completed by 16 and 17 year olds. Previously the minimum age for competition was 18.

The Trust's response rate was 26%, which equated to 315 responses; and it was noted this was significantly above the national average of 20%.

The results from the survey showed that the Trust had performed the same compared with other trusts in 25 of the 33 questions and somewhat better (3), better (4) or much better (1) than expected in the remaining 8 questions. The Trust did not score worse than expected compared with other Trusts in any of the survey questions.

The priority areas for improvement were highlighted and these included a focus around crisis care and assessing care and treatment.

DRAFT QUALITY ACCOUNT 2023/24

The Committee **received** the Draft Quality Account 2023/24, which provided a report on activities and targets from the previous year's Account, and sets out and introduces new objectives and proposed developments for the following year.

Input was sought from the Committee for further inclusion in to the section of the report showcasing achievements for the previous year, and it was suggested consideration be given to the celebration of QI projects in community hospitals, and the falls work undertaken at Charlton Lane Hospital.

OTHER ITEMS RECEIVED

The Committee **received** and **noted** the following reports:

- The Board Assurance Framework
- The Corporate Risk Register
- The Quality Assurance Group (QAG) Summary Report

ACTIONS REQUIRED BY THE BOARD

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

DATE OF NEXT MEETING:	4 July 2024

AUDIT AND ASSURANCE COMMITTEE

SUMMARY REPORT

DATE OF MEETING: **9 MAY 2024**

COMMITTEE GOVERNANCE	Committee Chair: Marcia Gallagher, Non-Executive Director

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

INTERNAL AUDIT BDO

The Committee **received** and **considered** the following internal audit reports:

Internal Audit	**Level of Assurance**	
	Design	**Effectiveness**
Cyber Key Financial Systems	Moderate	Moderate
	Confidence	**Risk**
Data Security and Protection Toolkit	High	Low

The Committee **received** and **noted** the **Internal Audit Progress Report** and **the follow up report**.

Internal Audit Annual Report & Head Of Internal Audit Opinion (2023/2024): The internal auditor's opinion was that they were able to provide ***moderate*** *assurance that there is a sound system of internal control, designed to meet the Trust's objectives and that controls are being applied consistently.'*

EXTERNAL AUDIT – KPMG

The Committee **received** the external audit progress report and technical update, which provided an update on the work progressed for the year ending 31 March 2024.The final audit plan was received noting that there had been no significant amendments made since the circulation of the draft plan.

COUNTER FRAUD, BRIBERY & CORRUPTION

The Committee **received** and **considered** the Counter Fraud progress report and summary of current investigations.

The Draft Annual Report for 2023/2024 was **received**, which would be finalised with the addition of the Counter Fraud Functional Standards Return and approved by the Chair and DoF outside the meeting.

The Annual Work plan for the year ahead was **noted** and would be adapted in year to reflect any changes in priorities or emerging risks.

The Committee also **received** a summary of counter fraud investigation and the Asset Management Report.

DRAFT ANNUAL ACCOUNTS

The Committee **received** the draft Annual Accounts which showed the draft position of the final accounts for 2023/24. The Committee:

- **Noted** the reconciliation from the management reported position to the Accounts
- **Approved** the updates to the Accounting Policies
- **Endorsed** the Trust's assessment of Going Concern and associated disclosures and recommended statements
- **Reviewed** the draft Accounts

The draft Annual Accounts were being audited by the external auditors, KPMG, with the final accounts being presented to the Committee for sign-off on the 17 June 2024.

FINAL DRAFT ANNUAL REPORT

The Committee **received** and **considered** the draft Annual Report **noting** that the report had been prepared in line with the NHS Foundation Trust Annual Reporting Manual for 2023/24. The draft report would be reviewed by the external auditors with the final version to be presented to the June meeting, prior to submission.

FINANCE COMPLIANCE REPORT

The Committee **received** the Finance Compliance Report, which provided an update on actions taken under delegated powers where a periodic report is required. The Committee were informed of four breaches of Standing Financial Instructions (SFIs), which had occurred during the reporting period. The Committee **noted** the report and **approved** the proposed additions to the SFIs.

ANNUAL ASSURANCE REPORTS & DECLARATIONS

The Committee **received**:

- The Annual SIRO (Senior Information Risk Owner) Report, which provided assurance on the effectiveness of controls for Information Governance, data protection and confidentiality and to document the Trust's compliance with legislative and regulatory requirements.
- The Trust Compliance Report, which provided assurance that the required Trust registers were held and maintained in line with statutory requirements and good practice.

OTHER ITEMS RECEIVED

The Committee **received** and **noted** the following reports:

- Corporate Risk Register and Board Assurance Framework
- Cyber Security Assurance Report
- Managing Conflicts of Interest Policy update
- Summary Reports from Management Groups

ACTIONS REQUIRED BY THE BOARD

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

DATE OF NEXT MEETING:	17 June 2024