TRUST BOARD MEETING

PUBLIC SESSION

Thursday, 26 September 2024

10:00 – 13:00

The Boardroom, Trust HQ, Edward Jenner Court, Brockworth, Gloucester, GL3 4AW

AGENDA

TIME	Agenda Item	Title	Purpose	Comms	Lead
OPENING BUSINESS					
10:00	01/0924	Apologies for absence and quorum	Assurance	Verbal	Chair
	02/0924	Declarations of interest	Assurance	Verbal	Chair
10:05	03/0924	Service User Story Presentation *(in the Cleeve Room)*	Assurance	Verbal	DoNTQ
10:30	04/0924	Draft Minutes of the meeting held on 25 July 2024	Approve	**Paper**	Chair
	05/0924	Matters arising and Action Log	Assurance	**Paper**	Chair
10:35	06/0924	Questions from the Public	Assurance	Verbal	Chair
10:40	07/0924	Report from the Chair	Assurance	**Paper**	Chair
10:50	08/0924	Report from Chief Executive	Assurance	**Paper**	CEO
ASSURANCE REPORTING (PERFORMANCE)					
11:00	09/0924	Finance Report	Assurance	**Paper**	DoF
11:10	10/0924	Performance Report	Assurance	**Paper**	DoF
11:25 – BREAK					
STRATEGY AND IMPROVEMENT					
11:35	11/0924	CAMHS Deep Dive *(in the Cleeve Room)*	Assurance	**Presentation**	COO
ASSURANCE REPORTING (QUALITY AND PATIENT EXPERIENCE)					
11:55	12/0924	Review of Standards of Care in Community Mental Health Services	Endorse	**Paper**	DoNTQ
12:15	13/0924	Quality Report	Assurance	**Paper**	DoNTQ
12:35	14/0924	Medical Appraisal Annual Report	Approve	**Paper**	MD
GOVERNANCE					
12:45	15/0924	Council of Governor Minutes – 10 July 2024	Information	**Paper**	Chair
BOARD COMMITTEE SUMMARY ASSURANCE REPORTS (REPORTING BY EXCEPTION)					
12:50	16/0924	Audit & Assurance Committee (8 Aug)	Information	**Paper**	Audit Chair

TIME	Agenda Item	Title	Purpose	Comms	Lead
	17/0924	Resources Committee (29 Aug)	Information	**Paper**	Resources Chair
	18/0924	Great Place to Work Committee (29 Aug)	Information	**Paper**	GPTW Chair
	19/0924	Quality Committee (5 Sept)	Information	**Paper**	Quality Chair
	20/0924	Charitable Funds Committee (18 Sept)	Information	Verbal	CF Chair
CLOSING BUSINESS					
12:55	21/0924	Any other business • Cyber Security Strategy – Delegated authority request	Note	Verbal	Chair DoF
	22/0924	**Date of next Trust Board meeting** Thursday, 28 November 2024	Note	Verbal	All

MINUTES OF THE TRUST BOARD MEETING

Thursday, 25 July 2024
Churchdown Community Centre, Churchdown, Gloucester

PRESENT:	Graham Russell, Trust Chair Steve Alvis, Non-Executive Director (NED) Sandra Betney, Director of Finance Douglas Blair, Chief Executive Nicola Hazle, Director of Nursing, Therapies & Quality Sumita Hutchison, Non-Executive Director Nicola de Iongh, Non-Executive Director Bilal Lala, Non-Executive Director Vicci Livingstone-Thompson, Associate Non-Executive Director Jan Marriott, Non-Executive Director David Noyes, Chief Operating Officer Neil Savage, Director of Human Resources (HR) & Organisational Development
IN ATTENDANCE:	Claire Kenny, Board Committee & Membership Officer Jon Haynes, Consultant Psychiatrist (Deputising for Amjad Uppal) Steve Lydon, Public Governor Bren McInerney, Member of the Public Louise Moss, Assistant Director of Corporate Governance (GHC) Annie Nightingale, Deputy Head of Communications (GHC) Lavinia Rowsell, Director of Corporate Governance/Trust Secretary (GHC) Jodi Sweet-Collins, Member of the public – item 3 Jazmin Turner, Member of the Public – item 3 Debbie Williams, End of Life Lead (GHC) – item 3 Hannah Williams, Deputy Director of Nursing, Therapies & Quality (GHC) – item 3

1. WELCOME AND APOLOGIES

1.1 The Chair welcomed everyone to the meeting. Apologies were received from Amjad Uppal, Kate Nelmes, Helen Goodey, Jason Makepeace and Des Gorman.

1.2 The Chair welcomed Nicola Hazle, Director of Nursing, Therapies and Quality to her first Trust Board meeting.

1.3 The Chair acknowledged that this would have been the final Trust Board meeting for Helen Goodey, Joint Director of Locality Development and Primary Care. Helen had stepped down from joint role but would continue her employment with Gloucestershire ICB on a full-time basis. On behalf of the Board, the Chair thanked Helen for her hard work and commitment to the Trust.

2. DECLARATIONS OF INTEREST

2.1 Nicola Hazle declared that she was registered as a bank Mental Health Inspector with the CQC (not within Gloucestershire), and also held a voluntary role as a lay panel member with the College of Optometrists.

3. SERVICE STORY PRESENTATION

3.1 The Board welcomed Jodi Sweet-Collins, Jazmyn Turner, and Debbie Williams (End of Life (EOL) Lead) to the meeting.

3.2 The Board was shown a video in which Jodi Sweet-Collins shared her story regarding the care her father, Christopher Collins had received in the summer of 2020, whilst he was dying at home; and the impact that the experience had had on Jodi and her family.

3.3 The story highlighted areas in which poor quality of care was provided, including communication between nursing staff and family members. By Jodi sharing her experience and raising a complaint following her experience, an investigation was initiated and this helped to identify several learning areas which had become a focus for the Trust's End of Life workplan. Jodi was also involved with working with the End of Life Quality Improvement Group in which her contributions were valued.

3.4 The Board thanked Jodi for sharing her story and experience and expressed empathy and praised her braveness in speaking out about the emotional circumstances encountered, and thanked her for enabling changes to be made.

4. MINUTES OF THE PREVIOUS BOARD MEETING

4.1 The Board **received** the minutes from the previous Board meeting held on 30 May 2024. The minutes were accepted as a true and accurate record of the meeting, subject to the following minor amendments:

- Paragraph 7.2 and 7.3, two commas to be replaced by decimal points, £5,454m should be £5.454m, and £1,584m should be £1.584m.

5. MATTERS ARISING AND ACTION LOG

5.1 The Board **received** the following updates on actions:

5.2 **25 January 2024 – 5.2 – Peer Support Worker Strategic Framework**
The Board **noted** that further work was required on the Peer Support Worker Strategic Framework ahead of being received by the Board. This would be received by the Board at the November meeting.

5.3 **System Financial Plan**
It was **noted** that Board approval of the System Financial Plan had been received via correspondence 10 June.

6. QUESTIONS FROM THE PUBLIC

6.1 The Board **noted** that no questions had been received in advance of the meeting. There were no questions from members of the public present.

7. REPORT FROM THE CHAIR

7.1 The Board **received** the Report from the Chair, which provided an update on the Chair's main activities and those of the Non-Executive Directors (NEDs), Council of Governor discussions and Board development as part of the Board's commitment to public accountability and Trust values.

7.2 The Chair highlighted activities which he had taken part in within his first few months as Trust Chair, which involved visiting colleagues and communities across the Trust and throughout the county. This included a range of different teams and the Chair shared how he felt in awe of the talent displayed across the organisation at all levels, and the importance of ensuring that talent was nurtured and valued.

7.3 The Board **noted** the report and the assurance provided.

8. REPORT FROM CHIEF EXECUTIVE

8.1 The Board **received** the Report from the Chief Executive which provided an update on significant Trust issues not covered elsewhere on the Board agenda, as well as on his activities and those of the Executive Team.

8.2 Douglas Blair informed the Board of the appointment of Sarah Branton as the new Chief Operating Officer (COO). Sarah Branton was expected to commence in the role at the beginning of Autumn and would succeed David Noyes who would be retiring at the end of September. The Board was informed that Sarah had worked as Deputy COO at Avon and Wiltshire NHS Partnership Mental Health (AWP) Trust since November 2018. Ahead of beginning in her role Sarah would be spending some days within the organisation, where she will meet colleagues and acquaint herself with the Trust and the Gloucestershire health and social care system.

8.3 Douglas Blair further informed the Board that since writing the report, a new Director of Improvement and Partnerships has also been appointed. The successful applicant for the post was Rosanna James who would also begin her role in Autumn 2024. Rosanna James would join from Bristol, North Somerset and South Gloucestershire Integrated Care System (ICS); where she was currently a Programme Director, leading an ICS-wide transformation programme, focused on improving older people's care.

8.4 The Board was informed that following the outcome of the general election, discussions with MPs would recommence with the mostly new set of MPs in Gloucestershire.

8.5 The Community Mental Health survey results were highlighted, and Douglas Blair reported that the Trust response rate was 26%, which was higher than the national average of 20%. Out of the 13 areas covered, the Trust had scored significantly better than other Trusts, however it was noted that further development work was required in the area of crisis services. Jan Marriott noted that some of the least positive survey results (compared to the national average) related to Crisis Care Support and queried what was being done to address these issues. Douglas Blair shared that this was being taken forward as part of wider system discussions with the opportunity to link

urgent and crisis response across both physical and mental health with active support including phone-based response. It was agreed that the survey provided a helpful data source and Nicola Hazle informed the Board that the Patient Experience Team would be working with a service user group to review and consider the survey further.

8.6 The current news story relating to the backlog of adult ADHD assessments was discussed, noting the struggles faced by the NHS due to the increase in demand and referrals. Douglas Blair reported that the Trust did have investment in this service, however it was expected to take a long time to catch up with demand.

8.7 The Board **noted** the update provided.

9. FINANCE REPORT

9.1 The Board **received** the Finance Report, which provided an update on the financial position of the Trust at month 3.

9.2 Sandra Betney informed the Board that the revised system plan submitted on 12 June was a break even plan and that the Trust's plan was breakeven. At month 3, the Trust had a surplus of £0.096m, against a plan of £0.307m. The surplus was expected to be zero by year-end.

9.3 It was reported the Cost Improvement Programme was ahead of plan in terms of recurrent savings, with £2.368m delivered at month 3, compared to a plan of £1.741m. It was **noted** that the target for the year was £7.319m and of this £3.738m had not yet been identified. Sandra Betney reported that this was classified as a risk and details of this was included within the report.

9.4 The Board **noted** £1.093m of non-recurring savings had been delivered at month 3 against plan of £2.528m. The target of £5.661m for the year had all been identified.

9.5 The income and expenditure forecasts were shared with the Board and Sandra Betney noted that the Integrated Urgent Care budget was not included, as this had not yet been set and agreed. It was also noted that the forecast did not include inflation. Further discussions were planned with the System to look at the forecasts for the next four years.

9.6 The financial risks for 24/25 were considered by the Board. These included the risk (180) relating to the financial impact of the Mental Health Act reforms. Steve Alvis queried whether the risk score should be higher than 3 given the recent King's Speech and implications of the changes to the Act on clinical time. Sandra Betney agreed that the 'likelihood' element of this risk score was likely to increase given recent developments.

9.7 Sumita Hutchison requested more information regarding actions being taken to mitigate *risk 388 – staffing above establishment is not able to be reduced in inpatients.* Sandra Betney reported the key action to address this risk was the safer staffing review with the need for a business case to be agreed at system level.

9.8 The Trust Board **noted** the month 3 position.

10. PERFORMANCE DASHBOARD

10.1 Sandra Betney presented the Performance Dashboard, which provided a high-level view of performance indicators in exception across the organisation for the period to the end of June (Month 3 2024/25).

10.2 Where performance was not achieving the desired threshold, operational service leads prioritise appropriately to address issues. Service led Operational & Governance reports were presented to the operational governance forums and more widely account for performance indicators in exception and outline service-level improvement plans. Data quality progress would be more formally monitored through the Patient & Corporate Records Group.

10.3 Sandra Betney reported the KPIs (Key Performance Indicators) within the Performance Report had been updated for the new contract with the ICB and assured the Board that the detailed narrative was reviewed in the Business Intelligence Management Group (BIMG) and shared with operational teams.

10.4 It was reported there were no indicators presented in exception in the Board focus domain for this period.

10.5 Within the nationally measured domain, it was reported two indicators were in exception for the period. These were 'inpatient discharge follow-ups' and 'adolescent Eating Disorder routine referral to treatment waits.' It was noted that the adolescent eating disorders referrals were small numbers.

10.6 Sandra Betney highlighted the indicators which were not formally in exception, but included for the Board's awareness. These included Talking Therapies, which was below threshold for National Operational Planning expectations; and also, adult eating disorders where the wait time for adult psychological interventions would be 16 weeks.

10.7 Sandra Betney updated the Board on progress towards integrating the performance dashboard and quality dashboard. The first stage would be to remove duplication within the Quality dashboard for the next meeting of the Board.

10.8 David Noyes presented the COO Report (included within the Performance Dashboard) to the Board, and reported that in regards to the Trust's Community Bed offer and flow; of the 173 beds available, 14 were ringfenced for specialist stroke at the Vale and 10 were held for Community Assessment and Treatment in Tewkesbury. This meant that the weekly bed offer of between 30 and 40 beds meant that the Trust was generating good levels of capacity from what was available (after factoring in the 20% capacity which was lost to No Criteria to Reside).

10.9 David Noyes reported that bed occupancy remained high, and was reported as being at 97.9%. The challenges with sourcing onward packages for patients contributed to the average length of stay being above 30 days. In response to a request from the System, patients with more complexity and higher acuity were being admitted to the community hospitals. A business case to support enhancing the therapy offer was

under consideration. Following the blip in the previous month, it was reported that unplanned re-admissions had decreased back to 3.6%.

10.10 David Noyes reported the HomeFirst revised targets had been set and had delivered against 35 starts per week. The length of stay within the service was reported at a mean of 19 days and a median of 16.

10.11 The Board was informed that there was substantial progress being made to reduce the CAMHS waiting list and the referral to assessment within 4 weeks was currently achieving 59.1% with a target of 80%. This was an improvement from previous months, but was noted as a significant national issue. A deep dive on the service would be received at the next Trust Board meeting in September.

10.12 David Noyes referred to the ADHD waiting lists and reported that the waiting list currently had more than 3000 children and 1500 adults awaiting assessment. The teams currently only had capacity to carry out 20 assessments per month and the waiting list was continuing to grow. It was reported the Social Communication and Autism Assessment Service (SCAAS) had been commissioned to provide a multiagency approach to assessing ADHD and autism in children and was working closely with a range of partners across Gloucestershire, including education. Douglas Blair informed the Board that this was a national issue and that a taskforce had been set up by NHS England to consider what changes were needed.

10.13 It was **noted** the performance of Echo, which was hosted by GHFT had improved and was now reporting as achieving 69% against the 95% target. Further conversations would be held with GHFT and System partners to review the ongoing demand and performance of the service.

10.14 Jan Marriott highlighted the importance of language and requested that the use of the term ‘non-compliant’ in relation to children be reconsidered.

10.15 The Board **noted** the Performance Dashboard and the assurance provided.

11. QUALITY DASHBOARD REPORT

11.1 Nicola Hazle introduced the Quality Dashboard Report (June data), which provided a summary assurance update on progress and achievement of quality priorities and indicators across the Trust’s Physical Health, Mental Health and Learning Disability services. The report also included additional information regarding: Q4 2023/24 Learning from Deaths summary, Q4 2023/24 Guardian of Safe Working Report, and the continued development of ‘Closed Culture’ data and narrative.

11.2 Quality issues showing positive improvement this month included:

- Expansion of current patient safety data set to include themes related to restrictive practice.
- Development of Community Nursing data and associated narrative in line with key quality proxy measures as referenced by The Queens Nursing Institute
- Mental Capacity Assessments and Best Interest forms are now live in both SystmOne and RiO which aims to increase compliance with reporting, visibility across systems and accuracy of assessments.

- Continued progress continues with more detailed reporting of Statutory and Mandatory training and Clinical Supervision but further work is required to be able to use this data for full assurance.

11.3 Quality issues that require additional focus development included:

- Continued work regarding quality concerns at Berkeley House, noting ongoing challenges for colleagues against the backdrop of a new service model being created.
- Focussed work required to accelerate the uptake and recording of clinical supervision. A Trust wide Supervision Development Group has been established to review trust policy and practice.
- Further work is required to provide assurance in relation to the recording of rapid tranquilisation and associated post tranquilisation observations.
- To provide in partnership with operational colleague's additional focus to safeguarding supervision attendance in both adults and children's services) and recording of household contact details.

11.4 Nicola Hazle shared with the Board her initial reflections, from her first month in post, on the current format of the Quality Dashboard and her commitment to working with colleagues towards more integrated reporting with the performance report. She continued that her ambition for quality reporting was to focus on particular areas within the report in more detail in order for the Board to gain a greater understanding on the position, particularly around the assurance provided. Sandra Betney requested focus be given to ensuring that escalation points were working and that assurance was structured the same across quality, workforce and performance reporting, with consistency across all areas.

11.5 The key improvements were highlighted, and the Board was informed that the new community data metrics in line with The Queens Nursing Institute signalled the intention to improve visibility of quality reporting across the service, and would also align with the move to an integrated reporting structure.

11.6 Nicola Hazle highlighted the key issues and concerns of significance where further assurance was required and informed the Board that there would be collective vigilance in relation Berkeley House during the next twelve months to focus on the work to lift the S31 notice, gain clarity on the future service model, being mindful of the impact on the staff team and the importance to maintain safe, effective personalised care for each patient as the cohort changes.

11.7 In response to a question from the Chair, David Noyes provided an update on discharges from Berkeley House including the recent successful discharge of a long-term service user. Douglas Blair reported that learning from each discharge would be shared and discussed with the ICB (Integrated Care Board), to inform future developments.

11.8 Nicola Hazle highlighted key opportunities to be explored which included a focus on the culture of the organisation with particular attention to closed culture environments. It was noted that a range of audits, reviews and programmes were taking place to support this.

11.9 Statutory and mandatory and essential to role training data for the period was considered. Concern was expressed regarding training compliance levels for safeguarding, PMVA (Preventing and Managing Violence and Aggression) and rapid tranquilisation at Berkeley House. David Noyes assured the Board that this was being actively addressed and that since writing the report, the compliance rate for safeguarding had improved considerably. **ACTION** Nicola Hazle to provide further information on Rapid Tranquilisation training levels at Berkeley House.

11.10 The Board **received, noted** and **discussed** the June 2024 Quality Dashboard.

12. EQUALITY DIVERSITY & INCLUSION

12.1 Neil Savage introduced the Equality, Diversity and Inclusion Report, which provided a top-level workforce Equality, Diversity and Inclusion (EDI) update to inform a debate and a refreshing of Board commitment to prioritising the Trust's strategic focus and improvement plans in this business-critical area. It was noted that the report was not intended to provide a detailed report on each of the various individual EDI work streams reported elsewhere.

12.2 Neil Savage drew the Board's attention to section 8 of the report '*how we measure up on EDI'* which recognised that whilst there had been many continued improvements measured by how colleagues rated their experiences working within the Trust; there were also colleagues from minority groups and with protected characteristics that had reported a worse experience than those from majority groups.

12.3 Neil Savage shared that there would be focus given to strengthening the workforce experiences and finding new solutions and new ways of improving; and that the Trust needed to be more proactive and honest in speaking up when things go wrong.

12.4 Neil Savage highlighted the Trust's '*Our Strategy for the Future 2021-26',* which included explicit reference to the intent with EDI, declaring: *"Our values ensure we focus on equality of opportunity for all, treating people as individuals. We will continue to focus on …ensuring that everybody is treated with respect and feels valued for the contribution they make."*

12.5 The Board was informed that the Trust's subsequent *'People Strategy 2021-26'* further built on the Trust's Strategy and highlighted the Trust's ambition to create and develop an organisational culture that is welcoming, celebrates inclusivity and diversity, and also provides a sense of belonging and trust. This Strategy was reviewed annually by the Great Place to Work Committee.

12.6 Neil Savage referred to the Board Assurance Framework, and risk 4 within this which captured the EDI risk for the Trust. The risk described that the Trust could fail to deliver our commitment to having a fully inclusive and engaging culture with kind and compassionate leadership, strong values and behaviours which would negatively impact on retention and recruitment, colleagues experience and engagement and on our ability to address inequalities in service delivery (access, experience and outcomes). This risk was reviewed on a quarterly basis, and was currently rated as a 9, against a tolerance for scoring a 6.

12.7 Neil Savage highlighted the staff survey results, which were included in the report, and noted that although the Trust benchmarked well against other similar organisations, it was not the best and some poor experience was recorded.

12.8 It was **noted** that although the Trust was on the right path with EDI and was mostly improving, there remained areas for further strategic development and improvement and to guard against complacency.

12.9 The Board discussed areas of focus and agreed not to rely solely on survey responses, but to triangulate this with other sources of data and intelligence; noting that the Staff Survey questions did not necessary focus on what was required and were not always action specific. This information should form part of regular reporting to Board. Sumita Hutchison suggested that agreement was needed on the top three priority actions and how these would be measured and reported going forward. Progress would be reviewed via the Great Place to Work Committee.

12.10 The Board refreshed its strategic commitment to prioritising focus, activity and improvement in EDI delivery.

13. AUDIT & ASSURANCE ANNUAL REPORT

13.1 The Board **received** the Audit and Assurance Annual Report, which had been endorsed by Marcia Gallagher, immediate past chair of the Audit and Assurance Committee. The Board noted the report and extended thanks to Marcia Gallagher.

14. COUNCIL OF GOVERNOR MINUTES

14.1 The Board **received** and **noted** the minutes from the Council of Governors meeting held on 15 May 2024.

15. BOARD COMMITTEE SUMMARY REPORTS

15.1 The Board **received** the summary report from the **Audit and Assurance Committee** (17 June) and approved the following self-certification statement in line with NHS Provider Licence Condition COS7.

"After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate."

15.2 The Board also **received** and **noted** the following summary reports for information and assurance.

- Charitable Funds Committee (19 June)
- Resources Committee (27 June)
- Quality Committee (4 July)
- Great Place to Work Committee (10 July)
- Working Together Advisory Committee (11 July)

- Mental Health Legislation Scrutiny Committee (17 July)

15.3 Appointments and Terms of Service (ATOS) **Committee** (5/16/24 July) – Douglas Blair asked the Board to **note** Helen Goodey (Joint Director of Locality Development and Primary Care's) resignation from the joint position and her role as non-voting member of the Trust Board, effective from 9 July 2024. Helen would continue her employment with Gloucestershire ICB on a full-time basis. It had been agreed by the Committee that this aspect of the joint role would be discontinued but that the inclusion of primary care relationships in the portfolio of the new Director of Improvement and Partnerships and the recent appointment of the new Deputy Director for Community Health Services would ensure an ongoing focus on the Trust's commitment to working more closely at a local level with primary care.

16. ANY OTHER BUSINESS

16.1 The Board **noted** that the Public and Staff Governor Elections would open later today (25 July). The vacancies were for:

- Staff: Health and Social Care Professionals - 1 vacancy
- Staff: Management and Administration - 1 vacancy
- Staff: Medical, Dental and Nursing (reserved for Medical Staff only) - 1 vacancy
- Public: Cheltenham - 2 vacancies
- Public: Forest of Dean - 1 vacancy
- Public: Greater England and Wales - 1 vacancy

16.2 The Board **noted** that self-nominations would be received by email and were invited to cascade to interested parties and diversity networks.

17. DATE OF NEXT MEETING

17.1 The next meeting would take place on **Thursday, 26 September 2024**.

AGENDA ITEM: 05/0924

TRUST BOARD PUBLIC SESSION: Matters Arising and Action Log – 26 September 2024

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

Meeting Date	Item No.	Action Description	Assigned to	Target Completion Date	Progress Update	Status
25 Jan 2024	5.2	It was agreed that a Peer Support Worker Strategic Framework would be scoped and a progress report presented at the Board.	Des Gorman	Nov 2024	Programme of engagement and consultation has been carried out and reports have been presented to the Executive Team and the Working Together Advisory Committee. Further work required for the Executive to review and finalise/agree the ambitions/resourcing included in the scoping, along with clear timelines. Timeline confirmed as November 2024 Board.	
25 July 2024	11.9	Nicola Hazle to provide further information on Rapid Tranquilisation training levels at Berkeley House.	Nicola Hazle	Sept 2024	• None of the patients at Berkeley House are prescribed medication to be administered as rapid tranquilisation either oral or intramuscular medication • Berkeley House do not keep any stock of rapid tranquilisation medication on site, so unless this was clinically requested there is no likelihood any patient could receive rapid tranquilisation if in distress/crisis	

Meeting Date	Item No.	Action Description	Assigned to	Target Completion Date	Progress Update	Status
					• Current staff training compliance for rapid tranquilisation is at 81.8%. • Berkeley House staff need this training as it is essential to role for an RN to be able to work and support in other inpatient settings • Staff who are currently out of date have been spoken with and are either booked or booking on training. The matron continues to monitor this	

AGENDA ITEM: 07/0924

REPORT TO:	**TRUST BOARD PUBLIC SESSION – 26 September 2024**
PRESENTED BY:	Trust Chair
AUTHOR:	Graham Russell, Trust 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

This report updates the Board and members of public on the Chair's main activities and those of the Non-Executive Directors (NEDs), Council of Governor discussions and Board development as part of the Board's commitment to public accountability and Trust values.

Recommendations and decisions required

The Board is asked to:

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

Executive summary

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

- Board development – including updates on Non-Executive Directors
- Governor activities – including updates on Governors

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 – July and August 2024

Report authorised by: Graham Russell	Title: Chair

REPORT FROM THE CHAIR

1. INTRODUCTION AND PURPOSE

This report informs the Board and members of the public of the key points arising from the Council of Governors and members' discussions, Board development and the Chair's and Non-Executive Directors most significant activities.

2. CHAIR'S UPDATE

I have been out and about meeting colleagues and service users. I have also met with stakeholders and partner organisations.

Underpinning the Trust's values, I have four key areas of focus:

- Working together
- Always improving
- Respectful and kind
- Making a difference

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 our colleagues across the Trust. My update to the Board is structured in line with these four areas.

Working together

- It has been a real pleasure to visit services, meet colleagues and service users across the county. Since our last Board meeting, I have undertaken the following visits:
  - **Tewkesbury Hospital** where I spent time with the Volunteers and Team Administrators
  - **Tewkesbury** and **Cheltenham Recovery Team** which also included the **Later Life (North) Team** at Avon House
  - **Quality Improvement Team** at Trust HQ, where I was invited to join their Team meeting
  - **Homeless Healthcare Team** who also provide the **Special Allocation Scheme** based at Rikenel. I spent time with Homeless Healthcare and Special Allocation Team Lead, Dawn Harris, along with Lucy Gorton-Williams, Danielle Miles and Rachel James.

I would like to personally thank all services who have taken time out of their busy schedules to accommodate my visit. I have met so many amazing colleagues who are truly great at what they do.

I have many more service visits scheduled across the county over the coming weeks and I look forward to meeting further teams and service users.

- I attended on 18th September the virtual **ICB Gloucestershire Neighbourhood Transformation Steering Group meeting.**

- To continue to deepen our understanding of our Trusts' work together, Deborah Evans, Chair and Al Sheward, Chief Operating Officer of Gloucestershire Hospitals NHSFT; Dame Gill Morgan, Chair and Jane Cummings, Deputy Chair and Non-Executive Director of Gloucestershire ICB; Martin Holloway, Non-Executive Director of South Western Ambulance Service and I undertook a fascinating **joint visit** on 15th August. Our visit focussed on the urgent and emergency care pathway. It was very encouraging to see how well colleagues from different parts of the system were working together and the appetite to go further. I would like to personally thank colleagues who made the time in their busy schedules to accommodate the visit.

- I had the pleasure of inviting **Councillor Allaway-Martin**, Cabinet Member for Adult Social Care to the Forest of Dean Community Hospital on 7th August. The visit was an opportunity for Cllr Allaway-Martin to view first-hand the excellent facilities at the hospital and to meet members of staff.

Always improving

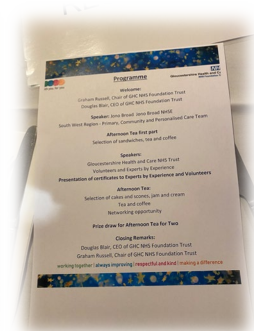
- The Chief Executive and I met with the newly elected **MP for Gloucester, Alex McIntyre** on 19th September. This in person meeting was an opportunity to introduce Alex to the many services provided by the Trust and for Alex to ask any specific questions. As referred to in the Chief Executive's report, introduction meetings are currently in the process of being arranged with all Gloucestershire MPs.

- Partnership working and learning from the **Community Mental Health Transformation programme** took place on 31st July with a subsequent meeting with the Chief Executive on 14th August.

Respectful and kind

- I attended the **Network Chairs and Senior Leaders' session** on 24th September. This in person session provided an opportunity for the Network Chairs and senior leaders to set an ambition for where we want to be with EDI networks and EDI more broadly and ascertain where we are right now – the baseline.

- I had the pleasure of attending the **Volunteer and Experts by Experience Thank You Tea Party Celebration** on 11th September. A simply marvellous occasion to celebrate the difference made by Experts by Experience and volunteers. The Trust is a better organisation because of their contribution and we improve through their insights, lived experience, and engagement. A massive personal 'thank you' from me. The tea party was an opportunity to thank our dedicated Volunteers and Experts by Experience for the valuable contribution they make to our services.



Programme

Welcome:
Graham Russell, Chair of GHC NHS Foundation Trust
Douglas Blair, CEO of GHC NHS Foundation Trust

Speaker: Jono Broad Jono Broad NHSE
South West Region - Primary, Community and Personalised Care Team

Afternoon Tea first part
Selection of sandwiches, tea and coffee

Speakers:
Gloucestershire Health and Care NHS Trust
Volunteers and Experts by Experience
Presentation of certificates to Experts by Experience and Volunteers

Afternoon Tea:
Selection of cakes and scones, jam and cream
Tea and coffee
Networking opportunity

Prize draw for Afternoon Tea for Two

Closing Remarks:
Douglas Blair, CEO of GHC NHS Foundation Trust
Graham Russell, Chair of GHC NHS Foundation Trust

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

Making a difference

- I was delighted to be invited to attend the '**Rethink Mental Illness'** barbeque on 13th August which took place in the wonderful Weavers Croft Garden. It was an opportunity for me to find out more about the service whilst enjoying the beautiful surroundings.

- I met with Cordell Ray MBE on 27th August. Cordell is the Chief Executive of the **CCP Charity** (Caring for Communities and People) which has its head office in Cheltenham. The charity was founded in response to the growing numbers of homeless young people. CCP delivers services and projects across the county including Worcestershire, Herefordshire, South Gloucestershire, Bristol, Wiltshire, Dorset and Teignbridge. It was fascinating to learn more about the charity which exists to prevent the causes and reducing the effects of homelessness, family breakdown and exclusion.

- I met with Richard Hobbs, **Volunteer Coordinator** on 12th September where we discussed volunteers within the Trust and the invaluable service they provide in the day to day running of our services.

- On 10th September I joined the **Freedom to Speak Up Champion Network** where I shared my commitment to speaking up. We discussed how to continue to break down barriers to create change so that people feel safe to speak up. I challenged the Network by asking them to think about how we can spot the 'early warning signs', what can we do to improve on this to become a truly amazing organisation.

3. BOARD UPDATES

- The **Trust's AGM** took place on 19th September. This was a virtual event which provided a review of last year and an account of our quality and financial position as well as a review by our Lead Governor, Chris Witham. There was an opportunity to ask questions of the Council of Governors and the Board.

- As referred to in my July Board report, we continue the process to **recruit** a new **Non-Executive Director** to the Board. With the summer break and availability of shortlisted candidates, interviews are scheduled to take place in October 2024.

- A Board Seminar took place on 5th September where the topic for discussion was **Integrated Urgent Care Service (IUCS) – Service Model and Assurance**. The

seminar was led by David Noyes, Chief Operating Officer. David was joined by colleagues from the IUCS and the Chief Strategy and Transformation Officer from IC24.

- The Non-Executive Directors and I continue to meet regularly as a group. NED meetings are helpful check-in sessions as well as enabling us to consider future plans, reflect on any changes we need to put in place to support the Executive and to continuously improve the way the Trust operates. I am delighted to advise Dr Cathia Jenainati joined the Trust as an Honorary Associate Non-Executive Director, representing the University of Gloucestershire on 19th September. Cathia is Professor of Gender and Leadership, and the Head of the School of Business, Computing and Social Sciences at the University. I am sure you will join me in welcoming Cathia to the Trust.

4. GOVERNOR UPDATES

- I continue to meet on a regular basis with the **Lead Governor Chris Witham**, where matters relating to our Council of Governors are discussed including agenda planning, governor elections and membership engagement.

- A meeting of the **Nominations and Remuneration Committee** took place on 4th September where the Committee received an update on Non-Executive Director recruitment. The Committee also received an update on Non-Executive Director renumeration, the setting of objectives for the Chair and NEDs for 2024/25 and noted the appointment of Dr Cathia Jenainati as the Trust's Honorary Associate Non-Executive Director, representing the University of Gloucestershire.

- On 18th September we held our **Council of Governors meeting** via MS Teams. At the meeting we received an update on Governor's ways of working, an informative update on key developments from the CEO, and we also received a presentation on the new IUCS service.

- A **Governor Information Session** took place on 22nd August where Governors had the opportunity to meet with Sandra Betney, Director of Finance, Bilal Lala, Audit and Assurance Committee Chair and the External Auditors where they were able to learn more about our Annual Report and Accounts.

- **Elections** have taken place for our vacant Governor positions. We received some fantastic nominations this round and voting took place in the following constituencies:
  PUBLIC: Forest of Dean
  PUBLIC: Greater England & Wales
  STAFF: Management & Administration
  STAFF: Health & Social Care Professional
  The results are due to be declared in advance of the Board meeting and an update will be provided.

  In the meantime, I am delighted to welcome Tussie Myerson and Neil Hubbard who have been elected unopposed as Public Governors representing the Cheltenham

constituency. Tussie and Neil officially joined the Trust on 1st September and I look forward to introduction meetings with them in due course.

5. 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 July and August 2024.

6. CONCLUSION AND RECOMMENDATIONS

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

Appendix 1

Non-Executive Director – Summary of Activity 1st July – 30th August 2024

NED Name	Meetings with Executives, Colleagues, External Partners	GHC Board / Committee meetings
Dr Stephen Alvis	1:1 with Bilal Lala 1:1 with Jason Makepeace 1:1 with Medical Director 1:1 with Moiz Nayeem Board Development IUCS Council of Governors Meeting and Development Session GGI Webinar ICS NED Development of a 10-year Infrastructure Strategy NHS Confederation ICB NED Forum Non-Executive Director Informal meeting Non-Executive Directors Informal Meeting Objective Setting meeting with Chair Quality Visit to North Cotswolds Hospital	Extraordinary Appointments and Terms of Service Extraordinary Appointments and Terms of Service Mental Health Legislation Scrutiny Committee Quality Committee Quality Committee Resources Committee Trust Board: Private Trust Board: Public
Sumita Hutchison	Diversity Network Agenda Setting Meeting Diversity Network Meeting Diversity Networks meeting with Vicci Livingstone-Thompson Great Place to Work Committee Planning Meeting Great Place to Work Committee pre-meet Meeting with Deputy Director of Strategy and Partnerships Meeting with People Promise Manager Non-Executive Director Informal meeting Non-Executive Director Informal meeting	Audit and Assurance Committee Extraordinary Appointments and Terms of Service Great Place to Work Committee Mental Health Legislation Scrutiny Committee Trust Board: Private Trust Board: Public
Nicola de longh	Chief Operating Officer Recruitment Focus Group Chief Operating Officer Recruitment Interview Panel Meeting with Director of Corporate Governance and Trust Secretary Non-Executive Director Informal Meeting Non-Executive Director Informal meeting Objective setting meeting with Chair Quality visit to Community Assessment Team	Appointments and Terms of Service Extraordinary Appointments and Terms of Service Extraordinary Appointments and Terms of Service Resources Committee Trust Board: Private Trust Board: Public

Jan Marriott	Chief Operating Officer Recruitment Focus Group Forest of Dean Health Forum Freedom to Speak Up Champions Meeting ICB System Quality Committee Introduction meeting with Director of Nursing, Therapies and Quality Meeting with Chair and Non-Executive Director regarding CMHT Meeting with person with lived experience Non-Executive Director Informal meeting Non-Executive Directors Meeting Objective setting meeting with Chair Quality Assurance Group Quality Assurance Group Meeting Quality Committee pre-meet Quality Committee pre-meet with Director of Nursing, Therapies and Quality Quality Visit to Forest of Dean Community Hospital Voluntary Sector partnership meeting Working Together Advisory Committee meeting to review Terms of Reference 1:1 w Assistant Director of Strategy and Partnerships regarding Working Together Advisory Committee 1:1 with Acting Director of Strategy & Partnerships regarding Working Together Advisory Committee 1:1 with Director of Nursing, Therapies and Quality 1:1 with Internal Audit regarding Operational Governance 1:1 with Service Development Manager (Involvement, Inclusion, Engagement)	Audit and Assurance Committee Extraordinary Appointments and Terms of Service Extraordinary Appointments and Terms of Service Quality Committee Trust Board: Private Trust Board: Public Working Together Advisory Committee
Vicci Livingstone-Thompson	Allied Health Professional Massive at Westonbirt Chief Operating Officer Recruitment Focus Group CMHT Partnership Working Meeting Diversity Networks meeting with Sumita Hutchison ICS NED Development of a 10-year Infrastructure Strategy Introduction meeting with Bilal Lala Introduction meeting with Jason Makepeace Meeting with Chair and Non-Executive Director regarding CMHT Meeting with Chair, GHT	Audit and Assurance Committee Extraordinary Appointments and Terms of Service Extraordinary Appointments and Terms of Service Mental Health Legislation Scrutiny Committee Resources Committee Trust Board: Private Trust Board: Public Working Together Advisory Committee

	Non-Executive Director Meeting Objective Setting meeting with Chair Quality visit to Functional Family Therapy Service	
Bilal Lala	Annual Report and Accounts session with Governors Audit and Assurance Pre-meeting with Director of Finance Corporate Induction Council of Governors Meeting ICS Development of a 10 Year ICS Infrastructure Strategy Introduction meeting with Chief Executive Introduction meeting with Chief Operating Officer Introduction Meeting with Director of HR & OD Introduction meeting with Dr Steve Alvis Introduction meeting with Medical Director Introduction meeting with Vicci Livingstone-Thompson Meeting with Counter Fraud Meeting with Director of Corporate Governance and Trust Secretary Meeting with Director of Finance Meeting with Director of Finance & Director of HR & OD Non-Executive Directors Meeting Objective setting meeting with Chair Risk Management Framework Meeting	Appointment and Terms of Service Committee Meeting Audit and Assurance Committee Extraordinary Appointments and Terms of Service Extraordinary Appointments and Terms of Service Quality Committee Resources Committee Trust Board: Private Trust Board: Public
Jason Makepeace	1:1 with Chair ICB System Resources Committee Introduction meeting with Acting Director of Strategy and Partnerships Introduction meeting with Director of Finance Introduction meeting with Director of Locality Development and Primary Care Introduction meeting with Steve Alvis Introduction meeting with Vicci Livingstone-Thompson Non-Executive Directors Informal Meeting Resources Committee Planning Meeting Trust Corporate Induction	Appointment and Terms of Service Committee Meeting Audit and Assurance Committee Extraordinary Appointments and Terms of Service Extraordinary Appointments and Terms of Service Resources Committee

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 08/0924

REPORT TO: **TRUST BOARD PUBLIC SESSION – 26 September 2024**

PRESENTED BY: Douglas Blair, Chief Executive Officer

AUTHOR: Douglas Blair

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

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

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

The purpose of this report is to

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

Recommendations and decisions required

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

Executive Summary

The report summarises the 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
- National / Regional updates
- Events
- Achievements / Awards
- Right Care, Right Person
- Death Certification and Medical Examiners: New Law

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

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

Where has this issue been discussed before?
N/A

Appendices:	Report attached

Report authorised by: Douglas Blair	**Title:** Chief Executive Officer

CHIEF EXECUTIVE OFFICER AND EXECUTIVE TEAM REPORT

1.0 CHIEF EXECUTIVE OVERVIEW

1.1 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. In addition to a number of internal events I have attended (described in more detail below), I have also spent time since the last Board meeting at:

- Cirencester hospital
- Multi Agency Safeguarding Hub (MASH) (based at Shire Hall)
- Gloucestershire Rural Community Council
- Rikenel – visit to GRIP (Early Intervention in Psychosis) Team and Young Minds Matter service
- Cardiac Rehabilitation service
- Forest of Dean hospital

1.2 General Practice (GP) Collective Action

Earlier this year, the British Medical Association (BMA) balloted its GP contractor / partner members in England on collective action. The ballot closed on 29 July and collective action has now commenced. Individual GP Practices can introduce actions, incrementally if they wish, from the following list: GP contract 2024/25 changes (bma.org.uk).

The Trust and wider system have been planning for this eventuality and our partners in the Integrated Care Board are continuing to work closely with the Local Medical Committee and GP practices to understand the likely impact across the county. Patient care, health outcomes and minimising the impact on other local services are the most important considerations for all Gloucestershire NHS partners. GP practices will continue to provide urgent assessment and care and refer patients to other services to meet their health needs.

Across the system, we have communication plans in place to ensure patients and the public receive clear, timely and proportionate advice about collective action and accessing local care and services. Patients are being advised to continue to:

- visit their community pharmacy for advice on minor ailments and medicines. No appointment is needed, and they can advise on whether another local NHS service is required
- contact their GP practice if they have a medical need and attend their GP appointments as planned unless advised otherwise
- use NHS 111 online or the 111-phone service if they are not sure on their care options. The local ASAP Glos NHS website and app also provide information on local services, including how to access Community Minor Injury and Illness Unit services
- use 999 in a life or limb threatening emergency.

Our partners and us will be doing all we can to ensure stability in the health and care system and will be monitoring any impact on local services very closely, including on urgent and emergency care.

1.3 Pay Award

On 29 July the government confirmed that it had accepted the headline recommendations of the independent Pay Review Bodies (PRB) in full. Details of the pay award uplifts are summarised below:

NHS Agenda for Change colleagues:
- With effect from 1 April 2024, a 5.5 per cent consolidated uplift for all Agenda for Change staff on NHS terms and conditions.
- The NHS Staff Council has ratified the government decision to add intermediate points into bands 8a and above, following the NHS PRB recommendation.

Doctors and Dentists:
- Consultants' salaries to be uplifted by 6 per cent on a consolidated basis.
- Specialty and specialist (SAS) doctors' salaries to be uplifted by 6 per cent on a consolidated basis.
- Doctors and dentists in training to get a 6 per cent consolidated increase plus an additional consolidated uplift of £1,000 to all the pay points.
- No uplifts in Local Clinical Excellence Awards (these remain frozen).

The Trust will be working to implement these recommendations.

Doctors and dentists in training (residents)

The government has also announced that a revised offer for doctors in training has been agreed with the BMA Resident Doctor Committee as they look to bring an end to the dispute for the 2023/24 pay round. The BMA RDC will now put this offer to a vote of its members with a recommendation to accept the offer, they have agreed that no further industrial action will be taken during this process.

1.4 Appointment of New Director of Improvement and Partnership

We are pleased to confirm the appointment of Rosanna James as our new Director of Improvement and Partnership. Rosanna will take over from Angela Potter, who retired earlier this year, and we expect her to start at the beginning of November. Before then, Rosanna will spend some days meeting with colleagues and getting to know the Trust and the wider Gloucestershire integrated care system.

Rosanna joins us from the Bristol, North Somerset and South Gloucestershire Integrated Care System (ICS). She is currently a Programme Director, leading an ICS-wide transformation programme, focused on improving older people's care. This programme is working in partnership with health and social care organisations and the VCSE sector, to redesign acute and community models of care, with an aim of improving system flow and maximising the opportunity for older people to retain their independence, through HomeFirst integrated options. Prior to that, Rosanna was Deputy Chief Operating Officer at North Bristol Trust for eight years, across elective and emergency portfolios, having originally joined the NHS as a Graduate

Management Trainee. Outside her NHS roles, Rosanna is passionate about engaging and harnessing the power of communities to support families and young people in need; and is chair of Baby Bank Network in Bristol, as well as a board member of the National Baby Bank Alliance.

1.5 Joint Role of Director of Locality and Primary Care

Since 1 April 2019, Helen Goodey has held a joint position with Gloucestershire Health and Care and the Gloucestershire Integrated Care Board as Director of Locality and Primary Care. At the beginning of July, Helen formally resigned from the GHC element of her role to allow her to focus on her role with Gloucestershire ICB.

On behalf of the Board, I would like to thank Helen for her significant contribution in developing partnership working with the Gloucestershire ICB and strengthening GHC's connection to Primary Care and Locality services. Helen has agreed to continue to support these ongoing positive relationships and this will include her wider team working closely with GHC Transformation and Operational teams. The Trust will continue to forge strong links with localities and primary care, in close partnership with Integrated Care Board colleagues.

1.6 Stakeholder Engagement

Following the outcome of the recent election, we have made contact with all the MP offices in the Gloucestershire County, to offer the mostly new set of MPs a meeting with the Chair, Graham Russell, and me. It is customary that we provide an annual briefing to local MPs on the services provided by the Trust and an opportunity for them to raise queries on areas of interest. These meetings are currently being scheduled and will take place over the coming month. The Integrated Care Board are also looking to arrange some further briefings on the system as a whole, of which I will be a part.

Further information on specific stakeholder engagements are detailed at section 2.0 of this report.

2.0 SYSTEM UPDATES

2.1 Health Overview Scrutiny Committee - Members Briefing

On 30 July the Deputy Director of Strategy and Partnerships and I briefed some of our local councillors, who are members of the Health and Overview Scrutiny Committee, wanting to know more about mental health support for children and young people. We provided information on the extent of our services, our links to the voluntary sector, social care and education partners and the progress we are making in reducing what have been very long waits for specialist treatment in CAMHS. Although waiting times are still long, there has been real progress in the last year as a result of all the hard work of colleagues across our services focused on children and young people.

2.2 ICB Board Meetings

The NHS Gloucestershire ICB Confidential and Public Board Meetings were held on 31 July and 25 September. The papers for the Public Board meetings can be located on their website - [Board Meetings : NHS Gloucestershire ICB (nhsglos.nhs.uk)]

2.3 CHMT Update

Locality Community Partnerships(LCP's) continue to run across the county with ongoing liaison with ILP's and Clinical Directors involvement in these. Very encouraging that there are representatives form partners from Housing attending some LCP's and we hope to have this more consistently mirrored across the county.

We have agreed at our August CMHT Partnership Board that we would extend the life of the Board until March 2025 so that we can continue to ensure our feedback loops with all partners in VCSE and wider groups are working effectively and while we scope and formalise the evaluation of CMHT. Work is progressing on aligning Mental health Neighbourhood teams to the Physical health locality structures.

2.4 Urgent and Emergency Care Intermediate Care

On 12 August I, along with Sarah Scott, Executive Director of Adult Social Care, Wellbeing and Communities at Gloucestershire County Council, chaired the first, in a series of three workshops, aimed at supporting the design of our mid-to longer term pathway 1 model and Reablement within Gloucestershire.

This first workshop focused on the plan for this winter (2024/2025), with an opportunity to review the current performance against the expected demand, and how forecasted capacity compares to this demand. This helped to identify gaps the system may experience and how they can be proactively addressed.

The second and third workshops will both confirm planning for this winter and look ahead to 2025 and beyond, for a more in-depth discussion about what our Pathway 1 and Reablement services within Gloucestershire to would ideally include, how they should function and any changes that need to be implemented to realise the future model.

I have also been chairing weekly meetings for a regional Ambulance Handover Task and Finish Group. This is looking at ambulance handovers to acute hospitals, in particular at how we can better connect some of our community services to help avoid the use of the ambulance service across the South West. The group's findings will be presented to NHS England on 30 September.

3.0 NATIONAL / REGIONAL UPDATES

3.1 Briefing with Amanda Pritchard, Chief Executive of NHS England

On 5 August I took part in a national call with Amanda Pritchard to discuss the national disorder which took place at the end of July following the tragic events in Southport and the impact that this has had on NHS colleagues. During the meeting, the importance of maintaining a zero-tolerance stance on racism was strongly expressed, as well as prioritising support and advice to colleagues working across our services. The NHS is opposed to all hatred, violence and aggression and colleagues were reminded to report any concerns through existing processes and not to hesitate to seek help if required.

3.2 NHS Leadership Event

On 3 September I attended a national NHS England session with Chief Executives in London. We were joined by the new Health and Social Care Secretary, Wes Streeting, who set out his early priorities and his approach to working together to make improvements over the longer term. It was recognised that whilst colleagues continue to work hard daily, the reality of service delivery is often difficult and it is vital that we continue to seize opportunities to improve wherever they arise.

3.3 Mental Health Act Quality Improvement Programme

On 7 August I attended a briefing session for Chairs and Chief Executives of organisations participating in the Mental Health Act Quality Improvement Programme. At the session we discussed the national priorities and their alignment with the programme, an overview of the programme including the programme aim and key building blocks and the expectations of organisations, leaders, and staff taking part. There was an opportunity to hear from one of the pilot site teams and their executive sponsor about their experience of co-production and delivering tangible impact for their organisation.

3.4 NHS Leadership & Management Framework: Code of Practice

I have attended a number of workshops to support the early development of a Leadership and Management Framework, which will consist of a universal Code of Practice across the NHS and social care, as well as standards, competencies and development curricula for all leaders and managers in the NHS, as recommended in the Messenger review, across all levels of seniority. I will be part of the Steering Group for this work, which will meet from October onwards.

4.0 EVENTS

4.1 Volunteer and Expert by Experience Celebration Event

On 11 September, I was really pleased to attend and be a part of the annual celebration event which was held at Bowden Hall Hotel in Gloucester to thank GHC Volunteers and Experts by Experience for the valuable contribution they make to our services and for their continued support to patients, carers, GHC Colleagues and visitors. Further details regarding the celebration can be found in the Chair's Board report.

4.2 Race and Cultural Awareness Network (RCAN) Bring and Share Lunch

On 17 September I attended our Race and Cultural Awareness Network (RCAN) Bring and Share Lunch at the Forest of Dean Community Hospital to mark Onam, an annual harvest and cultural festival related to Hinduism, which is celebrated mostly by people of Kerala in Southern India.

The lunch was open to all colleagues to join and bring some speciality foods and drinks to celebrate all cultural backgrounds within GHC. A multi-coloured floral carpet "Pookalam" that most Indian families place at the entrance of their residence was designed on the day. The event provided a welcome opportunity to celebrate the

diverse cultures within our organisation, and marked the importance of belonging and inclusion.

5.0 ACHIEVEMENTS / AWARDS

5.1 Apprenticeships

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

- Carley Loveridge – Level 5 Operational/Departmental Manager
- Julie Mackie – Level 7 Systems Thinking Practitioner
- Lois Cracknell – Level 4 Associate Project Manager
- Morgan King – Level 3 Assistant Accountant (AAT)
- Lizzie Nesbitt – Level 4 Associate Project Manager

5.2 'Lifeline' Project Shortlisted for Prestigious Award

An ambitious partnership project in Gloucestershire is helping thousands of veterans and serving members of the armed forces to access the healthcare and support they need. The NHS Gloucestershire Armed Forces Veterans Programme, which works with GP practice teams to determine what kind of help veterans might need, has been shortlisted in the Military and Civilian Health Partnership category of the 2024 Health Service Journal Awards.

By signing up to the Royal College of General Practitioners (RCGP) Accredited Veteran Friendly Practice scheme, GP practices are supported to increase their understanding of the health needs of veterans and the services available to them. They are able to appoint a clinical lead who is trained to act as a champion for issues relating to veteran healthcare. In Gloucestershire 70% of GP practices have already signed up to the scheme, with more practices currently in the process.

The team are now awaiting judging for the Awards which will take place in October, with an awards ceremony scheduled for November.

5.3 Liaison Team Wins Regional Award

On 5 September the NHS in the South West celebrated the remarkable achievements of staff and teams who have won regional categories in the 2024 Parliamentary Awards, after being nominated by their local MPs.

The 2024 regional winners, selected by NHS leaders in the South West, included GHC's **Mental Health Liaison and Emergency Department team** (nominated by Alex McIntyre MP), for the Excellence in Urgent and Emergency Care Award.
.
The Mental Health Liaison Team is a team of mental health professionals who jointly work with Emergency Department staff at Gloucestershire Royal Hospital to identify people with mental health needs and provide appropriate support and treatment. Their

nomination detailed how they have introduced new ways of identifying people with mental health needs as soon as they attend, so their risk and previous history can be assessed straight away. This has seen waiting times decrease considerably, reducing overcrowding in Emergency Departments and improving the experience of patients, with better health outcomes and less chance of needing a hospital bed.

Congratulations to the team for winning this regional award which recognises the excellent work of the team in supporting our local population. Their new and innovative ways of working with hospital colleagues ensure that people receive the best possible care in a timely way. They will represent the South West in the national awards ceremony at the prestigious Queen Elizabeth II Centre in Westminster on 14 October.

6.0 RIGHT CARE, RIGHT PERSON

Right Care, Right Person (RCRP) is an operational model that changes the way the emergency services respond to calls involving concerns about mental health.
It is aimed at making sure the right agency deals with health-related calls, so that vulnerable people get the support they need from the most appropriate services.

RCRP has a recognised National Partnership Agreement to ensure consistency across the country. It is an approach designed to ensure that people of all ages, who have health or social care needs, are responded to by the right person, with the right skills, training and experience to best meet their needs. At the centre of the RCRP approach is a threshold to assist police in making decisions about when it is appropriate for them to respond to incidents.

The threshold for a police response to a mental health-related incident is:

- to carry out their designated police powers under the mental health act.
- to investigate a crime that has occurred or is occurring; or
- to protect people, when there is a real and immediate risk to the life of a person, or of a person being subject to or at risk of serious harm.

RCRP will not stop the police attending incidents where there is a threat to life, and where they have duties under the Mental Health Act. The Police have a duty to protect our communities and they will continue to do so. RCRP is about working together to make the necessary changes to service provisions to ensure that vulnerable people are given appropriate care by the appropriate agency.

This model is being rolled out across the county in phases, the first of which was implemented on 31 July 2024. The Trust is working with relevant clinical leads, wider colleagues and system partners to revise and update our policies and processes to support the full implementation of this and future phases.

7.0 DEATH CERTIFICATION AND MEDICAL EXAMINERS: NEW LAW

On 9 September, the government formally introduced their reforms to death certification laws. These follow recommendations from the Shipman and Francis inquiries (2003 and 2013) to provide greater safeguards for the public and offer opportunities for bereaved people to understand why their relative died and raise concerns if applicable.

It introduces the role of medical examiner (ME) who is a senior doctor and trained in legal and medical aspects of this new law. Gloucestershire Hospital's Bereavement Services now incorporate the Gloucestershire Medical Examiner Service, and the team will be responsible for providing an independent review of the circumstances leading to deaths and supporting bereaved people across all care provider organisations countywide.

It is important to note that bereaved families will no longer be able to register a death without a Medical Examiner having countersigned the attending doctor's medical certificate of cause of death (MCCD). For further details about the death certification reforms please see: www.gov.uk/government/publications/changes-to-the-death-certification-process/an-overview-of-the-death-certification-reforms

8.0 CONCLUSION AND RECOMMENDATIONS

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

AGENDA ITEM: 09/0924

REPORT TO: **TRUST BOARD PUBLIC SESSION – 26 September 2024**

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

AUTHOR: Stephen Andrews, Deputy Director of Finance

SUBJECT: **FINANCE REPORT FOR PERIOD ENDING 31st August 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 5 position.

Executive summary

- The revised system plan submitted on the 12th June is break even and the Trust's plan is break even
- At month 5 the Trust has a surplus of £0.289m compared to a plan of £0.288m
- 24/25 Capital plan is £10.704m with £4.000m of disposals leaving a net £6.704m programme. Spend to month 5 is £1.252m against a budget of £2.636m.
- Cash at the end of month 5 is £44.905m compared to plan of £47.997m
- Cost improvement programme has delivered £3.137m of recurring savings at month 5 compared to plan of £2.746m
- £3.765m of non-recurring savings have been delivered at month 5 against plan of £3.615m
- The Trust spent £2.043m on agency staff up to month 5. This equates to 2.13% of total pay compared to the agency ceiling of 3.2%.

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

NHS

Gloucestershire Health and Care
NHS Foundation Trust

Agenda Item: 09.1/0924

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Overview

- The revised system plan submitted on the 12th June is break even and the Trust's plan is break even
- At month 5 the Trust has a surplus of £0.289m compared to a plan of £0.288m
- 24/25 Capital plan is £10.704m with £4.000m of disposals leaving a net £6.704m programme. Spend to month 5 is £1.252m against a budget of £2.636m.
- Cash at the end of month 5 is £44.905m compared to plan of £47.997m
- Cost improvement programme has delivered £3.137m of recurring savings at month 5 compared to plan of £2.746m. Target for the year is £7.319m of which £2.297m is currently unidentified.
- £3.765m of non recurring savings have been delivered at month 5 against plan of £3.615m. Target for the year is £5.661m, and all have been identified.
- In total the Trust has 18% of its savings target unidentified, a reduction of 3%
- Worked WTEs were 133 below the budgeted WTEs in August
- The Trust spent £2.043m on agency staff up to month 5. This equates to 2.13% of total pay compared to the agency ceiling of 3.2%.
- Better Payment Policy shows 89.5% of invoices by value paid within 30 days, the national target is 95%.
- The 7 day performance at the end of July was 63.4% of invoices by value paid

GHC Income and Expenditure

Gloucestershire Health and Care
NHS Foundation Trust

	2024/25	2024/25	2024/25	2024/25	2024/25
	NHSE Plan 12th June	Revised budget	YTD revised budget	YTD Actuals	Variance - ytd actual to ytd revised budget
Operating income from patient care activities	272,338	286,529	119,387	119,185	(202)
Other operating income	16,993	16,222	6,759	7,559	800
Employee expenses - substantive	(198,597)	(229,218)	(95,508)	(86,267)	9,241
Bank	(17,771)	(2,202)	(918)	(7,648)	(6,730)
Agency	(7,152)	(1,128)	(470)	(2,043)	(1,573)
Operating expenses excluding employee expenses	(63,887)	(69,600)	(29,000)	(30,865)	(1,865)
PDC dividends payable/refundable	(2,624)	(2,624)	(1,093)	(1,077)	16
Finance Income	825	2,146	894	1,461	567
Finance expenses	(212)	(212)	(88)	(95)	(7)
Surplus/(deficit) before impairments & transfers	**(87)**	**(87)**	**(36)**	**211**	**247**
Gains/ (losses) from disposal of assets					0
Remove capital donations/grants I&E impact	87	87	36	78	41
Surplus/(deficit)	**0**	**(0)**	**(0)**	**289**	**289**
Adjust (gains)/losses on transfers by absorption/impairments	0		0		0
Remove net impact of consumables donated from other DHSC bodies					
Revised Surplus/(deficit)	**0**	**(0)**	**(0)**	**289**	**289**
WTEs	4702	4699	4699	4566	133

I&E Forecasts

Gloucestershire Health and Care
NHS Foundation Trust

Forecasts	Forecast 24/25 £000s	Forecast 25/26 £000s	Forecast 26/27 £000s	Forecast 27/28 £000s	Forecast 28/29 £000s	Forecast 29/30 £000s
Recurring						
Income	-296,684	-307,524	-309,516	-311,523	-313,529	-315,549
Pay	229,727	232,086	232,519	232,955	233,394	233,837
Non Pay	70,312	78,077	78,958	79,759	80,533	81,275
Total Recurring Deficit/ (surplus)	**3,355**	**2,638**	**1,960**	**1,191**	**398**	**-437**
Non Recurring						
Income	-10,133	-8,616	-8,618	-8,631	-8,643	-8,656
Pay	4,514	5,370	6,120	5,850	5,850	5,850
Non Pay	2,391	734	665	1,717	1,775	1,725
Total Non Recurring Deficit/ (surplus)	**-3,228**	**-2,512**	**-1,833**	**-1,064**	**-1,018**	**-1,081**
Total Deficit/ (surplus)	**127**	**127**	**127**	**127**	**-620**	**-1,518**
Depreciation on donated assets	-127	-127	-127	-127	-127	-127
Performance Deficit / (surplus)	**-0**	**-0**	**0**	**0**	**-747**	**-1,645**
Recurrent savings	-7319	-6,994	-6,957	-7,020	-7,033	-7,046
Recurrent Savings as % of budget	2.5%	2.3%	2.3%	2.3%	2.3%	2.2%
Non recurrent savings	-5662	-3,866	-3,285	-2,233	-2,175	-2,225
Non recurrent Savings as % of budget	2.0%	1%	1%	1%	1%	1%
Total savings	-12,981	-10,860	-10,242	-9,253	-9,208	-9,271
TOTAL Savings %	4.5%	3.6%	3.3%	3.0%	3.0%	3.0%

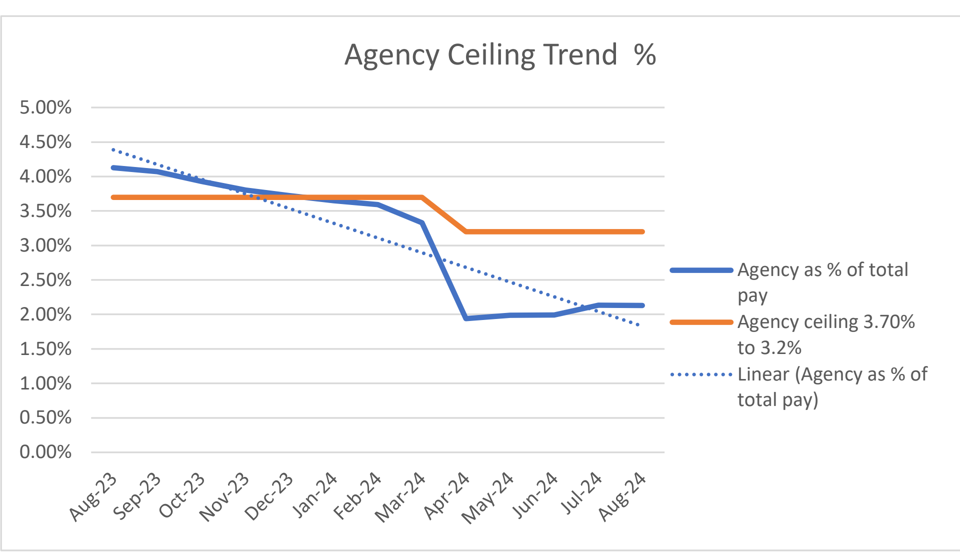
Nb. Integrated Urgent Care service added c.£10.6m full year effect
Income and Pay include c.£9.5m for employers contribution of nationally funded pensions costs

Pay analysis

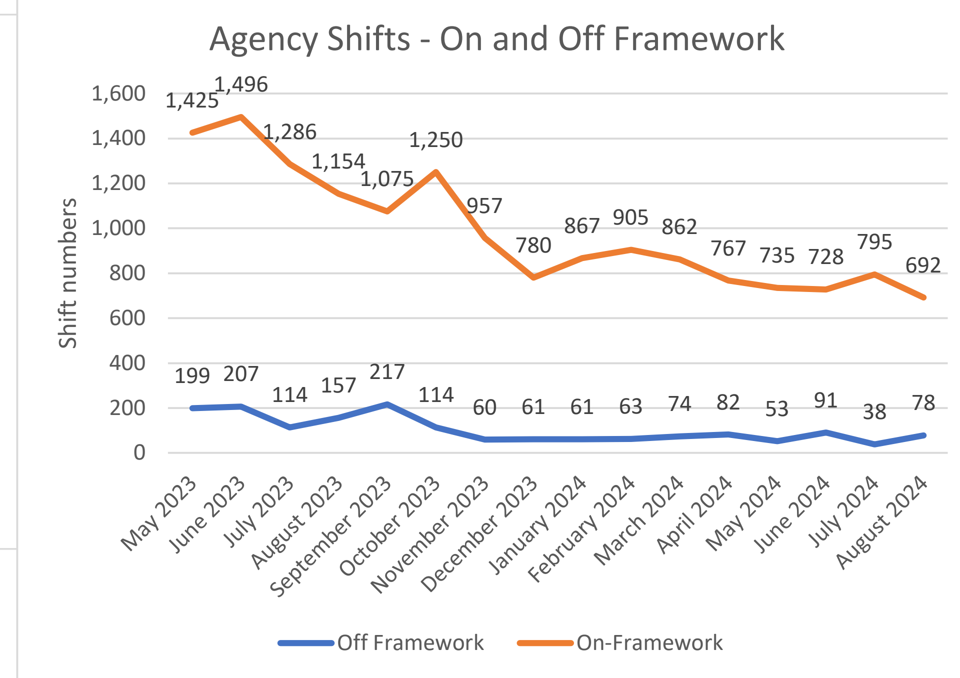
Gloucestershire Health and Care
Foundation Trust

Pay analysis month 5						
	Plan WTE Month 5	Budget WTE Month 5	Budget year to date £000s	Actual WTE Month 5	Actual year to date £000s	Actual ytd £ as % of Total £
Substantive	4,197	4,693	95,508	4,198	86,267	89.9%
Bank	369	6	918	337	7,648	8.0%
Agency	54	0	470	31	2,043	**2.13%**
Total	**4,621**	**4,699**	**96,895**	**4,566**	**95,958**	**100.0%**

- the Trust used 78 off framework agency shifts in August. The target is 0.
- substantive costs include employers contribution of nationally funded pension costs of 6.3% (£9.3m)
- Trust does not routinely set budgets for bank and agency but the plan includes assumed levels
- 2.13% of pay bill spent on agency year to date. System agency ceiling 3.2%



From Mar 24 pay costs include nationally funded pension costs



Balance Sheet

Gloucestershire Health and Care Trust

STATEMENT OF FINANCIAL POSITION (all figures £000)		2023/24	2024/25			
		Actual	NHSE Plan	YTD revised budget	YTD Actual	Variance
Non-current assets	Intangible assets	1,618	2,106	1,700	1,630	(70)
	Property, plant and equipment: other	120,401	120,161	119,151	117,885	(1,266)
	Right of use assets*	17,358	16,886	16,668	16,753	85
	Receivables	1,013	1,013	1,013	1,010	(3)
	Total non-current assets	**140,390**	**140,166**	**138,533**	**137,279**	**(1,253)**
Current assets	Inventories	356	356	356	343	(13)
	NHS receivables	3,184	3,184	3,184	12,689	9,505
	Non-NHS receivables	9,248	9,248	9,248	10,571	1,323
	Credit Loss Allowances	(1,565)	(1,565)	(1,565)	(1,457)	108
	Property held for Sale	5,025	1,201	5,025	5,024	(1)
	Cash and cash equivalents:	51,433	54,152	47,997	44,905	(3,092)
	Total current assets	**67,681**	**66,576**	**64,245**	**72,076**	**7,831**
Current liabilities	Trade and other payables: capital	(2,743)	(2,743)	(243)	(1,012)	(769)
	Trade and other payables: non-capital	(35,320)	(35,319)	(33,319)	(39,193)	(5,874)
	Borrowings*	(1,454)	(1,385)	(1,425)	(1,405)	21
	Provisions	(8,464)	(7,464)	(8,013)	(7,227)	787
	Other liabilities: deferred income including contract liabilities	(1,086)	(1,086)	(1,086)	(1,928)	(842)
	Total current liabilities	**(49,067)**	**(47,997)**	**(44,087)**	**(50,764)**	**(6,677)**
Non-current liabilities	Borrowings	(14,925)	(14,752)	(14,358)	(14,307)	51
	Provisions	(2,510)	(2,510)	(2,510)	(2,504)	6
	Total net assets employed	**141,569**	**141,482**	**141,823**	**141,780**	**(43)**

Taxpayers Equity	Public dividend capital	131,876	131,876	131,876	131,876	(0)
	Revaluation reserve	13,821	13,821	13,821	13,821	0
	Other reserves	(1,241)	(1,241)	(1,241)	(1,241)	1
	Income and expenditure reserve	(2,888)	(2,974)	(2,634)	(2,888)	(254)
	Income and expenditure reserve (current year)		0	0	211	211
	Total taxpayers' and others' equity	**141,569**	**141,482**	**141,822**	**141,779**	**(43)**

NHS Receivables high due to pay award and pensions 6.3% accruals, and matched by expenditure accruals

Balance Sheet Forecasts

Gloucestershire Health and Care NHS Foundation Trust

STATEMENT OF FINANCIAL POSITION (all figures £000) Forecasts		2024/25 Full Year Forecast	2025/26 Forecast £000s	2026/27 Forecast £000s	2027/28 Forecast £000s	2028/29 Forecast £000s
Non-current assets	Intangible assets	1,280	2,394	2,409	2,197	1,985
	Property, plant and equipment: other	119,385	123,405	122,743	122,605	122,467
	Right of use assets*	17,924	16,079	14,769	13,482	12,195
	Receivables	1,002	1,013	1,013	1,013	1,013
	Total non-current assets	**139,591**	**142,891**	**140,934**	**139,297**	**137,660**
Current assets	Inventories	343	356	356	356	356
	NHS receivables	6,689	3,134	3,104	3,074	3,044
	Non-NHS receivables	8,571	9,148	9,098	9,048	8,998
	Credit Loss Allowances	(1,457)	(1,565)	(1,565)	(1,565)	(1,565)
	Property held for Sale	1,200	0	500	0	0
	Cash and cash equivalents:	52,591	52,237	52,597	54,146	55,180
	Total current assets	**67,938**	**63,310**	**64,090**	**65,059**	**66,013**
Current liabilities	Trade and other payables: capital	(2,827)	(2,743)	(2,743)	(2,743)	(2,743)
	Trade and other payables: non-capital	(36,615)	(35,320)	(35,320)	(35,320)	(35,320)
	Borrowings*	(1,405)	(1,293)	(1,215)	(1,202)	(1,202)
	Provisions	(7,227)	(7,464)	(7,464)	(7,464)	(7,464)
	Other liabilities: deferred income including contract liabilities	(1,928)	(1,086)	(1,086)	(1,086)	(1,086)
	Total current liabilities	**(50,001)**	**(47,906)**	**(47,828)**	**(47,815)**	**(47,815)**
Non-current liabilities	Borrowings	(13,582)	(14,448)	(13,733)	(13,045)	(12,329)
	Provisions	(2,504)	(2,510)	(2,510)	(2,510)	(2,510)
	Total net assets employed	**141,442**	**141,337**	**140,953**	**140,986**	**141,019**

Taxpayers Equity	Public dividend capital	131,876	131,876	131,876	131,876	131,876
	Revaluation reserve	13,821	13,821	13,821	13,821	13,821
	Other reserves	(1,241)	(1,241)	(1,241)	(1,241)	(1,241)
	Income and expenditure reserve	(2,888)	(3,119)	(3,503)	(3,470)	(3,437)
	Income and expenditure reserve (current y	(127)				0
	Total taxpayers' and others' equity	**141,441**	**141,337**	**140,953**	**140,986**	**141,019**

Cash Flow Summary

Gloucestershire Health and Care
NHS Foundation Trust

Statement of Cash Flow £000	YEAR END 23/24		YTD ACTUAL 24/25		FULL YEAR FORECAST 24/25		2025/26 Forecast £000s	2026/27 Forecast £000s	2027/28 Forecast £000s	2028/29 Forecast £000s
Cash and cash equivalents at start of period		**48,836**		**51,433**		**51,433**	**52,591**	**52,237**	**52,597**	**54,146**
Cash flows from operating activities										
Operating surplus/(deficit)	475		(81)		(695)		**1,991**	**1,853**	**2,374**	**2,374**
Add back: Depreciation on donated assets	189		78		233		28	28	28	28
Adjusted Operating surplus/(deficit) per I&E	**664**		**(3)**		**(462)**		**2,019**	**1,881**	**2,402**	**2,402**
Add back: Depreciation on owned assets	9,856		4,282		10,792		8,143	8,732	8,395	8,395
Add back: Depreciation on Right of use assets	0		0		0		1,796	1,810	1,787	1,787
Add back: Impairment	277						0	0	0	0
(Increase)/Decrease in inventories	50		14		13		0	0	0	0
(Increase)/Decrease in trade & other receivables	8,262		(11,069)		(2,936)		1,057	80	80	80
Increase/(Decrease) in provisions	502		(1,243)		(1,243)		0	0	0	0
Increase/(Decrease) in trade and other payables	(3,556)		2,929		1,295		0	0	0	0
Increase/(Decrease) in other liabilities	(21)		842		842		0	0	0	0
Net cash generated from / (used in) operations		**16,034**		**(4,250)**	**0**	**8,301**	**13,015**	**12,503**	**12,664**	**12,664**
Cash flows from investing activities										
Interest received	2,843		1,461		3,400		825	825	825	825
Interest paid	0		(4)		(6)		-7	(7)	(7)	(7)
Asset Held for Sale					0		0	0	0	0
Purchase of property, plant and equipment	(15,371)		(2,948)		(10,577)		(11,049)	(13,613)	(8,073)	(8,073)
Sale of Property	1,356				4,324		1,201	5,000	500	0
Net cash generated used in investing activities		**(11,172)**		**(1,491)**	**0**	**(2,859)**	**(9,030)**	**(7,795)**	**(6,755)**	**(7,255)**
Cash flows from financing activities										
PDC Dividend Received	1,710				0		**0**	**0**	**0**	**0**
PDC Dividend (Paid)	(2,409)				(2,624)		**(2,790)**	**(2,890)**	**(2,990)**	**(2,990)**
Finance lease receipts - Rent	230		4		4		**0**	**0**	**0**	**0**
Finance lease receipts - Interest	(8)		(1)		(1)					
Finance Lease Rental Payments	(1,559)		(701)		(1,457)		**(1,385)**	**(1,293)**	**(1,201)**	**(1,216)**
Finance Lease Rental Interest	(229)		(89)		(206)		**(164)**	**(165)**	**(169)**	**(169)**
		(2,265)		**(787)**	**0**	**(4,284)**	**(4,339)**	**(4,348)**	**(4,360)**	**(4,375)**
Cash and cash equivalents at end of period		**51,433**		**44,905**	**0**	**52,591**	**52,237**	**52,597**	**54,146**	**55,180**

Capital – Five year Plan

Gloucestershire Health and Care
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	2,577	144	(4)	1,900	3,000	3,000	3,000
Backlog Maintenance	1,612	887	106	1,393	1,393	1,393	1,393
Buildings - Finance Leases	255	0	0	989	250	250	250
Vehicle - Finance Leases	239	11	34	0	250	250	250
Other Leases	721	0	0	0			
Net Zero Carbon	645	258	0	0	0	0	0
LD Assessment & Treatment Unit				2,000	0	0	0
Cirencester Scheme				2,000	5,000	0	0
Medical Equipment	903	271	4	1,030	1,030	1,030	1,030
		0					
IT		0					
IT Device and software upgrade	880	0	515	320	600	600	600
IT Infrastructure	1,865	513	0	1,300	1,300	1,300	1,300
Transforming Care Digitally	770	315	0	1,260	790	250	250
Sub Total	**10,467**	**2,399**	**655**	**12,192**	**13,613**	**8,073**	**8,073**
Forest of Dean	237	237	597	0	0	0	0
Total of Updated Programme	**10,704**	**2,636**	**1,252**	**12,192**	**13,613**	**8,073**	**8,073**
Disposals	(4,000)	0	0	(1,233)	(5,000)	(500)	0
Ambrose House		0		(733)	0		
Holly House	(2,000)	0		0			
Hatherley Road	(500)	0		0			
Trinity Hall/Stokeshay/Lexham Pav.							
Forest of Dean	(1,500)	0		(500)	0	(500)	
Total CDEL spend	**6,704**	**2,636**	**1,252**	**10,959**	**8,613**	**7,573**	**8,073**
Funded by;							
Anticipated System CDEL	**4,239**			**11,562**	**8,613**	**8,073**	**8,073**
IFRS 16	**1,215**			**989**	**500**	**500**	**500**
Additional CDEL	**3,250**						
Frontline Digitisation funding	**0**						
CDEL Shortfall / (under commitment)	**(2,000)**	**2,636**	**1,252**	**(1,592)**	**(500)**	**(1,000)**	**(500)**

Risks

24/25 potential risks are as set out below:

Risk No.	Risks 24/25	Risk Value	Made up of: Recurring	Made up of: Non Recurring	Likelihood	Impact	RISK SCORE
391	There is a risk that GHC does not fully deliver recurrent CIP savings in year, resulting in GHC not achieving its financial targets	2672	2672		3	4	12
390	There is a risk that ICS deficits will lead to financial impact on GHC through the risk share mechanism	860		860	3	3	9
388	There is a risk that staffing above establishment will lead to over spends in Inpatients	1450	1450		2	3	6
443	There is a risk that insufficient budget is available for implementation of Safer staffing project.	850	850		2	3	6
447	Gloucestershire County Council (GCC) are reviewing their budgets to identify significant savings which could affect the Trust's finance position	950	950		3	3	9
180	Mental Health Act White paper reforms	400	1100	-700	3	2	6
	Total of risks	7732	7572	160			

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AGENDA ITEM: 10/0924

REPORT TO: **TRUST BOARD PUBLIC SESSION – 26 September 2024**

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

AUTHOR: Chris Woon, Deputy Director of Business Intelligence

SUBJECT: **PERFORMANCE DASHBOARD AUGUST 2024/25 (MONTH 5)**

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 August (Month 5 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 Patient & Corporate Records Quality Group.

Recommendations and decisions required

The Board are asked to:

- **NOTE** the Performance Dashboard Report for August 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. The performance indicator portfolio has been finalised but final engagement with Resources Committee in August 2024 was deferred to October 2024.

This month's Performance Dashboard for Board continues with a reduced detail format; however, members can be assured detailed exception narrative is reviewed within BIMG.

Initial steps have been taken by the Nursing, Therapies and Quality (NTQ) Directorate to reduce and remove the duplication within the Quality Dashboard for September's Board. This will support the longer-term aim to integrate and better align monitoring within the Performance and Quality Dashboards into a single report. Initial planning conversations are underway to develop a plan to realise this ambition over the coming financial years. Details are mentioned within the Director of NTQ Report Update on page 5.

Chief Operating Report
The Chief Operating Officer's Report is presented on page 2-4 of the performance dashboard.

Performance Update
The performance dashboard is presented from page 6 within the Board's four domain format:

- **Nationally measured domain** (under threshold)
  There are 2 indicators in exception this month; 'New Psychosis (EI) cases treated within 2 weeks of referral' (N04) and 'Adolescent Eating Disorder routine referral to treatment waits' (N11).
- **Specialised & directly commissioned domain** (under threshold)
  5 health visiting indicators (S02, S03, S06, S12 & S15) are all very slightly behind their thresholds for the period. School related cumulative indicators now will reset for a new Sept term.
- **ICS Agreed domain** (under threshold & outside of statistical control rules)
  There are 5 indicators in exception for the period:
  - CYPS Core CAMHS referral to assessment within 4 weeks (L03)
  - CYPS LD referral to assessment within 4 weeks (L04) is in exception, after three months of compliance
  - Eating Disorders Adult wait for adult assessments within 4 weeks (L07)
  - Perinatal routine referral to assessment within 2 weeks (L12)
  - Social Care Package Reviews within 8 weeks of commencement (L19)
- **Board focus domain** (under threshold & outside of statistical control rules)
  2 indicators are in exception; Data quality maturity index (DQMI B08) which appears to have be impacted by Mental Health Services DataSet (MHSDS) and the removal of a refresh submission putting more focus on contemporaneous clinical record recording. PH stroke rehab discharges within LOS 42days (B25) is the other indicator.
- **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 12) include:
  - *'L08 Eating Disorders – Wait time for adult psychological interventions will be 16 weeks'* is for information.
  - *'O09 ICT Occupational Therapy (OT) % treated within 8 weeks'* details the support from the external 'OT Practice' provider.
  - *'O03 Podiatry % Urgent referrals treated within 2 weeks'* presents positively.

- *'O021 Paediatric Occupational Therapy (OT) % routine referrals treated within 18 weeks'* presents positively.
- The narrative within '*B23 – Physical Health (PH) Inpatients Average Length of Stay within 26 days'* now details the impact of No Criteria to Reside patients.

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 Meeting held 19 September 2024

Appendices:	Performance Dashboard

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

Snapshot Month
August

Performance Dashboard Report & BI Update

Aligned for the period to the end August 2024 (month 5)

In line with the Performance Indicator Portfolio and the Trust's Performance Management Framework; this report presents to Board, performance indicators across five domains including **Nationally measured**, **Specialised & Direct Commissioning**, **ICS Agreed** and **Board Focus** domain. The **Operational** domain is only presented to Resources Committee, not Board however this is reviewed within Business Intelligence Management Group (BIMG).

In support of these metrics 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 is reporting into BIMG.

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 2-4).

The Dashboard itself (on pages 5-11) 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. All services are using this tool, alongside their operational reporting portfolios 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 11-12 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 2024/25 performance indicator portfolio update, which takes into consideration 2024/25 operational planning, GICB contractual requirements, operational and Board performance monitoring demands is being presented to the Resources Committee in October 2024. This was deferred from August's Committee due to a busy agenda. Agreed updates are being integrated into a planned development programme across 2024 & 2025.

Focus continues to ensure implementation of the new Integrated Urgent Care Service (IUCS).

Initial work has begun to integrate the Performance Dashboard and Quality Dashboard and this is summarised (on page 5). Stakeholders have initially arranged for duplication to be removed from the September Quality report, and planning has begun for longer term and more wide reaching integration ambitions. A timeline with delivery phasing across the next few financial years will be prepared.

Another decent month for Community Hospital performance in terms of availability, with our offer generally between 20 and 30 beds a week, which given we have c.20% of capacity utilised by non criteria to reside remains a good offer. Our Length of Stay for patients with criteria to reside is just a shade over 20 days (which is excellent), while for non criteria it is close to 50 days. Now that we are routinely and easily able to extract this data it shows a powerful message to the system. Bed occupancy remains at 97%, and we are performing well in terms of readmission within 30 days, which is at 4.7% (very slightly up from last months 3.2% but still below 5% where I set the target). Entirely appropriately, the weight of effort in the Working As One programme - as regards community hospitals - is focussed on back door flow.

Another month of really strong performance within the MIIUs, seeing approximately 7,500 patient contacts in month and meeting the four hour target in 99.6% of the cases. The Rapid Response team saw 369 referrals in the month, which is above their performance threshold in terms of both performance and the level set in the system financial risk share agreement; the team also delivered in excess of the two hour urgent response target of 70%.

We have continued to deliver against the revised targets agreed at system level back in June (35 starts per week for us) for Pathway One (Homefirst), and the length of stay for patients within this service remains good, with a mean length of stay of 20 days and median 16 days. There are system workshops being held to re-look at the delivery model here and the capacity commissioned (co-chaired by our CEO), while internally we continue to work to try and improve the effectiveness of the intervention; we currently achieve around 65% of patients being discharged with reduced (often no) ongoing needs, and aspire to get this up to close to 80%.

Unusually, I am going to copy below the report I presented to Resources Committee last month, as this is good news that I wanted all Board members to have sight of:

Colleagues are aware that we have invested considerable time and energy into reducing length of stay in our Mental Health in patient units. There remains work to do, but this month we were pleased to be visited by senior policy colleagues from the Department of Health and NHSE Region. We were able to present to them on the changes and progress we have made in this area over the past two years or so, and I was delighted by how impressed they were with what our team have done and achieved. Indeed we may well be asked to share our work with other Trusts as good examples of practice. In a similar vein to physical health, albeit amplified in scale and with different cause, the data now shows us pretty clearly that in Wootton Lawn (working age) where the focus has really been, we do have some very long stay (highly complex) patients, but there is a growing number of much shorter admissions of between 20 and 30 days; our objective remains to make the latter the norm. The change in performance is very favourably reflected in inappropriate out of area bed days, where we are now very low users (none since May).

This doesn't mean that our performance with regard Length of Stay is close to where we want it to be, because it isn't, but it is pleasing to have confirmation that we have put a lot of rigour into this area, and while there is more to come, we should start to see this reflect in performance. We have commenced very similar work using the same approach for Older Adults, and had a second workshop on this just a week ago.

Our excellent Mental Health Liaison Team, recently recognised by winning the South West Parliamentary award for excellence in urgent and emergency care, have had another good month, seeing 406 patients within 2 hours (against a target of 395). The team have now been asked to present, and share learning, with NHSE regional Executives.

Narrative continued on next page...

Continued from last page...

Board will receive a deep dive presentation from the CAMHS team during the meeting, but accepting there remains work to do, the trajectory of recovery here remains on track, greatly helped by some successful recruitment, lower turnover and very low sickness rates amongst colleagues. While we achieved 56% (target 80%) to see patients within 4 weeks of referral to assessment, I remain confident that September data will show we have achieved the target, or at least come very close. At the time of writing, the numbers on the waiting list were down to 279 (almost 800 2 years ago), and we have made good progress in reducing very long waits (none over 2 years and 11 in the 18 month to 2 year bracket); our recovery trajectories continue to predict a best case/ worse case recovery timeframe of end of this year/ Easter next.

I'm delighted to report that Childrens OT service recovery remains very strong and on track to achieve full KPI compliance next month. In August they achieved 67% for urgent work, with 3 of the 4 cases seen within the timeframe, and the fourth slightly delayed as originally screened to be non urgent. They achieved 87% (target 95%) performance against the 18 week target for non urgent, up from 72% last month. This has been a very significant area of service recovery focus, which the team should be rightly proud to have achieved.

Children's Physiotherapy performance against the urgent 4 week (95%) target was 74.3%, with 20 out of 78 being seen outside 4 weeks; this is slightly down but we did encounter a higher than usual number of cancelled appointments (likely due to Summer holidays). We also saw a deterioration in the achievement of the non-urgent (95% within 18 weeks) at 61.4%. There is more work to do in this area, rather similar to the journey we have been on with OT, but the ability to now delineate between urgent and non-urgent is really helping with the planning and allocation to match demand and capacity.

In children's speech and language therapy we saw 57% of children within 18 weeks – there were no urgent referrals in month. As is the national trend referral rates continue to be high and despite the adoption of digital toolkits (SHARE) and the ELSEC roles/investment, it seems there is an enduring demand/capacity mismatch that we will have to address with commissioning colleagues as part of the next business planning cycle.

GHFT ECHO performance remains an ongoing concern, achieving 58% against the 95% target. 27 patients are waiting on the priority (2 week) list, and 235 on the routine 6 week list. Since my last report, while diaries haven't yet allowed a meeting, more positive discussions have taken place with commissioner colleagues. As Board colleagues are well aware, we remain extremely anxious to resolve these issues and expect to have further meetings in the next few weeks to take this forward.

The demand on our Special Allocation Scheme service continues to be very high and exceeds capacity, and this has been a topic of significant interest with ICB colleagues for a while now. Commissioned to manage up to ten patients, this very small team have been doing exceptionally well and working extremely hard to manage with up to 25. Given that is 250% of capacity, mindful of the risks of staff burnout (which would result in no service), as well as the safety of colleagues and patients we have understandably not felt able to go even further. But the process controls, panels etc are controlled by ICB colleagues and we have been clear that as patients are able to be discharged we will continue to hold up to 25; at the same time we will support ICB colleagues as they consider an alternative future model for this work.

Our Wheelchair Service generally performs well and achieves targets, and I always keep a close eye on performance for under 18s in particular, as here the timely provision of equipment is so important given the natural growth of people in the age group. Unusually this month performance against the 18 week handover for wheelchairs for under 18s met 54% against the 92% KPI (5 out of 11 patients). Further investigation revealed that performance here had indeed dipped, predominantly due to representatives from the wheelchair technician company being unavailable to support due to their attendance supporting athletes at the Paralympics. I anticipate full recovery next month.

Narrative continued on next page...

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Pleasingly a tick up in our MSK service, having recruited to posts as per previously reported staffing issues. In August we achieved 89% compliance against a KPI of 95%. Podiatry achieved 94.2% against the 18 week 95% target but has essentially recovered in terms of performance with some staffing churn just being managed through. While performance in Adult Speech and Language again missed the 18 week 95% target, at 87.8% I remain confident that with new leadership in place and two colleagues returning from maternity leave this should recover in the next month or two.

I am concerned about performance within our Dental Services, where in Community Dental we achieved just 17% against an 18 week KPI of 95% as the waiting list continues to grow due to the unavailability of dentists which has resulted in the cancellation of patient appointments. We have successfully recruited to fill gaps here, but we need more – and similarly we need to be a bit more creative about skill mixing and how we can safely but effectively utilise the expertise of our Dental Therepist colleagues in an ACP type role – an area our new Deputy Medical Director is supporting us with. There are similar issues in the Minor Dental Surgery Service, where the longest patient waiting time to receive this service has reached 37 weeks, although recruitment here has been successful, with a new colleagues starting work in December.

Board colleagues are aware that our perinatal service has encountered challenges, predominantly due to losing capacity due to a couple of long term vacancies, quite high sickness and some maternity leave. But we have also experienced quite a high non-attendance rate for appointments, and the service is specified such that only face-to-face appointments count (so virtual consultations do not). It is noteworthy that when this service was at full strength neither DNA rates or KPI compliance were an issue. Following a small internal reshuffle of lead responsibility, and with the assistance of the QI team, a Recovery Plan has been formulated with recruitment key, but also some data led adjustments to process and practice, I anticipate tangible recovery by the end of the year, and (subject to recruitment timelines) full recovery by Feb 25. In August we achieved 35.4% against a 50% KPI for routine referral to assessment within 2 weeks.

We have seen a dip in our performance for both occupational therapy and physiotherapy in our ICT teams to see patients within 18 weeks, 83.1% against a target of 95%, and 89.9% against a target of 95% respectively. For Physiotherapy this was due to short term absences within the team. For OT however, we are seeing a steady increase in referrals and experiencing an unanticipated handback of OT work from the third party provider that GCC colleagues engaged to help clear the backlog that had accumulated in this service. Naturally this is subject to ongoing dialogue, including with the newly appointed Principal OT appointed by the Council.

Director of Nursing, Therapies and Quality Update

Nicola Hazle, Director of NTQ

The Nursing, Therapies and Quality services, alongside Business Intelligence team have initiated a programme of work to develop an integrated performance report that will reduce duplication and ensure we have a blended approach to reporting. The long term ambition is to integrate the Performance and Quality Dashboards into a single report.

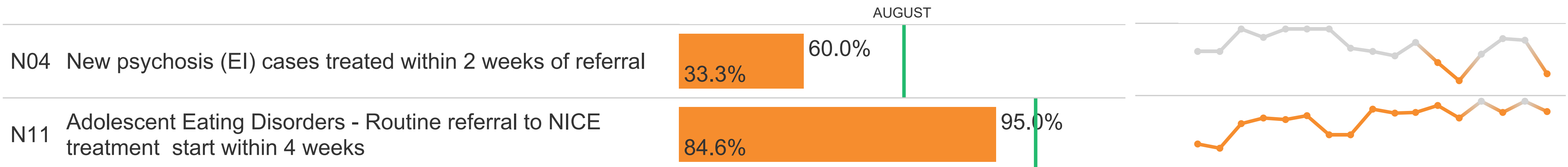
The first phase for the Board's Quality Dashboard in September, NTQ have removed the following areas, noting that they are already catered for in the Performance Dashboard portfolio (by exception):

- Staff Statutory & Mandatory Training
- Essential to Role Training
- Supervision Date
- Inpatient Ward Sickness and Vacancy Rates
- Ward Fill rates

The aim of this work will broaden the understanding and the impact our performance has on people who use our services. We will include in future iterations of this report a focus on safety, effectiveness and experience for those services/ team where a performance indicator is in exception. We can use these exceptions to triangulate any safety and clinical risks associated with the performance.
The next milestone for Q3 is to develop a plan to map out the phases and milestones to realise an integrated Performance and Quality Report over the coming years.

KPI Breakdown

National Contract Domain



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

N04 - New psychosis (EI) cases treated within 2 weeks of referral
August performance is *reported* at 33.3% against a 60% threshold. There were 2 cases that were under threshold in August out of 3. Statistical process control (SPC) is not used for this KPI as performance is too variable.

The updated August performance position has now increased to 50% with 1 non-compliant case out of 2.

The latest Nationally published three month average from May to July 2024 was 71.6% which is less than GHC's position of 74% for the same period.

N11 - Adolescent Eating Disorders - Routine referral to NICE treatment start within 4 weeks
August performance is reported at 84.6% against a performance threshold of 95.0%. There were 2 cases that were under threshold in August out of 13. Statistical process control is not used for this KPI as performance is too variable.

At the end of August there were 42 routine adolescent patients with an assessment completed that were waiting for treatment to commence. A decrease from July at 53.

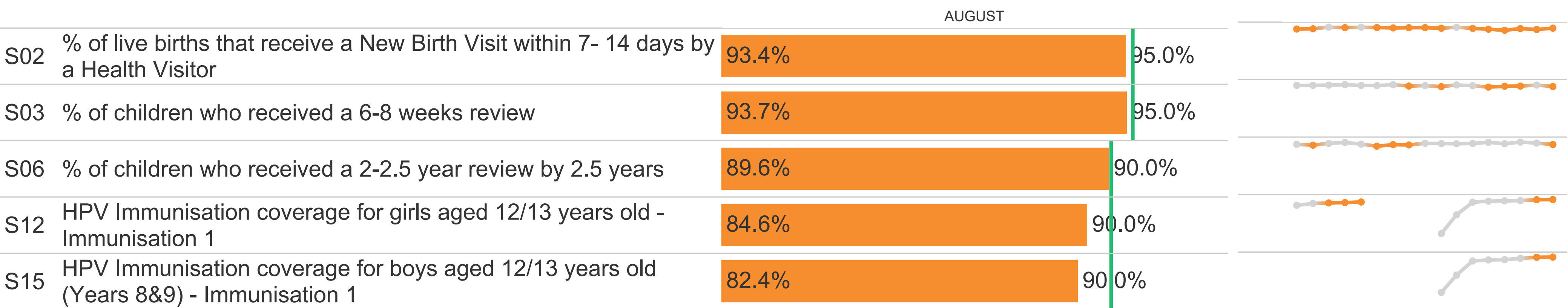
The Business Intelligence service waiting list model provides an indication of capacity required to address the routine treatment waiting list backlog, of which assumptions rely on patients only receiving 20 sessions. Currently 24.4% of the under 19 caseload have received more than 20 treatment appointments. This reflects the challenges within the service of freeing up clinician capacity for patients to be allocated for treatment.

The service continues to focus on offering all routine adolescent patients an assessment within 28 days of the referral. In most instances the clinicians leading the assessment can provide treatment to then enable patient and families to progress with a plan until the patient is assigned a clinician for continued treatment.

KPI Breakdown

Non Compliant

Specialised Commissioning Domain



		AUGUST	Threshold
S02	% of live births that receive a New Birth Visit within 7- 14 days by a Health Visitor	93.4%	95.0%
S03	% of children who received a 6-8 weeks review	93.7%	95.0%
S06	% of children who received a 2-2.5 year review by 2.5 years	89.6%	90.0%
S12	HPV Immunisation coverage for girls aged 12/13 years old - Immunisation 1	84.6%	90.0%
S15	HPV Immunisation coverage for boys aged 12/13 years old (Years 8&9) - Immunisation 1	82.4%	90.0%

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 August is 93.4% (July was 91.2%) compared to a threshold of 95.0% with 33 out of 501 babies not seen within 14 days. Current performance is within normal variation (as defined by SPC control limits).

S03 - % of children who received a 6-8 weeks review

Performance in August is 93.7% (July was 96.2%) compared to a threshold of 95.0% with 27 out of 435 infants not seen within 8 weeks. Current performance is within normal variation (as defined by SPC control limits).

S06 - % of children who received a 2-2.5 year review by 2.5 years

Performance in August is 89.6% (July was 92.2%) compared to a threshold of 90.0% with 46 out of 444 children not receiving a 2-2.5 year review by the time they turned 2.5 years old. Current performance is within normal variation (as defined by SPC control limits).

S12 - HPV Immunisation coverage for girls aged 12/13 years old - Immunisation 1

Performance in August was 84.6% compared to a cumulative threshold of 90.0%, with 643 out of 4,182 pupils not having been vaccinated. SPC limits do not apply as this is a cumulative KPI.

385 of the 643 pupils have active refusals to immunise where either parental consent was not given (95.6%), withdrawn (1.8%), or the immunisation was given elsewhere (2.6%).

Narrative continued on next page...

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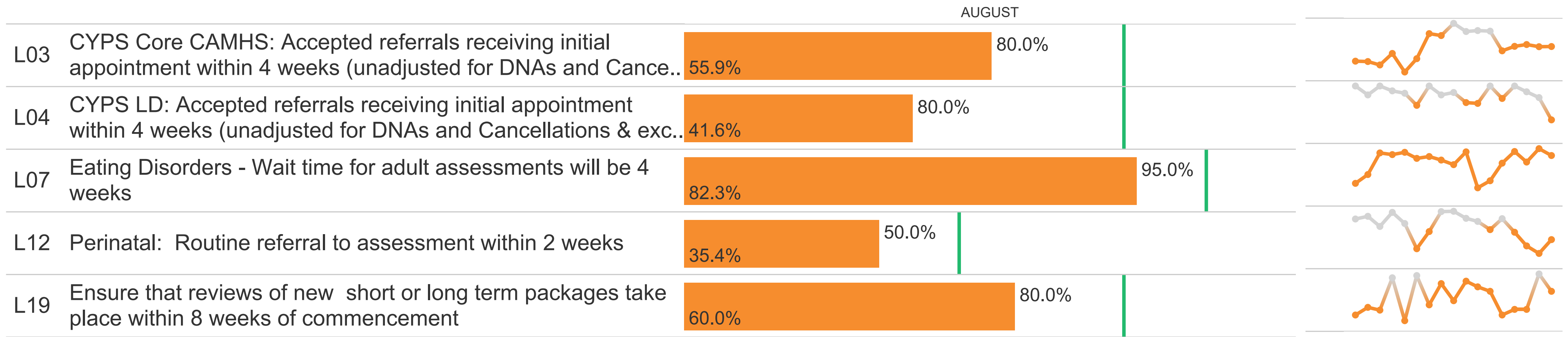
S15 - HPV Immunisation coverage for boys aged 12/13 years old (Years 8&9) - Immunisation 1
Performance in August was 82.5% compared to a cumulative threshold of 90.0%, with 717 out of 4,087 pupils not having been vaccinated. SPC limits do not apply as this is a cumulative KPI.

421 of the 717 pupils have active refusals to immunise where either parental consent was not given (94.5%), withdrawn (3.8%), or the immunisation was given elsewhere (1.7%).

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.*

L03 - CYPS Core CAMHS: Accepted referrals receiving initial appointment within 4 weeks (unadjusted for DNAs and Cancellations)
Performance in August was 55.9% (July was 55.6%) compared to a threshold of 80.0%, with 41 out of 93 accepted referrals receiving an initial appointment outside 4 weeks. Currently performance is too unstable to apply SPC limits this will be reviewed as and when performance becomes stable.

The current forecast is for compliance above 80% in September. 90% of appointments in September have been offered within timeframe so far. Final prosition will depend on the numbers of DNAs and cancellations.

L04 - CYPS LD: Accepted referrals receiving initial appointment within 4 weeks (unadjusted for DNAs and Cancellations & excluding Group work)
Performance in August was 41.6% (July was 80.0%) compared to a threshold of 80.0%, with 7 out of 12 accepted referrals receiving an initial appointment outside 4 weeks. Current performance is within normal variation (as defined by SPC control limits), however it is considerably lower than the mean of 84.4%.

Average wait to assessment in August was 40 days and the median wait was 33 days. 75% of first appointments were offered within timeframe.

The current forecast for the indicator in September is 70%. This is evaluated with 80% of appointments in September have been offered within timeframe so far. However, 2 have been cancelled due to staff sickness and therefore not offered within timeframe. The other case outside of timeframe was due to patient choice for a Sept school term time appointment.

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L07 - Eating Disorders - Wait time for adult assessments will be 4 weeks
August performance is reported at 82.3% against a 95% threshold. There were 6 cases that were under threshold in August out of 34. Statistical process control is not used for this KPI as performance is too variable.

Due to the length of time patients have been on the waiting list, performance is expected to currently be below the threshold. The number of adults waiting for assessment at the end of August was 49, an increase from July at 43.

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).

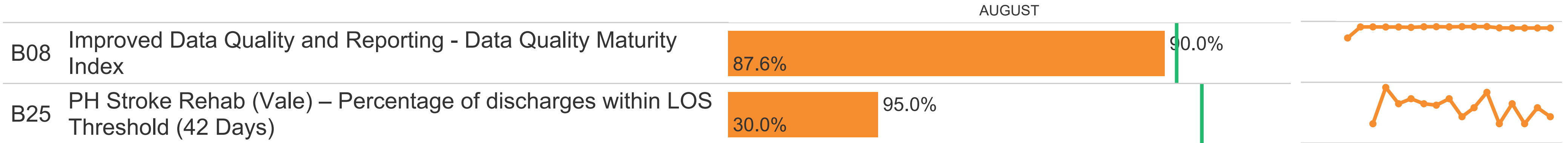
L12 - Perinatal: Routine referral to assessment within 2 weeks
Performance is reported at 35.4% against a performance threshold of 50.0%. There were 40 cases that were under threshold out of 62. Currently performance is too unstable to apply SPC limits. This will be reviewed as and when performance becomes stable.

A service recovery plan has been submitted to COO, David Noyes. It plans for full recovery by February 2025. The plan will be brought to BIMG in October 2025 for review.

L19 - Ensure that reviews of new short or long term packages take place within 8 weeks of commencement
August performance is reported at 60% against an 80% performance threshold. SPC is not applied to this indicator due to the small number of cases. There w..

KPI Breakdown

Board Focus Domain



		AUGUST	
B08	Improved Data Quality and Reporting - Data Quality Maturity Index	87.6%	90.0%
B25	PH Stroke Rehab (Vale) – Percentage of discharges within LOS Threshold (42 Days)	30.0%	95.0%

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

B08 - Improved Data Quality and Reporting - Data Quality Maturity Index
The latest performance is 87.6% against a performance threshold of 90%. Current performance is within normal variation (as defined by SPC control limits). This indicator is an amalgamation of Data quality performance across national data sets:

- APC: Admitted patient care data set 99.6% (no change since previous month)
- CSDS: Community services data set 88.6 % (previous month 88.5%)
- ECDS: Emergency care data set 74.3% (previous month 74.1%)
- IAPT: Talking Therapies data set 99.8% (no change since previous month)
- MHSDS: Mental Health services data set 89.4% (previous month 96.9%)

The main impact on performance is the ECDS and CSDS due to the challenges in configuration and data capture in SystmOne. The aim is for this to be addressed at the Patient Record Quality Governance Forum and future action plans and updates will come from this Forum. To note, improved compliance will come as a result of the Core Assessment work which is within the Clinical Systems Team workplan.

The published performance (May 2024) for the MHSDS has reduced due to a move to a single month submission, meaning organisations are unable to submit a refresh with later data entries input into the clinical system. There are 3 measures for which there is a noticeable decrease. These are Referral closure reason, Decided to admit date and Restrictive Intervention. The latter two are Inpatient related. Referral closure reason isn't isolated to Inpatients and the drop appears to be due to a change in the MHSDS versions; specifically where staff are populating the data rather than a delay in recording. MHSDS V7 was implemented in April 2024. Trust-wide communication will be issued to remind users of contemporaneous record keeping best practice and the Trust's Data Quality Policy.

B25 - PH Stroke Rehab (Vale) – Percentage of discharges within LOS Threshold (42 Days)
In August the average LOS for a stroke rehab patient was 56.1 days, compared to the threshold of 42 days, (July was 42 days). Of the 10 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 65.9 days. (July was 66.3). Currently performance is too unstable to apply SPC limits. This will be reviewed as and when performance becomes stable.

The KPI has been redeveloped 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.

Work has begun to look at seperating the Stroke and Community Hospital elements of the Inpatient spell.

Performance to note

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**

August performance is reported at 84.6% against a 95.0% performance threshold. There were 4 cases that were under threshold in August out of 26. Current performance is within normal variation (as defined by SPC control limits).

At the end of August there were 197 adult patients with an assessment completed that were waiting for treatment to commence. A decrease from July at 211.

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).

- **O09 - ICT Occupational Therapy Services - % treated within 8 Weeks**

August performance was 78.3% which was below the performance threshold of 95.0%. 161 out of 745 referrals were seen outside the 8 week target timeframe for referral to treatment. This was decrease a compared to a performance of 84.2% in July. Current performance is within normal variation (as defined by SPC control limits).

1,091 patients were waiting for their first contact at the end of August. The number waiting overall has decreased again. However, the number waiting 18-52 weeks has increased for the third month in a row. This is due to the long waiters that were transferred to the OT Practice, a third party provider commissioned to treat those on the waiting list at the end of April 2024. 281 of 303 waiting for 18-52 weeks at the end of August were on an OT Practice caseload. The OT Practice are telling patients they could wait up to 4 months for an assessment and possibly longer.

The number of people seen this month has decreased compared to July and the time to see referrals has increased. This is in part due to the impact of the transfer of cases to the OT Practice. The documentation for cases assessed by the OT Practice takes considerable clinician time to review. There are also increasing numbers of patients being returned to the OT service for treatment. This is reducing the clinical time available to see new patients.

It is recognised that the 8 week referral to treatment (RTT) threshold is unattainable with current and changing demands on therapy services. A paper is due to be presented by the service to BIMG in September proposing the KPI to be split into urgent (2 weeks) and routine (18 weeks).

- **O03 - Podiatry - % urgent referrals treated within 2 Weeks**

August performance was 91.6%, which is below the 95.0% threshold. There has been an increase in performance compared to 75.0% in the previous month. There was 1 out of 12 referrals seen outside 2 weeks. Performance is outside of normal variation (above the upper statistical process control chart limit) and performance this month is seen as a positive outlier.

Since the KPI was introduced in April 2024 the service has been working to improve the recording of urgent and routine referrals. This has driven the improvement in performance in the past few months.

Please note that the waiting list figure has decreased from 15 at end of July to 8 by the end of August.

Narrative continued on next page...

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- **O21 - Paediatric Occupational Therapy - % treated within 18 Weeks for routine referrals**

Performance in August is 86.5% (July was 71.7%) compared to a threshold of 95.0% with 12 out of 89 referrals seen outside of 18 weeks. Current performance is above normal variation (as defined by SPC control limits) and deemed a positive outlying position.

306 patients were waiting for treatment at the end of August. The number of patients waiting has been on a downwards trajectory over the last 6 months, averaging 366.

The average waiting time is now 10.4 weeks. This is an improvement from the position a year ago, where it was 15.2 weeks. Backlog clearing initiatives continue to be in place, and there are now only 26 referrals that have been waiting in excess of 18 weeks. Each of these referrals now has an appointment scheduled. Based on current conditions, the service is optimistic about achieving KPI compliance by the end of September 2024.

- **B23 - PH Inpatients - Average Length of Stay (exclude CATU & Stroke) (Discharge)**

In August the average LOS for a community hospital patient (not in CATU or stroke rehab) was 36 days, against the threshold of 26 days, (July was 38 days). Of the 141 patients discharged from a community hospital stay in August, 77 exceeded 26 days. For the patients who exceeded 26 days the average length of stay of these patients was 51 days. (July was 52). Current performance is within normal variation (as defined by SPC control limits).

With No Criteria to Reside (NCTR) patients removed from the calculation, the average LoS for all patients would be 30 days (reduced from 36 days), and for those patients who exceeded the threshold it would reduce to 42 days (reduced from 51 days).

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 12/0924

REPORT TO: **TRUST BOARD PUBLIC SESSION – 26 September 2024**

PRESENTED BY: Nicola Hazle, Director of Nursing Therapies & Quality

AUTHOR: James Wright, AD of Patient Safety, Quality and Clinical Compliance

SUBJECT: **QUALITY AND SAFETY OF COMMUNITY MENTAL HEALTH SERVICES - CQC REQUEST FOR TRUST BOARDS**

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

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

The purpose of this report is to:

This report outlines the requirements of the Board in response to a request from CQC, received on 20th August 2024 to complete an initial questionnaire by 30th September 2024 relating to recommendations from the special review of Nottinghamshire Healthcare Foundation Trust.

It will identify what information we plan to share with CQC and to demonstrate we have considered the impact for our services and any plans we have in place or may be required to address the findings of the special review.

Recommendations and decisions required

The Board is asked to:

- **Acknowledge** the key findings from CQC's special review (links to CQC reports are included).
- **Note** and **discuss** the content of this report
- **Endorse** our initial response to the CQC

Executive summary

We are required to complete a high-level questionnaire by CQC in relation to our community mental health services following the publication of a rapid review of Nottinghamshire Healthcare NHS Foundation Trust, following the conviction of Valdo Calocane in January 2024 for the killings of Ian Coates, Grace O'Malley-Kumar, and Barnaby Webber. This has to be submitted by 30th September 2024.

Trust Boards are tasked to set out how, following the special review, they have:

- Reflected on the issues and recommendations identified in the special review
- Self-assessed and/or audited community mental health services
- Identified areas for improvement in quality of care, patient safety, public safety and staff experience
- Put in place, or are putting in place, action plans and timescales to address the areas for improvement

The Secretary of State for Health and Social Care commissioned CQC to carry out a rapid review of Nottinghamshire Healthcare NHS Foundation Trust (NHFT) under Section 48 of the Health and Social Care Act 2008. The first part of this review was published in March 2024 and the second part in August 2024 (links to the reports are included to inform the discussion).

It should be noted that concurrently NHS England, on 29th August 2024 contacted all ICBs and Trusts in relation to an ICB review of intensive and community care. This requires us to complete a separate self-assessment by 30 September 2024. Although we can utilise elements of that request to inform our CQC response, this paper does not specifically address the requirements of the NHSE request.

This paper provides a summary of the following:

- Core recommendations from the special review
- The key lines of enquiry by CQC
- A high-level summary of existing governance arrangements that support our response to CQC's recommendations and outlines our next steps.

Risks associated with meeting the Trust's values

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

Corporate considerations	
Quality Implications	Yes, relates to safety, experience and outcomes
Resource Implications	Yes, specifically workforce and training
Equality Implications	Yes, vulnerable patient groups

Where has this issue been discussed before?
Trust Quality Committee on 05/09/2024

Appendices:	Appendix 1: Initial High-Level Overview Against CQC Special Review Recommendations

Report authorised by: Nicola Hazle	**Title:** Director of Nursing, Therapies and Quality

QUALITY AND SAFETY OF COMMUNITY MENTAL HEALTH SERVICES
CQC REQUEST FOR TRUST BOARDS

1.0 INTRODUCTION

1.1 This report provides the Trust Board with information to support an opportunity to reflect and discuss the recommendations of the rapid special review by Care Quality Commission (CQC), commissioned by the Secretary of State for Health and Social Care of Nottinghamshire Healthcare NHS Foundation Trust (NHFT) under Section 48 of the Health and Social Care Act 2008, following the conviction of Valdo Calocane in January 2024 for the killings of Ian Coates, Grace O'Malley-Kumar, and Barnaby Webber.

1.2 In addition and although not directly related to the asks of this paper, we reference the requirements by NHSE for ICBs to review their community services by Q2 2024/25 to ensure that they have clear policies and practice in place for patients with serious mental illness, who require intensive community treatment and follow-up but where engagement is a challenge.

1.3 To fulfil this NHSE requirement, GHC & the ICB have worked together to complete a self-assessment using the ICB Maturity Index Self-Assessment Tool which was presented to the GHC Executive Meeting on 17th September 2024. Whilst not included in this paper, we intend to use the tool and any associated actions to support our response to the CQC questionnaire.

1.4 The CQC contacted all Trust Boards on the 20th August 2024 to ask they complete a short questionnaire by 30 September to set out how, following the special review, they have;

- Reflected on the issues and recommendations identified in the special review
- Self-assessed and/or audited community mental health services
- Identified areas for improvement in quality of care, patient safety, public safety and staff experience
- Put in place, or are putting in place, action plans and timescales to address the areas for improvement.

1.5 The link for the reports part 1 and 2 of the CQC special review are below. In the hyperlinks there are summaries of the scope of the special review and some background information which would be helpful for Board members to read to inform the discussion. Due to the breadth of the special review it isn't possible to summarise this within the body of this report.

Part 1: Special review of mental health services at Nottinghamshire Healthcare NHS Foundation Trust - Care Quality Commission (cqc.org.uk)

Part 2: Special review of mental health services at Nottinghamshire Healthcare NHS Foundation Trust: Part 2 - Care Quality Commission (cqc.org.uk)

1.6 The key questions arising from the CQC recommendations are set out in in **Appendix 1**. Alongside is provided a high-level summary of current reporting arrangements that

flow through existing business as usual governance reporting processes in the trust. It has been set out in this chart to help inform the Board discussion.

1.7 We have some large-scale transformation programmes of work in train, that link to the areas the CQC review has focused on. Most of the developments considered relevant in this context link to the Community Mental Health Transformation Programme, Right Care Right Person and the changes in clinical practice related to Personalised Care Planning & Formulation Informed Risk Management. In Appendix 1 we have identified which transformation programmes link to the key questions.

1.8 As part of our own internal assurance of regulatory compliance, we complete self-assessments with all services with the aim of completing a two-year rolling programme, but annually if possible. All community mental health services have had a self-assessment within this timescale. In addition to this we carry out focussed peer reviews which are a deeper dive into the findings of the self-assessment and use CQC's regulatory framework as a reference guide. The following teams have had a peer review within the last 18 months. This list represents those community mental health teams that were not inspected in any of the recent CQC core inspections in 2022. Some of these services have not had an inspection since the 2016/2018 CQC Core Inspections:

- CDLT & Recovery North
- CDLT & Recovery South
- CDLT & Recovery West
- CRHTT Cheltenham
- Later Life

The peer reviews have resulted in action plans which are managed locally by the teams with a future overview from the Quality Assurance Team. Learning and development from these peer reviews has identified some core themes for our community mental health services:

- Variability on the understanding of Duty of Candour, with teams having already engaged with the Duty of Candour Lead to improve training.
- The quality of recording in the clinical records which has resulted in the development of Electronic Patient Record (EPR) regular audit outputs that are shared through local governance and quality reporting.
- Improvement for recording and sharing of Friends and Family Test data, where changes to how information is presented on patient information boards has improved this issue.
- Interface issues with partner organisations and services such as social workers and independent Trusts that need to be improved; this is part of the wider CMHT transformation work currently under way.

1.9 The CQC Manager oversees the completion of these internal action plans and reports updates in the Quality and Regulatory Compliance Group, Improving Care Group and Quality Committee on a quarterly basis.

2.0 BOARD SPECIFIC QUESTIONS/ASSURANCE

2.1 We have been able to partially complete the questionnaire on CQC's portal with high level details (the initial ask from CQC is to provide a high-level response and note that we have discussed this at Board level and recorded any implications for us as a Trust). We can't complete the questionnaire until the Board session has concluded. To meet the requirements of the questionnaire and expectations of CQC, the Board are asked to discuss and reflect on the following questions. We have provided high-level supporting information in **Appendix 1** that links to the recommendations of the CQC special review and will assist the Board discussion:

CQC Question	Response
Has your Trust's board reviewed and reflected on the findings and recommendations in the report?	We presented the findings of the special review to the Quality Committee on Thursday 5th September to support preparation for this Board discussion.
Have the Trust's community mental health services been self-assessed and/or audited?	We have assurance of our own self-assessment and existing areas of governance as capture in **Appendix 1**. Once available, we intend to use the findings of the ICB Maturity Tool and any associated actions to support our response to the CQC questionnaire.
What areas for improvement have been identified following the self-assessment or audit?	A specific action plan remains to be finalised. **Appendix 1** details the current governance arrangements and existing transformation programmes that will support our identification of areas for improvement. In some areas we have well established line of sight on activity, performance and quality which we routinely share with the CQC. We will seek clarification from the CQC on any areas where additional information is required.
What is the action plan and timescales for addressing the areas for improvement identified above?	It is likely that some of the timescales for improvement will sit within the timescales of our existing transformation programmes. We recognise that as we do further work on our assurance and action planning some of these timescales may need to be adjusted to respond to the areas of improvement identified and we expect to take a continuous review approach to this.

3.0 NEXT STEPS

3.1 We are seeking **approval** from the Board to support our initial submission to the CQC questionnaire (as outlined in the 4 points above). Included in this submission will be a summary from this discussion that has taken place at Board.

3.2 Our next engagement meeting with CQC is on 27th September 2024 and we will share with the local relationship manager the return we have submitted and the work in progress to develop a more detailed plan to address any gaps in provision related to the review.

3.3 It is our intention to link ongoing oversight against the CQC recommendations on community mental health teams (CMHTs) into the Trust transformation programme to avoid duplication of work. Where appropriate this will be linked to any further areas of development identified from the ICB Maturity Tool review.

3.4 Oversight of our delivery of this work will sit with the Quality Committee alongside the assurance through our usual relationship arrangements with CQC and the ICB.

APPENDIX 1

Initial High-Level Overview Against CQC Special Review Recommendations

	CQC Recommendations for the Board to consider	Current position	Plan, Proposed or Existing Transformation Programmes
1	Do all patients have an ongoing assessment of their risk including those on waiting lists?	All patients open to a CMHT are eligible for an assessment of their risk factors. We monitor compliance on a monthly basis (B06 & B07) via the performance dashboard. August compliance is 99.8% against a target of 95%. We complete and annual audit of clinical risk assessments (last completed in April 24 – demonstrated in CMHT's that 87% compliance with a timely risk assessment).	We are reviewing our clinical practice in line with guidance from NHS England and moving to a formulation-based approach to risk management. The programme of work is being overseen by NTQ, Ops and Clinical Leads. We plan to implement a new system of risk management in the next 12 months. This is in line with all Trusts in England.
2	Are we assured that people have timely access to crisis services without delay, this includes oversight by ensuring calls to the crisis line are answered and that 4-hour and 24-hour targets are met more often and consistently?	Yes. We routinely report on call activity, and response times to Ops Governance. We have developed a dataset for the 111 since April this year and this is monitored through the MHDS nationally.	Neighbourhood Team Development programme/ CMHT programme
3	Do we have effective measures and controls in place to manage waiting times in community mental health services?	We produce a monthly report to support the requirements of the MHDS to NHSE.	BAU/ Operational Governance forums
4	Do our patients have equitable access to a full range of evidence-based care and treatment through multidisciplinary teams with clear pathways, including psychological	The CMHT Transformation project continues to explore how the Integrated Locality Partnerships (ILPs) can ensure the needs of patients are more focused at a locality level.	CMHT programme/ Integrated Locality Partnerships - ongoing development

	CQC Recommendations for the Board to consider	Current position	Plan, Proposed or Existing Transformation Programmes
	therapies, regardless of where patients live?		
5	Are our services, including GP practices, integrated and use shared systems to provide patients with seamless transitions in care and treatment?	We have acknowledged that we have multiple clinical systems in Gloucestershire that are not integrated. JUYI is the vehicle to share critical information that connects the system, although has some limitations. GHC has a Clinical System Strategy which aims to mitigate the risks of multiple IT platforms and optimise our 5 clinical systems. The proposal for JUYI 2 will also develop the range of information available to system partners and seeks to widen the range of clinical information to improve communication and continuity.	JUYI2 (system programme) and Transforming Care Digitally (GHC programme)
6	Are we assured that we identify and learn from incidents and that learning is shared in a timely manner?	We have a Patient Safety Plan (PSIRP) Strategy which utilises the Patient Safety Incident Response Framework (PSIRF) to manage incidents and identify opportunities for learning. We routinely report Trust activity to the Quality Committee and Board through the Quality Dashboard and work with individual teams following a patient safety incident. Any learning and associated actions are monitored through our learning assurance framework. We have a fidelity testing programme to test the embedded nature	A fidelity testing report is due to be presented to the Improving Care Group in October with a focus on our benchmarking work of Prevention of Future Deaths Notices from the HM Coroner. A BDO audit of PSIRF is planned to start in Q1 2025, which will incorporate 12 months of activity and data to review.

	CQC Recommendations for the Board to consider	Current position	Plan, Proposed or Existing Transformation Programmes
		of actions and report activity into multiple operational governance forums.	
7	Are we assured we have systems and process in place to ensure we have an effective approach to bed management to ensure beds are available when needed?	We have a dedicated bed management service. We have a daily internal and external meeting to manage flow and escalate issues or risks. We have a length of stay programme of work to reduce the requirement for out of area beds (OOA). We have good oversight of bed management within the system and understand the barriers to discharge.	BAU – The Length of Stay programme of work continues to evaluate the effectiveness of bed use and will report updates on programme to the Pan Ops Delivery Board
8	Are we assured that staff are appropriately trained and that mandatory training is available to support staff in working with autistic people and people with a learning disability?	We have access to the Oliver McGowen training programme for those working in MH & LD Teams. Our compliance is monitored on a monthly basis through the performance dashboard report. The current rate of compliance stands at 85.4%	BAU – Reports are produced each month for team managers. The integrated report will be able to triangulate hotspots and this is currently under development.
9	Are we assured that we have appropriate joint working protocols in place with GP practice, which ensure that patients with complex mental health needs have joined up care?	The Assessment & Care Management policy set out the relationship and information shared between agencies. This policy is currently under review due to national changes to the Care Programme Approach.	CMHT Programme – further actions may develop from the ICB Maturity Tool.
10	Do we review treatment plans on a regular basis to ensure that treatment prescribed is in line with national guidelines, including from NICE (National Institute for Health and Care Excellence), specifically when it relates to treatment of	All patients open to services will have an identified care co-ordinator and a frequency of review will be determined by the level of need. In addition, we have a NICE guidance audit programme which routinely reports into the Quality Assurance Group. NICE guidance	Care pathways are being reviewed as part of the CMHT Transformation. A further NICE audit is planned for Q1 2025.

	CQC Recommendations for the Board to consider	Current position	Plan, Proposed or Existing Transformation Programmes
	schizophrenia and medicines optimisation?	CG178 Psychosis and Schizophrenia in adults was completed in January which was able to demonstrate that we are 100% compliant with the areas monitored by NICE.	
11	Do we ensure clinical supervision of decisions to detain people under section 2 or section 3 of the Mental Health Act (MHA) 1983 and regularly carry out audits of records for people detained under these sections, which are reported to the Board?	We complete an annual audit of detentions under the MHA which is reported into the Audit Committee. Doctors receive clinical supervision which discuss caseloads and complex cases.	Future changes to the Mental Health Act may require changes in reporting. We will respond to any national requirements as published.
12	How do we ensure that regular auditing of medicines monitoring takes place within community mental health teams to identify any themes, trends and required learning?	We have a Medicines Optimisation Committee that reviews a wide range medicine activity. Broadly it oversees activity by: 1. Reviewing all medicines related Datix incidents and onward summary of activity and learning to the bi-monthly Medicines Safety Group. 2. Annual Medicines Safe and Secure Handling Audit which looks at safe storage and management and will include community teams that hold medications 3. Supports Clinical Pharmacists linked to the majority of community mental health teams, who oversee and support clinical teams and support learning.	We have an annual review planned (27th October) with CQC as part of the medicines management. The outcome of this review may generate a further programme of audit. We understand that the theme for this year's review is the use of Sodium Valproate and accessibility and support for those with a learning disability.

	CQC Recommendations for the Board to consider	Current position	Plan, Proposed or Existing Transformation Programmes
13	How do we ensure that, in line with national guidance and best practice, staff are aware of the importance of involving and engaging patients' families and carers and that they do so in all aspects of care and treatment, including at the point of discharge, with patient consent? The Trust should ensure that where patients do not give consent, this is reviewed on a regular basis in line with best practice and on all the available information available to the multidisciplinary team?	The Trust has clear guidelines on "Common-sense Confidentiality," allowing essential information sharing with carers, even when consent is withheld. The policy is supported by safeguarding training and documentation practices, particularly within CAMHS. As a result of recent fidelity testing it was recognised this is an area for improvement and will be addressed in the "Assessment and Care Management Policy" is under review, and further standardisation is needed to ensure consistent application. The Trust follows the Triangle of Care (ToC), and a dedicated Carer Practice Development Facilitator supports carer involvement. A recent fidelity test has highlighted that we have inconsistencies in practice. We have a quality priority that has a clear focus on improving ToC and this is routinely reported in the quarterly updates to the Quality Committee.	The Carers Trust has reaffirmed out 2-star rating (Jan 2024) and have given us permission to pursue the 3rd star. This work is captured in our quality priorities which is reported to the Quality Committee on a quarterly basis.
14	Do we have a robust policy and processes for discharge that consider the circumstances surrounding discharge and whether discharge is appropriate, including those who DNA?	We have a Trustwide policy – Assessment & Care Management which outlines our arrangements for discharge and the steps clinical staff need to demonstrate for those being discharged and those who DNA appointments. We are currently revising this policy in line	The Quality Committee oversees this programme of work. We are currently evaluating the resources for this project and may need to consider additional recourse or re-prioritisation due to the increased focus by the CQC.

	CQC Recommendations for the Board to consider	Current position	Plan, Proposed or Existing Transformation Programmes
		with the national mandate to move away from the Care Programme Approach (CPA). NTQ are overseeing a programme of work and have completed workshops with clinical staff and expert by experience forums. We plan to launch our new policy in August 25.	
15	How do we ensure all practicable efforts are made to engage patients who have disengaged from the early intervention in psychosis service? This includes referring people who find it difficult to engage with services to a team that provides assertive and intensive support.	The Assessment & Care Management Policy outlines our approaches to people who DNA or disengage with services in secondary care.	CMHT Programme – further actions may develop from the ICB Maturity Tool.
16	How do we ensure that there is a standard operating procedure in place for early intervention in psychosis and community teams to follow up when a patient does not attend for appointments and follow-up actions are defined for care coordinators?	The Assessment & Care Management Policy outlines our approaches to people who DNA or disengage with services in secondary care.	CMHT Programme – further actions may develop from the ICB Maturity Tool.

AGENDA ITEM: 13/0924

REPORT TO: **TRUST BOARD PUBLIC SESSION – 26 September 2024**

PRESENTED BY: Nicola Hazle, Director of Nursing, Therapies and Quality

AUTHOR: Nicola Hazle, Director of Nursing, Therapies and Quality

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

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

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

The purpose of this report is to:

To provide the Gloucestershire Health & Care NHS Foundation Trust (GHC) Quality Committee 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 Committee are asked to **RECEIVE, NOTE** and **DISCUSS** the August 2024 Quality Dashboard

Executive summary

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

The Nursing, Therapies and Quality services, alongside Business Intelligence team have initiated a programme of work to develop an integrated performance report that will reduce duplication and ensure we have a blended approach to reporting. The long-term ambition is to integrate the Performance and Quality Dashboards into a single report.

Marking this transition and stepped approach to integration the Board's Quality Dashboard in September has been refined in line with agreement from the Quality Committee. NTQ have removed the following areas, noting that they are already catered for in the Performance Dashboard portfolio (by exception):

- Staff Statutory & Mandatory Training
- Essential to Role Training

- Supervision Date
- Inpatient Ward Sickness and Vacancy Rates
- Ward Fill rates

A principle aim of this work will broaden the understanding and the impact our performance has on people who use our services.

This month's report also includes additional information regarding:

- Q1 2024/25 Non-Executive Director Audit of Complaints
- Q1 2024/25 Guardian of Safe working Hours Report
- Community Nursing data
- 'Closed Culture' data and narrative
- A summary of the proposed changes to the content and delivery of the Quality Dashboard.

Quality issues showing positive improvement:

- Friends and Family Test – 95% reporting a positive experience, which is the highest rate this year.
- Adult Safeguarding Audit – demonstrating an upward trend in compliance.
- Feedback from Junior Doctors in the 'Guardian of safe working'.
- Reduction of duplicated data and developments of the integrated performance report.

Quality issues for priority development:

- Increase in the use of Rapid Tranquilisation at Wotton Lawn.
- Increased in no and low harm incidents since April 2024

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 - August 2024 Data

Report authorised by: Nicola Hazle	Title: Director of Nursing, Therapies and Quality

AGENDA ITEM: 13.1/0924

Quality Dashboard 2024/25

Physical Health, Mental Health and Learning Disability Services

Data covering August 2024

Executive Summary

This Quality Dashboard reports quality focussed performance, activity and developments regarding key quality measures and priorities for 2023/24. 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 Nicola Hazle, 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. As part of our plans to integrate our approaches to reporting we are working with colleagues across all services to ensure these principles remain consistent and present in that aim.

This month we continue to work collaboratively to produce an integrated report with the operations teams to enhance the Business Intelligence (BI) Performance Report. The quality dashboard is transitioning to ensure we reduce duplication and have a clearer focus on the quality impacts of the areas we provide assurance under the three pillars of quality.

Are our services SAFE?
An overview of safeguarding information highlights the completion of the adult safeguarding audit, which has demonstrated an increase in compliance from the previous year. The audit notes that improvement is required to recording on the electronic patient record and a new mental capacity assessment and best interest form was developed to address this issue, and now is live and further audit will be completed in November. The guardian of safe working highlights the measures we have in place to support junior doctors to prevents doctors working excessive hours. Acknowledging there were breaches, we have effective systems in place to mitigate the risk and feedback from junior doctors indicates we have the measures in place to support the wellbeing of colleagues.

We have provided a summary on the Q1 learning from deaths review. 116 patients died whilst under the care in Q1 and whilst the deaths were judged not to be a result of care delivery we have utilised the review to develop practice with the ICB around the availability of Community Pharmacy and safe storage of medication in care and nursing homes. There were a total of 1,218 patient incidents reported in August. The top four overall categories of incident, excluding skin integrity, were falls, clinical care, medical emergencies and self-harm. 3 serious incident/Care review reports were undertaken in August. We have noted a small increase month on month in no and low harm incidents, in particular falls at Charlton Lane Hospital, this reflects a positive approach to mobilising people and all safeguards have been in place to support people in our care. We are undertaking a deep dive of these trends and this will include a 10% quality review to ensure the correct levels of harm are being recorded. This month we note an overall decrease in PU harm incidents with the majority occurring within ICT Teams. A review of Rapid Tranquilisation (RT) data in month as has shown an overall increase of 30% compared to last years average. The Clinical Director is reviewing the use of RT with the clinical team and deeper dive planned for 9th October and feedback and themes will be shared in Octobers update. Work is ongoing relating to sexual safety via an Organisation Development/Human Resource (OD/HR) project to promote the Sexual Safety Charter through the Violence and Harm Reduction workstream. With regard to these incidents there is good assurance that the necessary processes are being followed/implemented as per Trust policy guidance. We continue to provide a summary of closed cultures showing a range of metrics that we monitor and review the detail with the CQC monthly. This highlights some of the innovative approaches ward are taking to improve the experiences of people in service and quality of life indicators which was a driver of this enhanced view. This provides ongoing assurance to the regulator and we have plans to develop the metrics further as part of the integrated reporting ambitions to cover all services within GHC.

Are our services CARING?
Overall, 95% of Friends and Family Test (FFT) respondents reported a positive experience which was the highest rate achieved this year and meets target. Across the Trust there were 2314 FFT responses last month. 10 formal complaints were received in August, with 10 complaints closed, of which 5 were closed within 3 months. 0 complaint was re-opened in August and the PCET continue to work collaboratively with patients and carers to ensure post-complaint actions are completed. There were 140 enquiries (a reduction of 9 from last month). 100% of complaints were acknowledged within the national 3-day requirement. At the end of August, there were 29 open complaints (same as July). There are 7 complaints that are with the Parliamentary and Health Service Ombudsman (PHSO). There were 211 compliments recorded for the month. PCET visits continue at Berkeley House. Feedback from the new FoD hospital shows a positive rating of 75% from Inpatients (16 responses) and 98% for MIIU (82 responses). This month we include the NED Audit of complaints for Q1 2024/25 where assurance is given that, overall, the Trust is investigating and responding to complaints appropriately.

Are our services EFFECTIVE?
We have identified an increase in the rise of patients with delayed transfers of care in our community hospitals. We are collaborating with operational colleagues to determine the quality impacts of this increase. Acknowledging the barriers relate to availability of housing and self funded placements further analysis is required to understand any safety, effectiveness and impact on health outcomes as a result of the delays. Feedback will be presented Octobers dashboard. This month's dashboard includes developmental slides showing a set of Community Nursing data and associated narrative in line with key quality proxy measures, as referenced by The Queens Nursing Institute. These will be further developed in future dashboards. Noting the developments of the dashboard and integrated reporting we have removed duplication slides related to staff statutory & mandatory training, essential to role training, supervision data, inpatient ward sickness, vacancy rates and ward fill rates which are reported on by exception through the performance dashboard report. We have also removed the summary Quality Indicators slide as progress and assurance will be overseen by Quality Assurance Group then brought to Board.

Learning from Deaths Summary Q1 2024/25

- **Overview**

- This summary's aim is to inform the Board of the Trust's Learning from the Deaths review process, data analysis and outcomes during Quarter 1 2024/25. It includes learning from 'expected' and 'unexpected' End of Life care incidents, concerns, queries and compliments and local Gloucestershire LeDeR reviews.

- It is a regulatory requirement for all NHS Trusts to identify, report, investigate and learn from deaths of patients in their care, as set out in the **National Quality Board National Guidance on Learning from Deaths: A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care**, published March 2017.

- The full paper has been presented to the Trusts Quality Assurance Group (QAG) and Quality Committee (QC) for approval and assurance.

Quarter 1 2024/25 Learning from Deaths Summary:

- The Learning from Deaths Policy was refreshed and approved by the Quality Committee

- **No concerning trends** or themes have been identified.

- 116 patients died whilst under the care of the Trust in Q1, the deaths reviewed during this period were judged not to be due to problems in the care provided.

- Learning from End-of-Life care incidents, concerns, queries and compliments shows the need for :

- Ongoing work with EOL leads of GHC and GHFT and the hospices to enhance collaborative working, to identify and clarify the role of the hospice Registered Nurses.
- Collaborative work with ICB to ensure 24/7 availability of Community Pharmacy support for medication
- The Care Home Support team to support Care and Nursing Homes regarding safe storage of medication

- 1 learning summary (Learning on a Page) was generated this quarter and has been shared with operational services via the Patient Safety Notice Boards. The learning from this case promoted recognition of the signs of end stage Parkinson's disease and the exploration of available medication options for patients unable to swallow.

- 7 learning summaries from the county's learning from deaths of people with a learning disability or an autistic person (LeDeR) were generated, and as above, these have been shared with operational services via the Patient Safety Notice Boards. Learning included :

➢ Quarter 1 2024/25 Learning from Deaths Summary (Continued):

- Applauding the use of multiple services to maintain good health rather than reactive healthcare once an individual is already unwell
- Raising awareness of the community dental offer and specialist dental clinics that can offer additional support to individuals who may be struggling to attend.
- There needs to better understanding of the difference between care homes and nursing homes when considering a safe and appropriate hospital discharge. This is learning that has already been noted and raised by LeDeR on past reviews.
- Hospital passports need to be kept up to date with baseline data around what is normal for the person and adapted to include preferred pain scale communication where possible.
- There is need for better understanding of 'shared care' to ensure continuity wherever possible, and to avoid unnecessary confusion for individuals and their loved ones

➢ The inpatient death rate for Community Hospitals (CoHos) and Charlton Lane continues to remains higher than historical data but it has been observed that more patients are being transferred from the acute trust who require end-of-life care.

➢ Cancer, frailty of old age, respiratory and cardiovascular illness remain the most prevalent causes of death, and respiratory infections remain the most prevalent cause of death of people with a learning disability, consistent with the findings from LeDeR reviews. Data regarding natural cause deaths for community mental health patients identifies that deaths from cardiovascular illness and respiratory illness within the patient group with Severe Mental Illness (SMI) are more prevalent than within the CoHo population. This supports the increased resource identified to promote annual physical health checks for patients with SMI.

➢ The System Mortality Group identified that mortality rates were higher at weekends at the acute trust, reflecting higher admission activity of acutely unwell patients on these days. GHC activity has been remodelled as a rate (rather than showing numbers of deaths) and death rates are currently highest on Tuesdays and Saturdays, however, admissions at weekends are lower. There is not true variation across days of the week, any variation is not statistically significant and no more than can be explained by the play of chance. There does not, therefore, appear to be a correlation between date of admission and date of death. This metric continues to be developed.

➢ Feedback from the Medical Examiner service continues to provide significant assurance that that the care provided to inpatients at the time of their death was of a good standard, that families were appreciative of the ME service input and were happy with the cause of death given, and gladly gave feedback about care when asked. The ME was involved with 64 deaths in Q1.

➢ Conclusions of inquests continue to show that ***suicide prevention*** must remain a key priority for the Trust.

Quality Dashboard

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	1	0	0	0	0	0								0			N/A
Number of Patient Safety Incident Investigation (PSII) / Care Reviews	N - R		22	4	1	2	4	3								14			N/A
No of overdue SI actions (incomplete by more than I month)	L - R		N/A	0	0	0	0	0								0			N/A
No of unallocated PSII / Care Reviews (waiting more than 1 month for allocation).	L - R		0	0	0	0	0	0								0			N/A
Number of Patient Safety Incident Investigations regarding self-harm or attempted suicide	N - R		1	0	0	0	0	0								0			N/A
Number of Learning and Engagement Sessions meetings taking place	L - R		168	19	26	18	8	3								74			N/A
Total number of Patient Safety Incidents	L - R		14148	1130	1191	1204	1215	1218								5958			N/A
Number of incidents reported as resulting in low or no harm	L - R		13298	1043	1112	1118	1125	1134								5532			N/A
Number of incidents reported as resulting in moderate harm, severe harm or death	L - R		946	87	79	86	90	84								426			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	1	2	2	2								12			N/A
Total number of medication errors reported as resulting in moderate harm, severe harm or death	L - R		5	1	0	0	0	0								1			N/A
Total number of sexual safety incidents	L- R		112	13	5	10	12	8								48			N/A
Total number of Rapid Tranquilisations (RT)	N - R		563	74	73	106	123	85								460			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 - R/L - C	Measure that is treated differently at national and local level, e.g. nationally reported/local target

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

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

Patient incidents reported by overall severity - 01/09/2022 to 31/08/2024

Number of incidents reported

	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 of a patient (excluding deaths for Mortality Review)
	17635	8140	1698	85	73

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 August 2024 there were 1218 patient incidents reported on Datix, 3 more than July (1215). 1134 were reported as No and Low harm incidents, 9 more than July (1125) and 84 as Moderate or Severe harm or Death, 6 less than July (90).

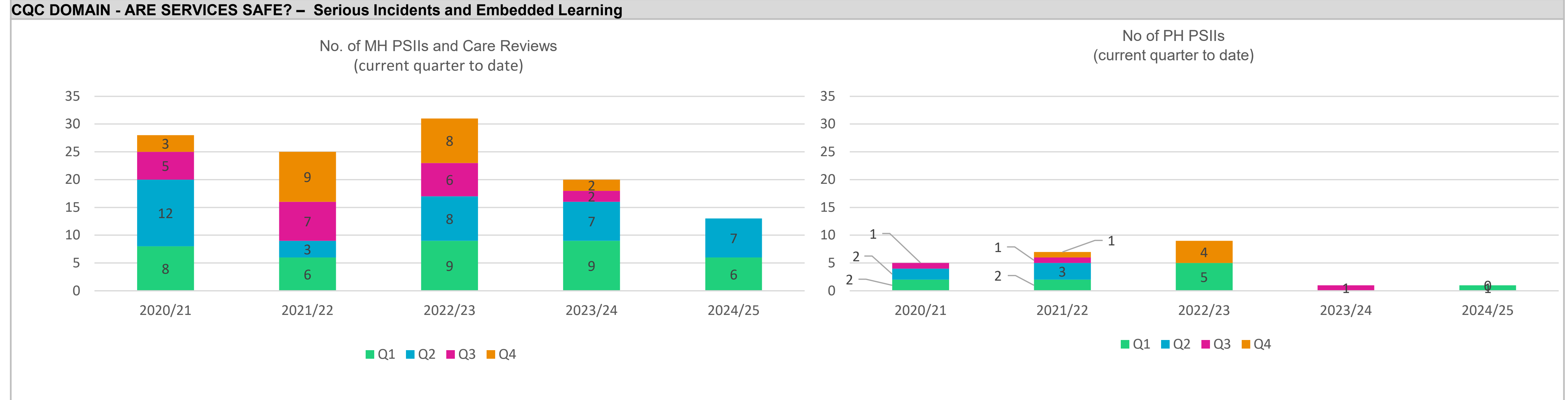
It should be noted that the data on this dashboard is presented by date incidents were reported (or date a PSII/care review was declared), due to technical issues related to incident dates being recorded incorrectly in Datix. The date the incident was reported provides the most accurate and reliable presentation of the data currently available and allows for comparison with 2023/24 outturn, which has also been shown based on date reported (or date a SI/PSII was declared). Data regarding severity (level of harm) and categorisation may be subject to revision when incidents are reviewed by handlers (managers). These revisions would then be reflected in the Quality Dashboard in later months.

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.

Quality Dashboard

Gloucestershire Health and Care
NHS Foundation Trust

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



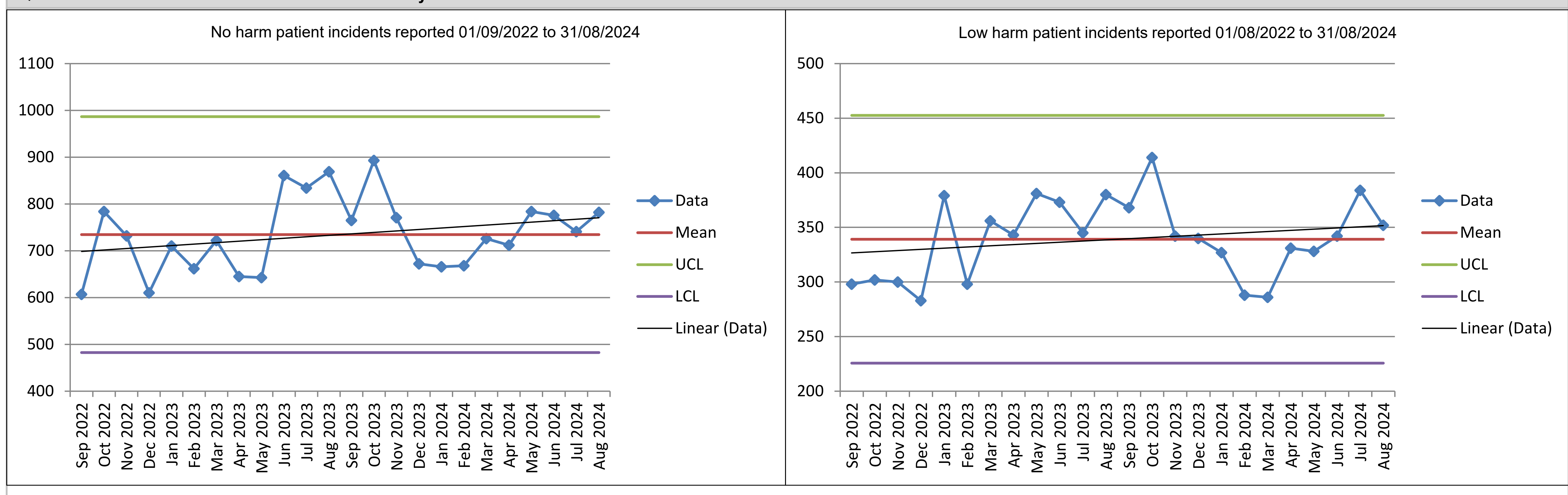
Key Highlights

There were 3 New Patient Safety Incident Investigations (PSIIs) and Care Reviews in the month , details have been reviewed due to confidentiality. There were 7 We have held 7 After Action Reviews (AARs) in August: and again the details have been removed due to confidentiality.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

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



Key Highlights from No and Low harm incidents:

- We have observed that there has been a small increase month on month since February 2024 with the number of combined no and low harm incidents being reported. In February 2024, 956 no and low harm incidents were reported compared to 1134 in August 2024 (an increase of 178 incidents in seven months). There was an increase of 41 no harm incidents being reported in August (total 782) compared to July (741 incidents) and a reduction of 32 low harm incidents in August (total 352) compared to July (384 incidents). Within the no and low harm range, we saw the biggest increase in the falls category (August 122 incidents / July 99 incidents), with Willow Ward continuing to see an increase for the past 2 months. See slide 6 for further details on the Charlton Lane Falls Strategy.
- A high level of incident reporting is positive, and patterns observed will be monitored and reported through services and Quality Assurance Group (QAG) with assurance given to QAG that incidents were correctly reported. A resulting action from the Quality Committee, we are seeking to enhance our analysis of low and no harm data. The will enable us to identify trends and activity at a ward/team level and by incident type. Included in this development will be sampling (minimum 10%) of the no and low harm incidents to ensure that the right level of harm are being recorded and to ensure that we are not missing learning opportunities / themes. We will be in a position in November to report our findings on the grading of low and no harm.

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

Moderate harm patient incidents reported 01/09/2022- 31/08/2024

Moderate harm patient incident (inc PU)
Moderate harm patient incidents (exc PU)
Mean
UCL
LCL
Linear (Moderate harm patient incident (inc PU))
Linear (Moderate harm patient incidents (exc PU))

Severe harm patient incidents reported 01/09/2022- 31/08/2024

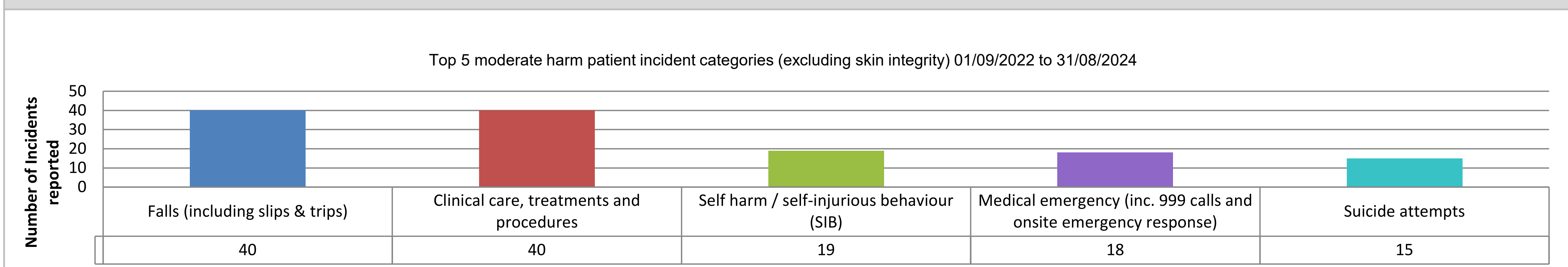
Data
Mean
UCL
LCL
Linear (Data)

Moderate harms: 79 Moderate harm incidents were reported in August, which saw a small decrease when compared with 85 incidents June and July. Skin integrity incidents continue to make up the highest number of moderate harm incidents (66). In line with this, the widest fluctuations in incident reporting tend to be in the Integrated Care Teams (ICT). For example, 'ICT Cotswold South 2' saw a 150% increase in moderate harm incidents between July (n=4) and August (n=10). At the other end of the scale, 'ICT Forest North' saw a 55% reduction in moderate harm incidents between July (n=11) and August (n=5). When excluding skin integrity incidents, 13 moderate harm incidents were reported in August which is an increase of 3 when compared with July. Further analysis assures us that this is in line with normal fluctuations in reporting. Overtime there is a steady increase in moderate harm reporting and work is under way to understand if this is accounted for by increasing caseloads or other reasons.

Severe Harm: The 2 severe harm incidents reported in August were both Category 4 pressure ulcers (one inherited and one developed / worsened during care by this trust). With regards to the pressure ulcer that deteriorated under our care, the patient had multiple comorbidities, including diabetes, dementia and Parkinson's and increased frailty, global deterioration and reduced mobility. There was evidence of good multi-disciplinary working and escalation to other services.

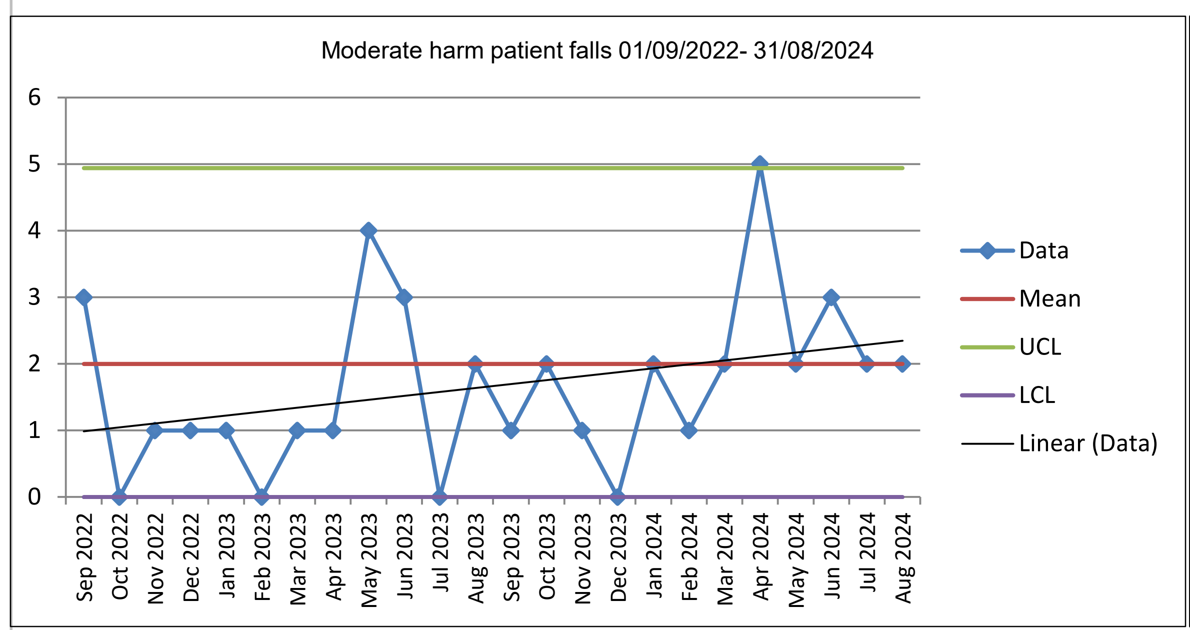
Quality Dashboard

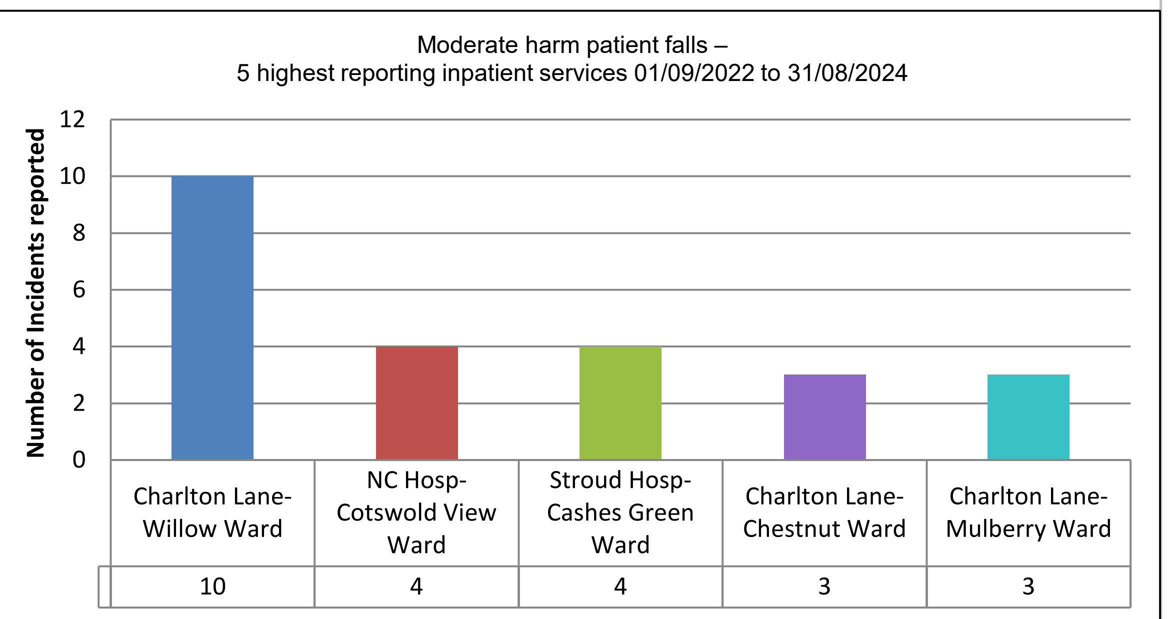
CQC DOMAIN - ARE SERVICES SAFE? – Patient Safety Incident Data



Falls (including slips & trips)	Clinical care, treatments and procedures	Self harm / self-injurious behaviour (SIB)	Medical emergency (inc. 999 calls and onsite emergency response)	Suicide attempts
40	40	19	18	15

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 . Charlton Lane Hospital (CLH) continue to work on their Falls Strategy, which is based on current up to date evidenced based practice from NICE & National audit for inpatient falls (NAIF). It has around 70 different points that have been implemented or are being implemented (since October 2021) to support practice in line with the national guidance in preventing and minimising harm from a fall's incident. The Lead Physiotherapist reviews this strategy every 6 months and clinical leads at CLH actioning anything required. As CLH has a high number of falls compared to physical health & mental health working age settings, the Matron ensures that the falls incidents data is understood on a twice a month basis. This is completed by the Matron and Lead Physiotherapist monthly reviewing the falls numbers, frequent falls and look for areas that might need development, gathering this information and cascading it back to the clinical teams and within the CLH governance meeting. A 'mid-month falls huddle' is also completed with representation from each ward & therapy to review the incidents and complete a themes analysis. This information is shared with all clinical staff also.





Charlton Lane-Willow Ward	NC Hosp-Cotswold View Ward	Stroud Hosp-Cashes Green Ward	Charlton Lane-Chestnut Ward	Charlton Lane-Mulberry Ward
10	4	4	3	3

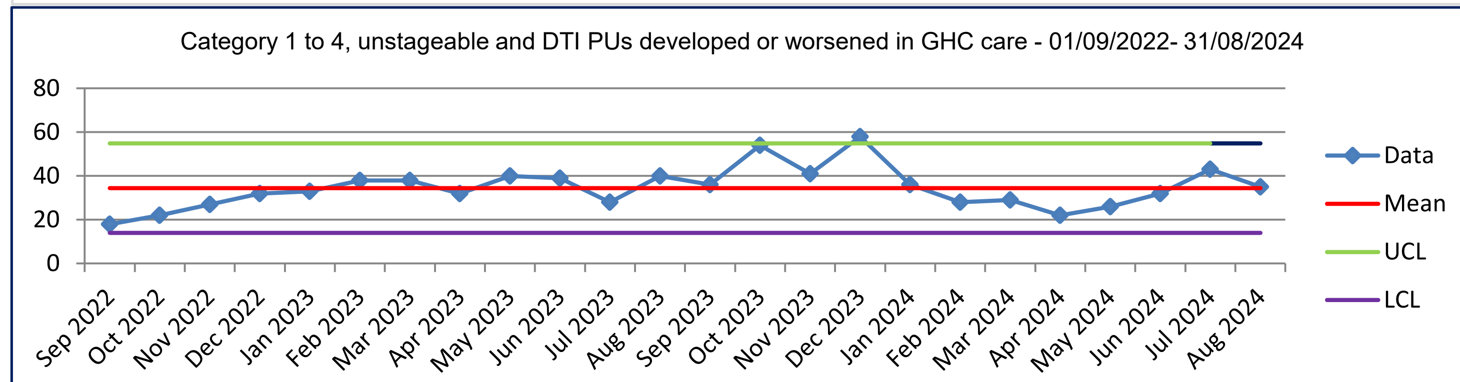
Quality Dashboard

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%	97.8%	100%	97%	98%	98%								98%	G		
Number of HODA Clostridium Difficile Infections (C Diff)	N	16	16	1	0	0	0	0								1	G		
Number of C Diff cases (days of admission plus 2 days = 72 hrs) - avoidable	N	0	0	0	0	0	0	0								0	N/A		
Number of MRSA Bacteraemia	N	0	0	0	0	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		1433	117	101	110	122	123*								573			
Number of Category 1 & 2 pressure ulcers developed or worsened within our care.	L - R		912	87	70	72	70	79*								378			
Number of Category 3 pressure ulcers developed or worsened within our care.	L - R		44	4	4	5	6	6*								25			
Number of Category 4 pressure ulcers developed or worsened within our care.	L - R		16	4	1	1	3	3*								12			
Number of unstageable and deep tissue injury (DTI) pressure ulcers developed or worsened within our care.	L - R		461	22	26	32	43	35*								158			

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

HCAI: There were 0 post 48-hour Clostridium Difficile in September (C. Diff), and no MRSA infections recorded in September Note our ICB threshold has been set at 16 for the year.



Pressure Ulcers:

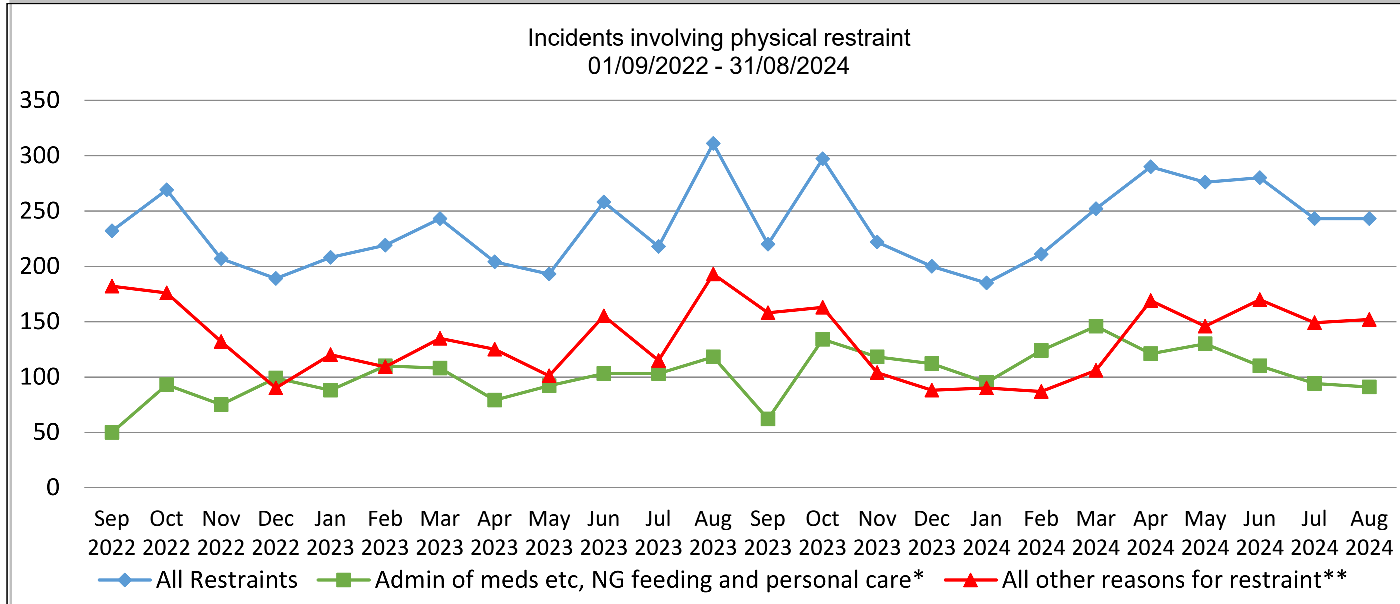
All cat 3, 4 & unstageable pressure ulcers each month are subject to senior clinical review as part of our validation process.

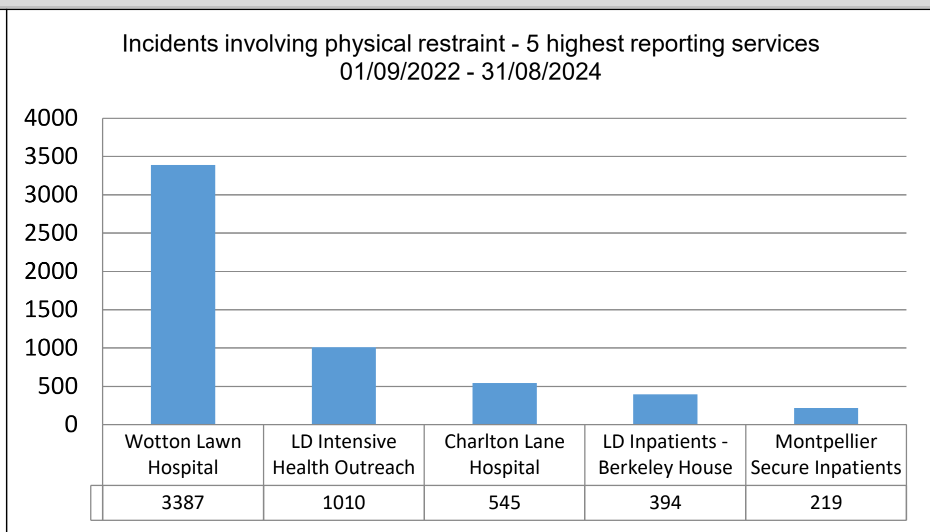
*August 2024 data has not been fully validated so PU classification is likely to alter due to duplication of reporting etc. 50.3% of skin integrity incidents reported in July 2024 had been reviewed and closed by 02/08/2024.

There are no significant changes to the incident data in august compared to previous months, with August sitting on the mean. The highest incidents are reported within the ICT nursing teams who have robust monitoring processes, such as PU tracker and oversight by community nursing leads within the ICT. This data / oversight allows the teams to look for themes and support learning and implement change. For the most accurate data, clinicians are requested to report promptly.

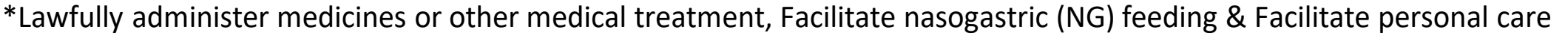
Quality Dashboard

Incidents involving restraint





Wotton Lawn Hospital	LD Intensive Health Outreach	Charlton Lane Hospital	LD Inpatients - Berkeley House	Montpellier Secure Inpatients
3387	1010	545	394	219

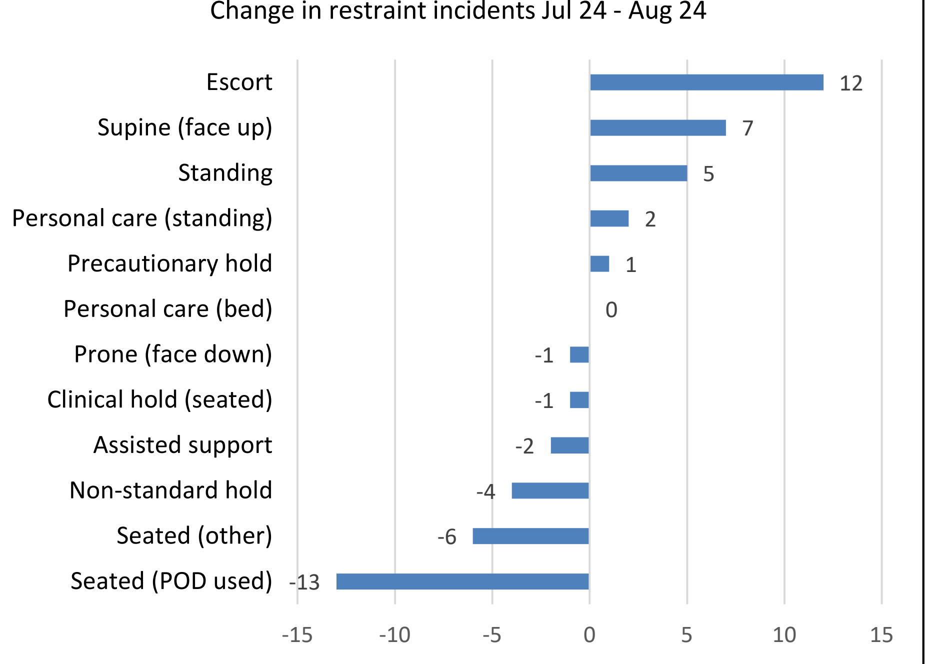


*Lawfully administer medicines or other medical treatment, Facilitate nasogastric (NG) feeding & Facilitate personal care
**Prevent a patient being violent to others, Prevent a patient causing serious intentional harm to themselves, Prevent a patient causing serious physical injury to themselves by accident, 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.

Incidents involving physical restraint are largely consistent with reporting last month. Last month's report also identified the high use of rapid tranquillisation (RT) with a particular patient on Priory Ward who accounts for 34% (n=155) of RT incidents since April 24. It is noted, however, that this usage has reduced over recent weeks. The Behaviour Management Team are working closely with the ward MDT to ensure that the patient's positive behaviour support plan is holistic, and the patient's Responsible Clinician is reviewing use of RT with the Clinical Director to ensure efficacy.

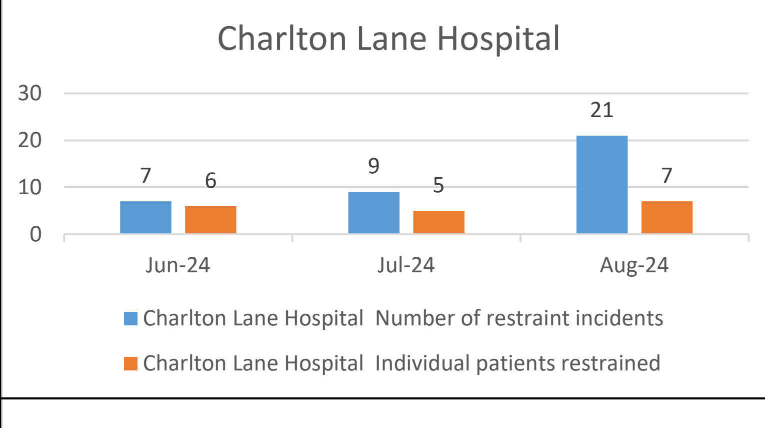
When this patient is removed from the data set, there remains a trend of an increased number of RT incidents being reported (30% increase when compared with last year's average). This will be reviewed as part of the Positive and Safe workshop taking place on 9th October and the output will feature in Octobers dashboard. This will inform the planned review of restrictive practice in January.

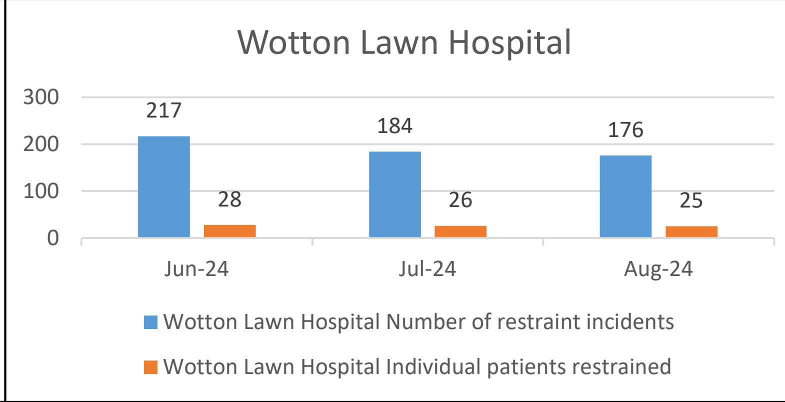
Low levels of RT were reported at Charlton Lane during this month, linked to a small number of new admissions. Berkeley House continues to report no such usage. There were no recorded episodes of harm to patients as a consequence of physical interventions this month.

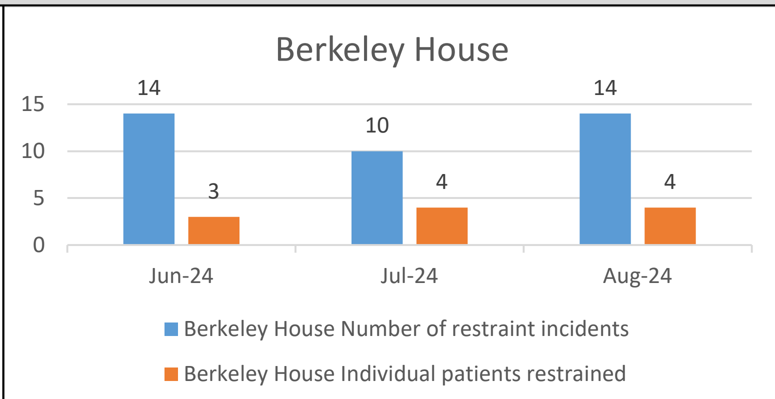


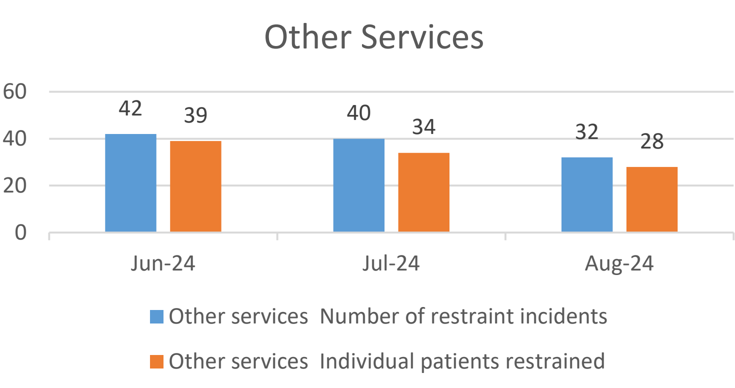
Quality Dashboard

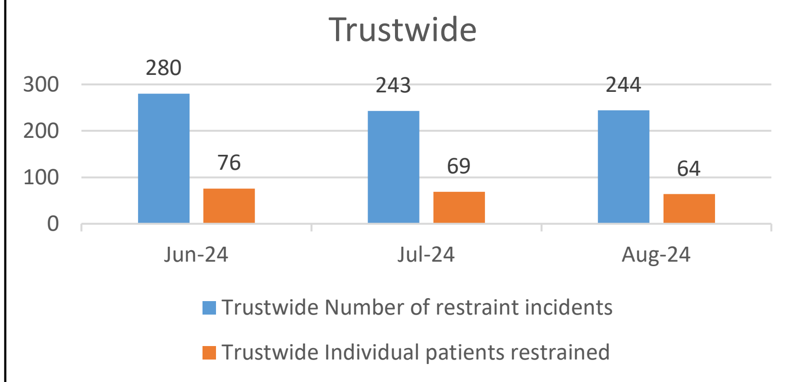
Incidents involving restraint – individual patients restrained

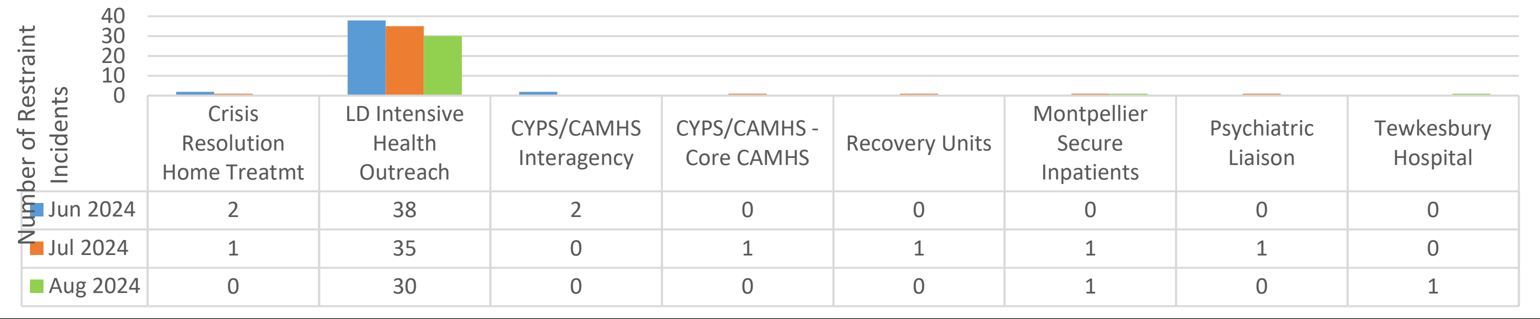












	Crisis Resolution Home Treatmt	LD Intensive Health Outreach	CYPS/CAMHS Interagency	CYPS/CAMHS - Core CAMHS	Recovery Units	Montpellier Secure Inpatients	Psychiatric Liaison	Tewkesbury Hospital
Jun 2024	2	38	2	0	0	0	0	0
Jul 2024	1	35	0	1	1	1	1	0
Aug 2024	0	30	0	0	0	1	0	1

Mental health and learning disability inpatient services continue to account for the settings where individual patients are likely to have the highest frequence of restraints. Looking more widely at other services:

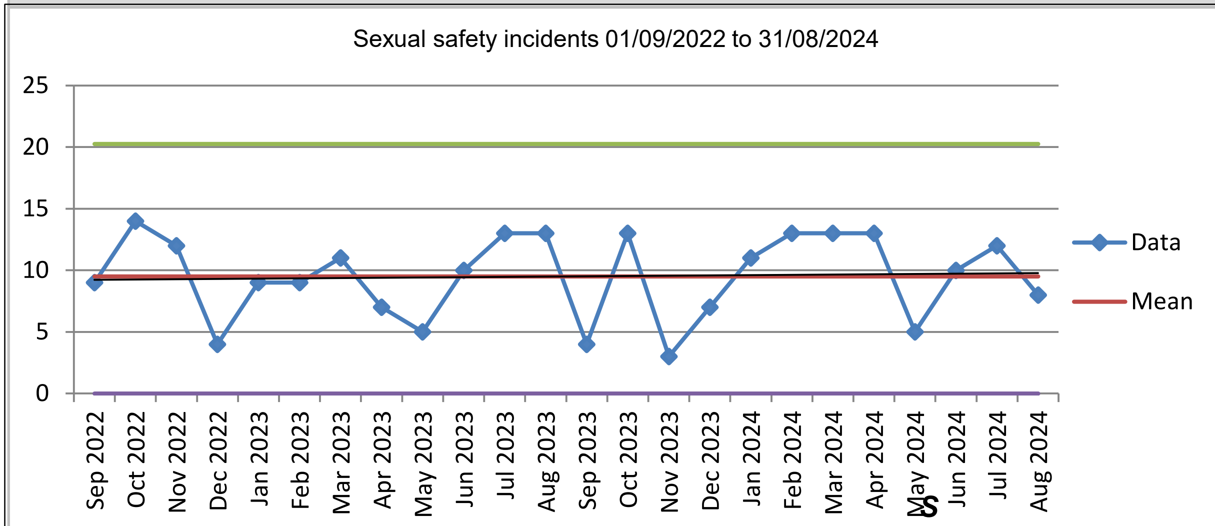
In June 2024 42 restraint incidents were reported across the other services of CRHT (2), LD IHOT (38) and CYPS/CAMHS Interagency (2). These involved 2 patients in CRHT, 36 patients in LD IHOT and 1 patient in CYPS/CAMHS Interagency.

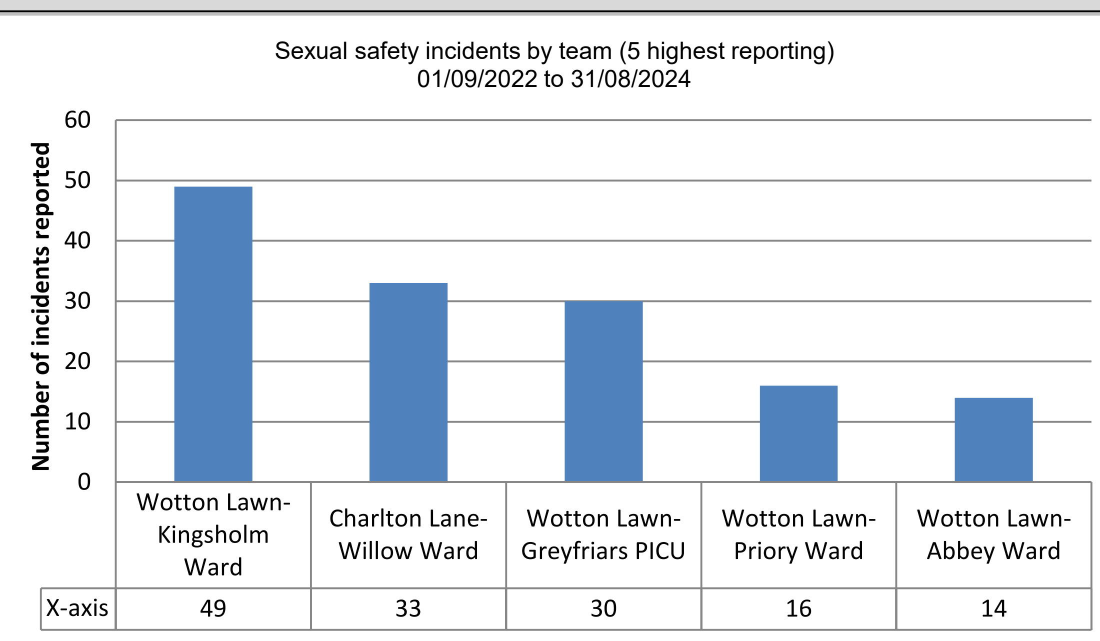
In July 2024 40 restraint incidents were reported across the other services of CRHT (1), LD IHOT (35), CYPS/CAMHS Core (1), Recovery Units (1), Montpellier Unit (1), and Psychiatric Liaison (1). These involved 1 patient in CRHT, 29 patients in LD IHOT, 1 patient in CYPS/CAMHS Core, 1 patient in Recovery Units, 1 patient in Montpellier Unit and 1 patient under Psychiatric Liaison.

In August 2024 32 restraint incidents were reported across the other services of LD IHOT (30), Montpellier Unit (1) and Tewkesbury Hospital (1). These involved 26 patients in LD IHOT, 1 patient in Montpellier Unit and 1 patient in Tewkesbury Hospital. The incident at Tewksbury hospital relates to a patient known to mental health services who was being nursed by trained RMNs on a 2:1. The patient became aggressive towards their son, and PBM techniques were used in line with Trust policy.

Quality Dashboard

Sexual Safety Incidents





	Wotton Lawn-Kingsholm Ward	Charlton Lane-Willow Ward	Wotton Lawn-Greyfriars PICU	Wotton Lawn-Priory Ward	Wotton Lawn-Abbey Ward
X-axis	49	33	30	16	14

Sexual Safety update:

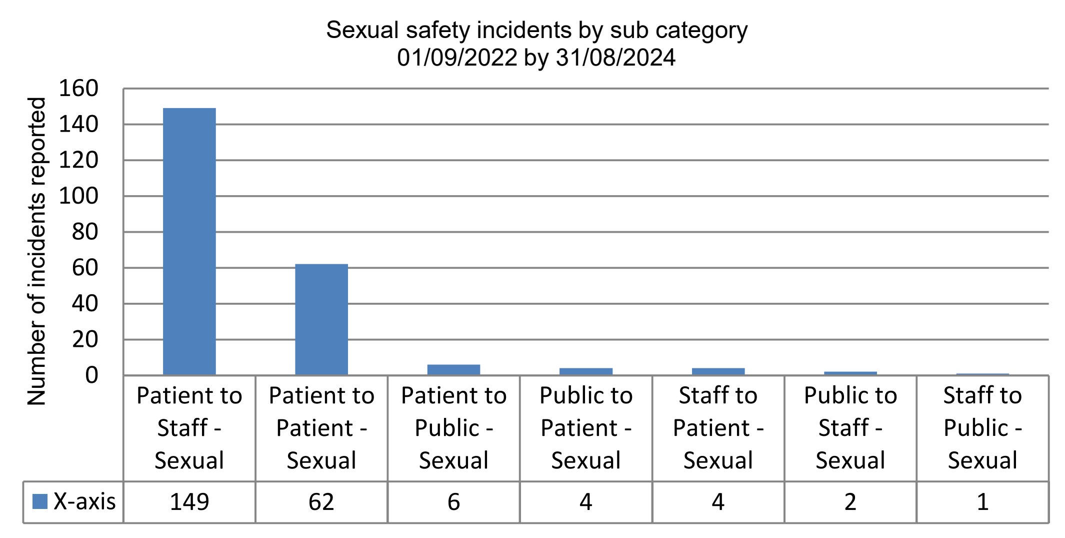
8 sexual safety incidents were reported in August, a reduction of 4 incidents compared to July (12 incidents). One incident categorised as "other" detailed a search carried out on a service user known to the eating disorders service whilst in the care of GHFT. This incident is being investigated by the Deputy Director of Quality & Nursing, GHFT and therefore not further reported here.

The other 7 reported incidents occurred in mental health inpatient services, 5 occurring at WLH and 2 at CLH. Zero harm was reported for 6 of these incidents, and Moderate harm for one incident which is detailed below.

4 incidents reported patient to patient activity (embracing, flirtation, and unwitnessed allegation of inappropriate touching), and were categorised as affectionate activity or "other" sexual safety incidents, as remaining reporting categories did not fit the details of the incidents, which sometimes happens.

2 sexual disinhibition incidents reported were patient to staff.
1 allegation of sexual assault was reported The necessary processes are being followed/implemented as per Trust policy guidance. Safeguarding colleagues are involved, as well as police.

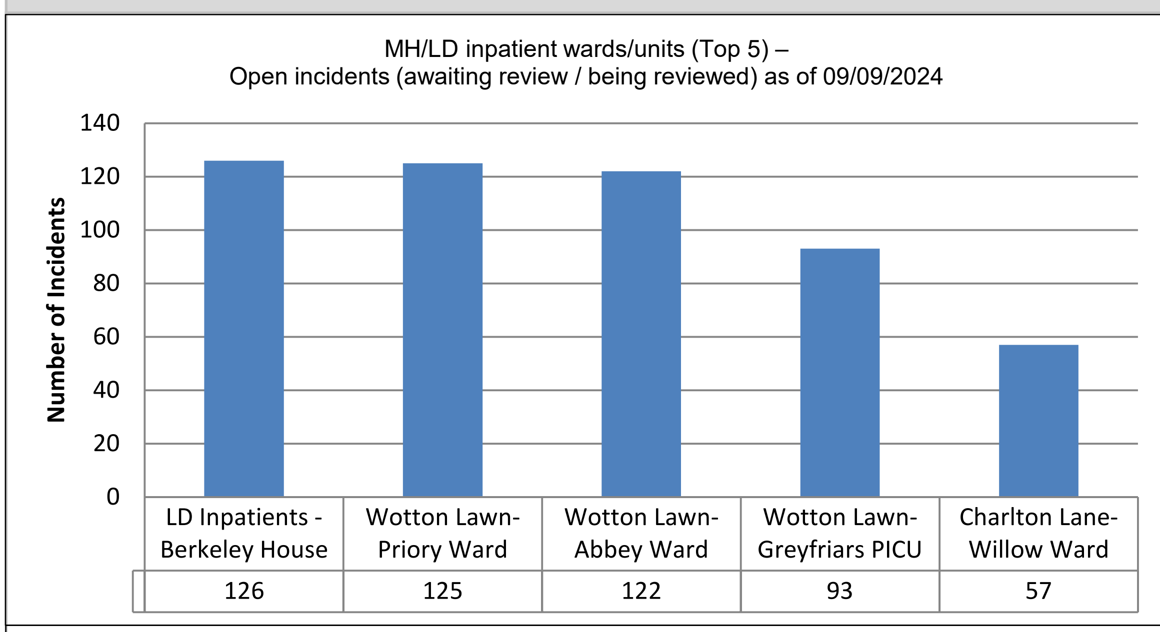
Funding has been agreed to update the existing sexual safety awareness e-learning for general access trust wide which will be completed in October. A revision of the sexual safety policy is currently in consultation.



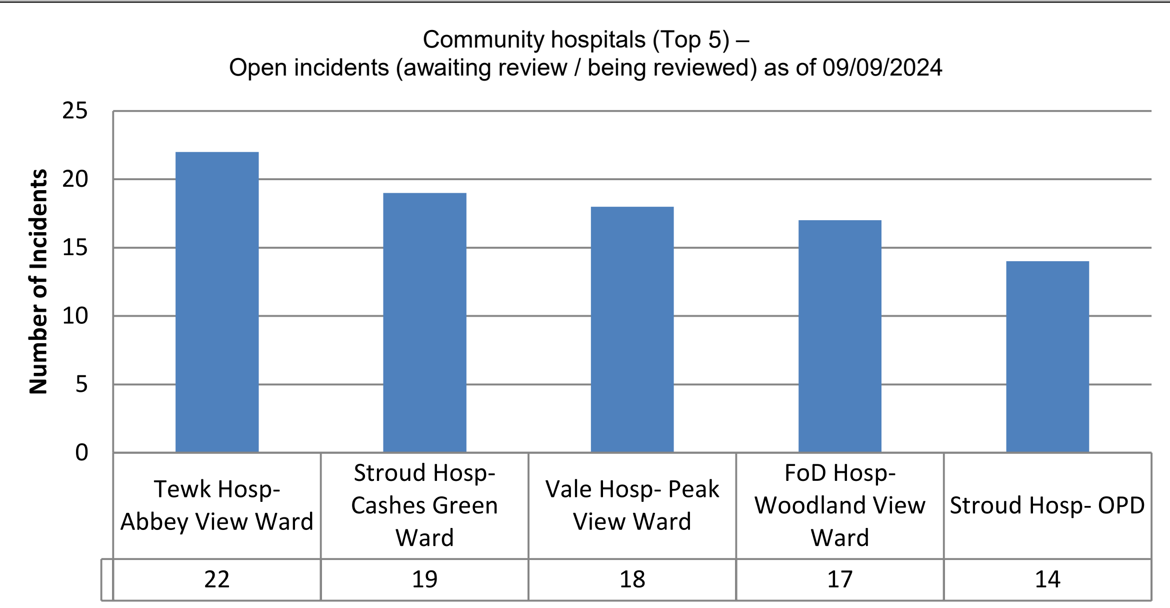
	Patient to Staff - Sexual	Patient to Patient - Sexual	Patient to Public - Sexual	Public to Patient - Sexual	Staff to Patient - Sexual	Public to Staff - Sexual	Staff to Public - Sexual
X-axis	149	62	6	4	4	2	1

Quality Dashboard

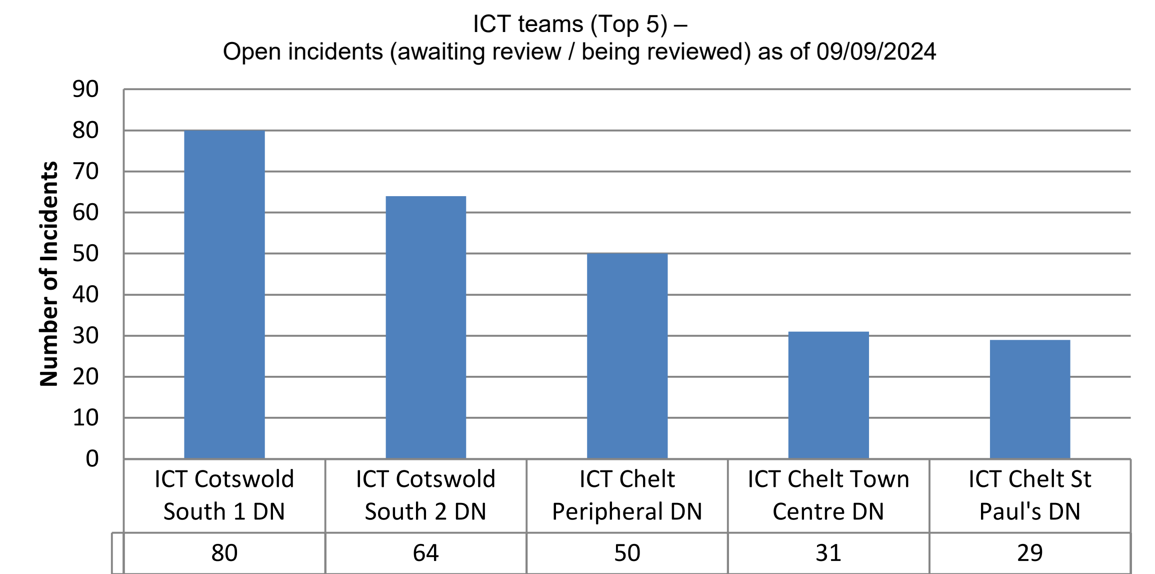
Incidents awaiting review and confirmation of level of harm: data priority areas and actions underway



LD Inpatients - Berkeley House	Wotton Lawn- Priory Ward	Wotton Lawn- Abbey Ward	Wotton Lawn- Greyfriars PICU	Charlton Lane- Willow Ward
126	125	122	93	57



Tewk Hosp- Abbey View Ward	Stroud Hosp- Cashes Green Ward	Vale Hosp- Peak View Ward	FoD Hosp- Woodland View Ward	Stroud Hosp- OPD
22	19	18	17	14



ICT Cotswold South 1 DN	ICT Cotswold South 2 DN	ICT Chelt Peripheral DN	ICT Chelt Town Centre DN	ICT Chelt St Paul's DN
80	64	50	31	29

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 2254 as of 09/09/2024.

National incident reporting changed from NRLS to LFPSE within GHC Datix from 9 January 2024. Any moderate/severe harm or death patient incidents reported before 9 January, but which remained open at that time, needed to be reported nationally via LFPSE, with the mandatory LFPSE questions completed retrospectively. 48 such incidents remain open as of 09/09/2024.

Quality Dashboard

CQC DOMAIN - ARE SERVICES SAFE? Closed Cultures: eliminating the risk of our patients experiencing abuse

Closed cultures – identification and risk factors (August 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.

Greyfriars Ward,

Staffing: Band 6 -1 vacant post which is out to advert. **All Band 4&5** posts are fully recruited to. **Band 3** - 2 vacancies interviews 25th September.

Incidents:. There has been an increase in Datix reportable incidents in August, largely in context to an increase in acuity on the ward. The themes surrounding the Datix reportable incidents are the use of proactive PMVA and RT administrations, acknowledging how disturbed some of our patients are at present.

Training: A significant increase of staff members who are currently at 100% for their training, however the overall rating for the ward is currently at 90%. This figure appears to be drawn down due to staff on maternity leave, long-term sickness and new starters. The ward is currently in the progress of securing funding for relational safety e-learning, which has been delivered within the trusts low secure hospital and has received positive feedback. The vision is to ensure that all staff working on the ward are provided with a comprehensive understanding of the importance of utilising relational secure in their practice. In turn this should support patient experience and safety on the ward.

Issues:. On-going challenges regarding bed management and PICU beds being used for acute patients however improvements re. bed flow evident.

Other: Participating in the National MH QI programme, first workshop attended. Greyfriars hosted 'Greyfest' on the ward, marking the end of the summer. Patient and staff engaged in a range of fun activities such as designing T-shirts, karaoke and limbo. 'Greyfest' was well attended by both staff and patients, with positive feedback provided.

Montpellier Unit

Staffing: All vacancies now filled apart from 0.6 WTE HCA vacancy.

Incidents: The team are taking a person-centred systems-based approach to learn from incidents. Staff are encouraged to use the SEIPS model to learn, reduce blame culture and encourage staff to speak up. Learning includes: working with clinical systems to optimise RIO to reduce medication incidents, change to processes to aid clinical decision-making around leave, staff search training to become refresher rather than one-off.

Training: The unit now has 9 relational security facilitators who are actively running quality improvement projects. Statutory and mandatory and essential for role training is within target although availability of courses is preventing an improvement in figures (Safeguarding, moving and handling and rapid tranquilisation).

ISSUES: Ongoing estates issues: Bed is closed due to damage to the door. Variability of bedroom cameras and a replacement programme is in place. Both issues currently on risk register – unit manager attending South West CCTV working group to share ideas and develop a business case for an alternative system.

Other: Management team have attended a HR supporting attendance policy update to ensure staff are supported using the correct processes and resources. Ongoing completion of the gym instructor course by EAP practitioner and nursing colleague to enhance the opportunities available to patients. Use of team board for idea sharing for discussion in team meeting, encouraging staff to bring their own ideas to discussions and promoting the speak up agenda within Montpellier.

Berkeley House Staffing:

We have recruited 2.6 WTE Band 5 Nurses, 1.6 WTE RNLD and the other 1 WTE RMN. All are due to start by the 7th October 2024 with Staff and Registered Nurses meetings occurring monthly.

Incidents: In August we had an outside worker get burnt in one of our Patient Kitchens, this had a Datix completed and we have made some changes to the layout of the kitchen and replaced the type of kettle that caused the burn.

Training and supervision: Statutory and mandatory training levels remain good at 93.%.

Issues: Discussions continue regarding the future model of care for learning disability services in Gloucestershire.

Other: There are regular trips for patients, often daily, sometimes twice daily. Patients are attending community activities, including music workshops. Plans to transition/discharge patients continue. These plans are often complex and take a lot of input and resource.

Charlton Lane Hospital, including Willow Ward

Staffing: Staffing levels good with 3.3% vacancy rate.

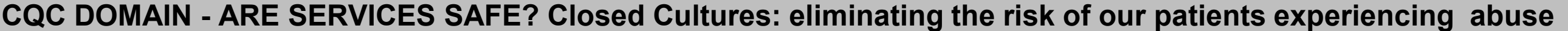
Incidents: 194 incidents across CLH in August – falls (65), violence and aggression patient to staff (30) and Restrictive Interventions (22) were the top 3 types of incident.

Training: Statutory and mandatory training compliance is good, currently 96.4%

Issues: None to report this month.

Other: Hospital garden party to take place on 4th September .

Gloucestershire Health and Care NHS Foundation Trust



CQC DOMAIN - ARE SERVICES SAFE? Closed Cultures: eliminating the risk of our patients experiencing abuse

Closed cultures – Trust safeguards against risks

Safeguarding Training

Compliance (%) 100 95 90 85 80 75 70

Nov Dec Jan Feb Mar Apr May June July Aug

Violence and Aggression

Compliance (%) 100 90 80 70 60 50 40

Sept Oct Nov Dec Jan Feb Mar Apr May June July Aug

Conflict Resolution and Breakaway

Compliance (%) 100 90 80 70 60 50 40 30

Sept Oct Nov Dec Jan Feb Mar Apr May June July Aug

Supervision and Appraisals

Compliance (%) 100 90 80 70 60 50 40

Sept Oct Nov Dec Jan Feb Mar Apr May June July August

Staff vacancies (%)

Trained Staff

40 20 0

Nov Dec Jan Feb Mar Apr May June July August

Healthcare Support Workers

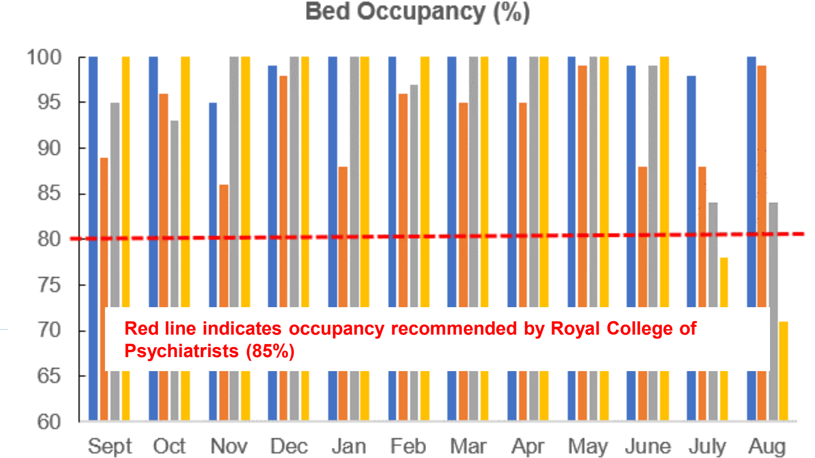
40 20 0

Nov Dec Jan Feb Mar Apr May June July August

Therapies

100 80 60 40 20 0

Nov Dec Jan Feb Mar Apr May June July August



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 since May 2024)

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

CQC DOMAIN - ARE SERVICES SAFE? Closed Cultures: eliminating the risk of our patients experiencing abuse

Closed cultures – Trust safeguards against risks

Patient to patient incidents

		Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July	Aug
Attempted assault	Willow W	2	0	4	3	3	4	1	4	5	5	2	4
	Greyfriars	0	1	0	0	0	1	2	3	0	0	0	0
	Montpellier	1	0	0	0	1	0	0	0	0	0	0	0
	Berkeley H	0	0	0	0	0	0	0	0	0	0	0	0
Physical	Willow W	17	5	8	3	3	7	8	1	14	8	3	3
	Greyfriars	0	4	3	2	2	3	2	13	2	4	0	4
	Montpellier	0	0	0	0	0	0	0	1	0	0	1	0
	Berkeley H	0	0	2	0	0	0	0	0	0	0	0	0
Verbal	Willow W	0	0	0	1	0	0	2	1	1	2	0	0
	Greyfriars	0	0	2	0	0	1	0	0	0	0	0	1
	Montpellier	0	0	0	0	1	1	1	1	0	0	0	0
	Berkeley H	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
	Greyfriars	0	0	1	0	0	0	0	0	0	0	0	4
	Montpellier	0	0	0	0	1	1	2	0	0	0	0	0
	Berkeley H	0	0	0	0	0	0	0	0	0	0	0	0
RT (RT only + PI and/or RT)	Willow W	6	9	8	6	7	28	56	5	30	4	2	18
	Greyfriars	5	28	9	27	26	31	18	54	20	19	16	38
	Montpellier	53	4	1	0	2	1	1	2	1	0	1	1
	Berkeley H	25	31	33	6	5	11	20	16	16	14	10	14
Total sexual safety incidents	Willow W	0	1	0	2	6	2	0	1	1	4	0	0
	Greyfriars	0	2	0	0	0	3	3	2	2	0	5	1
	Montpellier	0	0	0	0	0	0	0	0	0	0	0	0
	Berkeley H	0	0	0	0	0	0	0	0	0	0	0	0
PALS/PCET													
Visits (no. patients giving feedback)	Willow W	1	5	2	4	4	6	0	3	3	4	2	0
	Greyfriars	0	0	4	3	1	1	1	2	2	3	3	0
	Montpellier	0	2	5	1	2	3	0	2	2	2	1	0
Enq/comment	Willow Ward	0	0	0	0	0		0	0	0	0	0	0
	Greyfriars	1	1	0	1	1	2	1	0	0	1	2	1
	Montpellier	2	0	1	0	0	0	0	0	0	0	0	0
	Berkeley House	1	0	0	0	0	0	0	0	0	0	0	0
Early resn	No new incidents												

Patient to staff incidents

		Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July	Aug
Attempted assault	Willow W	2	1	0	1	3	0	2	0	6	3	1	3
	Greyfriars	1	5	2	3	5	2	1	5	0	1	2	4
	Montpellier	23	2	1	0	0	1	1	0	0	0	0	1
	Berkeley H	16	15	8	8	1	5	3	11	9	4	4	1
Physical	Willow W	9	10	17	6	7	3	6	4	8	5	1	13
	Greyfriars	1	18	6	15	18	6	5	23	8	2	4	24
	Montpellier	10	2	2	0	2	1	3	0	1	0	2	0
	Berkeley H	56	61	46	29	15	11	14	30	18	21	10	19
Verbal	Willow W	0	0	0	0	3	0	0	0	0	0	0	1
	Greyfriars	0	0	1	4	6	4	1	1	1	0	1	2
	Montpellier	0	3	1	3	1	2	3	2	3	1	1	1
	Berkeley H	2	2	3	2	0	1	0	0	0	0	0	0
Racial abuse	Willow W	0	0	1	0	1	2	0	0	0	0	0	1
	Greyfriars	0	1	3	1	1	0	1	11	2	0	2	7
	Montpellier	1	0	2	2	0	2	0	2	0	0	0	0
	Berkeley H	0	0	0	0	0	0	0	0	0	0	0	0

Reported incidents of physical intervention and/or rapid tranquilisation in August, by individual. Montpellier only had 1 incident in August.

Willow Ward, 18 incidents

Greyfriars, 38 incidents

Berkeley House, 14 incidents

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.

CQC DOMAIN – ARE SERVICES SAFE? Q1 2024/25 Guardian of Safe Working Report

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

Reporting time: April – June 2024	**Guardian of Safe Working Hours: Dr Sally Morgan** **In Quarter 1 2024/25 (April-June) there were 51 doctors in training posts**.
Number of doctors in training (all on 2016 contract)	• 16 Higher Trainees • 6 CT3s • 6 CT2s • 7 CT1s • 5 GP Trainees • 4 FY2s • 7 FY1s
Exceptions in this period	• **29 on call shifts had a junior doctor gap due to sickness or other reasons.** • 27 on-calls shifts were covered by Doctors in training. 1 by a consultant acting down and 1 by a Higher Trainee acting down. • Due to strike action June also saw a further 15 shifts needing cover (not including any daily normal working hours cover required). • All shifts were covered with Advanced Nurse support, specialty doctors and doctors in training. • **3 exception reports in this time period - all relating to hours worked. Outcomes agreed were 2 toil and 1 payment.** • One of the exception reports (relating to hours worked when a junior doctor stayed on to cover a last minute night shift gap on the rota) constituted a breach incurring a fine. • **There was no Junior Doctors Forum held during this period.** • **GOSWH continues to work with the Modern Matrons from WLH and CLC** to ensure adequate junior doctor office and rest spaces at both sites to take into account the increase in the numbers of trainees. • **A Junior Doctors Wellbeing Day** took place on 7th June 2024 which was well attended with excellent feedback. • A **webpage** on the intranet to provide information about GOSWH and exception reporting is being developed

Summary
Trust Safeguarding Data

Summary information – August 2024:

- 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.

Highlights:

- Work continues with the Training team to look at the current training offer across adult and child Safeguarding, prompted by the NHS England Strategy for Statutory and Mandatory Training. This review will ensure our courses are aligned to the Intercollegiate Documents (adult and child) and the Core Skills Training Framework (CSTF), will compare training across the ICB and with other trusts, and will look at how we can improve compliance.
- The new children's supervision offer went live on 1st August 2024 with sessions booked up until new year and more dates added.
- Mental Capacity Assessment and Best Interest Forms are now live in SystmOne and Rio. These new forms replace the previous MCA forms and can be found in the MCA & BI folder on Rio and the Questionnaires section on SystmOne. Re-audit of mental capacity assessments and best interest decisions will take place in November 2024.
- The adult Safeguarding annual audit is now complete and awaits sign off by clinical audit and will be presented at the next Safeguarding Group. Overall compliance is 65% (previous year 41%)
- Work to measure the impact of the Adult Safeguarding template which was introduced to SystmOne on 22nd April is underway as In a number of cases staff have used the existing proforma process to document the concern. This has highlighted a training need for awareness to ensure staff are utilising the new template. It is hoped that improvements will be evident over the coming weeks and compliance will be captured through monthly DIP audits.
- A report containing Adult Safeguarding referral data continues to be received from the local authority on a monthly basis. While there are some question marks as to whether the data captures all referrals made by GHC staff, we are cross-referencing the report with our own internal data and therefore we have a clearer picture of referral activity than we have at any time since 2021.
- The Named Nurse for Safeguarding Adults is now meeting monthly with the local authority's Adult Safeguarding team, and it is hoped that this will further aid the identification of trends. This will be monitored over the coming quarter; our ongoing analysis is expected to aid the identification of trends or patterns.
- The ICB has offered group supervision for the band 7/8's in the adult's team which will replicate the children's model, first date scheduled for 28th October. The plan is for 2-hour supervision sessions on MS Teams (with a view to possible face to face in the future) every other month and the team have been invited to attend 2-3 a year or more if they feel they would benefit from attending. The days and times will be changed to make it easier for everyone to attend.

Challenges/risks:

- The launch of the children's template has been delayed due to the introduction of the 111 service into GHC. While there is no new firm launch date, the Named Nurse for Safeguarding Children is working on some actions to minimise the delay.

Quality Dashboard

CQC DOMAIN - ARE SERVICES SAFE

Safe Staffing Inpatient data August 2024

Ward Name	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions
Gloucestershire										
Dean	0	0	25	3	0	0	0	0	0	0
Abbey	0	0	67.5	9	0	0	0	0	0	0
Priory	30	4	0	0	0	0	0	0	0	0
Kingsholm	0	0	0	0	0	0	0	0	0	0
Montpellier	0	0	30	4	0	0	0	0	0	0
Greyfriars	0	0	22.5	3	0	0	0	0	0	0
Willow	0	0	45	6	0	0	0	0	0	0
Chestnut	0	0	7.5	1	0	0	0	0	0	0
Mulberry	0	0	15	2	0	0	0	0	0	0
Laurel	180	21	15	2	0	0	0	0	0	0
Honeybourne	82.5	11	0	0	0	0	0	0	0	0
Berkeley House	947.5	64	0	0	0	0	0	0	0	0
Total In Hours/Exceptions	1240	100	227.5	30	0	0	0	0	0	0

Key highlights:

The 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 includes staffing data for Community Hospitals which is reported within the Performance Dashboard. We have cross referenced highest exceptions with patient safety and patient experience data with no adverse trends being noted. Berkeley House have reported the highest code 1 exception levels, followed by Laurel House. The Matrons report no adverse impact on care delivery or patient experience. As per last month Code 1 exceptions at Laurel House were attributable to HCA vacancies on early and late shifts. Code 1 exceptions at Berkeley were attributable to HCA vacancies on all shifts.

ARE SERVICES CARING? Non-Executive Director audit of complaints Q1 2024/25

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 (NED) 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 Q1 2024/25 audit provides 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 CARING? Non-Executive Director audit of complaints Q1 2024/25

	Time scale of response	Quality of investigation	Accessibility, style and tone of letter	Learning actions identified	Comments
Complaint 1 Patient reported the treatment was rushed as they were the last patient to be seen – felt there was no care or compassion.	**FULL ASSURANCE** • Appropriate acknowledgement and clarification of issues. • Formal response letter was sent well within 3 months.	**FULL ASSURANCE** • Very thorough investigation by the Clinical Director with the appropriate knowledge and ability to discuss the issues both with the patient and relevant clinicians • Very measured judgement.	**FULL ASSURANCE** • Letter contained full and honest account of events. • Appropriate apologies were offered.	**FULL ASSURANCE** • Learning was identified and actions agreed including who is accountable and by when.	• Complaint was not upheld
Complaint 2 Patient was unhappy with various mental health services, along with services provided by Glos County Council.	**FULL ASSURANCE** • Complaint was acknowledged appropriately, and time was taken to clarify issue	**SIGNIFICANT ASSURANCE** • The investigation template was not completed. • Investigation appeared to rely on review of patient notes without interviewing colleagues. • No explanation re refusal of another organisation to accept referral.	**FULL ASSURANCE** • Appropriate apologies were offered.	**SIGNIFICANT ASSURANCE** • Learning was identified but not clear who is accountable for the action	• A flexible and pragmatic approach to the investigation was taken due to time constraints relating to key staff who were about to leave the trust. • The investigator was a senior member of staff with good oversight into the issues. • Complaint was partially upheld.
Complaint 3 Patient unhappy with treatment from the AMHP team and the Crisis team and is seeking an apology from both.	**FULL ASSURANCE** • Appropriate acknowledgement and clarification of issues. • Response letter sent well within 3 months	**FULL ASSURANCE** • Thorough investigation by a very knowledgeable person • Very balanced and informed judgements made	**SIGNIFICANT ASSURANCE** • Very good empathic letter to the complainant setting out the findings and learning very clearly.	**SIGNIFICANT ASSURANCE.** • Very clear about the person to deliver the actions but not by when or how it will be monitored	• Complaint was upheld 22

Quality Dashboard

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

	Level	TH	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		30519	2,471	3,093	2,638	2,274	2,314								12790	
% of respondents indicating a positive experience of our services	N - T	95%	94%	94%	93%	93%	93%	95%								95%	
Number of compliments received in month	L - R		2,506	151	241	156	203	211								962	
Number of enquiries (other contacts) received in month	L - R		1,186	150	172	133	149	140								744	
Number of complaints received in month *Includes ALL complaints (closer look complaint / early resolution complaint)*	N - R		161	8	9	15	9	10								51	
Of complaints received in month, how many were early resolution complaints	L - R			8	9	14	9	10								50	
Number of open complaints (not all opened within month) *Includes ALL complaints (closer look complaint / early resolution complaint)*	L - R			24	21	27	29	29									
Percentage of complaints acknowledged within 3 working days	N - T	100%	100%	100%	100%	100%	100%	100%								100%	
Number of complaints closed in month *Includes ALL complaints (closer look complaint / early resolution complaint)*	L - R			11	13	9	7	10								50	
Number of complaints closed within 3 months	L - I			9	9	7	4	5								34	
Number of re-opened complaints (not all opened within month)	L- R			3	1	1	1	0									
Number of external reviews (not all opened within month)	L - R			7	7	6	8	7									

Quality Dashboard

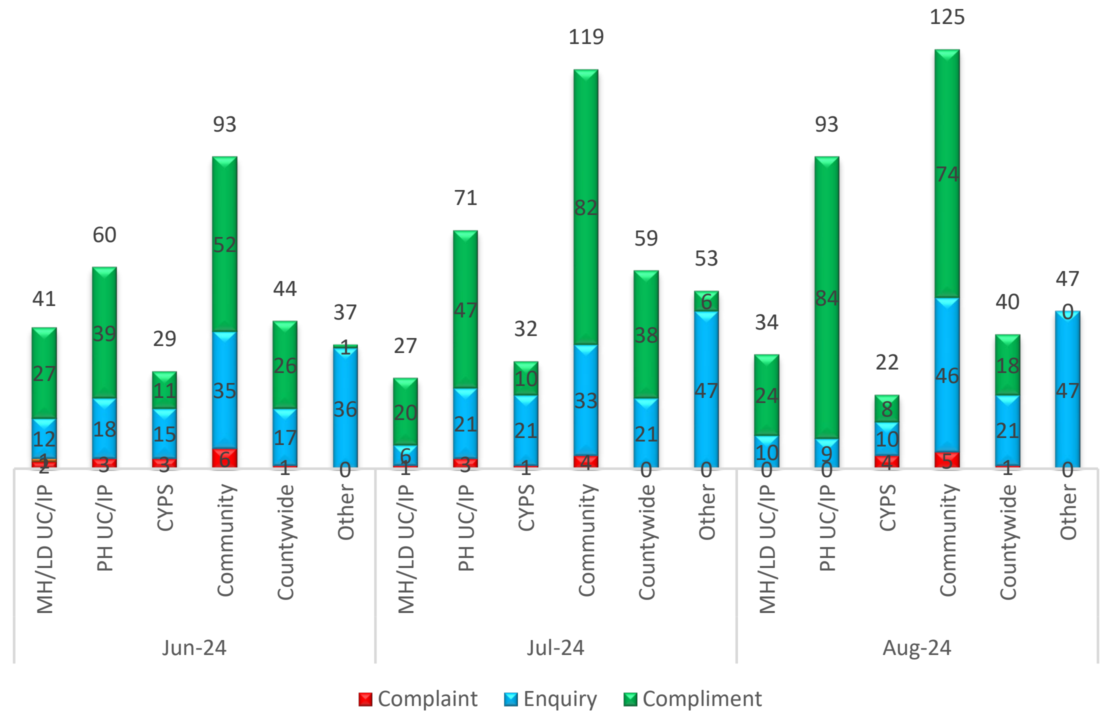
CQC DOMAIN - ARE SERVICES CARING? Patient and Carer Experience Team (PCET)

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 be 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	0	Early resolution:	**0**	10	24
		Closer look:	**0**		
PH urgent care and inpatient	0	Early resolution:	**0**	9	84
		Closer look:	**0**		
CYPS	4	Early resolution:	**4**	10	8
		Closer look:	**0**		
PH/MH/LD Community	5	Early resolution:	**5**	46	74
		Closer look:	**0**		
Countywide	1	Early resolution:	**1**	18	21
		Closer look:	**0**		
Other	0	Early resolution:	**0**	47	0
		Closer look:	**0**		
Totals	10	Early resolution:	**10**	140	211
		Closer look:	**0**		



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.

Quality Dashboard

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.

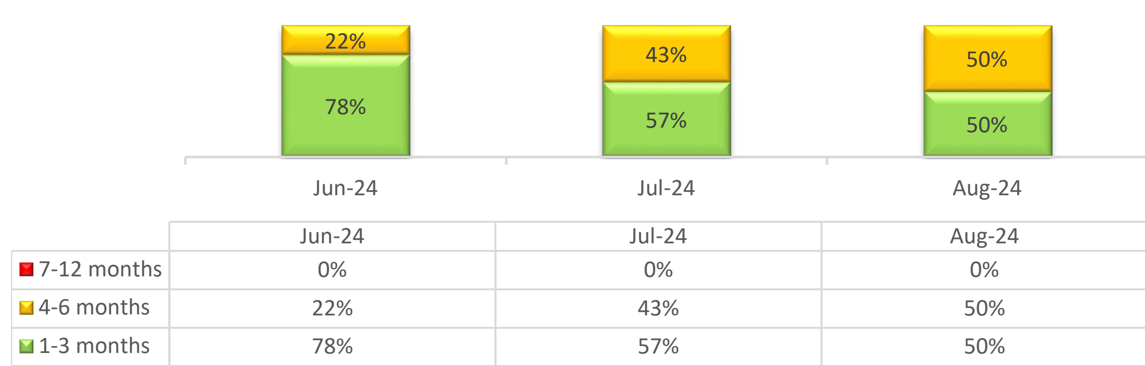
Directorate	Upheld	Partially upheld	Not upheld	Withdrawn	Other	Total
MH/LD urgent care, inpatient	0	1	1	0	0	2
PH urgent care, inpatient	0	1	0	0	0	1
CYPS	0	1	0	0	0	1
PH/MH/LD Community	0	0	5	0	0	5
Countywide	0	0	1	0	0	1
Other	0	0	0	0	0	0
Totals	**0**	**3**	**7**	**0**	**0**	**10**

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	Ensure clinicians give families a better understanding of why we ask them to complete Routine Outcome Measure Forms. **Communication** Conflicting information provided to parents regarding referral **Communication**
MH Uc/IP	Ensure referrals are completed in timely way and family updated. **Care/treatment** Reassurance regarding patient safety concerns not clearly communicated. **Communication**
PH UC/IP	Not made clear to patient that the ward cannot guarantee the cordless phone would be available at specific times. **Communication**

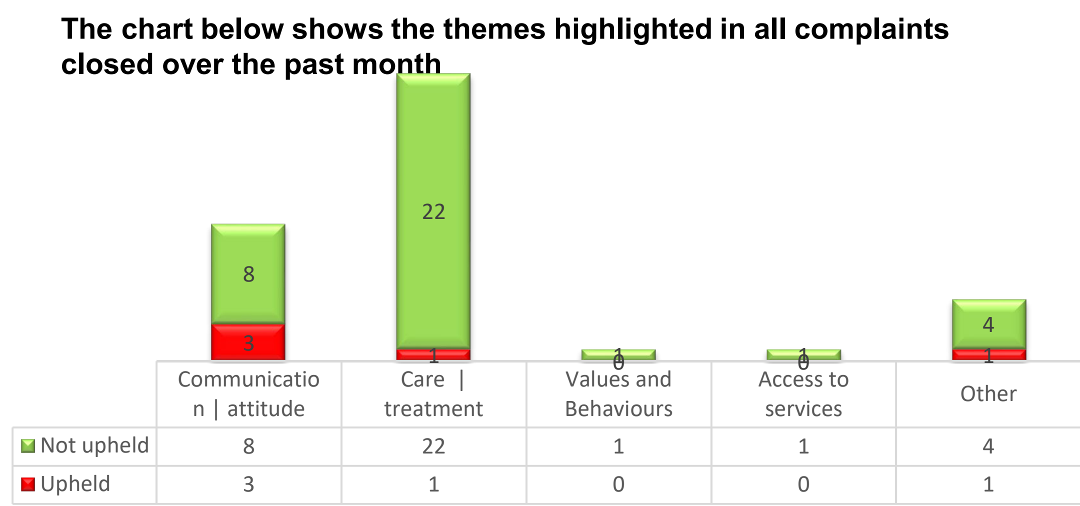
The below graph shows improvements in the length of time taken to close complaints.

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



	Jun-24	Jul-24	Aug-24
7-12 months	0%	0%	0%
4-6 months	22%	43%	50%
1-3 months	78%	57%	50%

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



	Communication | attitude	Care | treatment	Values and Behaviours	Access to services	Other
Not upheld	8	22	1	1	4
Upheld	3	1	0	0	1

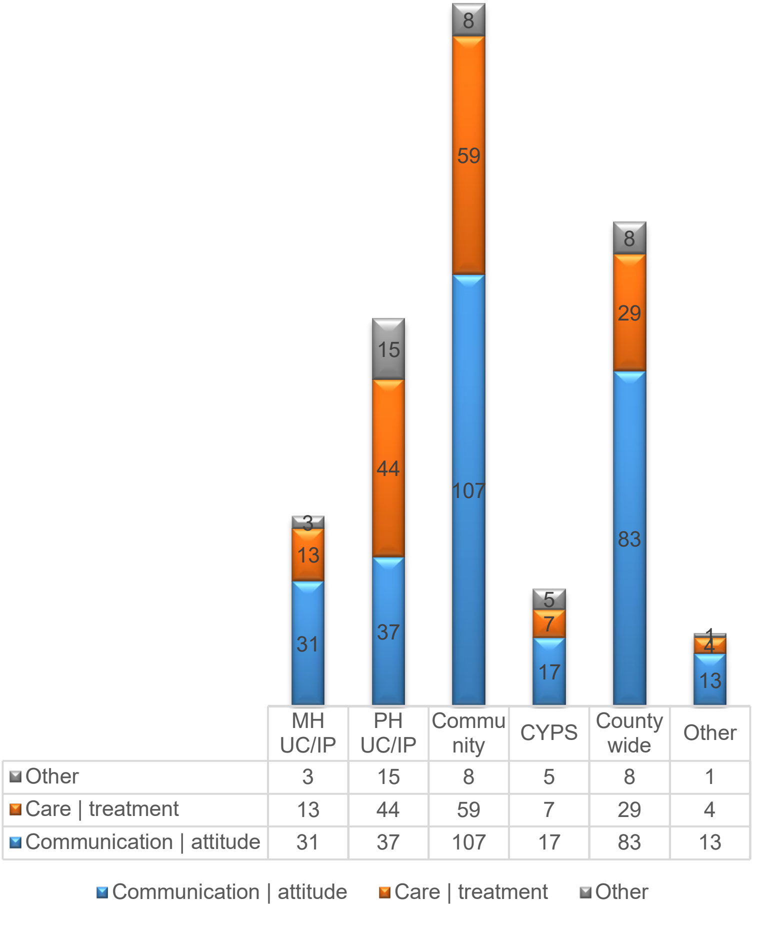
Quality Dashboard

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 203 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
23/07/2024	14941	ICT Chelt Management	Thank you kindly, we genuinely appreciate all of your hard work and support. You are amazing!
15/07/2024	14834	ICT Glos Inner City DN	Grateful thanks for the care and support given by the District Nurses during my husband's last days.
03/07/2024	14709	MHICT - South	Patient I have been working with since January 2024 advised on discharged that the treatment and support they have received has been the most beneficial they have ever had. Patient was hugely grateful for care, support and referral to LCP and acceptance for Guidepost therapy.
22/07/2024	14919	FAES (Falls Assessment & Ed Service)	'I'm getting so much help from everyone in the NHS, so I'm feeling very optimistic. The assessment today has been so thorough, and I have learnt a lot from you. Thank you for being so patient with me.'
18/07/2024	14916	FoD Hosp-Woodland View Ward	Thank you to all the staff for Mum's care. It's all been brilliant. Communication has been excellent.
09/07/2024	14787	Tewk Hosp-ARU	Thanks again for all the support, you have helped me so much to get where I am with my recovery.
26/07/2024	15001	Wotton Lawn-Abbey Ward	Letter detailing gratitude for care received during admission.
16/07/2024	14855	MSK Advanced Practitioner	The patient contacted to say the service exceeded their expectations and the staff were very kind and empathetic.
17/07/2024	14872	MH Admin Stroud & Cots	A client thanked his care co-ordinator for her support in helping him gain full custody of his son.



	MH UC/IP	PH UC/IP	Community	CYPS	County wide	Other
Other	3	15	8	5	8	1
Care | treatment	13	44	59	7	29	4
Communication | attitude	31	37	107	17	83	13

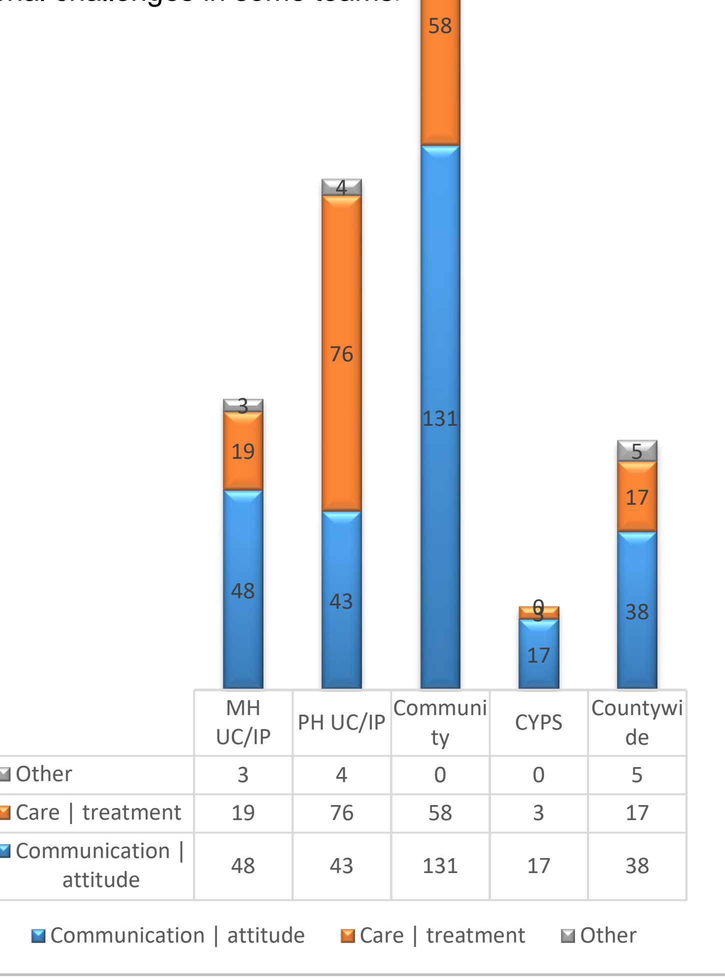
Quality Dashboard

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 203 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
14/08/2024	15288	ICT Forest Referral Centre	Grandson of patient rang in to thank the Referral Centre - particularly the triage team and call handlers the whole family are really grateful.
14/08/2024	15266	MHICT - South	Compliment received for the MHICT South nursing team -Initially wanting an ADHD referral doing research engaging in therapy and no longer requires an ADHD referral and after talking to me has more perspective on her own life.
16/08/2024	15429	Complex Care at Home Chelt	Daughter of patient rang to thank the whole team for everything that had been done for her father and they are really appreciative.
22/08/2024	15405	Ciren Hosp- Windrush Ward	Just to say a 'great big thank you' to all the team involved in dad's care. We really appreciate all of the support that you gave him. He is now settled into his new home at Millbrook Lodge in Brockworth and seems quite happy.
112/08/2024	15234	Rapid Response	Just wanted to say a very big thank you for the amazing care given to our mother last week. You were all fantastic, providing thorough care which kept her out of hospital and was extremely reassuring to us, and to mum. Communication was superb throughout.
29/08/2024	15458	MH Liaison Acute Hospitals	Email received from a parent sharing that they were grateful for each and every one of the professionals involved in their daughter's care. They described that our collective support and input for their daughter and them as a family over the past month has been gratefully received.
15/08/2024	15295	Podiatry	To all podiatry team at the Vale, many thanks for helping me for the last 22 months and finally I'm there. Many thanks it's been a long journey. Wish you all best in the work you do.
14/08/2024	15278	Homeless Healthcare Team	Patient expressed gratitude for our service and said she feels very safe with us and the best practice she has been registered with. Thanked us for our support and apologised for sometimes being mean.
20/08/2024	15325	Stroud - Jubilee Ward	Compliment for the staff at Stroud Hospital - my husband could not have been in better care all the staff were marvellous, nothing was too much trouble, always with a smile from them. The staff were always ready to talk to him



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

Aug-24	MH UC / IP	PH UC / IP	CYPS	Community	Countywide
No. of positive responses	7	1163	179	210	634
No. of negative responses	3	55	11	17	35
Postive score	70%	95%	94%	93%	95%

Patient feedback

Overall experience of our service | August 2024

95%

95% 'Very good' or 'Good'

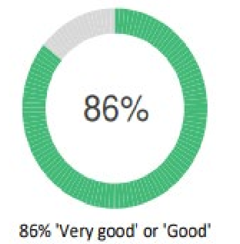
85% Very good (1969)
10% Good (224)
Neither good nor poor (51)
Poor (28)
Very poor (29)
Don't know (13)

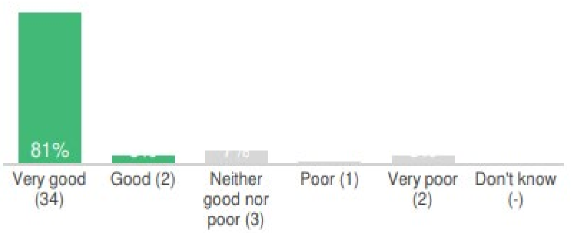
Highlights for this month:

- The overall positive experience rating is 95% which is the highest positive feedback received this year.
- 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.
- Feedback from the new FoD hospital – Positive rating of 75% from Inpatients (16 responses) and 98% for MIIU (82 responses).
- A pilot to share feedback through ‘You Said, We Did’ Boards is underway as part of the FFT QI project.
- Service users made 5 requests for contact/action through the FFT.

Carer feedback

Overall experience of our service | August 2024





CQC DOMAIN - ARE SERVICES EFFECTIVE? Community Hospital Delayed Patients

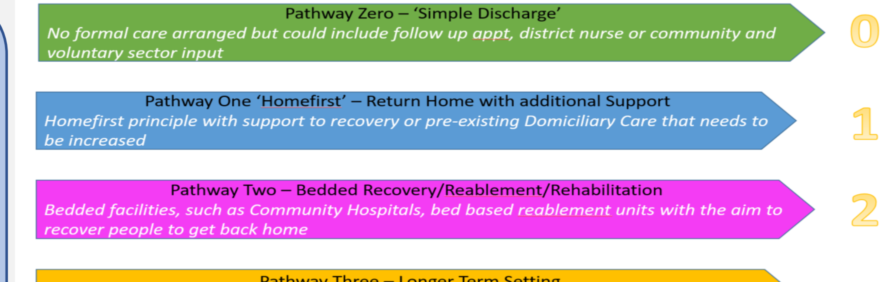
Long Length of Stay Patients – Community Hospitals

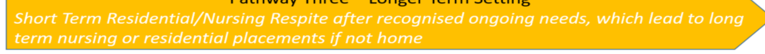
The information presents a summary of data relating to long length of stay in our Community Hospitals. The detrimental effect that a prolonged hospital admission has upon a patient is well evidenced. When a patient is deemed to ' *no longer meet the criteria to reside'* (nCTR), timely and effective discharge plans should be in place to enable a discharge.

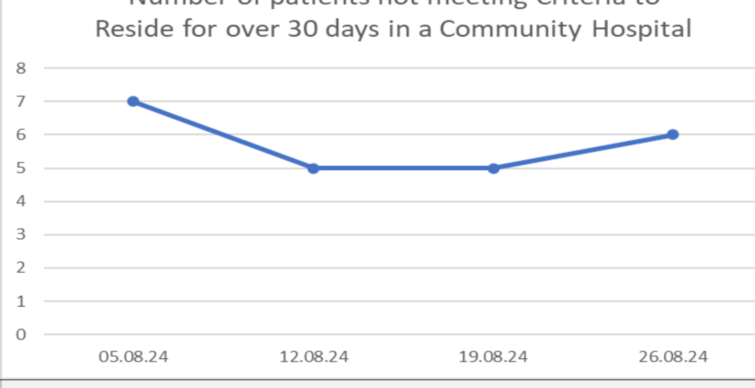
Headline Data - August 2024

- There has been an average of 41 patients that have Not Met the Criteria to Reside (nCTR) in a community hospital in August 2024
- There has been an average of 6 patients in total (nCTR) for over 30 days in August 2024

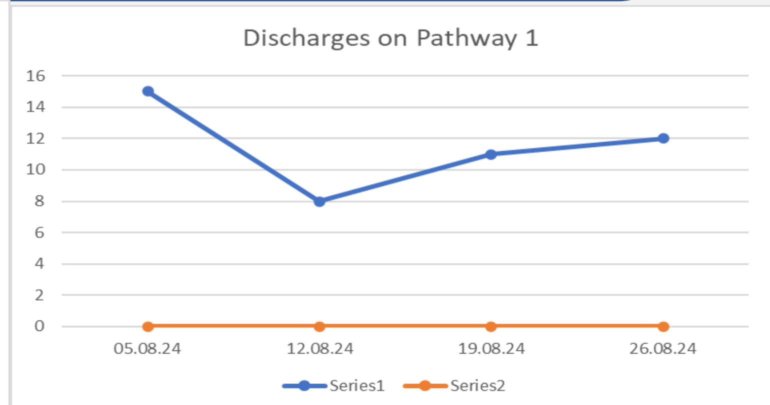
- Overall, the number of patients that have not met the Criteria to Reside in a Community Hospital, has increased further, and on average occupying 24% of the Community hospital bed base.
- There has also been a significant rise in the number of patients who have not met the Criteria to Reside >30 days, due to delays with housing and the sourcing of an out of County placement.
- There has been an increase in the number of patients that do not meet the criteria to reside, waiting self-funded placement. Delays have been due to lack of family engagement with sourcing, and the absence of the Community hospital discharge policy is further hindering this.
- Positively there has been a noted decline in the number of bed days lost due to housing since July.







Showing the number of patients that do not meet the Criteria to Reside for > 30 days. Date ranges week commencing 05/08/2024 – 26/08/2024.



Showing the number of patients **discharges** on Pathway 1 who did not meet the criteria to reside for > 30 days. Date range: week commencing 05/08//2024 – 26/08/2024. 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.

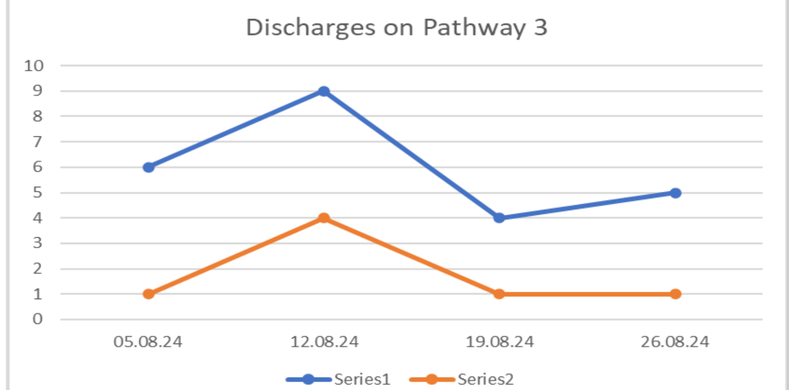


Chart 3 - Showing the number of patients delayed on Pathway 3 for over 30 days. Date range: week commencing 05/08//2024 – 26/08//2024. Pathway 3 is defined as discharge to a Care home, either funded by the individual or through Social Care funding.

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

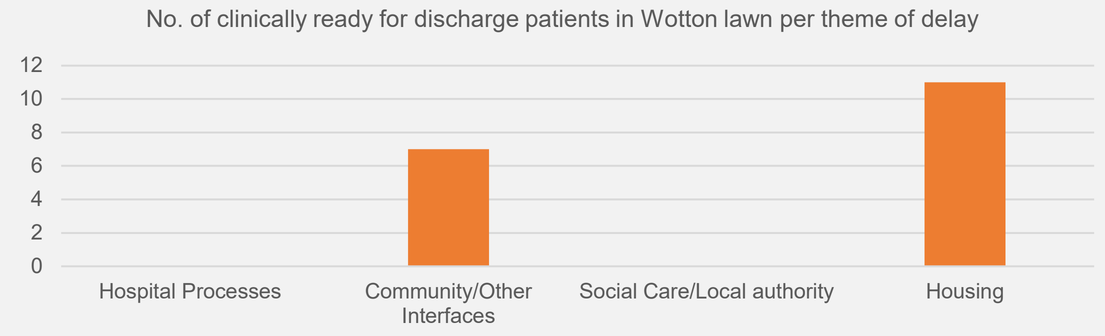
Long Length of Stay Patients- MH Hospitals.

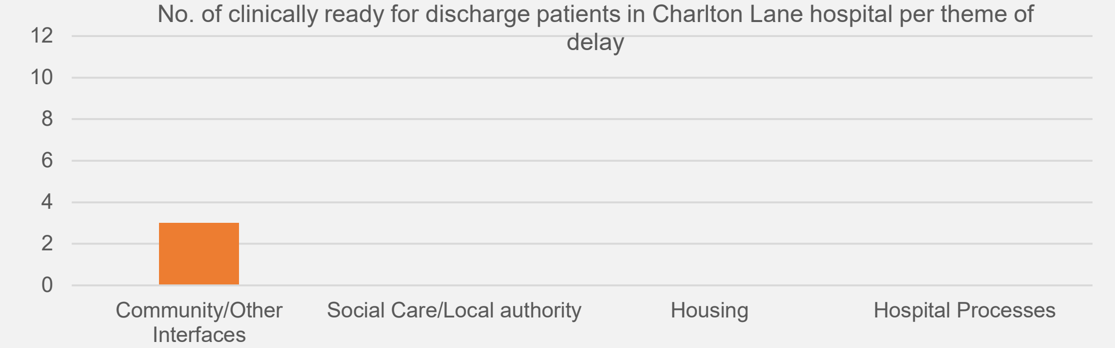
Clinically Ready for Discharge (CRfD), formally known as DTOC, is the new terminology for reporting delays in MH since January 2023. "Clinically Ready" does not indicate complete recovery, it is the point at which a person could be safely assessed, cared for and treated at home or in a less restrictive setting. Being (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 - August 2024: Total of patients across WLH, CLH, Recovery, LD = 23 WLH = 18 CLH = 3 Recovery Units = 2 Learning Disability = 0





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

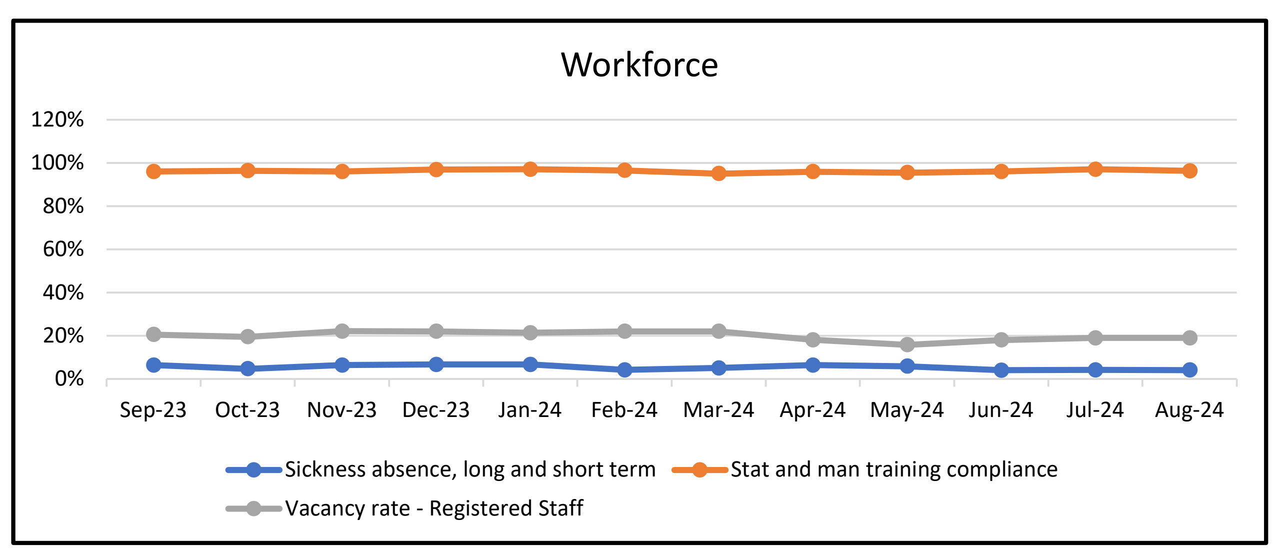
Themes related to delays:-
Hospital Processes – patient/family choice regarding care home placement
Community/Other Interfaces – awaiting care home placement (under care of hospital social work team)
Social Care/Local Authority – Awaiting care home through brokerage

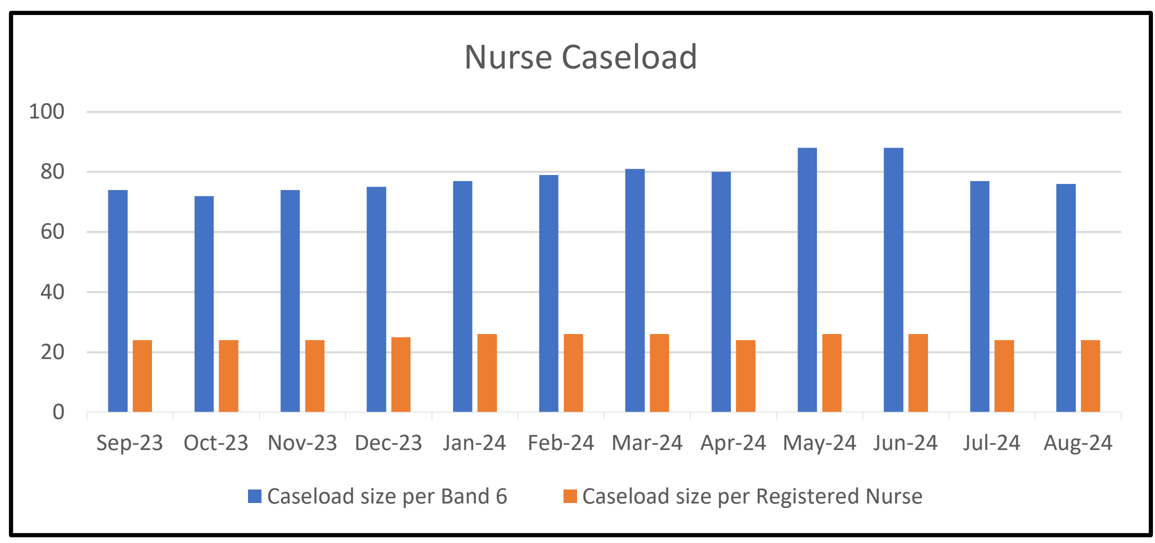
Themes related to delays:-
Community/Other Interfaces – awaiting public funding, await outcome of legal requirements e.g. awaiting mental capacity assessment

Themes related to delays:-
Lack of appropriate housing

Quality Dashboard

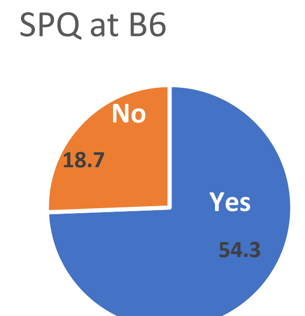
ICT Community Nursing Workforce - August 2024





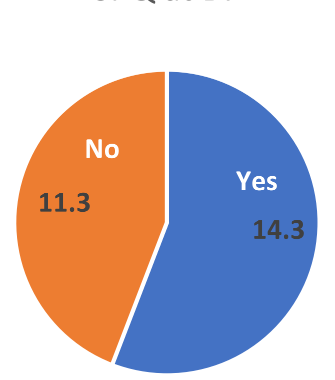
Sickness has remained at just above 4% for the past 3 months with vacancy levels static for the past 2 months, the % of rescheduled visits has increased to 2.3% (n=665)

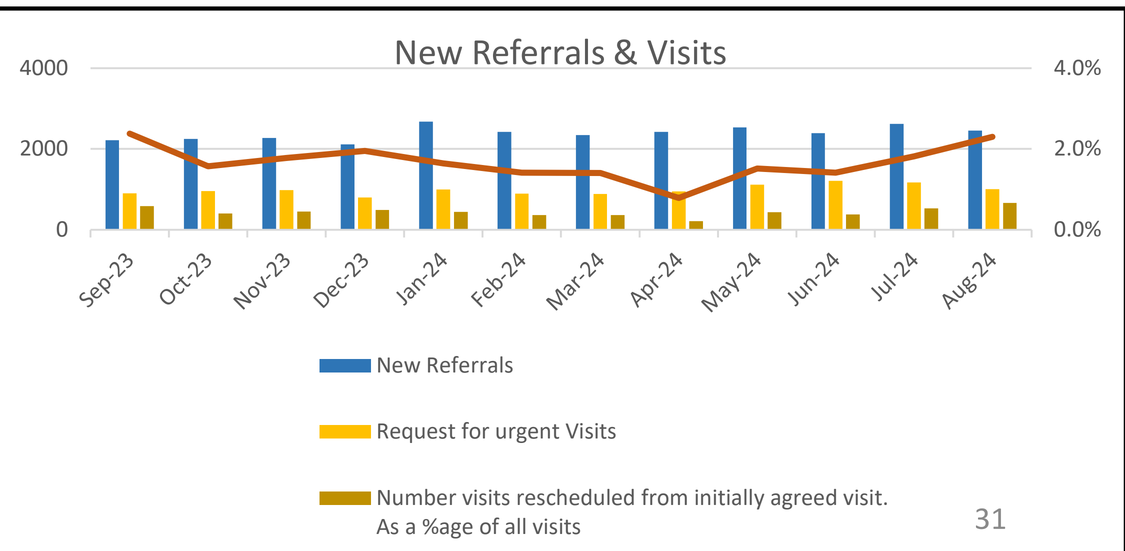
SPQ at B6



Community nursing leadership benefits from Specialist Practice District Nursing qualified colleagues at senior levels throughout the ICT localities.

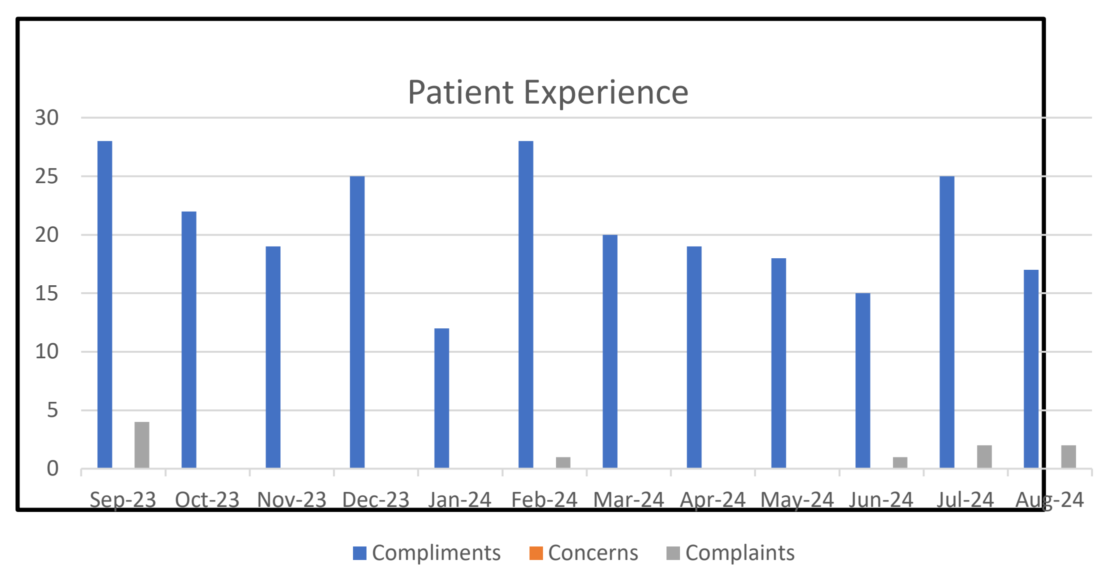
SPQ at B7

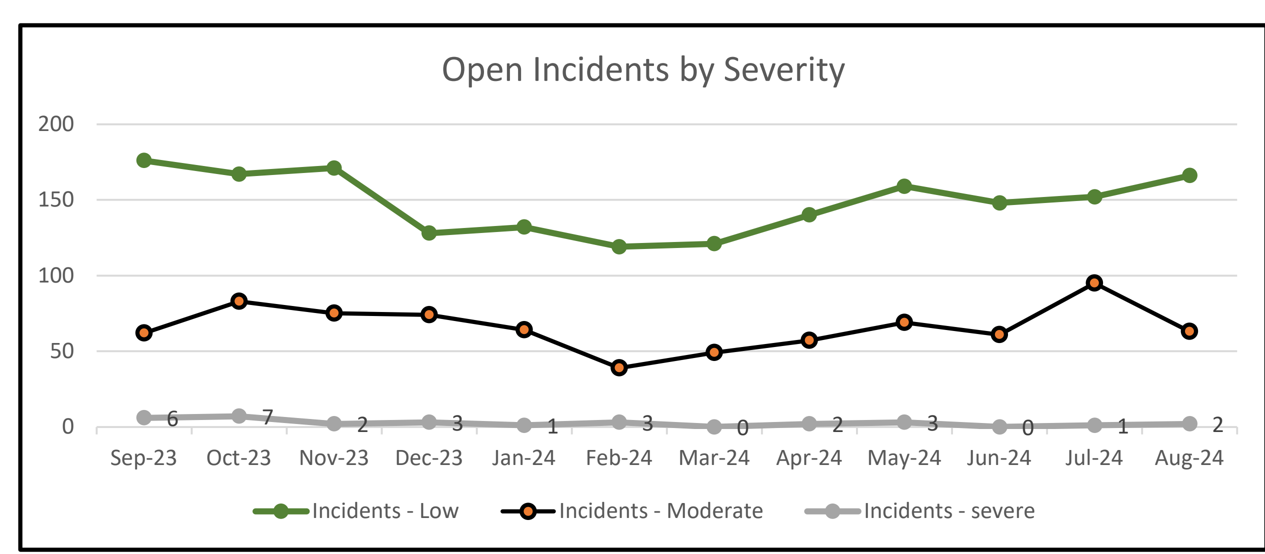


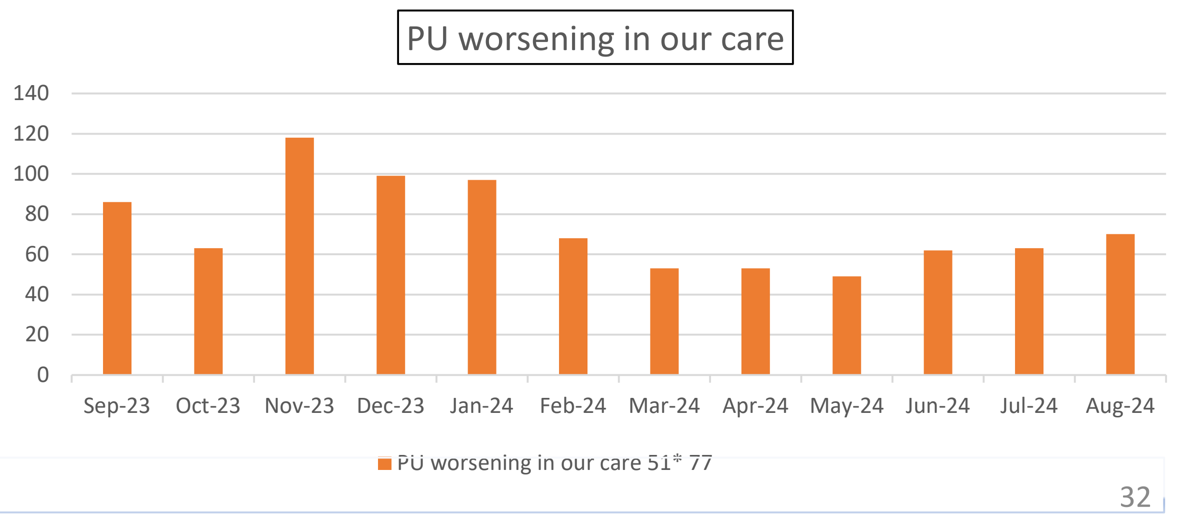


Quality Dashboard

ICT Community Nursing – August 2024







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

- =Supporting the testing and learning of acute care pathway in LD
- = Clinical System Team Model
- = Improving work related stress processes
- = Inappropriate use of fluid and balance charts
- =reducing violence and aggression and complaints in MIIU
- =Improving access for mothers from ethnic minority into perinatal service
- = (s) Gloves off - reducing PPE glove waste
- = (s) Streamlining triage process for adult SLT
- =Wrong site dental extractions
- +(s) Local and national AAC pathways for children who may benefit from AAC
- =The Vale Stroke Unit
- =(s) Guidance on treatment of hyponatraemia and hypernatremia in the community
- + People Promise - Learning from Leavers
- + Culture of 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

- +(s) Sexual health triage capacity and improving patient access
- ↑ Team nursing on Abbey Ward, WLH
- = Improve giving and recording of snacks for CoHo patients
- = (s) Homeward Assessment Team and ICT pathway
- = Improving health inequalities in school age immunisation
- = Paired ROMs compliance – Outreach Team
- = Paired ROMs compliance – Vulnerable Children's Team
- = Paired ROMs compliance – Young Adults team
- = Paired ROMs compliance –CORE CAMHs South
- = Paired ROMs compliance –CORE CAMHs North
- ↑ Transition from CAMHS to adult MH services

3. Improvement idea initiated

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

- ↑ Sustainability and consumables in dental services
- + MHA QIP
- ↑ On Call medical staffing review at Charlton Lane Hospital
- = 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
- = CYPS Public Health Liaison Nursing
- = Staff retention - itchy feet
- = Improving the number of patients receiving their depots in primary care
- = Weight management in SMI project
- = IPS project

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

- = Diabetes Service demand and capacity
- = Dental Services – medical history form
- = Improving Working Environment in Stroud Recovery Team
- = Increasing percentage of successful home visits in Home O2 Service
- =Improving self-referral form for MSK physiotherapy
- = (s) Creating a sustainable placement offer for AHP Students in GHC
- = (s) Improving mouthcare standards in inpatient areas
- = Single handed personalised care approach
- = Substance misuse in CAMHS
- = 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
- = DBT outcomes
- = QUITT

5. Improvement idea sustained & implemented

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

- ↑ School nursing duty system
- ↑ Sexual health specimen mis-labelling
- = Improving mouthcare standards in inpatient areas – Honeybourne
- = Improving mouthcare standards in inpatient areas – Willow Ward Charlton Lane Hospital

Training data August 2024:
34 Silver – 0.7% workforce
628 Bronze (current trained taken from Care to Learn) - 13% workforce
939 Pocket QI, total trained overtime – 20% workforce

Directorate	No of Projects
Countywide	9
MH Hospitals and UC	11
PH Hospitals and UC	5
Adult MH/PH/LD Community	12
CYPs	17
Corporate	7
Total: 61	

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AGENDA ITEM: 14/0924

REPORT TO: **TRUST BOARD PUBLIC SESSION – 26 September 2024**

PRESENTED BY: Dr Amjad Uppal, Medical Director

AUTHOR: Dr Emma Abbey, Chair of Medical Appraisal Committee

SUBJECT: **MEDICAL APPRAISAL ANNUAL REPORT**

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:

The Medical Appraisal and Revalidation Report provides a summary of the work that has been undertaken within the Trust to support the safe provision of clinical services by medical practitioners with a connection to this designated body.

It provides assurance as to the application of national policy with regard to the regulation and revalidation of medical practitioners and insight into the processes and resources that are required to undertake this work.

Recommendations and decisions required:

1) That the Trust Board accept and endorse the Medical Appraisal Annual Report and:

- Recognise that levels have been maintained in the application of appraisal, recording and quality assurance and that this has occurred without significant additional funding.
- Recognise that the figures for engagement in appraisal reflect a snapshot at one point in the year and that the Trust will continue to achieve appraisal consistent with the provision of safe medical services on an annual basis supported by the revalidation statistics provided.
- Recognise that there are a number of exceptions/reasons for non-compliance that contribute to a compliance point of less than 100%.
- Recognise that effective appraisal has supported timely and appropriate revalidation for all doctors to date.
- Recognise that good employment practice with regard to recruitment is supporting safe practice.
- Recognise that locum use remains necessary for the safe provision of clinical services but that this is monitored appropriately.

- To note in particular the assurance for NHS England that the Trust meets requirements

2) The Board is asked to note that the covering paper, annual report and Statement of Compliance have been presented to and endorsed by the Quality Committee on 5th September 2024 for onward Board approval.

3) That the Board agrees the submission of the Statement of Compliance to NHS England, as endorsed by the Quality Committee and that this is signed by the Chair on behalf of the Trust (see Reading Room).

Executive summary

- Medical Appraisal has continued to be instituted within Gloucestershire Health and Care NHSFT aligned with national policy.
- The Medical Appraisal Committee has instituted a work plan that will further deliver assurance annually and sustain quality.
- Headline figures demonstrate that of the 105 doctors requiring appraisal during the 2023-24 appraisal year 83 (79%) were compliant as of 1st April 2024 (this is slightly lower than the previous year). Of the 22 doctors who were non-compliant; 13 (12.4%) had acceptable reasons (3 being new starters; 6 on long term sickness; 1 on maternity leave and 3 having an agreed extension). The 9 (8.6%) without a reason were overdue by two months or less.
- Doctors' revalidation was effectively managed with no non-engagement referrals.
- Recruitment processes provide appropriate safety and quality checks aligned with national policy and best practice.
- Use of locum practitioners is being monitored and is necessary to sustain service commitments and activity appropriately.
- The MAC membership includes a range of subspecialties, including non-psychiatry, and consultant, specialist and SAS level doctors. Ivars Reynolds, a long-established MH Act Manager has provided lay oversight for the work of the Committee since 2019 but unfortunately will be stepping down at the end of 2024.
- This report does not include Dental staff as they are not subject to these GMC regulations.

Risks associated with meeting the Trust's values

There are significant risks both to quality, safety and reputation of failure to implement revalidation and annual appraisal effectively.

Corporate considerations	
Quality Implications	Appraisal contributes to patient safety.
Resource Implications	Continuing use of administrative and managerial time with clinician input to revalidation process.
Equality Implications	The annual appraisal monitoring process addresses equalities issues.

Gloucestershire Health and Care
NHS Foundation Trust

Where in the Trust has this been discussed before?
Medical Appraisal Committee, 3rd May 2024 Quality Assurance Group, 16th August 2024 Quality Committee, 5th September 2024

Explanation of acronyms used:	SARD – Strengthened Appraisal & Revalidation Database MAC – Medical Appraisal Committee

Report authorised by: Dr Amjad Uppal	**Title:** Medical Director

AGENDA ITEM: 14.1/0924

Annual Medical Appraisal Board Report

Appraisal year:	1st April 2023 – 31st March 2024
Author:	Dr Emma Abbey *On behalf of Medical Appraisal Committee*
Prepared for:	Trust Board via Trust Quality Committee and Quality Assurance Group

1. Executive summary

Of the 105 doctors requiring appraisal during the 2023-24 appraisal year, 83 (79%) were compliant as of 1st April 2024; this is down on the previous year (86% at end of Q4 2023).–This includes 9 that are not under our designated body.

In addition, there are another 79 doctors who are employed by GHC in a sessional or bank capacity but not under our designated body.

When the Medical Appraisal Committee (MAC) was set up in 2013 the focus was on developing and implementing the basics required to ensure doctors engaged in and completed a standardised medical appraisal. Since then the MAC have focussed on improving the quality of medical appraisals undertaken in the organisation.

Each year a quality assurance audit of appraisal outputs is conducted; to date this has demonstrated sustained improvement in quality, providing significant validation and assurance to the Trust Board through the Quality Committee and the Quality Assurance Group that the organisation is fulfilling its statutory obligations. The most recent verification visit by NHS England was in June 2019, with future visits expected on a 5-year cycle.

2. Purpose of the paper

The purpose of this paper is to report on the state of medical appraisal and revalidation to the Trust Board through the Quality Committee and the Quality Assurance Group over the preceding appraisal year. It is also to report on progress made towards further developing and refining systems and procedures to support medical appraisal and to improve the quality of medical appraisals taking place in the organisation. In addressing these two issues the paper provides assurance to the Trust regarding both the quality of the medical workforce and its sustainability.

3. Background

Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system. The strengthened annual appraisal process is the primary supporting mechanism by which revalidation recommendations are made to the General Medical Council (GMC) for the re-licensing of doctors.

All non-training grade doctors in an organisation relate to a senior doctor, the Responsible Officer (usually the Medical Director). Completion of satisfactory annual appraisals over a five-year period is a crucial factor in enabling the Responsible Officer (RO) to make a positive affirmation of fitness to practice to the GMC for revalidation.

4. Governance arrangements

The Trust Medical Appraisal Committee (MAC) was set up in 2013. The aim and objectives of the committee are; to oversee the process of appraisal of all licensed doctors employed within the Trust; to maintain robust systems for the recruitment, training, support and performance review of all medical appraisers within the organisation; and to review and quality assure the standard of appraisals conducted within the Trust.

The MAC comprises of the Medical Director/Responsible Officer, Revalidation Officer, a separate chair, the Director of Medical Education, at least 2 consultant representatives/lead appraisers (selected to represent the geographical and sub-specialty spread of consultants within the Trust) and at least 1 SAS doctor representative, and a lay representative.

The MAC convenes quarterly; this includes a year-end half-day to review the results of the quality assurance audit and to scrutinise the end of year appraisal compliance figures. The committee reviews the annual work plan and the progress made against the Terms of Reference developed at inception of the committee.

Key outputs from the MAC during the last year include:

- Review of the current terms of reference for the MAC
- Review of the membership of the MAC
- Completion of the annual quality assurance audit. The April 2024 audit covered all appraisals completed from 1st April 2023 to 31st March 2024
- Continued review of the currently active medical appraisers list
- Performance review of newly qualified medical appraisers
- Ensuring the continuation of high-quality appraisals

Alongside these new and ongoing developments, the MAC continues to regularly monitor appraisal compliance rates and engagement in the process; provide approved baseline and refresher training for medical appraisers (provision is determined by current need); monitor training compliance and output of approved appraisers; enforce required minimum and maximum numbers of completed appraisals conducted by each approved appraiser within a 2-year cycle; and regularly review appraisee feedback.

The Strengthened Appraisal and Revalidation Database (SARD JV) was introduced in 2013 and training made available for all users. All appraisals and job plans are completed and documented in this software package. Use of SARD JV contributes significantly to the ease and transparency of compliance monitoring, and hence maintaining the overall high compliance rates seen since its introduction.

Administrative support for the MAC, and for the use of SARD JV, is provided by the Medical Director's office. Additional technical support is also provided by SARD JV staff. All doctors requiring appraisal are sent email reminders 3 months and 6 weeks before their appraisal due dates. Weekly emails and correspondence are then undertaken from the due date onwards. If a doctor becomes non-compliant the Medical Director sends a firm reminder. If the doctor remains non-compliant after 1 month and no appraisal meeting date has been set, a face to face meeting with the Medical Director is arranged. A process for escalation to the GMC if non-engagement continues is also in place.

Priorities for the MAC for the next year include further refinement of the number and nature of active qualified medical appraisers within the organisation and further consideration of ways to improve patient and public involvement in appraisal and revalidation processes. The committee have sourced an easy read patient feedback form for 360-degree feedback as clinicians from certain sub-

specialities had previously identified this as being a barrier to collecting patient feedback.

5. Medical appraisal

5.1. Appraisal and revalidation performance data

Of the 105 doctors requiring appraisal during the 2023-24 appraisal year 83 (79%) were compliant as of 1st April 2024; this is down on the previous year (81.1% at end of Q4 2023).

In 2018-19 the ‘appraisal year’ was introduced (1 April to 31 March). This aims to prevent slippage of appraisal date, and expects that each appraisee will have one completed appraisal per appraisal year unless authorised by the RO.

Of the 22 doctors who were non-compliant; 13 (12.4%) had acceptable reasons (3 being new starters; 6 on long term sickness; 1 on a maternity leave and 3 having an agreed extension for other reasons). The 9 (8.6%) without a reason were overdue by two months or less.

The SARD JV system for monitoring compliance does not allow for any flexibility around the appraisal due date. Once the due date has passed (even by a day) the appraisee is deemed non-compliant. This is at odds with the Trust policy which allows for one month before or after the due date for completion of appraisal. Compliance rates are therefore unlikely to regularly reach 100% and will fluctuate monthly throughout the appraisal year.

To account for this, and given that at any time there will be a small number of doctors currently non-compliant with a reason, the MAC agreed in 2018 that overall compliance rates maintained above 75% should provide adequate assurance of engagement in the process and completion of medical appraisals within the medical workforce.

For further details see **Appendix A**.

5.2. Appraisers

There are currently 19 trained medical appraisers within the establishment of non-training grade doctors. All consultants and SAS doctors continue to be offered access to training in order to both provide a cohort of appraisers and increase awareness and knowledge of appraisal for appraisers and appraisees alike.

The MAC have set minimum numbers of completed appraisals required in a 2-year period by an appraiser. These standards were introduced in 2014 and enforced in 2016; 8 appraisers were then removed from the active list, and this review of activity has continued annually. Appraisers who consistently do small numbers are asked whether they wish to continue in this role.

The MAC have developed a formal recruitment process and set minimum baseline and refresher training requirements. The MAC continue to encourage SAS doctors to become trained and practising appraisers.

Not all appraisals undertaken by appraisers are captured by SARD JV or relate to doctors with whom GHC has a prescribed connection. Some appraisals are undertaken for colleagues working outside GHC, in retirement or within other roles such as the Deanery.

5.3. Quality assurance

In July 2015 the Trust was visited and scrutinised by the NHS England Independent Verification Review Team; whose purpose is to assess and validate

the status of appraisal and revalidation systems within all designated bodies. The process is designed to provide independent assurance to Trust Boards that the organisation is fulfilling its statutory obligations in respect of the RO's statutory responsibilities. A comparator report is received each year from NHS England, which allows the Trust to benchmark itself against other Trusts. As GHC is small compared to other Trusts, a small number of doctors can make a significant difference to percentages quoted.

Overall the Trust was highly commended and scored at least 5 out of 6 (equating to 'Excellence') in all core standards; scoring highest for 'Engagement & Enthusiasm'. No required actions were recommended by the scrutiny panel, and few suggestions made for improvement, mainly concerning HR procedures (since enacted). Many areas of good practice were noted including the overriding focus on quality of medical appraisals, use of SARD JV as a tool to support quality and compliance, automatic inclusion of complaints and serious incidents within individual appraisal portfolios, and the processes to support learning and quality improvement which result from the annual quality assurance audit. An Independent Verification Visit by NHS England took place in June 2019 and found no further actions required.

As RO/Deputy RO the Medical Director and/or Deputy Medical Director is required to individually review all completed appraisals for both completion and quality. The MAC has developed additional assurance processes to support this, as below:

5.3.1. Support for appraisers

Alongside ensuring robust recruitment and training processes for medical appraisers, regular support and review of the role takes place within annual appraiser support forums, existing consultant CPD peer groups, as part of appraisers' own appraisals and via informal support offered by members of the MAC itself.

5.3.2. Feedback from appraisees

Appraisee feedback forms are automatically generated by SARD JV and sent to appraisees after all completed appraisals. Return rates are high. Completed returns are screened by the Medical Director's office and reviewed quarterly by the MAC. Any concerning feedback is followed up individually by the MAC chair in order to address potential problems in a timely manner. Collated (anonymised) feedback covering the entire appraisal year is circulated to all appraisers, and individualised (anonymised) feedback to appraisers. Summarised feedback has previously been benchmarked against feedback collated from other similar organisations (and considered comparable).

5.3.3. Automatic uploading of complaints and anonymised SI reports

The Medical Director's office automatically populates individual doctor's SARD JV portfolios with anonymised complaints and anonymised serious incident reports. The expectation is that these will then be referred to and reflected on as part of the appraisal process.

5.3.4. Annual quality assurance audit

The annual medical appraisal quality assurance audit was conducted in May 2024 by all members of the MAC, using a nationally recognised medical appraisal QA tool (the Excellence Tool).

8 (10% of all) completed appraisal summaries were randomly selected for audit for completeness and quality; 2 appraisals done by a new appraiser were also audited. Consent was sought from individual appraisees; none declined. 10 appraisals were audited in total. Results were reviewed and an action plan developed, including:

- Preparation of a comprehensive audit report
- Dissemination of key learning points to all appraisers and appraisees and
- Individualised feedback provided to appraisers

The results demonstrated maintenance of quality of appraisal outputs. This year the average score from the Excellence Tool was slightly lower compared to last year (average score 19/22 compared to 20/22) but this nevertheless indicates a sustained high standard of appraisal documentation. The dip in 2022-23 and 2023-24 is partially accounted for by the inclusion of whether form A has been uploaded to SARD and discussed at appraisal. Form A is a summary of the appraisee's job plan and is recommended by NHSE to be used in appraisal. Its use is now increasing by appraisees and appraisers.

SARD JV has informed the MAC of its intention to develop its own audit tool, based on the ASPAT, which will be able to automate a lot of the data gathering currently done by this audit. The committee will consider this once it is available, a previous trial of the ASPAT tool in 2019 found that the Excellence Tool still provided better scrutiny of appraisal than ASPAT.

The audit will be repeated annually.

Please refer to **Appendix B.**

5.4. Access, security and confidentiality

Appraisees are advised to only upload anonymised documents to their appraisal portfolios so that no patient identifiable information is included. The Medical Director's office has administrative access to SARD JV portfolios in order to support appraisees and upload information with the agreement and knowledge of appraisees.

5.5. Lay participation in medical appraisal

Ivars Reynolds, an experienced member of the Mental Health Managers Review Panels serves as a lay member of the MAC. His background is in social work and performance management. Ivars has announced his intention to retire from this role following the October meeting, and the recruitment process for a new lay representative has already started.

5.6. Clinical governance

The Medical Director's office automatically populates individual doctor's SARD JV portfolios with anonymised complaints and anonymised serious incident reports. The expectation is that these will be readily available to both appraiser and appraisee so that they can be discussed and reflected on in the course of the pre-appraisal preparation and appraisal meeting.

The MAC has set an expectation of 2 completed multi-source feedback (MSF) exercises within each 5-year revalidation cycle. This is greater than the national minimum standard (one completed cycle per 5 years) but provides opportunity to gain more frequent and appropriate feedback allowing the identification, addressing and review of any issues highlighted. Provided the national standard is achieved and there is appropriate consideration in appraisal of one MSF this

does not prevent recommendation for revalidation being made. NHS England has a position statement on when to repeat MSF exercises following a change of role which the Trust adheres to.

6. Revalidation recommendations

During the last year 17 revalidation recommendations were due; positive recommendations were made for 14 of these (82.5%), and 2 were deferred (11.5%). 1 left before their revalidation was due (6%).

Deferrals are typically recommended either due to long term sickness or to provide additional time in order to gather further evidence required; such as statutory and mandatory training compliance or completion of a multi-source feedback exercise.

See **Appendix C** for further details.

7. Recruitment and engagement background checks

Recruitment and engagement checks are completed when doctors are first employed at Gloucestershire Health and Care NHS Foundation Trust; they are in line with the Trust's Pre-Employment Checks Policy. All pre-employment checks for substantive doctors are completed before employment is started. These checks include:

- Occupational health clearance, including any night working
- Identity verification
- Qualifications
- Right to work
- Disclosure and Barring Service (DBS) enhanced level checks
- References from two line-managers over the last two years
- Medical Practice Transfer Form (information from previous Medical Director)

Please see **Appendix E.**

8. Monitoring performance

The performance of doctors is monitored through the combination of perspectives provided by the following source materials and processes:

- Initial design of job description and person specification
- Effective recruitment and selection processes
- Job planning
- Peer group membership and attendance
- Appraisal
- Monitoring of serious incidents, complaints and compliments
- Participation in supervision
- Activity data
- Participation in continuing professional development (CPD)
- Completion of statutory and mandatory training
- Diary monitoring exercises
- Attendance/sickness absence

These perspectives are available through a combination of routine reports and intermittent reviews reporting to the RO, Clinical Directors, clinicians and managers. Most also constitute areas that are considered as part of the appraisal process.

Please refer to **Appendix D**.

9. Responding to concerns and remediation

The policy on the 'Management and Remediation for Concerns about the Professional Conduct and Clinical Performance of Medical Practitioners' provides a framework that interprets national policy and best practice for local delivery.

No doctors are currently in receipt of input within the framework provided by this policy.

Please refer to **Appendix D**.

10. Risk and issues

Overall engagement in and compliance with appraisal has remained high throughout the last appraisal year. This is largely due to the improved engagement of doctors achieved over recent years and also to the ongoing work of the Medical Director's team in monitoring compliance and providing prompting and support. This has been possible due to the universal use of the SARD JV software.

However, the sensitivity of the monitoring system, which allows no latitude in completion date before a doctor is flagged as non-compliant, combined with the limited range of exceptions, mean that rolling compliance rates vary from month to month without appraisal uptake having altered markedly. Exceptions this year are again accounted for mostly by new starters.

There is a significant time and therefore cost associated with both completion of appraisals as an appraisee (estimate 16-36 data collection hours per annum) and appraiser (4-6 hours per appraisal). This does not take account of the activity associated with populating appraisal documentation or undertaking multi-source feedback, audits, peer groups, supervision and training. This impacts on the availability of retired doctors to undertake locum and part time work and will create a particular pressure in Mental Health service provision in the future.

Recruits from outside the UK have not taken part in this process and thus for the first year of any practice have not undertaken appraisal whilst they are collecting data. This is a nationally recognised issue and one further expanded on in the Pearson review.

The scope of work that a doctor can undertake is determined by and determines their CPD and continuing medical education (CME) requirements. This does limit practitioner flexibility and cover to specialist areas, a particular issue in relation to on-call rotas and 7 day working.

11. Corrective actions, improvement plan and next steps

The MAC will continue to review its work plan against the terms of reference annually. The Trust Medical Appraisal Policy was reviewed during the appraisal year 21-22. Priorities for the MAC for the next year include ongoing consideration of ways to improve patient and public involvement in appraisal and revalidation processes; further refinement of the number and nature of active qualified medical appraisers within the organisation; and continuing focus on moving beyond compliance towards further quality improvement.

The MAC will investigate individual cases where appraisal is not completed (without reason) within a reasonable time frame. Subsequent investigation reports will be submitted to the Medical Director/Responsible Officer who will decide on further action. Doctors who have not completed annual appraisal are not eligible for routine pay progression or local clinical excellence awards; Gloucestershire Health and Care NHS Foundation Trust has the right to terminate the contract of a doctor if they do not undergo annual appraisal without having good reason.

Workforce planning will need to take account of the possible limitations to the scope of practice and perhaps the limited workforce that may be available due to retirement.

12. Recommendations

The Trust Board is asked to accept the Annual Report on Medical Revalidation and Appraisal and:

- Recognise the support provided to Appraisal and Revalidation within GHC through the use of SARD JV and the engagement of clinicians in this.
- Recognise the work undertaken and planned by the Medical Appraisal Committee to support the work of the Medical Secretariat and Responsible Officer in providing, maintaining and developing sustainable recording, reporting and assurance systems.
- Recognise that snapshot compliance figures do not reflect annual uptake of appraisal but are primarily a function of the way data is collected. In any year the expected outturn is for 100% of doctors with a prescribed connection to this designated body to be appraised; however, there will be exceptions which will reduce the overall figure.
- Appropriate processes are in place for the review of appraisals, appraiser performance, maintenance of appraisal capacity and the quality of appraisals.
- Employment checks are undertaken consistent with national standards and best practice.
- Locum use, whilst significant, is reviewed and regulated, aimed at maintaining clinical provision to cover mostly medium to long term absence.
- Approve that the Chair of the Trust completes the NHSE Statement of Compliance on behalf of the Trust.

Appendix A - Audit of all missed or incomplete appraisals (as of 1st April 2024)

Doctor factors (total)	
Maternity leave during the majority of the ‘appraisal due window’	1
Sickness absence during the majority of the ‘appraisal due window’	6
Prolonged leave during the majority of the ‘appraisal due window’	1
Suspension during the majority of the ‘appraisal due window’	0
New starter within 3 month of appraisal due date	3
New starter more than 3 months from appraisal due date	0
Postponed due to incomplete portfolio/insufficient supporting information	**0**
Appraisal outputs not signed off by doctor within 28 days	0
Lack of time of doctor	1
Lack of engagement of doctor	0
Other doctor factors	1
Appraiser factors	
Unplanned absence of appraiser	
Appraisal outputs not signed off by appraiser within 28 days	
Lack of time of appraiser	
Other appraiser factors (not known)	
Organisational factors	
Administration or management factors	
Failure of electronic information systems	
Insufficient numbers of trained appraisers	
Other organisational factors (describe) Waiting for appraisal to be undertaken by different designated body and evidence provided.	
Total	
NB. Dentists employed by the Trust are currently subject to different monitoring arrangements and not included in the figures on this page.	

Appendix B - Quality assurance audit of appraisal outputs using the Excellence Tool

		Frequency (% in brackets)		
Number	**Criterion** (following scrutiny of the appraisal summary, score 0-2 for each criteria)	absent	room for improvement	well done
1	Includes whole scope of work?	0	3 (30%)	7 (70%)
2	Free from bias?	0	0	10 (100%)
3	Challenging & supportive?	0	1 (10%)	9 (90%)
4	Exceptions explained?	0	0	10 (100%)
5	Reviews & reflects?	0	0	10 (100%)
6	Review of previous PDP?	1 (10%)	0	9 (90%)
7	Encourages excellence?	0	0	10 (100%)
8	Gaps identified?	0	0	10 (100%)
9	SMART PDP?	0	0	10 (100%)
10	Relevant PDP?	0	0	10 (100%)
11	Form A	8 (80%)	0	2 (20%)

Appendix C - Audit of revalidation recommendations

Revalidation recommendations between 1st April 2023 to 31st March 2024	
Recommendations completed on time (within the GMC recommendation window)	16
Late recommendations (completed, but after the GMC recommendation window closed)	0
Missed recommendations (not completed)	0
TOTAL	
Primary reason for all late/missed recommendations For any late or missed recommendations only one primary reason must be identified	n/a
No responsible officer in post	
New starter/new prescribed connection established within 2 weeks of revalidation due date	
New starter/new prescribed connection established more than 2 weeks from revalidation due date	
Unaware the doctor had a prescribed connection	
Unaware of the doctor's revalidation due date	
Administrative error	
Responsible officer error	
Inadequate resources or support for the responsible officer role	
Other – (late due to Staff unplanned absence)	
Describe other – Trust was in negotiations with Doctor and GMC	
TOTAL [sum of (late) + (missed)]	

Appendix D - Audit of concerns about a doctor's practice (1st April 23 to 31st March 24)

Please note this does not include information about dentists.

<table>
<tr><th>Concerns about a doctor's practice</th><th>High level[1]</th><th>Medium level[4]</th><th>Low level[4]</th><th>Total</th></tr>
<tr><td>Number of doctors with concerns about their practice in the last 12 months
Explanatory note: Enter the total number of doctors with concerns in the last 12 months. It is recognised that there may be several types of concern but please record the primary concern</td><td>1</td><td></td><td></td><td>1</td></tr>
<tr><td>Capability concerns (as the primary category) in the last 12 months</td><td rowspan="3">1</td><td></td><td></td><td rowspan="3">1</td></tr>
<tr><td>Conduct concerns (as the primary category) in the last 12 months</td><td></td><td></td></tr>
<tr><td>Health concerns (as the primary category) in the last 12 months</td><td></td><td></td></tr>
<tr><td colspan="4">Remediation/Reskilling/Retraining/Rehabilitation</td><td></td></tr>
<tr><td colspan="4">Numbers of doctors with whom the designated body has a prescribed connection as at 31 March 2023 who have undergone formal remediation between 1 April 2022 and 31 March 2023
Formal remediation is a planned and managed programme of interventions or a single intervention e.g. coaching, retraining which is implemented as a consequence of a concern about a doctor's practice
A doctor should be included here if they were undergoing remediation at any point during the year</td><td></td></tr>
<tr><td colspan="4">Consultants (permanent employed staff including honorary contract holders, NHS and other government /public body staff)</td><td>0</td></tr>
<tr><td colspan="4">Staff grade, associate specialist, specialty doctor (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS and other government /public body staff)</td><td>1</td></tr>
<tr><td colspan="4">General practitioner (for NHS England area teams only; doctors on a medical performers list, Armed Forces)</td><td>0</td></tr>
<tr><td colspan="4">Trainee: doctor on national postgraduate training scheme (for local education and training boards only; doctors on national training programmes)</td><td>0</td></tr>
<tr><td colspan="4">Doctors with practising privileges (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade)</td><td>0</td></tr>
<tr><td colspan="4">Temporary or short-term contract holders (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc) All Designated Bodies</td><td>0</td></tr>
</table>

[1] http://www.england.nhs.uk/revalidation/wp-content/uploads/sites/10/2014/03/rst_gauging_concern_level_2013.pdf

Other (including all responsible officers, and doctors registered with a locum agency, members of faculties/professional bodies, some management/leadership roles, research, civil service, other employed or contracted doctors, doctors in wholly independent practice, etc) All Designated Bodies	0
TOTALS	1
Other Actions/Interventions	
Local Actions:	
Number of doctors who were suspended/excluded from practice between 1 April and 31 March: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included	0
Duration of suspension: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included Less than 1 week 1 week to 1 month 1 – 3 months 3 - 6 months 6 - 12 months	n/a
Number of doctors who have had local restrictions placed on their practice in the last 12 months?	0
GMC Actions: Number of doctors who:	
Were referred by the designated body to the GMC between 1 April and 31 March	0
Underwent or are currently undergoing GMC Fitness to Practice procedures between 1 April and 31 March	0
Had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1 April and 31 March	0
Had their registration/licence suspended by the GMC between 1 April and 31 March	0
Were erased from the GMC register between 1 April and 31 March	0
National Clinical Assessment Service actions:	
Number of doctors about whom the NHS Resolution (previously NCAS) has been contacted between 1 April and 31 March for advice or for assessment	1
Number of NHS Resolution assessments performed	0

Appendix E - Audit of recruitment and engagement background checks (1st April 2023 to 31st March 2024)

Number of new doctors (including all new prescribed connections) who have commenced in last 12 months (including where appropriate locum doctors)	13
Permanent employed doctors	5
Temporary employed doctors	7
Temporary employed doctors who became substantive	0
Locums brought in to the designated body through a locum agency	0*
Locums brought in to the designated body through 'Staff Bank' arrangements	0
Doctors on Performers Lists	0
Other: Explanatory note: This includes independent contractors, doctors with practising privileges, etc. For membership organisations this includes new members, for locum agencies this includes doctors who have registered with the agency, etc	
TOTAL	13

For how many of these doctors was the following information available within 1 month of the doctor's starting date (numbers)?

NB. MPIT forms from previous designated body

These forms provide information from previous Responsible Officer. We have experienced huge difficulty getting responses to these requests for MPIT forms especially within 1 month of starting; the GMC have been made aware. Plus, this form is not required for all new doctors employed, i.e. trainees who are then appointed, bank staff, those under a different designated body etc.

	Total	Identity check	GMC issues	GMC conditions or undertakings	On-going investigations	DBS	2 references	Last RO	Reference from last RO	Language competency	Local conditions or undertakings	Qualification check	Revalidation due date	Appraisal due date	Unresolved performance concerns
Permanent employed doctors	5 (2 Rand R)	5	0	0	0	5	3			1		5			0
Temporary employed doctors	7	7	0	0	0	7	6 (1*)			0		7			
Temporary employed doctors who became substantive	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Locums brought in to the designated body through a locum agency	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Locums brought in to the designated body through 'Staff Bank' arrangements	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Doctors on Performers Lists	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other (independent contractors, practising privileges, members, registrants, etc.)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Total															

For Providers of healthcare i.e. hospital trusts – **use of locum doctors:**

Explanatory note: Number of locum sessions used (days) as a proportion of total medical establishment (days)

The total WTE headcount is included to show the proportion of the posts in each specialty that are covered by locum doctors

Locum use by specialty:	Total establishment in specialty (current approved WTE headcount)	Consultant: Overall number of locum days used	SAS doctors: Overall number of locum days used	Trainees (all grades): Overall number of locum days used	Total Overall number of locum days used
Surgery	0	0	0	0	0
Medicine	0	0	0	0	0
Psychiatry	120	700 days approx	680 days approx	15	1380 days approx
Obstetrics/Gynaecology	9	0	0	0	0
Accident and Emergency	0	0	0	0	0
Anaesthetics	0	0	0	0	0
Radiology	0	0	0	0	0
Pathology	0	0	0	0	0
Total in designated body (Includes all doctors, not just those with a prescribed connection)	129 (not including Doctors in training)				

Number of individual locum attachments by duration of attachment (each contract is a separate ‘attachment’ even if the same doctor fills more than one contract)	Total	Pre-employment checks completed (number)	Induction or orientation completed (number)	Exit reports completed (number)	Concerns reported to agency or responsible officer (number)
2 days or less					
3 days to one week					
1 week to 1 month					
1-3 months					
3-6 months	3	3	Local induction	NA	0
6-12 months	4	4	Local induction	NA	0
More than 12 months	4	4	Local induction	NA	0
Total	11	11			0

GLOUCESTERSHIRE HEALTH AND CARE NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS MEETING

Wednesday 10 July 2024

The Chamwell Centre, Longford, Gloucester

PRESENT:	Graham Russell (Chair) Steve Lydon Alicia Wynn Chas Townley	Kizzy Kukreja Peter Gardner Penelope Brown	Bob Lloyd-Smith Andrew Cotterill Mick Gibbons
IN ATTENDANCE:	Steve Alvis, Non-Executive Director Anna Hilditch, Assistant Trust Secretary Bilal Lala, Non-Executive Director Jan Marriott, Non-Executive Director Lavinia Rowsell, Director of Corporate Governance / Trust Secretary		

1. WELCOMES AND APOLOGIES

1.1 Graham Russell welcomed colleagues to the meeting.

1.2 Apologies had been received from the following Governors: Chris Witham, Ismail Surty, Alison Hartless, Paul Winterbottom, Sarah Nicholson, Cath Fern, Jenny Hincks Rebecca Halifax, and Laura Bailey. Lisa Crooks did not attend the meeting. Apologies had also been received from Nicola de Iongh, Sumita Hutchison, Jason Makepeace and Vicci Livingstone-Thompson, Non-Executive Directors.

1.3 The Council noted that David Summers (Public Governor) had tendered his resignation the previous day. Colleagues thanked David for his contribution and wished him well for the future.

1.4 Graham Russell said that it was disappointing to have received so many apologies for this session but understood that many colleagues had competing demands on the run up to holiday season. It was also noted that the Trust had a number of Governor vacancies and was shortly to commence a Governor election process for 7 posts. Anna Hilditch provided the Council with an update on those positions up for election, both Public Governors (4 positions) and Staff Governors (3 positions). The nomination process would open on Thursday 25th July and details would be shared with all Governors at that time to assist with promoting the roles across local networks.

1.5 Andrew Cotterill asked whether it was possible for people to be a Governor of both GHC and Gloucestershire Hospital's Trust (GHFT). It was noted that the Constitution included the following clause: *The following may not become or continue as a member of the Council of Governors…… A person who is a governor of another health service body, save where the Chair and Chief Executive are satisfied that any proposed or existing concurrent appointment would not constitute a conflict of interests which could not be managed or avoided.* Lavinia Rowsell advised that this clause had been added to the constitution a number of years ago when a situation had arisen and there had been a real conflict of interest in a person holding a Governor position for both GHFT and the predecessor Trust 2gether. This related to the bidding for contracts and

services. It was noted that GHFT also had a similar clause built into their constitution. It would be possible for someone to hold a position at both Trust's, as long as colleagues were satisfied that any potential conflicts could be mitigated.

2. DECLARATIONS OF INTEREST

2.1 There were no new declarations of interest.

3. MINUTES OF THE PREVIOUS MEETING

3.1 The minutes from the previous meeting held on 15th May were 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.

4.2 A copy of the Trust's Green Plan Strategy Delivery Progress report had been circulated to all Governors for information, as agreed as an action from the previous meeting. It was suggested that this could be the focus of a future session for Governors.

4.3 Steve Lydon **noted** that the Trust was notified the day after the previous Council meeting that it had been successful in its bid for the Integrated Urgent Care Service contract. Governors had been updated on this in a timely manner. However, Steve queried what the Governor role was in going for future business or contracts, as he felt that the IUCS contract was significant and there should have been some form of Governor involvement. The Trust's Constitution sets out the following definition: *'Significant transaction' means any transaction with a value equal to or greater than 20% of the Trust's income, assets or capital, excluding the Trust's principal contract with commissioners setting out the services to be delivered by the Trust in a given year.* This contract would not fall under this definition of "significant" and did not therefore hit the threshold for Governor approval. Chas Townley said that this would have been commercially sensitive and had appreciated that it was an operational level contract. However, colleagues agreed that it would be helpful for Governors to gain a better understanding of the new service offer and suggested that a session be arranged in due course to discuss the opportunities and risks associated with it.

5. NOMINATIONS AND REMUNERATION COMMITTEE SUMMARY REPORT

5.1 The purpose of this report was to provide a summary to the Council of Governors of the business conducted at the Nominations and Remuneration Committee meetings held on 6th and 24th June 2024, for information and approval.

5.2 This report was **noted** and the Council of Governors:

- **Approved** the recommendation that Jan Marriott's term of office be extended by 6 months to 31 March 2025, in line with the Trust constitution.
- **Approved** the continued payment of a responsibility allowance for two Non-Executive Director positions, and the level of this payment at £2k per role
- **Noted** the agreed direction of travel for upcoming NED recruitment.
- **Noted** the positive outcome of the 2023/24 NED appraisals

- **Noted** that the required Fit & Proper Person checks have been carried out on all Board members, and there are no issues of concern.

6. ANNUAL REPORT AND ACCOUNTS 2023/24 – FORMAL RECEIPT

6.1 The purpose of this report was to present the Council of Governors with the final draft Annual Report and Accounts 2023/24, to meet their statutory duty to "Receive the Trust's Annual Accounts and any report of the Auditor on them".

6.2 The Council **noted** that the Annual Report would be Laid before parliament during July and would be formally presented at the Trust's AGM taking place on Thursday 19th September 2024.

6.3 As in previous years a briefing session had been arranged for Governors to learn more about the Annual Report and Accounts, with the session led by Bilal Lala (Chair of Audit & Assurance Committee), Sandra Betney (Director of Finance) and a representative from the External Auditors. This session was scheduled to take place on 22nd August.

6.4 Lavinia Rowsell informed the Governors that a short film would be produced to accompany the written report this year, setting out the key highlights in a bitesize format.

6.5 Chas Townley said that the annual report would benefit from an easy read / plain English version as some sections were quite complex and not very accessible. Penny Brown agreed however she said that the Trust was required to use this language as it was required by statute. Lavinia Rowsell invited Chas Townley to send her some examples of the sections he felt could be reviewed and also a link to the accessibility tool/checker that he had referenced as this could assist with the production of the report next year.

6.6 The Council of Governors formally **received** the Annual Report and Accounts 2023/24.

7. ANY OTHER BUSINESS

7.1 Peter Gardner said that discussions had taken place at the recent Membership & Engagement Committee about the possibility of Governors setting up a pop-up Membership stand at the Community Hospitals to try and promote membership and to engage with patients and members of the public. He said that he would coordinate an email to go out to all Governors to see who might be willing to participate in their constituencies.

7.2 Penny Brown **noted** that the new Government were interested in policy around assisted dying and she queried who or where this would sit within the Gloucestershire system. Graham Russell suggested that those conversations would still need to take place to look at the implications. Lavinia Rowsell added that briefings had been sent out to the new MPs following the recent election and introductory meetings were in the process of being arranged where it was hoped that effective working relationships could be formed, and discussions of this nature could start to take place.

8. DATE OF NEXT MEETING

8.1 The next meeting would take place on Wednesday 18th September 2024 at 10.30 – 1.00pm via MS Teams.

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 16/0924

AUDIT AND ASSURANCE COMMITTEE

SUMMARY REPORT

DATE OF MEETING: **8 AUGUST 2024**

COMMITTEE GOVERNANCE	• Committee Chair – Bilal Lala, Non-Executive Director • Attendance (membership) – 100% • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

INTERNAL AUDIT (BDO)

Good progress is being made against the internal audit plan for 24/25. Progress with implementing recommendations from previous audits was reviewed. Of the 28 recommendations which had fallen due; 5 were overdue, 14 were in progress and 9 were complete.

Two internal audit reports were received and considered at the meeting:

- Safeguarding Children: scored moderate by design and effectiveness, with five moderate priority findings identified.
- Health and Wellbeing: scored moderate for both design opinion and design effectiveness, with three priority findings identified.

COUNTER FRAUD, BRIBERY & CORRUPTION

The Committee received and noted the Counter Fraud, Bribery and Corruption Progress Report, and it was reported the benchmarking exercise had been carried out and that this compared data from 18 counter fraud services. The report showed that the Trust was joint third in the highest number of allegations recorded across all of the 18 organisations in which it was benchmarked against demonstrating strong and effective fraud detection capabilities.

The Committee received and approved the Counter Fraud, Bribery Annual Report for 23/24 and noted the Trust was rated green against 11 of the 12 components. The area which had received an amber rating was the risk assessment component and action was being taken to improve the rating. It was noted that the Trust was not an outlier in this.

The Committee received and approved the Counter Fraud, Bribery and Corruption Functional Standard Return.

LYDNEY SALE & ASSET DISPOSALS UPDATE

The Committee received an update on the Lydney Sale and Asset Disposals, which set out the impact of the disposal of the Lydney Hospital site on Trust finances, and noted the Trust was proceeding with Open Market Valuations for the Lydney Hospital plots proposed for imminent sale, in accordance with IFRS 15.

RISK REVIEW

The Committee received and considered the Corporate Risk Register and Board Assurance Framework (BAF) for Q1.

The Committee queried the closure of *risk 5 – partnership and culture* and referred this back to the Executive Team for further discussion. The Committee discussed the proposed closure of *risk 7 – sustainability,* and agreed this would be referred to the Resources Committee for assurance that objectives relating to the Green Plan Strategy had been met.

OTHER ITEMS RECEIVED

The Committee **received** and **noted** the following reports:

- External Audit (KPMG) Progress Report.
- Finance Compliance Report
- Cyber Security Assurance Report
- Annual Health and Safety and Security Report
- The following Summary Reports:
    - Health and Safety and Security Management Group
    - Risk Management Group
    - Information Governance Group
    - Buildings Environment & Medical Equipment (BEME) Management Group

ACTIONS REQUIRED BY THE BOARD

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

DATE OF NEXT MEETING:	14th November 2024

Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 17/0924

ASSURANCE REPORT TO BOARD

REPORT TO:	**Trust Public Board - 26 September 2024**
COMMITTEE:	**RESOURCES COMMITTEE – 29 August 2024**
AUTHOR:	Trust Secretariat
PRESENTED BY:	Graham Russell, Chair of Resources Committee

ALERT: Alert to matters that require the Board's attention or action, e.g. non-compliance, safety or a threat to the Trust's strategy

Potential risks and delays associated with the disposals of Hatherley Road and Holly House properties were highlighted. Disposals are factored into the capital plan for 24/25 albeit a contingency position has been created. It was reported this was high on the agenda for the Strategic Housing Partnership and discussions were being held to progress this further. *(Post meeting note: Holly House has now been granted planning permission).*

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance

A downward trajectory of performance was noted for the Perinatal Urgent (L09) and Routine (L12) waits. A QI led recovery action plan was being put in place and the appointments profile was being reviewed. It was expected improvements would be seen in the upcoming months. These issues had previously been highlighted to the Trust Board.

Challenges in the dental services were discussed and maternity cover had been identified to help address the staffing issues and a demand and capacity plan had also been put in place to help resolve issues within the service. The service would continue to be closely monitored.

No Criteria to Reside (NCTR) remained a significant challenge for the Trust, however, the performance with the community hospital bed offer had improved for the month with the Trust now being able to offer between 20 to 30 beds per week.

ASSURE: Inform the Board where positive assurance has been achieved

System Finance Position and the Deficit Risk Share – assurance noted that the system was deemed to be improving as the risk score had improved from a regional perspective. There are significant interdependencies within any system, and patient and operational requirements/performance are often the main driver of financial positions. The system deficit risk share includes 2 operational measures that each organisation would be tracked against, as well as the financial position. The risk share for GHC relating to mental health

liaison and rapid response was currently exceeding target and was projected to do so for the year.

The Covid Outreach Vaccination Service tender had been awarded to the Trust until March 2025.

APPROVALS: Decisions and Approvals made by the Committee

The Committee approved the revenue budget for Integrated Urgent Care Service (IUCS) for 2024/25 and noted the recurring budgetary position; and noted the risks associated with the proposed budgets.

RISK & BOARD ASSURANCE FRAMEWORK (BAF) UPDATE

The Committee agreed the closure of *BAF Risk 7 – sustainability*, noting that assurance on the progress against the Green Plan had been received and considered by the Resources Committee and the Board, and evidenced the rationale for the closure of the risk.

Further discussion would be held with the Executive regarding the proposed closure of *Risk 5 – Partnership Culture;* as further assurance was required in regards to the Trust working effectively with voluntary sector organisations.

CELEBRATING OUTSTANDING: Share any practice innovation or action that the committee considers to be outstanding

The Committee received the Forest of Dean Hospital Financial Summary, noting a total spend of £27.4m. The Committee extended their thanks to all those involved in the successful delivery of the project/build.

It was reported that 70% of the business planning milestones (198 identified) had been completed at the end of quarter 1. A further 29% had been part achieved, which left only 1% not achieved.

ITEMS RECEIVED: The following items were received and discussed at the meeting

System Finance and Deficit Risk Share Update, Finance Report, Forest of Dean Financial Summary, Performance Report, Service Development Report, Business Plan Report (Q1), Integrated Urgent Care Budget, Risk Report.

Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 18/0924

GREAT PLACE TO WORK (GPTW) COMMITTEE

SUMMARY REPORT

COMMITTEE GOVERNANCE	• Committee Chair – Sumita Hutchison, Non-Executive Director

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

TO NOTE: The scheduled meeting of the GPTW Committee was cancelled and the following items were circulated to members for endorsement and information purposes.

WDES & WRES – DATA & ACTION PLAN

The Committee **received** the Workforce Race Equality Standards (WRES) & Workforce Disability Equality Standards (WDES) Data and Action Plan in readiness for publication by 31 October 2024. The Committee reviewed the proposed 2024/25 actions and **approved** the publication.

PERFORMANCE REPORT, WORKFORCE KPIS – MONTH 4

The Committee **received** and **noted** the Performance Report Workforces KPIs Month 4.

QUARTER 1 RISK REPORT

The Committee **received** and **noted** the Quarter 1 Risk Report.

ACTIONS REQUIRED BY THE BOARD

The Trust Board is asked to **NOTE** the contents of this summary.

DATE OF NEXT MEETING:	8 November 2024

QUALITY COMMITTEE

SUMMARY REPORT

DATE OF MEETING: **5 SEPTEMBER 2024**

COMMITTEE GOVERNANCE	• Committee Chair – Jan Marriot, Non-Executive Director (NED) • Attendance (membership) – 100% • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

QUALITY DASHBOARD REPORT

The Committee **received** and **noted** the Quality Dashboard Report. The report also included the Q1 Non-Executive Director Audit of Complaints and the Q1 Guardian of Safe Working Hours Report. There had been minor changes to the Quality Dashboard Report following requests made by the Trust Board; including the removal of flat data, which would be included in the Integrated Performance Report going forward.

There had been an increase in the number of pressure ulcer harm incidents reported for the month and it was noted that they remained in the control limit, however the mean had increased. A further deep dive in to community nursing that would include pressure ulcers is scheduled to be received by the Committee at its next meeting.

The report included data from the Friends and Family Test (FFT) and it was reported that 93% of respondents had reported a positive experience of the Trust's services in the month.

The enhanced monitoring of Berkeley House continued in line with the requirements of the section 31 notice and the Committee was informed that the application to the CQC to include the new integrated urgent care service to the Trust's portfolio of services had been completed.

QUARTER 1 RISK REPORT

The Committee **received** and **noted** the Quarter 1 Risk Report, which provided information and assurance in respect of the management of the corporate and strategic risks for which the Quality Committee has oversight for. There were 8 risks on the corporate risk register for attention of the Committee.

The Committee **received** the Board Assurance Framework and it was reported there were two strategic risks for the attention of the Committee. These were *risk 1 – quality* standards and *risk 9 – closed culture.* Both risks were currently rated 12.

MEDICAL APPRAISAL ANNUAL REPORT

The Committee **received** the Medical Appraisal Annual Report, which provided a summary of the work which had been undertaken within the Trust to support the safe provision of clinical services by medical practitioners with a connection to this designated body.

The Committee **accepted** and **endorsed** the Medical Appraisal Annual Report and **agreed** the content and submission of the Statement of Compliance to NHS England. This report would be presented to the September Board for final sign off.

REVISED MEDICAL APPRAISAL POLICY

The Committee **received** and **endorsed** the revised Medical Appraisal Policy.

INFECTION PREVENTION & CONTROL ANNUAL REPORT

The Committee **received** the Infection Prevention and Control Annual Report for 2023/24, and it was noted that the publication of this report was a statutory obligation and would be made available to the public.

The report covered the period from 1 April 2023 to March 31 2024, and outlined the infection prevention and control activities undertaken to fulfil the statutory requirements of the Health and Social Care Act 2008: code of practice on the prevention and control of infections.

The Committee was assured that the Trust had reported a very low incidence of UK Health Security Agency (UKHSA) reportable healthcare associated infections during 2023/24. A total of 6 cases of toxin positive Hospital Onset Healthcare Acquired *Clostridioides difficile* against a tolerance figure of 15 were reported.

The report provided positive assurance that the Trust had maintained good standards of infection prevention and control throughout the year. The Committee **noted** and **endorsed** the IPC Annual Report 2023/24 and **noted** the good level of assurance provided.

OTHER ITEMS RECEIVED

The Committee **received** and **noted** the following reports:

- Allied Health Professional Annual Report
- Annual Ligature Reduction Strategy
- Clinical Issues Report
- Learning from Deaths Report – Quarter 1
- Quality Assurance Group Summary Report

ACTIONS REQUIRED BY THE BOARD

The Trust Board is asked to **NOTE** the contents of this summary.

DATE OF NEXT MEETING:	7 November 2024