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NHS
Gloucestershire Health and Care
NHS Foundation Trust

TRUST BOARD MEETING

PUBLIC SESSION

Thursday, 28 November 2024

10:00 – 13:00

Trust HQ, Edward Jenner Court, Brockworth, Gloucester

AGENDA

TIME	Agenda Item	Title	Purpose	Comms	Lead
OPENING BUSINESS					
10:00	01/1124	Apologies for absence and quorum	Assurance	Verbal	Chair
	02/1124	Declarations of interest	Assurance	Verbal	Chair
10:05	03/1124	Service User Story Presentation	Assurance	Verbal	DoNTQ
10:30	04/1124	Draft Minutes of the meeting held on 26 September 2024	Approve	**Paper**	Chair
	05/1124	Matters arising and Action Log	Assurance	**Paper**	Chair
10:35	06/1124	Questions from the Public	Assurance	Verbal	Chair
10:40	07/1124	Report from the Chair	Assurance	**Paper**	Chair
10:50	08/1124	Report from Chief Executive	Assurance	**Paper**	CEO
ASSURANCE REPORTING					
11:10	09/1124	Finance Report	Assurance	**Paper**	DoF
11:20	10/1124	Quality Report	Assurance	**Paper**	DoNTQ
11:40 – BREAK					
11:50	11/1124	Performance Report	Assurance	**Paper**	DoF
12:10	12/1124	Board Assurance Framework	Assurance	**Paper**	DoCG
12:20	13/1124	Freedom to Speak Up Report	Assurance	**Paper**	FTSU Gdn
STRATEGY AND IMPROVEMENT					
12:35	14/1124	Intensive and Assertive Community Treatment Services Review	Endorse	**Paper**	MD
GOVERNANCE					
TO NOTE	15/1124	Council of Governor Minutes – 18 September 2024	Information	**Paper**	Chair
TO NOTE	16/1124	Working Together Advisory Committee Review	Information	**Paper**	WTAC Chair

TIME	Agenda Item	Title	Purpose	Comms	Lead
BOARD COMMITTEE SUMMARY ASSURANCE REPORTS (REPORTING BY EXCEPTION)					
12:45	17/1124	Mental Health Legislation Scrutiny Committee (16 October)	Information	**Paper**	MHLS Chair
	18/1124	Resources Committee (22 October)	Information	**Paper**	Resources Chair
	19/1124	Quality Committee (7 November)	Information	**Paper**	Quality Chair
	20/1124	Great Place to Work Committee (8 November)	Information	**Paper**	GPTW Chair
	21/1124	Audit & Assurance Committee (21 November)	Information	**Paper**	Audit Chair
CLOSING BUSINESS					
12:50	22/1124	Any other business	Note	Verbal	Chair
	23/1124	**Date of next Trust Board meeting** Thursday, 23 January 2025	Note	Verbal	All

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AGENDA ITEM: 04/1124

MINUTES OF THE TRUST BOARD MEETING

Thursday, 26 September 2024
Trust HQ, Edward Jenner Court, Gloucester

PRESENT:
Graham Russell, Trust Chair
Sandra Betney, Director of Finance
Douglas Blair, Chief Executive
Des Gorman, Interim Director of Strategy & Partnership
Nicola Hazle, Director of Nursing, Therapies & Quality
Sumita Hutchison, Non-Executive Director
Cathia Jenainati, Associate Non-Executive Director
Vicci Livingstone-Thompson, Associate Non-Executive Director
Jason Makepeace, Non-Executive Director
Jan Marriott, Non-Executive Director
David Noyes, Chief Operating Officer
Neil Savage, Director of Human Resources (HR) & Organisational Development
Amjad Uppal, Medical Director

IN ATTENDANCE:
Anna Hilditch, Assistant Trust Secretary (GHC)
Neil Hubbard, Public Governor (via MS Teams)
Michelle Kirk, Staff Governor (via MS Teams)
Bob Lloyd-Smith, Appointed Governor/Healthwatch (via MS Teams)
Bren McInerney, Member of the Public
Louise Moss, Assistant Director of Corporate Governance (GHC)
Tussie Myerson, Public Governor
Moiz Nayeem, NED Insight Programme
Kate Nelmes, Head of Communications (GHC)
Lavinia Rowsell, Director of Corporate Governance/Trust Secretary (GHC)

1. WELCOME AND APOLOGIES

1.1 The Chair welcomed everyone to the meeting. Apologies were received from Steve Alvis, Nicola de Iongh and Bilal Lala.

1.2 The Chair welcomed Cathia Jenainati to her first Trust Board meeting. Cathia 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.

1.3 The Board also welcomed Moiz Nayeem who had been placed with the Trust for 6 months as part of the aspiring NED Insight Programme.

1.4 Graham Russell **noted** that this would be the final Board meeting for David Noyes, Chief Operating Officer. David would be retiring on 27th September. On behalf of the Board, Graham Russell thanked David for his work and contributions over the past 3 years, acknowledging the positive impact he had had during that time.

2. DECLARATIONS OF INTEREST

2.1 There were no new declarations of interest.

3. SERVICE STORY PRESENTATION

3.1 The Board welcomed Jamie to the meeting, who was accompanied by his mother Pauline, and supported by Che Ming Leung (Principal Speech and Language Therapist in Brain Injury).

3.2 Che Ming introduced Jamie's story, telling the Board that he had sustained a traumatic brain injury after he was assaulted outside a nightclub in 2019. Che Ming spoke about Jamie's journey, from first referral to the Brain Injury Team, to specialist treatment out of county and then back into Gloucestershire where Jamie received rehabilitation as an outpatient with GHCs adult speech and language therapy brain injury team.

3.3 Jamie spoke about his experience, highlighting the challenges that he and his family had faced. As well as the physical challenges such as fatigue, the Board heard about the impact that Covid had had on Jamie's recovery journey, and issues experienced with supported living and benefits.

3.4 Jamie told the Board that he was now working as a support technician on the apprenticeship scheme for GET (Gloucestershire Engineering Training) which he really enjoyed. Che Ming said that it was important to acknowledge Jamie's achievements in his recovery and his return to work.

3.5 Vicci Livingstone-Thompson thanked Jamie for being so open about his experiences and some of the challenges he had faced. She asked about the staff who had supported Jamie and what he felt made a good supporter. Jamie said that staff had listened to him and understood him. He said that the continuity of seeing the same people had also been helpful as they were able to remember previous conversations and details he had shared which was important.

3.6 On behalf of the Board, Graham Russell thanked Jamie for attending and bravely sharing his story with colleagues. Thanks were also given to Jamie's mother Pauline, acknowledging the impact that such an incident can have on the wider family. Graham Russell thanked Che Ming for supporting Jamie to tell his story and asked that these thanks also be fed back to the wider team for their efforts.

4. MINUTES OF THE PREVIOUS BOARD MEETING

4.1 The Board received the minutes from the previous Board meeting held on 25 July 2024. The minutes were **accepted** as a true and accurate record of the meeting.

5. MATTERS ARISING AND ACTION LOG

5.1 The Board **noted** that the actions from the previous meeting were now complete or progressing to plan.

5.2 There were no further matters arising.

6. QUESTIONS FROM THE PUBLIC

6.1 The Board **noted** that no questions had been received in advance of the meeting.

6.2 Bren McInerney said that he had attended the Trust's AGM the previous week and thought that this was outstanding. He welcomed the opportunity for those in attendance to ask questions and comment throughout and he said that the Trust should be proud of operating such an open and inclusive model. Graham Russell thanked Bren for his kind comments.

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 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 Key issues highlighted within the report included an update on the 2024/25 pay award, Right Care Right Person, and Death Certification and Medical Examiners: New Law.

8.3 Douglas Blair drew the Board's attention to the section of the report which celebrated colleague achievements and awards. The 2024 Parliamentary Awards 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 Board offered their congratulations to the team for winning this regional award which recognises their excellent work 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. The national awards ceremony would be taking place at the prestigious Queen Elizabeth II Centre in Westminster on 14 October.

8.4 Sumita Hutchison asked about the messaging and support for colleagues being offered following the recent riots. Douglas Blair said that the Trust had shared the key messages with staff and had offered enhanced wellbeing support. The Trust continued to work closely with local resilience forums to ensure that we could keep colleagues as informed as possible. Sumita said that it was reported nationally that Internationally Educated Nurses (IENs) were feeling uncomfortable, and she asked what GHC was doing to monitor and gauge staff experience. Neil Savage said that regular meetings took place with the IEN workforce, and the Trust was working proactively with the pastoral support team and the Freedom to Speak Up team to ensure that all colleagues feel safe in the working environment. He said that a recent

IEN Council meeting had taken place, and he had heard about the negative experiences that people had encountered both in their personal and working lives and this was upsetting. The Trust was working hard to ensure colleagues were connected into all of the support available.

8.5 As a follow on to this, Jan Marriott asked whether GHC had a position on continuing to use social media platforms such as X (Twitter). Kate Nelmes said that discussions had taken place with system partners, and it had been agreed that GHC would continue to have a profile on X for now. This enabled the Trust to issue factual information for the aid of patients and carers and ensured that we could continue to hear what was being said about the Trust. She confirmed that this position would be monitored. Jan Marriott accepted this but said it was important to be very clear about the Trust's stance and that it would not condone racist abuse of any kind.

8.6 Sumita Hutchison asked for an update on progress with Right Care, Right Person (RCRP) implementation. 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. David Noyes noted that GHC was a member of the RCRP Oversight Steering Group. He advised that the operational model was being rolled out across the county in phases, the first of which was implemented on 31 July 2024, with phase 2 commencing at the end of September/October. The Trust is working with relevant clinical leads, wider colleagues and system partners, including Gloucestershire Constabulary, to revise and update our policies and processes to support the full implementation of this. David Noyes advised that additional resource would be required, and this would be built into the annual planning process. Updates would be reported back through the Resources Committee.

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 5.

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 5, the Trust had a surplus of £0.289m, against a plan of £0.288m.

9.3 The 2024/25 Capital plan was £10.704m with £4m of disposals leaving a net £6.704m programme. Spend to month 5 was £1.252m against a budget of £2.636m. Cash at the end of month 5 was £44.905m compared to plan of £47.997m.

9.4 It was reported the Cost Improvement Programme was ahead of plan in terms of recurrent savings, with £3.137m delivered at month 5, compared to a plan of £2.746m. It was noted that the target for the year was £7.319m and of this £2.297m had not yet been identified. Sandra Betney reported that this was classified as a risk and details were included within the report.

9.5 The Board **noted** £3.765m of non-recurring savings had been delivered at month 5 against plan of £3.615m. The target of £5.661m for the year had all been identified.

9.6 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%.

9.7 Sandra Betney advised that the Better Payment Policy performance showed 89.5% of invoices by value paid within 30 days, against the national target of 95%. It was noted that this position had improved from the previous month, but more work was needed to bring performance back up.

9.8 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. It was noted that work was taking place to understand the underlying issues and modelling was underway. The Board **noted** that GHC was working to agree the internal position before commencing wider system discussions.

9.9 The Trust Board **noted** the month 5 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 August (Month 5 2024/25).

10.2 This month's Performance Dashboard for Board continued with a reduced detail format; however, members were assured that a detailed exception narrative is reviewed within the Business Intelligence Management Group (BIMG).

10.3 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.

10.4 The Board **noted** those indicators that were in exception for the period within the nationally measured, specialised and directly commissioned, and ICS agreed domains.

10.5 David Noyes presented the Chief Operating Officer Report to the Board. He said that this had been a good month for Community Hospital performance in terms of availability, with our offer generally between 20 and 30 beds a week. Our Length of Stay for patients with criteria to reside was just over 20 days which was very positive, while for non-criteria it was close to 50 days. Bed occupancy remains at 97%, and the Trust was performing well in terms of readmission within 30 days, which reported at 4.7%.

10.6 The Board **noted** that it had been another month of really strong performance within the Minor Injury and Illness Units (MIIUs), seeing approximately 7,500 patient contacts in month and meeting the four-hour target in 99.6% of the cases.

10.7 David Noyes said that he was delighted to report that the Children's Occupational Therapy (OT) service recovery remains very strong and was on track to achieve full KPI compliance next month. Current performance details were set out within the report.

10.8 Gloucestershire Hospitals NHS FT echocardiogram 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. David Noyes advised the Board that whilst a meeting had not yet taken place, more positive discussions had taken place with commissioner colleagues. The Trust remained anxious to resolve these issues and expected to have the necessary meetings in the next few weeks to take this forward. The Board were reminded that this was not GHC's service to deliver, however, the delays did have a knock-on impact for our patients.

10.9 Within the Trust's wheelchair service, there had been an unusual drop in performance against the 18-week handover for wheelchairs for under 18s. David Noyes reported that further investigation revealed that performance here had dipped, predominantly due to representatives from the wheelchair technician company being unavailable to support due to their attendance supporting athletes at the Paralympics. The Board **noted** that full recovery was anticipated next month, and planning would be put in place to ensure that this service was covered during future similar events.

10.10 Jan Marriott reflected on this report, noting that this was David Noyes' final Board meeting. She said that David arrived at the Trust just after Covid, when services were at the initial stages of recovery and performance was down across the board. She said that he instantly had such a good grip on what needed to be done, looking at the longer-term picture of recovery. Jan Marriott said that the performance report received at this meeting still presented some challenges that needed to be worked through, but the Trust was in a much better place and she commended David and colleagues across the Trust for what was a positive last report.

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

11. CHILD & ADOLESCENT MENTAL HEALTH SERVICE (CAMHS) UPDATE

11.1 The Board welcomed Kirtsy Pritchard, CYPS Operational Lead and Andie Collins, Professional Lead for Psychological Services, CYPS who were in attendance to present an update on Core CAMHS Recovery and transformation.

11.2 The presentation provided a positive update on service recovery, in particular around waiting lists. In September 2022, there were 765 young people on the waiting list with a waiting time of up to 2 years. In September 2024, there were 286 people waiting and the length of wait was predicted to be closer to 5 months. The Board **noted** that there had been a significant decrease in referrals in 2020 due to Covid, as only priority patients were being accepted. When services re-opened there was a large spike in demand nationally. Kirsty Pritchard spoke to the Board about rapidly improving

waiting times and how this has been achieved, as well as providing an illustration of the changing demand for Core CAMHS over the past 2 years.

11.3 Andie Collins provided an update on what had been done to achieve reduced waits whilst ensuring that children and young people's needs were met. This included teams working additional hours, and providing additional groups and clinics, evaluating and re-directing waiters where clinically appropriate, working closely with other CAMHS service teams and system partners, and monitoring the workforce position and service flow.

11.4 In terms of service transformation, Andie Collins highlighted the four key areas where focus would be placed moving forward. This included Reducing Waiting Times, SEND, matching the core offer and the skills of the workforce to deliver it, and system wide working.

11.5 Douglas Blair said that CAMHS was one of the key topics when he joined the Trust in 2023, but he could see then that the service was going in the right direction. He said that it would be important to review the learning from some of the key initiatives such as evening and weekend clinics and to weave this into the longer-term planning for the service, noting the benefits for children and younger people.

11.6 Graham Russell thanked Kirsty and Andie for attending and presenting the huge amount of work that had taken place within the CAMHS service. He said that it would be great to hear more about the outcome measures at some point in the future to show the difference that this work had made to the lives of young people and their families.

11.7 The Board expressed their thanks also to Diana Scully, CAMHS Deputy Service Director and all colleagues working within CAMHS who had contributed to the recovery and transformation of the service.

12. REVIEW OF STANDARDS OF CARE IN COMMUNITY MH SERVICES

12.1 The purpose of this report was to outline the requirements of the Board in response to a request from the CQC, to complete an initial questionnaire relating 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.

12.2 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

12.3 Nicola Hazle advised 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 elements of that request can be used to inform our CQC response, it was noted that this paper did not specifically address the requirements of the NHSE request.

12.4 The Board **noted** that this report provided 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.

12.5 Nicola Hazle presented the initial high-level overview against the CQC special review recommendations (Appendix 1). She advised that this provided a reflection of the current position and was not necessarily an offer of full assurance. She said that work was underway to review sources of assurance, and a deep dive had been agreed for the next Quality Committee to work this through.

12.6 Sandra Betney referenced *Recommendation 7: can we be assured that we have systems and process in place to ensure we have an effective approach to bed management to ensure beds are available when needed.* She said that she would welcome a fuller review of this area to ensure that the Trust did have sufficient controls in place. This request was **noted**.

12.7 The Board agreed that this had been a tragic event and welcomed this important piece of work. The Board **endorsed** the initial response to the CQC, **noting** that oversight of the delivery of this work would sit with the Quality Committee.

13. QUALITY DASHBOARD REPORT

13.1 Nicola Hazle introduced the Quality Dashboard Report (August 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: 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, and a summary of the proposed changes to the content and delivery of the Quality Dashboard.

13.2 The Board **noted** that the Nursing, Therapies and Quality services, alongside the 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. A principle aim of this work is that it will broaden the understanding and the impact our performance has on people who use our services. Nicola Hazle acknowledged the hard work and willingness of colleagues in developing this report and the move to integrated reporting. She informed the Board that in the meantime there was still more to do in terms of the development of the Quality Report, making reference to formatting and font size and this would continue to be worked through.

13.3 Those key Quality issues showing positive improvement this month included:

- 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.

13.4 The Quality issues highlighted that required additional focus development included:

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

13.5 Jan Marriott informed the Board that there was nothing within this report that had not already been discussed or considered at the Quality Committee. She advised that the Quality Committee had requested a deep dive into restrictive practices, and this was scheduled for January 2025. Cathia Jenainati said that it would be helpful to have more socio-economic, gender, ethnicity data available to assist in analysing restrictive practice.

13.6 The Board **received, noted** and **discussed** the August 2024 Quality Dashboard.

14. MEDICAL APPRAISAL ANNUAL REPORT

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

14.2 The Board **noted** that this annual report and the NHSE Statement of Compliance had been presented to and endorsed by the Quality Committee at its meeting on 5th September 2024. The Board was therefore content to **note** the annual report and to **approve** the submission of the Statement of Compliance to NHS England.

15. COUNCIL OF GOVERNOR MINUTES

15.1 The Board **received** and **noted** the minutes from the Council of Governors meeting held on 10 July 2024.

16. BOARD COMMITTEE SUMMARY REPORTS

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

- Audit Committee (8 August)
- Resources Committee (29 August)
- Great Place to Work Committee (by correspondence)
- Quality Committee (5 September)

16.2 As part of a wider governance review, work had been carried out to look at the format of the Board Committee Summary Reports. The Resources Committee summary had incorporated a proposed new template and if supported by Board colleagues, this would be implemented for all Board Committees going forward. A copy of the summary would be sent out to all Board members seeking comments and feedback following the meeting. **ACTION**

17. ANY OTHER BUSINESS

17.1 Sandra Betney informed the Board that the System Cyber Security Strategy was currently in development and, due to timescales, requested that Board delegated authority be given for the final draft to be received and endorsed by the Resources Committee in October. This was agreed. The final strategy would be presented back to the Board to note once approved by the system.

18. DATE OF NEXT MEETING

18.1 The next meeting would take place on **Thursday, 28 November 2024**.

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AGENDA ITEM: 05/1124

TRUST BOARD PUBLIC SESSION: Matters Arising and Action Log – 28 November 2024

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

Meeting Date	Item No.	Action Description	Assigned to	Target Completion Date	Progress Update	Status
25 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	Jan 2025	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 January 2025 Board.	
26 Sept 2024	16.2	A copy of the Resources Committee summary report would be sent out to all Board members seeking comments and feedback on the new template following the meeting.	Trust Secretariat	Sept 2024	**Complete.** Summary report sent and new template being used for all Board Committees from November meeting onwards	

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AGENDA ITEM: 07/1124

REPORT TO: **TRUST BOARD PUBLIC SESSION – 28 November 2024**

PRESENTED BY: Graham Russell, Trust Chair

AUTHOR: 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 – September and October 2024

Report authorised by: Graham Russell	**Title:** Trust 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.

This has been an interesting period with many announcements at a national level about what needs to be done to improve the health and care sector. My numerous visits, conversations, and events lead me to four main reflections.

Firstly, that the shift to more delivery of health and care in the community is much needed. We know that our acute hospitals are under great pressure. We also know that many people did not need to attend an acute hospital to receive care but could have been better served either in or close to their home. There is now the clear opportunity to transform how we provide health and care services in the neighbourhoods and communities where people live. Better integration of services in the community and making them more personalised is one part; better use of technology such as virtual appointments and virtual wards is another; and making sure that we invest properly in preventing poor health is a key element of reducing demand. The scope and ambition to provide more services in the community applies as much to mental health services as to physical health services and therefore we are in an excellent position to make a real gear change and a real difference.

Secondly, we must ensure that we make the very best use of our fantastic community hospitals. I have recently visited all of our community hospitals and they are the most fantastic facilities with brilliant staff colleagues. Our community hospitals mean that people can access health and care close to home. However, there is scope for even better use of our community hospitals and this will be an important focus for the Trust as we continue to develop our offer to local communities.

Thirdly, we should never underestimate the power of partnership. Collaborative working with others is in our DNA and helps us to provide better services than if we were working on our own. On 19th November we launched a new Integrated Urgent Care Service in collaboration with IC24 which is a social enterprise. Our experience of healthcare in Gloucestershire combined with IC24's experience in providing 111 phone lines and patient assessment makes for a more effective service. Our appetite as a Trust is to work closely with partner organisations in order to better address the health needs of everyone in Gloucestershire. Together we can make more of a difference.

Fourthly, I have been struck by the critical importance of culture in the Trust and indeed in any organisation. Culture is how we operate; how we interrelate; how we work together; how we provide services; how we behave; and in line with one of our 4 values how we are 'respectful and kind'. Culture cannot be taken for granted and needs to be shaped and nurtured by everyone. A tolerant and inclusive culture does take time to

create but is easily lost and we should be mindful of that. 'Treat others as we would each like to be treated' and to really value each other will help us shape our culture alongside a shared commitment to inclusion and diversity. More diverse organisations are better performing organisations and better able to serve all communities in Gloucestershire. This is who we are – non negotiable.

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

- Once again, it has been a pleasure to visit services, meet colleagues and service users across the county. Since our last Board meeting, I have undertaken the following visits:

    - **Complex Emotional Needs Service** who are based at Eastgate House.
    - **North Cotswold Hospital** where I was accompanied by Deborah Evans, Chair of Gloucestershire Hospitals NHS Foundation Trust. Deborah and I had the pleasure of meeting Denise Gillett, Matron, Kate Dash, Outpatients Department Manager, Emma Hamilton, Ward Manager and Louise Chilvers, Minor Injuries and Illness Unit (MIiU) Manager.
    - The Trust's occupational health service **Working Well** who are based at Rikenel.

    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 moving into the new year and I look forward to meeting further teams and service users.

- I met informally with Margaret Greaves, **Stroud League of Friends** interim Chair where the discussed matters of mutual interest.

Always improving

- The Chief Executive and I met with the newly elected **MP for Cheltenham, Max Wilkinson** on 1st October and **MP for Stroud**, **Dr Simon Opher** on 22nd November. These virtual meetings were an opportunity to introduce Max and Simon to the many services provided by the Trust and for them to ask any specific questions.

- On 18th October, the ICB, Chief Executive and I met with **Dr Simon Opher MP** where he received a briefing on the system as a whole. Joint briefings will take place with all Gloucestershire MPs.

- On 4th October, I was delighted to attend **Bishop Rachel's Breakfast**. The gathering was an opportunity to network with a range of individuals committed to community transformation and to hear from those new to a variety of leadership roles across Gloucestershire and South Gloucestershire.

- To establish working together goals for the next year, I attended the **Working Together Advisory Committee workshop** on 17th October where we discussed the purpose, structure and function of the Committee. A further workshop will take place during December.

- Event number two – **Turning Uncertainty into Opportunity – One Gloucestershire Leadership Conference** took place on 23rd October at Kingsholm Stadium. This in person event saw colleagues come together from the Trust, ICB, Gloucestershire Hospitals NHS Foundation Trust and the County Council. Attendees had the opportunity to establish and build strong professional relationships with each other and demonstrate the benefits, and challenges, of collaboration. Event number three is scheduled to take place during June 2025.

- On 5th November, the Chief Executive and I were delighted to welcome **Matthew Taylor, Chief Executive of the NHS Confederation** to the Forest of Dean Community Hospital. Matthew met with the Chief Executive of NHS Gloucestershire and Trust colleagues and received a tour of the new facilities at the hospital followed by an informal meeting where we discussed, amongst other items, the transformation and integration of community-based services. I would like to take this opportunity to thank colleagues for taking time out of their busy schedules to accommodate Matthew's visit.

Respectful and kind

- The long service of colleagues who have worked in the NHS for 20, 30, 40 and even 50 years was celebrated at our annual **Long Service Awards** on 6th November. Colleagues gathered at Churchdown Community Centre to pay tribute to those who had achieved the significant milestones and given more than two decades of their lives to supporting communities in Gloucestershire and beyond. I had the pleasure of thanking colleagues for everything they had done - collectively those at the event had given more than 750 years of service.

  Particular tribute was paid to Single Point of Clinical Access clinician Christine Reeves, who had worked in various roles in Gloucestershire in her 50 years of service. She explained how she joined the NHS after leaving the RAF and had worked in both inpatient and community roles. She said her one wish for the NHS would be to have 'more time to spend with patients'.

Making a difference

- On 1st October, **Mary Hutton, Chief Executive of NHS Gloucestershire** and I welcomed key leaders across housing, health and social care sectors in Gloucestershire to discuss the scope for increased collaboration between the sectors and to explore the art of the possible, looking at potential barriers and solutions to enable better collaboration. The aim of the session was to have a free-flowing conversation and sharing unique perspectives on the opportunities for greater collaboration.

- I met with **Edward Gillespie OBE, Lord Lieutenant of Gloucestershire** on 31st October. Edward and I discussed matters of mutual interest and met with colleagues from the Integrated Urgent Care Service.

- I attended on 21st November the virtual **ICB Gloucestershire Neighbourhood Transformation Steering Group meeting**.

- To build upon already good working relationships, the Chief Executive and I met with **Deborah Evans, Chair** and **Kevin McNamara, Chief Executive** of **Gloucestershire Hospitals NHS Foundation Trust** on 24th October to discuss further how we can best work together on mutual issues.

- I was grateful to receive an invitation to attend the **Young Gloucestershire What We Do Showcase** which will take place on 28th November. It will be an opportunity for me to see first-hand how Young Gloucestershire transforms lives, address complex challenges and foster positive change in our community.

3. BOARD UPDATES

- The recruitment of a new **Non-Executive Director** concluded on 21st October. Following a rigorous recruitment process overseen by our Governors' Nominations and Remuneration Committee, I am delighted to advise Rosi Shepherd has been appointed. I am sure you will all join me in welcoming Rosi to the Trust. Rosi will commence in post on 6th January 2025.

- A **Board Development session**, facilitated by The Value Circle, took place on 3rd October. This face-to-face session focused on the mechanics and dynamics of high performing Boards and explored the dynamics of Board engagement.

- On 16th October, a **Board Seminar** took place where the topic for discussion was Interim Strategic Priorities. The seminar led by the Chief Executive focused on the Trust Strategy for the Future 2021 – 2026: Better Care Together and strategic aims.

- A meeting of the **Appointment and Terms of Service Committee** took place on 6th November. Amongst other items, the Committee discussed Executive Director succession planning.

- 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.

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.

- An Extraordinary meeting of the **Nominations and Remuneration Committee** took place on 23rd October. The committee considered and endorsed the appointment of a Non-Executive Director, following the interviews which had taken place on 21st October. An **Extraordinary Council of Governors meeting** subsequently took place on 24th October and this new appointment was approved.

- On 13th November we held our **Council of Governors meeting** via MS Teams. At the meeting we received an update on Governor's ways of working, and informative presentations on the review of the Working Together Advisory Committee – Governor engagement and the Trust Business Planning Process and Trust Strategy Refresh. Governors also received an update from the deputy CEO.

- A **Governor Induction Session** took place on 24th October for those Governors who joined the Trust in September.

- Sadly, for us, **Ismail Surty, Public Governor representing Gloucester City** and **Neil Hubbard, Public Governor representing Cheltenham** have tendered their resignations. We will be seeking new governors for Gloucester city and Cheltenham through the usual election process by our members in those constituencies. I would like to thank both Ismail and Neil for their contributions to the Trust.

- The quarterly **Staff Governor meeting** with Non-Executive Directors took place on 14th November. The meeting was an opportunity for Governors and Non-Executive Directors to raise items and topics for discussion.

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 September and October 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 September – 31st October 2024

NED Name	Meetings with Executives, Colleagues, External Partners	GHC Board / Committee meetings
Dr Stephen Alvis	Community Hospital Association Conference Gloucestershire ICS NEDs Network Meeting Good Governance Institute Webinar Introduction Meeting with Moiz Nayeem Introductory meeting with Cathia Jenainati Mental Health Act Managers (MHLS) Forum MHAM Personal Development Reviews x 3 MHLSC Assurance Report Meeting MHLSC Pre Meet NED Focus Group: Trust Board x2 NED Recruitment Focus Group Feedback	Board Seminar: Integrated Urgent Care Service Mobilisation Board Seminar: Interim Strategic Priorities Mental Health Legislation Scrutiny Committee Quality Committee Resources Committee
Sumita Hutchison	Council of Governors Meeting Diversity Network Agenda Setting Meeting Diversity Network Event Finalisation discussions Diversity Network Meeting with Vicci-Livingstone-Thompson and Trust Chair Great Place to Work Committee Effectiveness Review Meeting Great Place to Work Committee Pre-Meet Great Place to Work Committee Proposals and Feedback Meeting Meeting with Director of HR & OD Meeting with Karen Clements, ICB NED Network Chairs and Senior Leader Network Day NHS Gloucestershire People committee Non-Executive Directors Meeting Quality visit to Approved Mental Health Professional Service Review Meeting with Director of HR and OD Sustainability - Board Development scoping/prep	Board Development Session: The Value Circle Board Seminar: Interim Strategic Priorities (recording following the seminar) Great Place to Work Committee Integrated Urgent Care Service Mobilisation Board Seminar Mental Health Legislation Scrutiny Committee Trust AGM Trust Board: Private Trust Board: Public

NED Name	Meetings with Executives, Colleagues, External Partners	GHC Board / Committee meetings
Nicola de longh	Chair Objectives Discussion with Chief Executive Chair Objectives Discussion with Trust Chair Council of Governors Meeting Gloucestershire ICS NEDs Network Meeting Post Quality Visit Meeting with the Community Assessment Team Lead Quality Visit to Community Assessment Team Quality Visit to Greyfriars, Wotton Lawn	Board Seminar: Interim Strategic Priorities Charitable Funds Committee Nominations and Remuneration Committee
Jan Marriott	1:1 regarding Recovery College/PSW Review 1:1 with Consultant Psychiatrist 1:1 with Partnerships Team regarding Working Together Advisory Committee Accompany Senior Japanese Doctors visiting Tewkesbury Hospital and North Cotswold Hospitals Chair Consultant Interview Community Hospitals Association Conference Council of Governors Meeting Meeting with Acting Director of Strategy and Partnerships regarding Working Together Advisory Committee Workshop Meeting with Freedom to Speak Up Guardian Non-Executive Director Interviews Non-Executive Directors Meeting Quality Assurance Group Meeting Review of Quality Committee Effectiveness Volunteers and Experts by Experience Celebration Working Together Advisory Committee Workshop	Integrated Urgent Care Service Mobilisation Board Seminar Quality Committee Trust AGM Trust Board: Private Trust Board: Public
Vicci Livingstone-Thompson	1:1 with Trust Chair Diversity Network Agenda Setting Meeting Diversity Network Event Finalisation Discussions Diversity Network Meeting with Sumita Hutchison and Trust Chair ICS NEDs Network Meeting ICS Volunteering Network Meeting	Board Development Session: The Value Circle Board Seminar: Interim Strategic Priorities Charitable Funds Committee Integrated Urgent Care Service Mobilisation Board Seminar Quality Committee Trust AGM Trust Board: Private

NED Name	Meetings with Executives, Colleagues, External Partners	GHC Board / Committee meetings
	Meeting with Acting Director of Strategy and Partnerships regarding Working Together Advisory Committee Workshop NED Recruitment Focus Group Network Chairs and Senior Leader Network Day Non-Executive Directors Meeting Quality Visit Specialist Community Perinatal Mental Health Team Staff Member meeting System Leadership Conference Women's Leadership Network Working Together Advisory Committee Workshop	Trust Board: Public
Bilal Lala	Audit & Assurance Meeting Prep Evaluation of Audit and Assurance Committee Meeting with Director of Corporate Governance Introduction meeting with Director of Nursing, Therapies and Quality Meeting with Head of Partnerships and Service Development Manager Meeting with ICB Audit Chair Meeting with Jason Makepeace NHS England Chair & NED Welcome Event	Board Development Session: The Value Circle Board Seminar: Interim Strategic Priorities Resources Committee
Jason Makepeace	Integrated Urgent Care Service Mobilisation Board Seminar Quality visit to Greyfriars, Wotton Lawn Council of Governors Meeting System Resources Committee meeting with Jackie Bonnick Resources Committee Assurance Report Writing Resources Committee Agenda Planning Meeting with Bilal Lala 1:1 with Trust Chair Systems Leadership Conference	Board Development Session: The Value Circle Board Seminar: Interim Strategic Priorities Resources Committee Trust Board: Private Trust Board: Public

NED Name	Meetings with Executives, Colleagues, External Partners	GHC Board / Committee meetings
Cathia Jenainati	Informal Catch Up with Trust Chair Introduction meeting with Chief Executive Introduction meeting with Director of Nursing, Therapies and Quality Introduction meeting with Steve Alvis NED Focus Group	Board Seminar: Interim Strategic Priorities Trust AGM Trust Board: Private Trust Board: Public

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Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 08/1124

REPORT TO: **TRUST BOARD PUBLIC SESSION – 28th November 2024**

PRESENTED BY: Chief Executive Officer

AUTHOR: Douglas Blair, Chief Executive Officer

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

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

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

The purpose of this report is to

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

Recommendations and decisions required

The 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
- Change NHS
- Mental Health Bill
- Operational effectiveness of the Care Quality Commission

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:	**Title:**
Douglas Blair	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 Collingwood House, Wotton Lawn Hospital and the Forest of Dean Community Hospital.

1.2 Integrated Urgent Care Service - Go Live

Our new Integrated Urgent Care Service launched at 11am on 19 November. This marks a big step for our Trust, providing out of hours primary care and NHS111 services with our partners IC24. The service, led by Service Director Holly Smith, directs patients to IC24 call centres, then onwards as appropriate to the GP-led Clinical Assessment Service (CAS) based at Edward Jenner Court, in Brockworth.

They are then further triaged, advised and/or referred to other services either within or outside of GHC. This may include our Minor Injury and Illness Units, the ambulance service, Emergency Department, Rapid Response or pharmacies. Out of hours, patients may be given an appointment at one of our out of hours treatment centres around the county or visited at home, if required.

The service will be employing more than 140 colleagues - including more than 50 GPs, many employed via bank roles. We have welcomed approximately 60 colleagues into the Trust from former provider Patient Plus Group (PPG) by way of TUPE transfer.

1.3 Leadership and Culture Programme

The Trust is establishing an enhanced Leadership and Culture Programme to bring together various existing and new strands of work that focus on improving our culture, leadership and, in particular, our determination to tackle racial and other forms of discrimination.

In response to a reported rise in experiences of discrimination in last year's staff survey, the Trust has examined its current activities, sought further feedback from colleagues and carried out reviews in specific areas.

This work has, unfortunately, confirmed that, in common with the NHS as a whole, racism is a consistent feature and is affecting the working lives of our colleagues.
This new programme will include the following areas of focus:

- **Support for concerns about individual behaviour and attitudes.** This includes consistent and persistent encouragement, as well as providing an appropriate range of safe routes for individual complaints and grievances to be made to allow for timely and appropriate action to be taken.

- **Targeted training, awareness raising and support:** With aspects of a blended and mixed approach with universal offers and also targeted training and support in specific service areas.

- **Continued delivery of the NHS England Culture of Care programme:** Participation in national programme focused on culture of care within Mental Health inpatient unit.

- **Long term culture and leadership improvement support**. With dedicated organisational development and programme management resources made available.

It will be led by me and supported by some dedicated resources. It is proposed that its establishment will be overseen by a dedicated Assurance Committee reporting directly to the Trust Board. The programme itself will be long term in nature, recognising the nature of the issues involved.

1.4 Black History Month - October

Black History Month (BHM) was celebrated in October and provided an opportunity for colleagues to share, celebrate and understand the impact of black heritage and culture. The theme for this year's BHM was #Reclaiming Narratives which shone a spotlight on the untold stories, the unsung heroes, and the everyday individuals who have made an incredible impact on our communities.

We are proud of the contributions black colleagues have made to the past and present of the NHS in the county. The 'Saluting Our Sisters' photography exhibition paid tribute to influential black and minority ethnic women across Gloucestershire and provided an opportunity to highlight their contributions, ideas and voices, which have shaped history, inspired change and created impact in their communities. Tania Hamilton, our Equality, Diversity and Inclusion Lead and Lillianne Kanjau, Clinical Learning Disability Nurse at our Trust were both selected to be part of this photo exhibition. To view the exhibition, please visit: https://hundredheroines.org/nhs-saluting-our-sisters-gallery/

1.5 Speak Up Month - October

Freedom to Speak up Month took place during October. National Freedom to Speak Up Guardian Dr Jayne Chidgey-Clark visited the Trust and attended the Trust's Senior Leadership Meeting on 10 October, where she presented on the "Importance and power of listening in the speak up journey".

The theme this year was on the power of listening, and the important part listening plays in encouraging people to speak up. Speaking Up aims to improve safety and make our Trust a better place to work, by placing less emphasis on blame when things go wrong and more importance on transparency and learning from mistakes. Effective speaking up arrangements help to protect patients and improve the experience of colleagues. The National Guardian website provides useful information on the role guardians and how to access them.

1.6 Stakeholder Engagement

Following the outcome of the election, the Chair, Graham Russell, and I have started to meet with all the MP offices in the Gloucestershire County, for an annual briefing on the services provided by the Trust. The Integrated Care Board will meet with local MPs on a quarterly basis to provide updates on the Gloucestershire health system as a whole.

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

2.0 SYSTEM UPDATES

2.1 Informal Health Overview Scrutiny Committee - Members Briefing

On 22 October, the Chair, Graham Russell and I, hosted an informal meeting of the Health and Social Care Overview Scrutiny Committee at the new Forest of Dean Community Hospital, to provide an update on a number of our services. This included the Integrated Urgent Care Service which launched on 19 November and our Child and Adolescent Mental Health Services (CAMHS), including the work being undertaken to reduce waiting times. Members in attendance were given a tour of the hospital by the Matron and there was an opportunity for them to raise items of interest and meet with members of our senior team.

I also attended the formal Health and Social Care Overview Scrutiny Committee meeting on 15 October. The meeting largely focussed on the NHS Gloucestershire 2024/25 Winter Plan and a motion update on cancer waiting times. There was a further meeting of the committee on 26 November, which took place following the publication of this report.

2.2 ICB Board Meetings

The NHS Gloucestershire ICB Public and Confidential Board meetings were held on 27 November. The papers for the Public Board meetings can be located on their website - Board Meetings : NHS Gloucestershire ICB (nhsglos.nhs.uk)

The NHS Gloucestershire ICB Board Development meeting took place on 30 October, which was attended by Des Gorman, Deputy Director of Improvement and Partnerships and Graham Russell, Chair. Gloucestershire County Council provided a financial update and there was an update on medicines and prescribing from the ICB Chief Medical Officer, Chief Pharmacist and Chief Financial Officer. Some time was also spent reviewing the Board Assurance Framework and exploring the next steps for Integrated Performance Reporting.

A Board Away Day was held on 20 November, which was attended by the Chair, Graham Russell, our Chief Operating Officer, Sarah Branton, Director of Improvement and Partnerships, Rosanna James, Director of Nursing Therapies and Quality. Nicola Hazle, and I. The day provided a welcome opportunity to collectively consider areas of risk and how the system is responding. The main areas of focus for the day were Equality, Diversity & Inclusion, improving staff experience and continuous quality improvements.

2.3 Community Hospitals Association

On 10 and 11 October, the national Community Hospitals Association Conference was held at the Chase Hotel in Brockworth. The conference provided a welcome opportunity to connect with colleagues from across the sector and to share knowledge and learning. There were a variety of keynote speakers, some of which were delievered by GHC colleagues, including our Service Director for Community Hospitals & Urgent Care, who provided an update on the work "Our Community Hosptials" are currently delivering. There were also afternoon workshop sessions, which provided an opporutnity for delegates to share and inform future thinking in these spaces.

2.4 Urgent and Emergency Care Intermediate Care

On 18 October I, along with Sarah Scott, Executive Director of Adult Social Care, Wellbeing and Communities at Gloucestershire County Council, chaired the third, in a series of four workshops, aimed at supporting the design of our mid-to longer term pathway 1 model and Reablement within Gloucestershire and clarifying our expected levels of demand and capacity during the winter period.

The workshop confirmed planning for this winter and looked ahead to 2025 and beyond. Further work is in hand to work on the long term future model for HomeFirst and Reablement services within Gloucestershire.

2.5 One Glos System Leadership Conference

On 23 October I attended the One Glos System Leadership Conference, which was held at Kingsholm Rugby Stadium. The theme for this in-person conference was "Turning Uncertainty into Opportunity" and was aimed at communicating our ICS strategy, vision and objectives to the system leadership. The day allowed this group to work collaboratively to build networks, which will assist in developing and improving cohesive services. It is important for senior leaders and executives to take time to develop capacity to ensure solid partnership working, which can then be cascaded within the individual organisations. I joined the other system CEOs for a questions and answers panel which provided attendees with an opportunity to raise matters of interest for our response.

2.6 Gloucestershire Leadership Conference

On 8 November I, along with Rosanna James, Director of Improvement and Partnerships, attended the Gloucestershire Leadership Conference, which was hosted by Gloucestershire County Council to bring together the senior leadership teams from across the system. The purpose was to set a clear vision for how all the public sector services can best work together to deliver for the Gloucestershire residents, recognising and tackling the collective challenges and maximising opportunities.

The session was a welcome opportunity to renew our partnerships, strengthen our relationships and build a collective vision for what we can achieve together. There are likely to be further sessions in the coming months.

2.7 Launch of Gloucestershire's One Plan for Children and Young People

On 19 November I attended the official signing and launch of Gloucestershire's One Plan for Children and Young People, which was held in the Council Chamber in Shire Hall. The One Plan for Children and Young People captures the shared ambition and actions that will help ensure Gloucestershire's assets are used to enable children and young people in the county to grow up healthy, resilient, prosperous and connected within communities and environments that nurture. The plan draws its priorities from an analysis of the data and on what children, young people, their families and partners told us about their experience and priorities. At the launch event, there was an opportunity to sign up to the plan, underscoring our organisation's commitment to contributing to its delivery and to join the delivery groups that will help deliver its ambitions.

3.0 NATIONAL / REGIONAL UPDATES

3.1 South West Leadership Day

On 2 October I attended an in-person meeting in Exeter with my counterparts across the South West, which focussed on preparations for winter and how we approach improvement across the NHS. Elizabeth O'Mahony, SW Regional Director for NHS England, introduced the day and set out why, in the light of Darzi's report (covered in more detail below), increasing importance is being placed on co-production and culture and how leaders can work to ensure that change happens. There was also an update on the launch of the new Learning and Improvement Networks and how those will link with NHS Impact.

3.2 NHS Providers Conference

On 12 and 13 November, I attended the NHS Providers Conference along with Neil Savage, Director of HR & OD, and two of our Non-Executive Directors, Sumita Hutchinson and Vicci Livingstone-Thompson. Amongst many other items of interest, we heard from the Health and Social Care secretary Wes Streeting on his plans for the health service in the coming months and years. As well as new measures to hold Chief Executives and Trusts to account for performance, he reiterated his plans for three big shifts - moving care from hospitals into communities, from analogue to digital and from treating illness to prevention. These aims are very relevant to our Trust and our services.

NHS Chief Executive Amanda Pritchard also outlined plans to transform NHS leadership and management over the next two years and a new National Director of Management and Leadership, Samantha Allen, has been appointed to lead on the delivery of this important work. The focus will be on attracting, training and retaining the best leaders and managers. Healthcare managers and leaders are crucial members of all healthcare teams and influence the quality of care, the outcomes for patients and the experience of the workforce and culture.

3.3 South West Mental Health Chief Executive Meeting

On 15 November I attended in-person meeting for the South West Mental Health Chief Executives. There was a busy agenda which allowed us to collectively explore a

variety of items of interest, including a quality and performance overview, consideration of strategic risks and options to act and influence collectively. It was a welcome opportunity to connect with colleagues across the South West to discuss approaches and collectively learn and improve practices.

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 attended the first Steering Group meeting on 7 October, which provided an update on progress to date, including the discovery findings and initial framework design.

4.0 EVENTS

4.1 Allied Health Profession Community of Practice event

To celebrate National AHP Day, our Trust's held its second annual AHP Community of Practice Forum on 8 October at Dowty Sports and Social Club in Down Hatherley, Gloucester. The event was hosted by GHC's Chief Allied Health Professional Sarah Birmingham and was well attended by Allied Health Professionals, Health and Exercise Practitioners and AHP Support Workers working across the Trust in clinical, leadership, educational and management roles. I attended the event, along with Nicola Hazle, Director of Nursing, Therapies and Quality, to introduce the event and highlight the significant contribution of GHCs AHPs to the communities we serve.

Attendees enjoyed talks and presentations by a number of speakers and topics on the agenda included 'Children and Young People's Integration Initiatives' and our Head of Research presented on the subject of 'AHP Research'. One of our Experts by Experience talked about 'Integrated Care in Action'; sharing her experiences of growing up with cerebral palsy, the effects the condition had on her and her experiences of integrated care support.

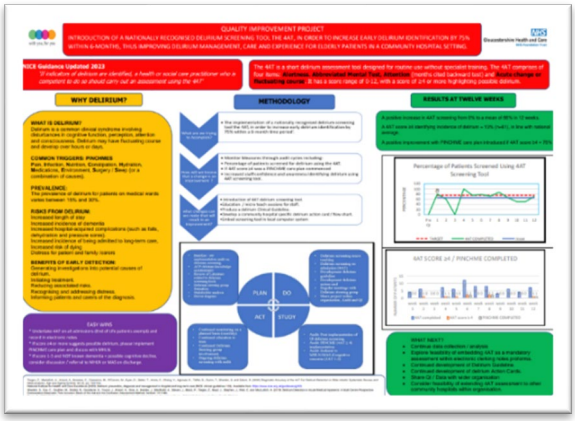
5.0 ACHIEVEMENTS / AWARDS

5.1 Apprenticeships

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

- Laura Smith – Level 3 Medical Administration
- Agnes Zivcakova - Level 3 Medical Administration
- Maisie Cuthbert – Level 3 Business Administrator
- Albon Lane – Level 3 HR Support

5.2 CATU delirium project wins CHA Innovation Award



Our Clinical Assessment and Treatment Unit (CATU) team's Jo Barnes was presented with an award by the Community Hospital Association (CHA) at the two-day conference on 10 and 11 October.

Advanced Practitioner Jo won in the Innovation and Best Practice category for designing a delirium screening tool which incorporated the latest guidance from the National Institute for Health and Care Excellence (NICE). This improvement introduces the 4AT screening into practice in a methodical and sustainable way, demonstrating Quality Improvement in action to improve patient care.

5.3 Wellbeing Line Collaborative Project

The Wellbeing Line's collaborative project with Alison Sedgwick-Taylor (mindfulness teacher and creator of A Mindful Practice) and the University of Bath has made it to the finals of the Innovations in Mindfulness Awards 2024. The project, providing mindfulness-based cognitive therapy (MBCT) to staff working in primary care across Gloucestershire, was funded by an NHS England grant.

The project is a great example of the role The Wellbeing Line can play in co-ordinating the development and delivery of projects supporting the mental health and wellbeing of our health and care workforce - 'Growing the Green Together'.

5.4 Cardiac Rehabilitation Team receive accreditation

The Cardiac Rehabilitation Team have achieved accreditation with the National Certification Programme for Cardiac Rehabilitation (NCP_CR) BACPR/NACR. The updated BACPR Standards & Core Components represent agreed national standards for the delivery of Cardiac Rehabilitation in the UK. Over the past few years, there has been a growing emphasis on quality assurance of services across the NHS. Only around a quarter of cardiovascular disease prevention and rehabilitation programmes in the UK meet quality standards, so well done to the team for this achievement.

5.5 National role for GHC Expert by Experience

One of our Trust's service users and Expert by Experience has been successful in securing a national role as Service User Representative on the Mental Health Network Board. This will allow them to continue to use their experience to help others in front

of a wider audience and to make a difference to the experience of service users both within our Trust and other Mental Health organisations nationally.

This role provides a unique opportunity to shape the work of the Network and become involved in shaping mental health policy and practice on a national level. The Board term will last three years, with an option for a second three-year term to a maximum of six years.

5.6 Health Visitors shortlisted for nursing awards

Two members of our Health Visiting team have received recognition at the recent South West NHS England Community & Primary Care Nursing Awards. The awards focus on celebrating the excellence of general practice nurses and the pivotal role they play in population health management. This is the first time that there has been a children and young people award for Specialist Public Health Nurses and winners must demonstrate inspiring and innovative approaches. They are also required to demonstrate sustainability, and engagement with others in this work and should produce an improvement in patient care or experience.

5.7 Award win for Working Well service

Our Working Well service was recently awarded Highly Commended at the NHS Health at Work Network Recognition Awards in the Growing Occupational Health and Wellbeing across the ICS category.

This award is a result of the partnership working with the South West Ambulance Service Trust to establish Occupational Health Services across the South West using a hub and spoke model. This piece of work was achieved through collaboration and partnership with Working Well, SWAST and the fantastic spokes across the South West.

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.

There are 4 phases to operationalise the roll out of this work:

- Phase 1 AWOLS - Live (implemented on 31 July 2024)
- Phase 2 Concern for Welfare and Frequent Callers (implemented on 24 September 2024)
- Phase 3 Walkout from Healthcare and Missing
- Phase 4 Section136 Mental Health Detentions

A Memorandum of Understanding (MOU) has been agreed to provide clarity on the role of police in responding to incidents within a mental health setting and to formalise the agreed working practices between Gloucestershire Constabulary and GHC. The intention is to outline when and how the responsibilities of the police service fit into the established roles and responsibilities of care providers.

The MOU aligns with the principles of the Right Care, Right Person approach and the national commitment by the Home Office, Department of Health and Social Care, National Police Chief Council, Police and Crime Commissioners and NHS England to work together to end avoidable police involvement in responding to people with mental health needs. All actions taken should be jointly agreed to ensure they are:

- Proportionate
- Legal
- Accountable
- Necessary
- Ethical

7.0 CHANGE NHS

The Secretary of State for Health and Social Care, Wes Streeting, along with NHS Chief Executive Amanda Pritchard have written to Trusts outlining **'Change NHS: help build a health service fit for the future**: **a national conversation to develop the 10-Year Health Plan.'**

On 12 September, Lord Darzi published his independent review of the NHS (the full report can be found here), which was intended to start an open and honest conversation about the state of our health and service and the reforms needed. The review revealed the scale of the challenge faced.

For decades, there has been broad consensus that to overcome the challenges facing the NHS, the focus must be on providing more care in the community, so hospitals are able to treat the sickest patients, make better use of technology, and do more to prevent ill health. A different approach is needed if we are to make these crucial shifts and deliver an NHS fit for the future.

NHS England and the Department for Health and Social Care are engaging with the public, as well as healthcare professionals, to develop a new 10-year plan and are inviting everyone to share their views to help co-design this Plan. They are committed to providing unprecedented levels of transparency to the policy making process and targeting those whose voices often go unheard. The national portal to share experiences and ideas can be found: here

8.0 MENTAL HEALTH BILL INTRODUCED IN PARLIAMENT

On 6 November the new Mental Health Bill was introduced in Parliament by the government to reform the Mental Health Act 1983 (MHA). The Bill is largely the same as the draft Mental Health Bill 2022, however, it does include several further changes, which include:

- **Detention Criteria** – 'how soon': the proposed requirement for clinicians to consider 'how soon' a harm might occur has been removed from the detention criteria.
- **Nominated Person**: the requirement for the Approved Mental Health Professional to see the Nominated Person in person has been removed.
- **Advanced Choice Documents**: the Bill seeks to introduce duties on Integrated Care Boards (ICBs) and NHS England (NHSE) to make arrangements so that people at risk of detention are informed of their ability to make an Advance Choice Document and (if they accept) are supported to make one.
- **Principles**: the Bill amends section 118, which makes requirements for the Code of Practice, to include the language of the four principles from the Independent Review.
- **Discharge**: the Bill contains measures for a new requirement for a patient's responsible clinician (or the responsible authority for the patient) to consult with a second professional involved in the patient's care when taking the decision to discharge them from certain powers under the Act.

Full implementation of these reforms once the Bill is passed, subject to future funding, is expected to occur in phases and take about ten years, largely due to the required training of additional clinical and judicial staff.

Next year's spending review will give clarity on the funding available up to 2027/28 and enable the Department for Health and Social Care (DHSC) to provide more clarity on implementation timeframes. Timeframes for the implementation of reforms introduced beyond 2027/28 will be contingent on future funding decisions.

Further information can be found: here

9.0 REVIEW INTO THE OPERATIONAL EFFECTIVENESS OF THE CARE QUALITY COMMISSION

In May 2024, Dr Penny Dash was asked by the Department of Health and Social Care (DHSC) to conduct a review into the operational effectiveness of the Care Quality Commission (CQC). The full report was published on 15 October and summarises the final findings of the review, outlining the necessary changes to start improving the CQC. The report makes 7 recommendations and is aimed at:

- health and care professionals
- health and social care services
- academic and professional institutions
- the general public

The full report can be found: here

A second review considering the wider landscape for quality of care, with an initial focus on safety, will be published in early 2025.

10.0 CONCLUSION AND RECOMMENDATIONS

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

REPORT TO: **TRUST BOARD PUBLIC SESSION – 28 November 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 October 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 7 position.
- The Trust Board is asked to **APPROVE** the changes to the Capital Programme

Executive summary

- At month 7 the Trust has a surplus of £0.21m compared to a plan of £0.198m.
- 24/25 Capital plan is £10.704m with £4.000m of disposals leaving a net £6.704m. programme. Spend to month 7 is £2.1m against a budget of £4.176m.
- Cash at the end of month 7 is £44.754m compared to plan of £49.881m.
- Cost improvement programme has delivered £3.658m of recurring savings at month 7 compared to plan of £3.997m.
- £4.818m of non-recurring savings have been delivered at month 7 against plan of £4.534m.
- The Trust spent £2.902m on agency staff up to month 7. This equates to 2.06% of total pay compared to the agency ceiling of 3.2%.
- Capital plan movements for 24/25 include reduced IFRS16 lease spend forecast (-£556k), adjustments to properties being sold, agreed final Buildings/Forest of Dean spend split.
- Capital plan movements for 25/26 include moving lease scheme to 26/27, introducing additional disposals, adjust Cirencester scheme costs, move other schemes into 26/27 and introduce NHS Net Transition scheme at £500k.

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 M7

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

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NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 09.1/1124

Finance Report
Month 7

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OVERVIEW

Gloucestershire Health and Care
NHS Foundation Trust

- At month 7 the Trust has a surplus of £0.210m compared to a plan of £0.198m
- 24/25 Capital plan is £10.704m with £4.000m of disposals leaving a net £6.704m programme. Spend to month 7 is £2.1m against a year-to-date budget of £4.176m.
- Cash at the end of month 7 is £44.754m compared to plan of £49.881m
- Cost improvement programme has delivered £3.658m of recurring savings at month 7 compared to plan of £3.997m. Target for the year is £7.319m of which £1.848m is currently unidentified.
- £4.818m of non recurring savings have been delivered at month 7 against plan of £4.534m. Target for the year is £5.661m, and all have been identified.
- In total the Trust has 15% of its savings target unidentified, a reduction of 2% from last month
- Worked WTEs were 59 below the budgeted WTEs in October
- The Trust spent £2.904m on agency staff up to month 7. This equates to 2.06% of total pay compared to the agency ceiling of 3.2%. There were 66 off framework agency shifts in October.
- Better Payment Policy shows 90.0% of invoices by value paid within 30 days, the national target is 95%.
- The 7 day performance at the end of October was 63.8% of invoices by value paid
- A number of amendments to the Capital Plan are proposed for the Board to approve

GHC Income and Expenditure

Gloucestershire Health and Care
NHS Foundation Trust

	2024/25 NHSE Plan 12th June	2024/25 Revised budget	2024/25 YTD revised budget	2024/25 YTD Actuals	2024/25 Variance - ytd actual to ytd revised budget
Operating income from patient care activities	272,338	299,917	172,662	172,785	123
Other operating income	16,993	17,365	10,130	11,151	1,021
Employee expenses - substantive	(198,597)	(240,861)	(139,802)	(126,868)	12,934
Bank	(17,771)	(2,523)	(1,472)	(11,124)	(9,652)
Agency	(7,152)	(1,165)	(679)	(2,904)	(2,224)
Operating expenses excluding employee expenses	(63,887)	(72,809)	(41,198)	(43,258)	(2,059)
PDC dividends payable/refundable	(2,624)	(2,624)	(1,531)	(1,508)	22
Finance Income	825	2,824	1,963	1,932	(31)
Finance expenses	(212)	(212)	(123)	(104)	20
Surplus/(deficit) before impairments & transfers	**(87)**	**(87)**	**(51)**	**102**	**153**
Gains/ (losses) from disposal of assets					0
Remove capital donations/grants I&E impact	87	87	51	108	57
Surplus/(deficit)	**0**	**(0)**	**(0)**	**210**	**211**
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)**	**210**	**211**
WTEs	4702	4742	4742	4683	59

I&E Forecasts

NHS
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	-311,959	-316,640	-319,284	-330,453	-333,425	-335,526
Pay	237,953	245,686	246,069	254,955	255,345	255,738
Non Pay	77,372	76,617	77,787	78,877	80,157	80,860
Total Recurring Deficit/ (surplus)	**3,367**	**5,663**	**4,571**	**3,379**	**2,077**	**1,073**
Non Recurring						
Income	-10,133	-8,616	-8,618	-8,631	-8,643	-8,656
Pay	4,514	6,430	6,120	5,850	5,850	5,850
Non Pay	2,391	1,570	1,680	1,825	1,775	1,725
Total Non Recurring Deficit/ (surplus)	**-3,228**	**-616**	**-818**	**-956**	**-1,018**	**-1,081**
Total Deficit/ (surplus)	**139**	**5,047**	**3,753**	**2,424**	**1,059**	**-8**
Depreciation on donated assets	-139	-127	-127	-127	-127	-127
Performance Deficit / (surplus)	**0**	**4,920**	**3,626**	**2,297**	**932**	**-135**
Recurring savings	-7319	-8,104	-7,276	-7,345	-7,364	-7,389
Savings as % of budget	2.5%	2.58%	2.30%	2.30%	2.29%	2.27%
Non recurring savings	-5662	-2,411	-2,270	-2,125	-2,175	-2,225
Savings as % of budget	2.0%	0.8%	0.72%	0.67%	0.68%	0.68%
Total savings	-12,981	-10,515	-9,546	-9,470	-9,539	-9,614
TOTAL Savings %	4.5%	3.35%	3.01%	3.0%	3.0%	3.0%

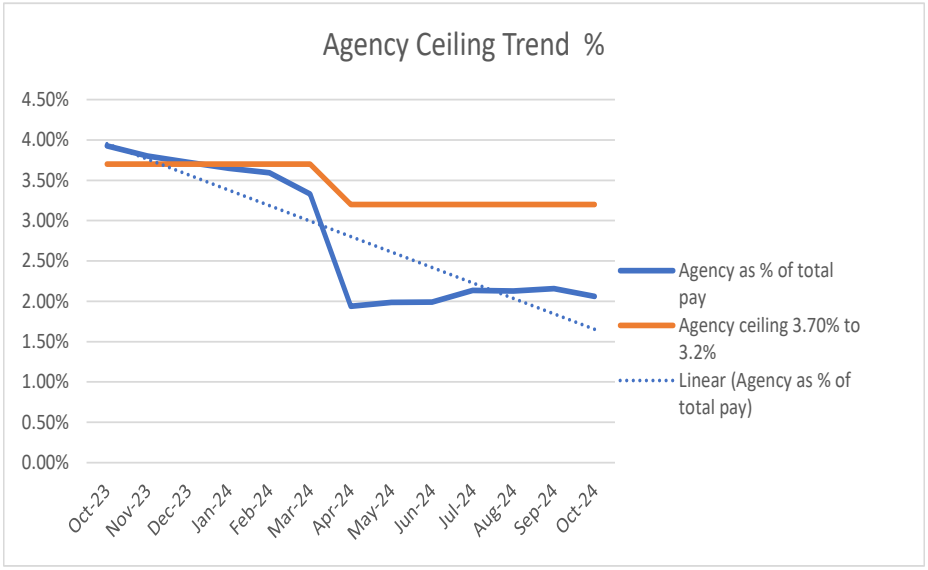
Integrated Urgent Care service added Inflation assumptions in line with NHSE guidance.
Income and Pay include c.£9.5m for employers contribution of nationally funded pensions.
Pay costs include National Insurance uplift from 2025/26 c. £4.2m

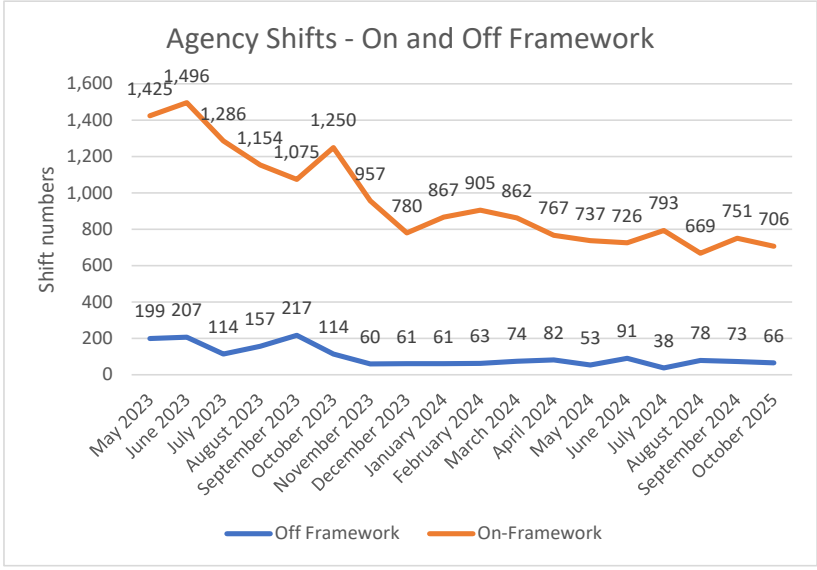
Pay analysis

Gloucestershire Health and Care
NHS Foundation Trust

Pay analysis month 7						
	Plan WTE Month 7	Budget WTE Month 7	Budget year to date £000s	Actual WTE Month 7	Actual year to date £000s	Actual ytd £ as % of Total £
Substantive	4,212	4,727	139,802	4,267	126,868	90.0%
Bank	368	16	1,472	366	11,124	7.9%
Agency	53	0	679	51	2,904	**2.06%**
Total	**4,634**	**4,742**	**141,953**	**4,683**	**140,895**	**100.0%**

- the Trust used 66 off framework agency shifts in October. 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
- 2.06% of pay bill spent on agency year to date. System agency ceiling 3.2%





From Mar 24 pay costs include nationally funded pension costs

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Balance Sheet

NHS
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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	1,816	1,634	(182)
	Property, plant and equipment: other	120,401	120,161	119,003	117,906	(1,096)
	Right of use assets	17,358	16,886	16,506	16,525	20
	Receivables	1,013	1,013	1,013	322	(691)
	Total non-current assets	**140,390**	**140,166**	**138,337**	**136,387**	**(1,950)**
Current assets	Inventories	356	356	356	343	(13)
	NHS receivables	3,184	3,184	3,184	12,453	9,269
	Non-NHS receivables	9,248	9,248	9,248	12,505	3,257
	Credit Loss Allowances	(1,565)	(1,565)	(1,565)	(1,457)	108
	Property held for Sale	5,025	1,201	3,025	5,024	1,999
	Cash and cash equivalents:	51,433	54,152	49,881	44,754	(5,127)
	Total current assets	**67,681**	**66,576**	**64,129**	**73,622**	**9,493**
Current liabilities	Trade and other payables: capital	(2,743)	(2,743)	(243)	(734)	(491)
	Trade and other payables: non-capital	(35,320)	(35,319)	(33,319)	(37,892)	(4,573)
	Borrowings	(1,454)	(1,385)	(1,414)	(1,410)	4
	Provisions	(8,464)	(7,464)	(7,930)	(7,736)	194
	Other liabilities: deferred income including contract liabilities	(1,086)	(1,086)	(1,086)	(3,926)	(2,840)
	Total current liabilities	**(49,067)**	**(47,997)**	**(43,992)**	**(51,698)**	**(7,706)**
Non-current liabilities	Borrowings	(14,925)	(14,752)	(14,245)	(14,153)	93
	Provisions	(2,510)	(2,510)	(2,510)	(2,488)	22
	Total net assets employed	**141,569**	**141,482**	**141,719**	**141,671**	**(48)**

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)	0
	Income and expenditure reserve	(2,888)	(2,974)	(2,737)	(2,888)	(151)
	Income and expenditure reserve (current year)		0	0	102	102
	Total taxpayers' and others' equity	**141,569**	**141,482**	**141,719**	**141,671**	**(48)**

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

Balance Sheet Forecasts

NHS
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STATEMENT OF FINANCIAL POSITION (all figures £000)		2024/25	2025/26	2026/27	2027/28	2028/29
Forecasts		Full Year Forecast	Forecast £000s	Forecast £000s	Forecast £000s	Forecast £000s
Non-current assets	Intangible assets	2,139	2,698	2,605	2,235	1,833
	Property, plant and equipment: other	120,841	123,736	123,909	123,922	123,915
	Right of use assets*	16,209	16,079	14,769	13,482	12,195
	Receivables	317	322	322	322	322
	Total non-current assets	**139,506**	**142,835**	**141,605**	**139,961**	**138,265**
Current assets	Inventories	343	343	343	343	343
	NHS receivables	3,453	3,134	3,104	3,074	3,044
	Non-NHS receivables	9,209	9,148	9,098	9,048	8,998
	Credit Loss Allowances	(1,457)	(1,449)	(1,565)	(1,449)	(1,449)
	Property held for Sale	2,743	1	501	1	1
	Cash and cash equivalents:	52,928	52,165	52,170	53,449	55,179
	Total current assets	**67,219**	**63,342**	**63,651**	**64,466**	**66,116**
Current liabilities	Trade and other payables: capital	(2,734)	(2,743)	(2,743)	(2,743)	(2,743)
	Trade and other payables: non-capital	(35,421)	(35,320)	(35,320)	(35,320)	(35,320)
	Borrowings*	(1,410)	(1,293)	(1,215)	(1,202)	(1,202)
	Provisions	(7,474)	(7,464)	(7,464)	(7,464)	(7,464)
	Other liabilities: deferred income including contract liabilities	(1,086)	(1,086)	(1,086)	(1,086)	(1,086)
	Total current liabilities	**(48,125)**	**(47,906)**	**(47,828)**	**(47,815)**	**(47,815)**
Non-current liabilities	Borrowings	(14,682)	(14,448)	(13,733)	(13,045)	(12,329)
	Provisions	(2,488)	(2,510)	(2,510)	(2,510)	(2,510)
	Total net assets employed	**141,430**	**141,313**	**141,185**	**141,057**	**141,727**

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)	(3,143)	(3,271)	(3,399)	(2,729)
	Income and expenditure reserve (current y	(138)				0
	Total taxpayers' and others' equity	**141,431**	**141,313**	**141,185**	**141,057**	**141,727**

Cash Flow Summary

NHS
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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**	**52,929**	**52,165**	**52,170**	**53,449**
Cash flows from operating activities										
Operating surplus/(deficit)	475		(219)		(642)		**1,835**	**1,697**	**2,218**	**3,016**
Add back: Depreciation on donated assets	189		109		93		28	28	28	28
Adjusted Operating surplus/(deficit) per I&E	**664**		**(110)**		**(549)**		**1,863**	**1,725**	**2,246**	**3,044**
Add back: Depreciation on owned assets	9,856		5,992		10,932		8,100	8,121	8,286	8,454
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		(12,769)		359		150	80	80	80
Increase/(Decrease) in provisions	502		(750)		(1,013)		0	0	0	0
Increase/(Decrease) in trade and other payables	(3,556)		2,376		101		0	0	0	0
Increase/(Decrease) in other liabilities	(21)		2,840		0		0	0	0	0
Net cash generated from / (used in) operations		**16,034**		**(2,408)**		**9,844**	**11,909**	**11,736**	**12,399**	**13,365**
Cash flows from investing activities										
Interest received	2,843		1,930		3,309		998	1,237	820	820
Interest paid	0		(5)		(10)		-7	(7)	(7)	(7)
Asset Held for Sale							0	0	0	0
Purchase of property, plant and equipment	(15,371)		(3,977)		(9,684)		(12,068)	(13,613)	(8,073)	(8,073)
Sale of Property	1,356				2,283		2,743	5,000	500	0
Net cash generated used in investing activities		**(11,172)**		**(2,052)**		**(4,102)**	**(8,334)**	**(7,383)**	**(6,760)**	**(7,260)**
Cash flows from financing activities										
PDC Dividend Received	1,710				0		**0**	**0**	**0**	**0**
PDC Dividend (Paid)	(2,409)		(1,179)		(2,586)		**(2,790)**	**(2,890)**	**(2,990)**	**(2,990)**
Finance lease receipts - Rent	230		4		4		**0**	**0**	**0**	**0**
Finance lease receipts - Interest	(8)		(2)		(1)					
Finance Lease Rental Payments	(1,559)		(947)		(1,457)		**(1,385)**	**(1,293)**	**(1,201)**	**(1,216)**
Finance Lease Rental Interest	(229)		(95)		(206)		**(164)**	**(165)**	**(169)**	**(169)**
		(2,265)		**(2,219)**	**0**	**(4,246)**	**(4,339)**	**(4,348)**	**(4,360)**	**(4,375)**
Cash and cash equivalents at end of period		**51,433**		**44,754**	**0**	**52,929**	**52,165**	**52,170**	**53,449**	**55,179**

Capital – Five year Plan

Gloucestershire Health and Care
NHS Foundation Trust

Capital Plan	Full Year Revised 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	2,197	390	51	1,900	3,000	3,000	3,000
Backlog Maintenance	1,612	1,290	639	1,893	1,393	1,393	1,393
Buildings - Finance Leases	420	0	0	256	1,900	250	250
Vehicle - Finance Leases	239	130	130	250	250	250	250
Other Leases	0	0	0	0			
Net Zero Carbon	645	388	60	1,000	0	500	500
LD Assessment & Treatment Unit				0	2,000	0	0
Cirencester Scheme				3,500	5,500	0	0
Medical Equipment	903	361	77	1,030	1,030	1,030	1,030
IT							
IT Device and software upgrade	880	0	519	320	600	600	600
IT Infrastructure	1,865	855	0	1,300	1,300	1,300	1,300
Transforming Care Digitally	770	525	8	1,260	790	250	250
NHS Net Transition				500			
Sub Total	**9,531**	**3,939**	**1,483**	**13,209**	**17,763**	**8,573**	**8,573**
Forest of Dean	617	237	617	0	0	0	0
Total of Updated Programme	**10,148**	**4,176**	**2,100**	**13,209**	**17,763**	**8,573**	**8,573**
Disposals	(2,281)	0	0	(3,599)	(5,000)	(500)	0
Total CDEL spend	**7,867**	**4,176**	**2,100**	**9,610**	**12,763**	**8,073**	**8,573**
Funded by;							
Anticipated System CDEL	**4,239**			**11,562**	**8,613**	**8,073**	**8,073**
IFRS 16	**659**			**506**	**2,150**	**500**	**500**
Additional CDEL	**3,250**						
Frontline Digitisation funding	**0**						
CDEL Shortfall / (under commitment)	**(281)**	**4,176**	**2,100**	**(2,458)**	**2,000**	**(500)**	**0**

Risks

Gloucestershire Health and Care
NHS Foundation Trust

2024/25 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	1848	1848		3	3	9
443	There is a risk that the costs of the Safer staffing project are greater than expected	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	350	950	-600	3	2	6
180	Mental Health Act White paper reforms	150	1400	-1250	4	1	4
	Total of risks	3198	5048	-1850			

NB: Mental Health Act reform risk impact greater in 2025/26

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Gloucestershire Health and Care

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REPORT TO: **TRUST BOARD PUBLIC SESSION 28th NOVEMBER 2024**

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

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

SUBJECT: **QUALITY DASHBOARD REPORT – OCTOBER 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 Trust Board are asked to **RECEIVE, NOTE** and **DISCUSS** the September 2024 Quality Dashboard.

Executive summary

This dashboard provides an overview of the Trust's quality activities for October 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.

Embarking on this journey involves a stepped approach to integration with the first steps taken being the removal of duplicated flat data followed by a scene setting meeting on the 4th November which clarified the Executive/ Board expectations around developing the new Integrated Quality and Performance Report. In addition, this session discussed the role, agreed a format and membership for an, Integrated Dashboard Development Working Group; to first develop a plan (*to be reported back to 19th Dec 2024 Resources Committee*), and then the delivery of that plan over the coming months and years (this is a multi-year

ambition). The reporting lines will be back into the Business Intelligence Management Group (BIMG) with the second planned meeting taking place on 19th November.

Quality issues showing positive improvement:

- Positive feedback has been received following the latest NED Quality Visits.
- The Q2 2024/25 NED audit has provided good assurance that overall, the Trust is investigating and responding to complaints appropriately.
- During October reassurances were received from the Local Authority that full data relating to both Adult Safeguarding referrals and Children's referrals will be received in November.
- There has been a decrease in the rates of rapid tranquilisation (RT).
- Overall, the number of patients that have not met the Criteria to Reside in a Community Hospital has reduced and shows as 19% average occupation of the Community hospital bed base.
- Developments of the integrated performance report.

Quality issues for priority development:

- We continue to report against an agreed set of metrics in relation to closed cultures, further work is needed to improve our approach and this will be developed over the next few months
- Further work is needed in some Community Hospitals in relation to further embedding improved compliance with MCA/DOLS. Work is planned to identify and implement ways to overcome this and will be explored and escalated as appropriate

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 - October 2024 Data

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

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 10.1/1124

Quality Dashboard 2024/25

Physical Health, Mental Health and Learning Disability Services

Data covering October 2024

This Quality Dashboard reports quality focused performance, activity and developments regarding key quality measures and priorities for 2024/25. 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).

Executive Summary

Are our services SAFE?

- During October reassurances were received from the Local Authority that full data relating to both Adult Safeguarding referrals and Children's referrals will be received in November. This means that going forward we can effectively audit, quality assure and monitor safeguarding referrals and the recording of safeguarding information in the trust . The adult Safeguarding annual audit is now complete, was signed off on 21.10.24 by Clinical Audit and will be presented at the next Safeguarding Group – Monday 11th November. Overall compliance is 65% (previous year 41%).
- There are fifteen statutory reviews - Safeguarding Adult Reviews (SARs) and Domestic Abuse Related Death Reviews (DARDRs) which are either currently progressing or being considered, including one new DARDRs that we've been notified of in October.
- There were a total of 1,231 patient incidents reported in October. Four new Patient Safety Incident Investigations were declared in October and four After Action Reviews (AAR) were undertaken in October
- Whilst no harm incidents have been trending upwards over time a significant reduction was recorded in October . Inpatient mental health and learning disability services saw the most significant reduction in no harm incidents: The primary drivers for this within inpatient mental health and learning disability services are a reduction in no harm restrictive interventions and a reduction in no harm falls . The positive developments of the self harm pathway and falls work continues at Wotton Lawn & Charlton Lane and any future analysis of activity will consider the impact on low and no harm incident reporting The total number of pressure ulcers developed or worsened under our care has potentially increased by 12 compared to the previous month. This includes an increase of 5 in the Cat 3 pressure ulcers, an increase of 10 for unstageable and deep tissue pressure ulcers, however, a potential decrease of 1 in the most serious pressure ulcer category (Cat 4).
- There is a decrease in the rates of rapid tranquilisation (RT) and this is attributable to a reduction in NG feeding however we see an increase in clinical holds which is attributable to the seasonal vaccination and Covid 19 Booster Programme.
- 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 report against an agreed set of metrics in relation to closed cultures. We intend to improve our approach in this area going forward and continue to engage with CQC as part of this work.
- We have agreed through QAG that Datix open and outstanding incident data will inform future operational governance meetings from December as a mechanism to reduce the variance, timeliness of completion and target those over 40 days old.
- Appendix 1 is included this month as a summary of the activity in relation to the 11 quality priorities.

Are our services CARING?

- Overall, 93% of Friends and Family Test (FFT) respondents reported a positive experience. Across the Trust, there were 2443 FFT responses last month.
- 14 formal complaints were received in October, with 81% of complaints being closed within 3 months and 100% of complaints being closed within six months, against targets of 50% and high-level respectively. 1 complaint were re-opened in October and the PCET continue to work collaboratively with patients and carers to ensure post-complaint actions are completed.
- There were 157 enquiries. 100% of complaints were acknowledged within the national 3-day requirement. At the end of October, there were 28 open complaints. There are 4 complaints that remain with the Parliamentary and Health Service Ombudsman (PHSO).
- There were 241 compliments recorded for the month. PCET visits continue at Berkeley House. Feedback from the new Forest of Dean hospital shows a positive rating of 90% from Inpatients (10 responses) and 95% for MIIU (63 responses).
- This month we include the Non-Executive Director (NED) Audit of complaints for Q2 2024/25 where assurance is given that the Trust is investigating and responding to complaints appropriately.
- At Appendix 2 is the Non-Executive Director (NED) Quality Visit summary for Q2. This process is being reviewed, and the format is expected to change in future submissions.

Are our services EFFECTIVE?

- Overall, the number of patients that have not met the Criteria to Reside in a Community Hospital has reduced and shows as 19% average occupation of the Community hospital bed base. There has been a decline in the number of patients who have not met the Criteria to Reside >30 days.
- The developmental Community Nursing data and associated narrative is in line with key quality proxy measures, as referenced by The Queens Nursing Institute. These will be further developed in future dashboards.
- Operations have been reviewing their lists of those who have the longest waits for our services and have started discussions around how we manage and understand any harm that our patients may be experiencing, whilst they are on our waiting list, waiting for a service. Discussions are planned with our colleagues in Operations to enable a joint approach to this work.

Additional information

- Appendix 3 identifies the planned programme of improvement for the dashboard, a high-level summary of the changes and proposed timeframes. To note no data will be lost as the changes will not go live until there is assurance that all required data is included.

Summary
Trust Safeguarding Data October 2024

- *There is assurance that Safeguarding activity which is a Trust priority function, is closely monitored and 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 and there are arrangements in place to monitor and provide assurance 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 of work in progress:

Progress is being made to further improve performance and therefore increase patient safety ,examples of this are detailed below**:**

- Progress continues to be made against the MCA work plan (risk 416) and a re-audit of mental capacity assessments and best interest decisions will take place in November 2024.
- During October reassurances were received from the Local Authority that full data relating to both Adult Safeguarding referrals and Children's referrals will be received in November. This means that going forward we can effectively audit, quality assure and monitor safeguarding referrals and the recording of safeguarding information in the trust (Risk 298)
- The changes made to the Safeguarding training offer prompted by the NHS England Strategy for Statutory and Mandatory Training were published on the Intranet on 28th October . The next part of our work in this area will look at how we can improve compliance (all risks)
- There are fifteen statutory reviews - Safeguarding Adult Reviews (SARs) and Domestic Abuse Related Death Reviews (DARDRs) which are either currently progressing or being considered, including one new DARDR that we've been notified of in October.
- The adult Safeguarding annual audit is now complete, was signed off on 21.10.24 by Clinical Audit and will be presented at the next Safeguarding Group – Monday 11th November. Overall compliance is 65% (previous year 41%) (risk 109)
- Work to measure the impact of the Adult Safeguarding template which was introduced to SystmOne in April continues, and we have also received confirmation that work towards the introduction of the Children's template will recommence mid to late December. (risks 109. 298 & 299)
- Members of the Adult's team are currently developing a 'Domestic Abuse in Older People' training package.
- A Safeguarding Monthly Focus on the Local Authority's Section 42 Duty was published in October.
- A presentation on Unexplained Injury in Adults was delivered recently to Safeguarding Champions around the Trust. The GSAB (Gloucestershire Safeguarding Adults Board) and the ICB have expressed interest in developing a policy as a result.

Challenges/risks:

- While we will shortly receive Safeguarding referral data as noted above, we do not currently have a clear idea as to GHC's referral activity (risk 298).
- Due to assisting with the preparation for the IUC service, work towards actions identified via the external Children's audit was temporarily put on hold but this is picking up pace again.
- There remain areas of the Trust where our MCA Lead has encountered resistance to implementation of improvement work regarding the application of MCA / DOLS responsibilities. Work to identify and implement ways to overcome this is being undertaken (risk 416) .

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

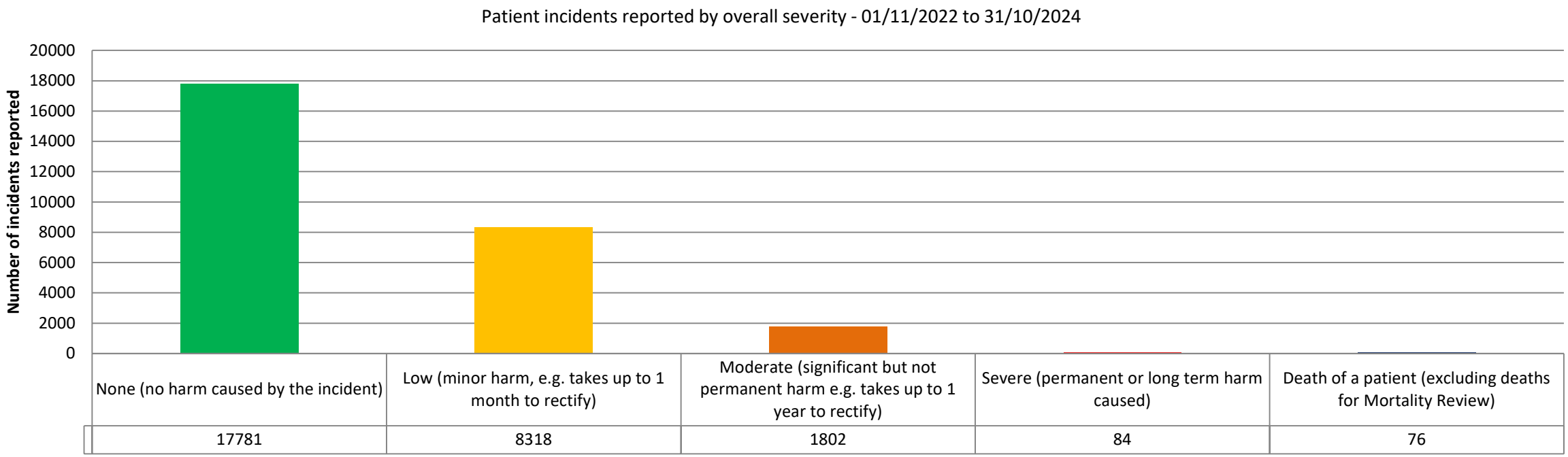
CQC DOMAIN - ARE SERVICES SAFE? INCIDENTS (Whole Trust data)

	Reporting Level	Threshold	23-24 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2024-25 YTD	R / A / G	Exception Report?	Benchmarking Report
Number of Never Events	N - T	0	1	0	0	0	0	0	0	0						0			N/A
Number of Patient Safety Incident Investigation (PSII) / Care Reviews	N - R		22	4	1	2	4	4	0	4						19			N/A
No of overdue SI actions (incomplete by more than I month)	L - R		N/A	0	0	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	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	0						0			N/A
Number of Learning and Engagement Sessions meetings taking place	L - R		168	19	26	18	8	3	18	17						109			N/A
Total number of Patient Safety Incidents	L - R		14148	1131	1191	1202	1215	1218	1314	1231						8502			N/A
Number of incidents reported as resulting in low or no harm	L - R		13298	1044	1115	1117	1126	1139	1213	1091						7845			N/A
Number of incidents reported as resulting in moderate harm, severe harm or death	L - R		946	87	76	85	89	79	101	140						657			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	1	2	0						13			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	0						2			N/A
Total number of sexual safety incidents	L- R		112	13	5	10	12	8	4	9						61			N/A
Total number of Rapid Tranquilisations (RT)	N - R		563	74	75	105	120	85	124	67						650			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



Key highlights:

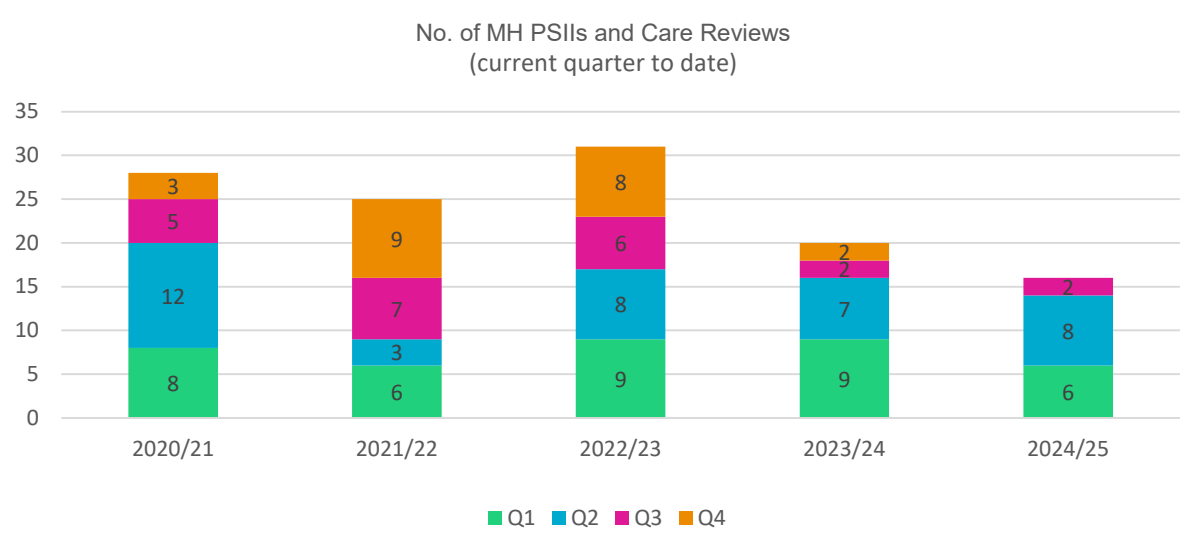
We have included in this dashboard a summary of patient safety incidents reported over the last 2 years and seek to present data that can identify patterns requiring deeper analysis.

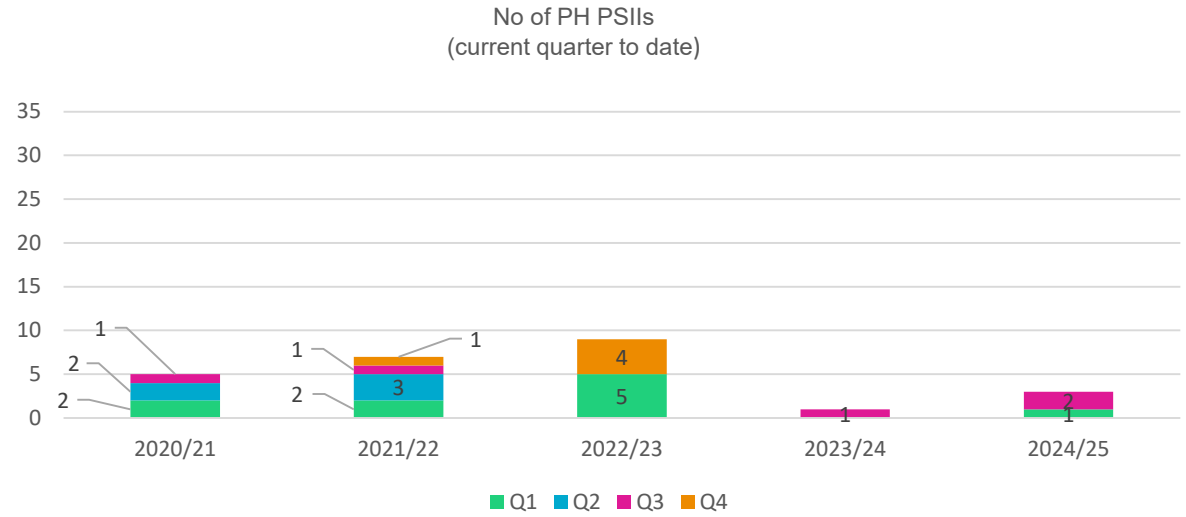
In October 2024 there were 1231 patient incidents reported on Datix, 83 less than September (1314). 1091 were reported as No and Low harm incidents, 122 less than September (1213) and 140 as Moderate or Severe harm or Death, 39 more than September (101).

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.

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





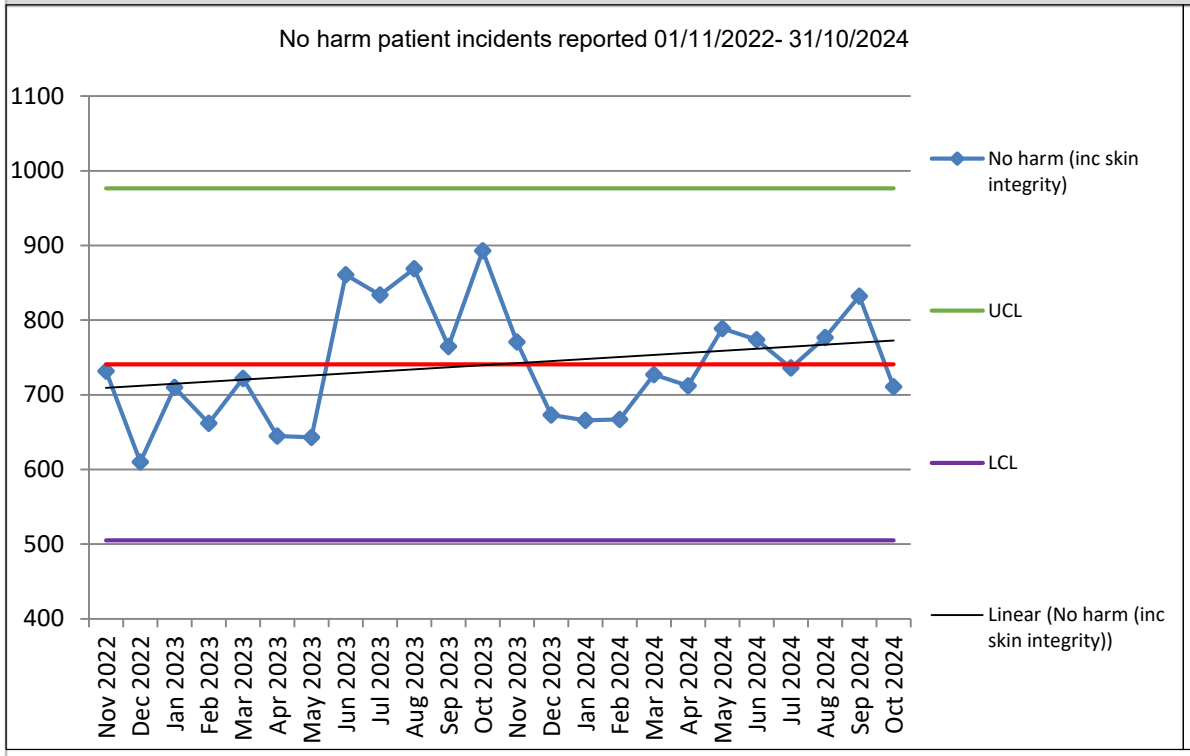
Key Highlights

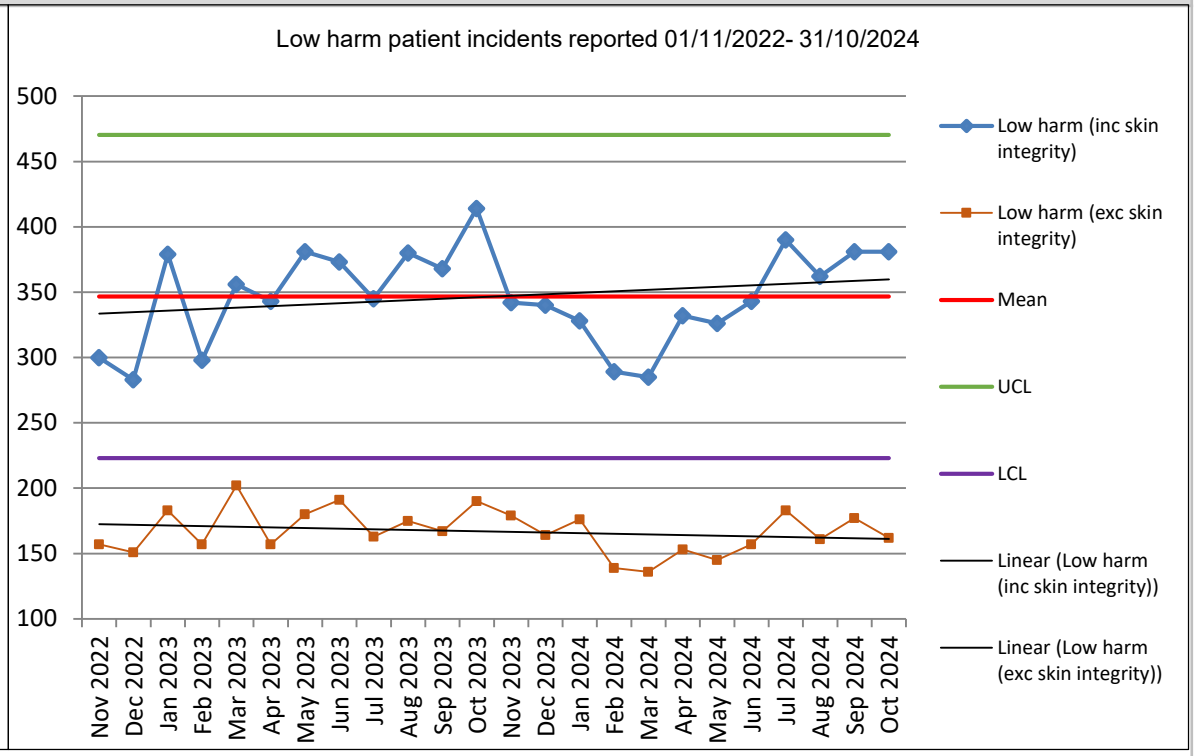
New Patient Safety Incident Investigations (PSIIs) and Care Reviews

Full details of all reviews have been presented at QAG and in the interests of patient confidentiality detail has been removed from this report.

- Four new PSIIs were declared in October , for each a review will be completed any learning shared .
- We have held four After Action Reviews (AARs) in October: 3 of the reviews identified areas of learning and action plans are being developed in relation to this , plus any learning will be shared . That said no significant commonalities were noted however the patient safety team will continue to monitor this.

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

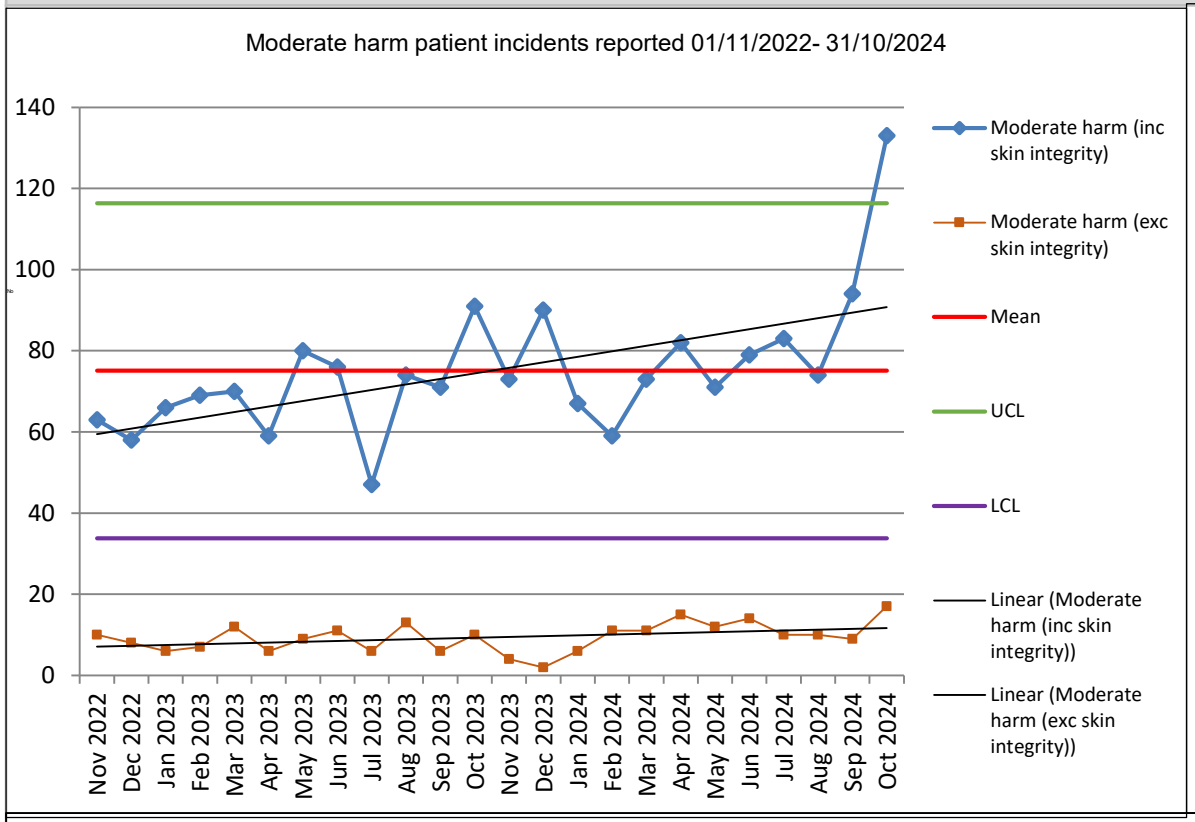


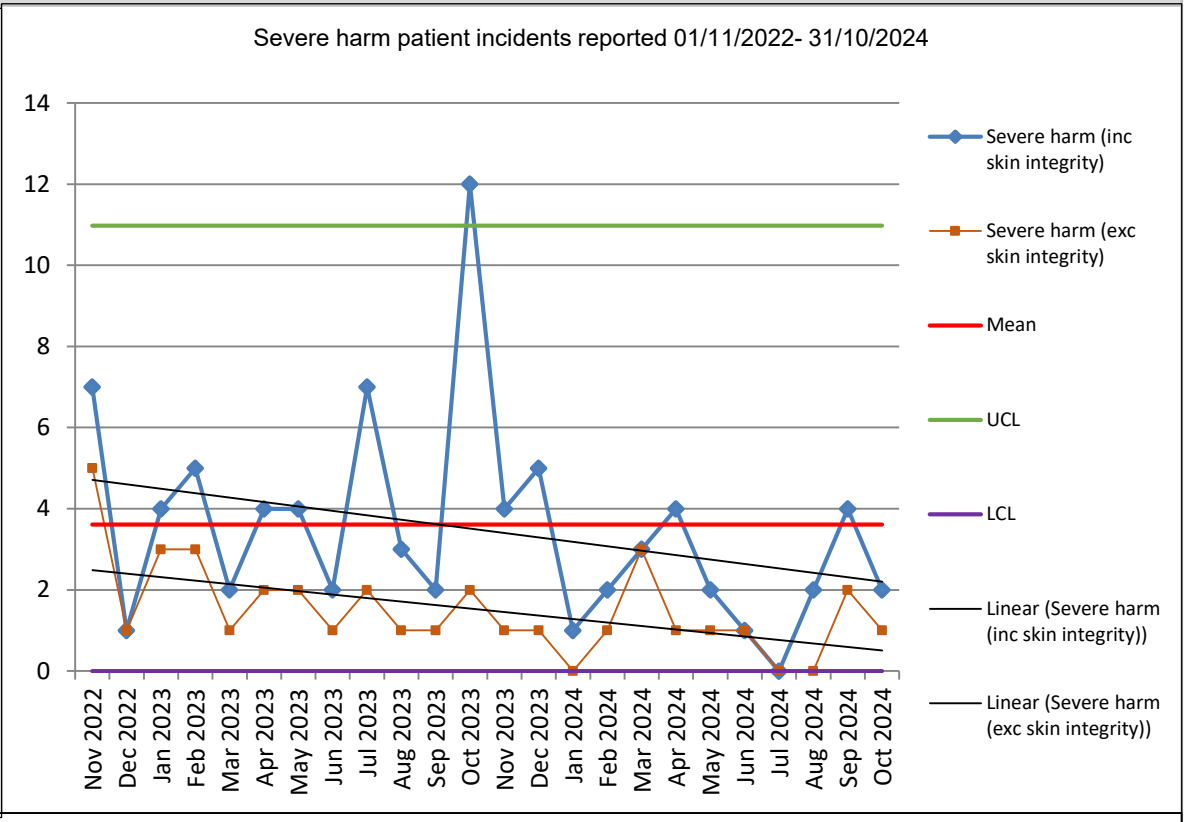


Key Highlights from No and Low harm incidents: (Note that the graphs have different axis to enable clear identification of data points).

- Whilst no harm incidents are trending upwards over time, 711 No harm incidents were reported in October, which is a significant reduction when compared with 832 in September. Inpatient mental health and learning disability services saw the most significant reduction in no harm incidents: 366 no harm incidents were recorded in October compared with 508 in September. The primary drivers for this within inpatient mental health and learning disability services are a reduction no harm restrictive interventions, specifically seeing a significant reduction for a patient at Wotton Lawn (227 in September versus 119 in October) and a reduction in no harm falls (113 in September versus 89 in October), noting that 89 no harm falls is still the second highest figure in 2024. The self harm pathway and falls work continues at Wotton Lawn & Charlton Lane and any future analysis of activity will consider the impact on low and no harm incident reporting.
- When skin integrity incidents are removed, a small reduction in low harm incidents was also seen (177 in September versus 162 in October). Similarly to no harm incidents, the biggest reduction was seen across our inpatient mental health and learning disability services (132 in September versus 103 in October). Small reductions in falls, restrictive interventions and self injurious behaviour were the primary drivers for this.
- 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. In October 2024 Patient Safety reviewed the harm of 28% (307) no and low harm incidents (including skin integrity). Of these, 9% (29) required the harm level regrading (6 – low to moderate harm, 19 – no to low and 4 – no harm to moderate) It should be noted, however, that these incidents are reviewed before handling by local managers and this approach helps to reduce inaccuracies and improves the accuracy of trend reporting. 1:1 feedback and support is offered to managers as part of the ongoing quality improvement offer from patient safety.

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





Key Highlights from moderate and severe harm incidents: (Note that the graphs have different axis to enable clear identification of data points).

- **Moderate harms:** Data for October indicates a rise in moderate harm patient safety incidents, this rise is predominantly driven by an increase in reported skin integrity incidents. Of the 133 skin integrity incidents, 53% (n=61) of these relate to skin damage that developed or worsened during GHC care. Noting that this data has not been validated and is not categorised, we anticipate that there will be further clarity when we report in December 2024. When skin integrity incidents are removed, 18 moderate harms incidents were reported in October 2024, 6 more than in September (12). The 18 moderate harms are heterogenous, with the exception of two incidents (different patients) of head banging at Berkley House. These incidents are both awaiting handling, and initial review suggests that the harm grade may be reduced.

- **Severe Harm:**. Severe harm incidents continue to show decreasing trend over time. In October 2024 two severe harm incidents were reported. One incident relates to a pressure ulcer present before admission to the Trust, and one incident relates to deterioration of a surgical wound as detailed on slide 2 (PSI-19-24/25, GHC78418)

Quality Dashboard

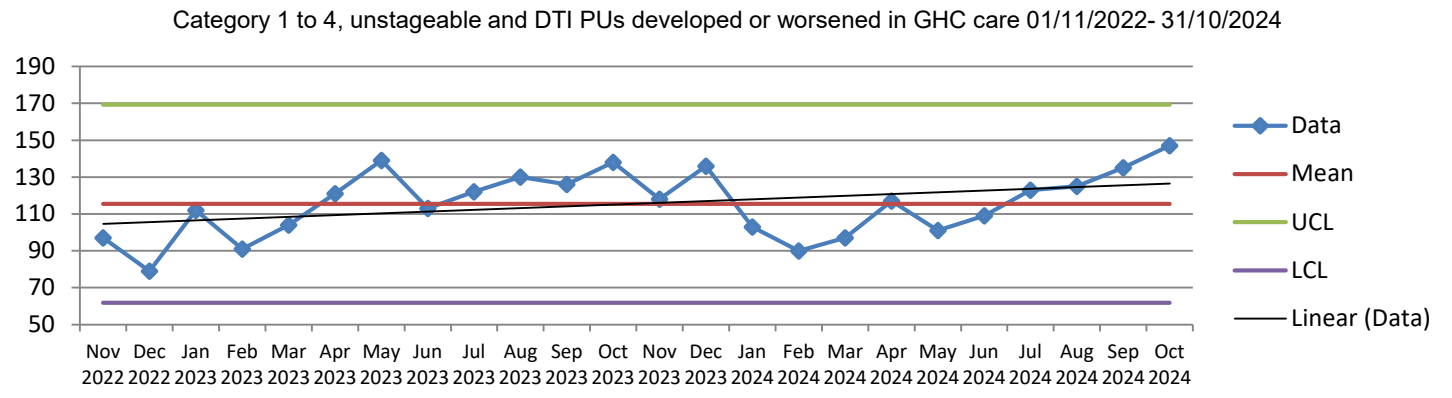
Gloucestershire Health and Care NHS Foundation Trust

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

	Reporting Level	Threshold	2023/24 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2024/25 YTD	R / A / G	Exception Report?	Benchmarking Report
VTE Risk Assessment - % of inpatients with assessment completed	N - T	95%	99%	97.8%	100%	97%	98%	98%	98%	99%						98%	G		
N02 - Minimise rates of C. Diff (Clostridium Difficile) - Hospital-onset Healthcare acquired (HOHA) cases only	N	14	5	1	0	0	0	0	1	2						4	G		
Number of MRSA Bacteraemia	N	0	0	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	109	123	125	135	147*						857			
Number of Category 1 & 2 pressure ulcers developed or worsened within our care.	L - R		912	87	70	72	72	81	82	80*						544			
Number of Category 3 pressure ulcers developed or worsened within our care.	L - R		44	4	4	4	5	2	8	13*						40			
Number of Category 4 pressure ulcers developed or worsened within our care.	L - R		16	4	1	1	3	3	1	0*						13			
Number of unstageable and deep tissue injury (DTI) pressure ulcers developed or worsened within our care.	L - R		461	22	26	32	43	39	44	54*						205			

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

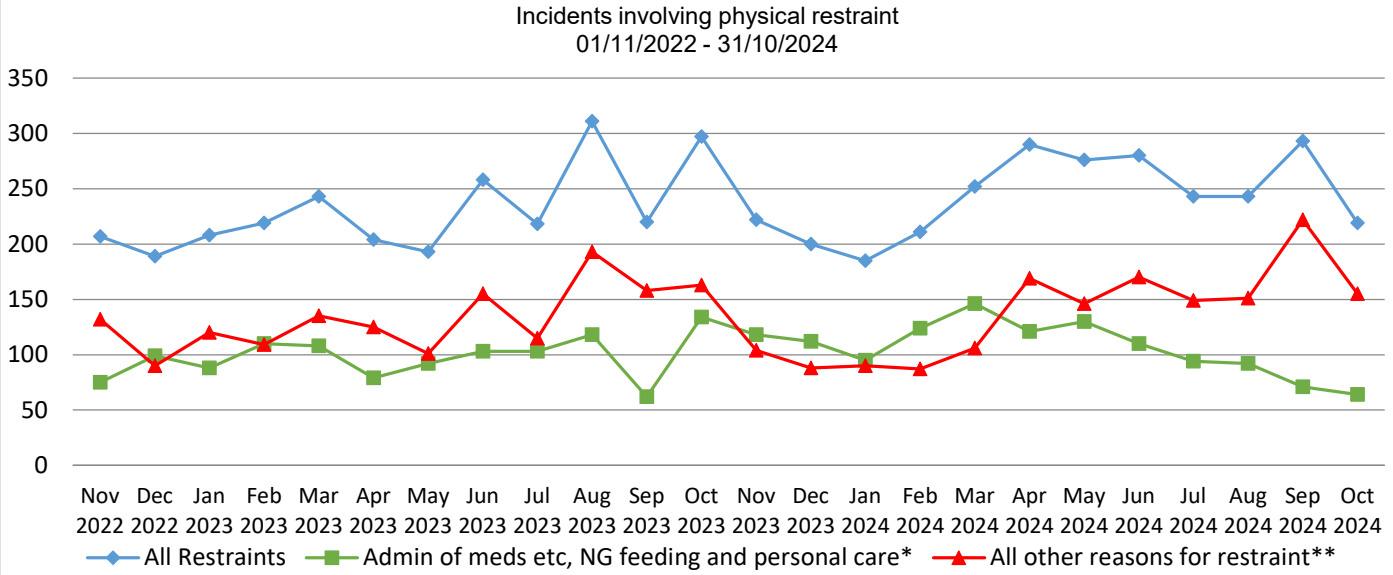
HCAI: C. Diff 1 patient on Cashes Green Ward was a transfer from GRH following treatment for UTI and Hospital acquired pneumonia. 1 Patient on Willow Ward was treated with antibiotics for cellulitis, standard process followed for both patients with good effect. Note our ICB threshold has been set at 14 for the year.

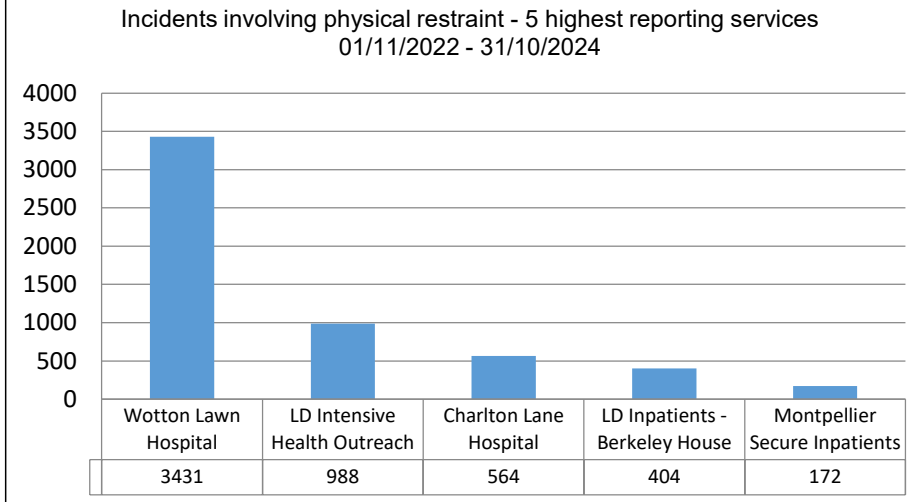


Pressure Ulcers:
All cat 3, 4 & unstageable pressure ulcers each month are subject to senior clinical review as part of our validation process.

*October 2024 data has not been fully validated so PU classification may alter after review. 57.9% of skin integrity incidents reported in October 2024 had been reviewed and closed by 04/11/2024.
Following validation of the September data, changes in the categories have occurred, with the largest change noted within the Category 3 pressure ulcers, seeing a reduction from 14 to 8 incidents.
Since June 2024, there has been a noted increase in reported pressure ulcers developed or worsened in our care. Further exploration to identify any recurring themes, including specific teams and / or patient characteristics associated with the rise will occur and findings will be shared in Decembers QAG meeting.

Incidents involving restraint



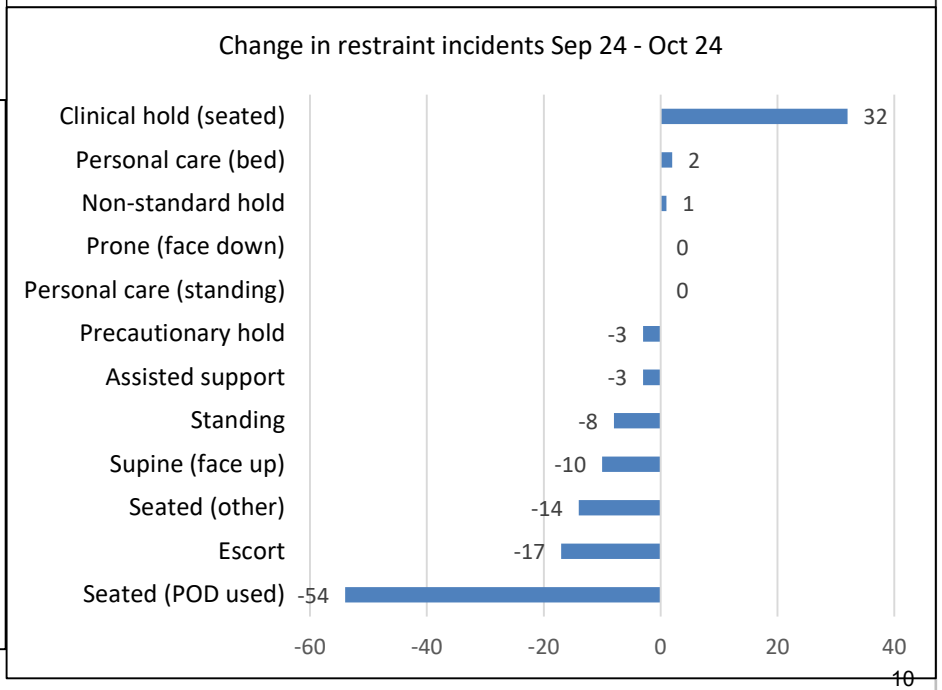


*Lawfully administer medicines or other medical treatment, Facilitate nasogastric (NG) feeding & Facilitate personal care
**Prevent a patient being violent to others, Prevent a patient causing serious intentional harm to themselves, Prevent a patient causing serious physical injury to themselves by accident,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

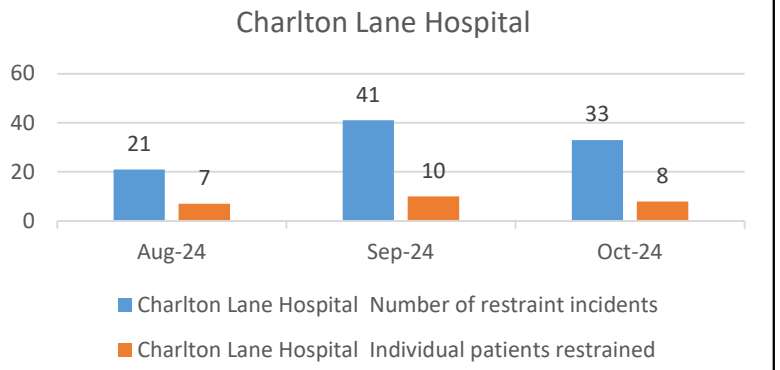
The levels of physical intervention to support the patient with NG feeding have been diminishing monthly since May 2024 and there has been a reduction in both physical interventions and RT used to manage self-harm on Priory Ward. Wotton Lawn Hospital has seen an overall reduction of 38% in physical interventions since August.

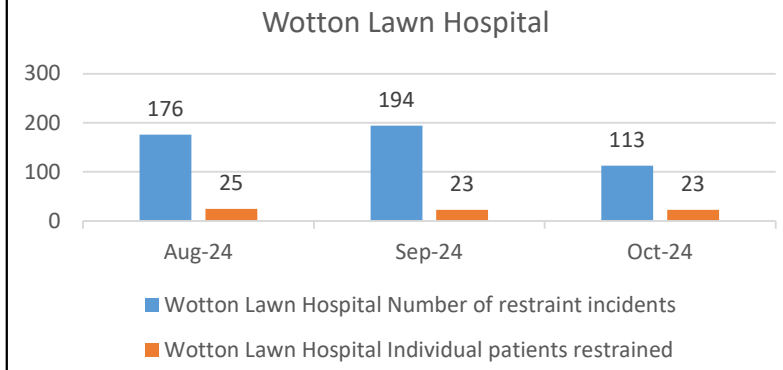
The increase in physical interventions within the IHOT team in October is associated with the seasonal vaccination and covid 19 booster programme. The chart to the right is an indicator of the type of incident reported and shows a significant reduction in seated (POD) use which is a reflection of the reduction in NG feeding.

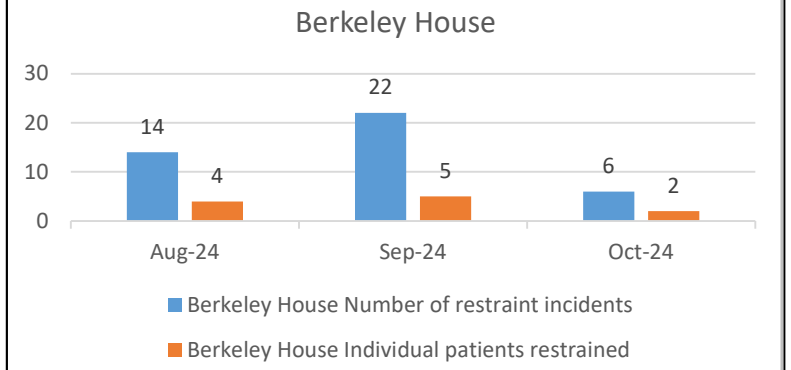
There were no recorded episodes of harm to patients as a consequence of physical interventions this month.

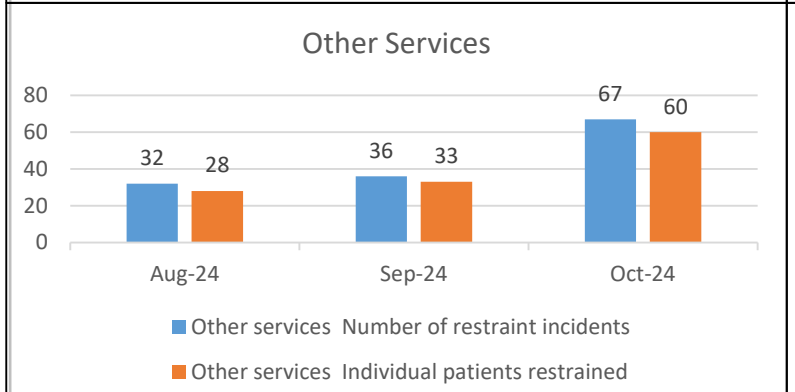


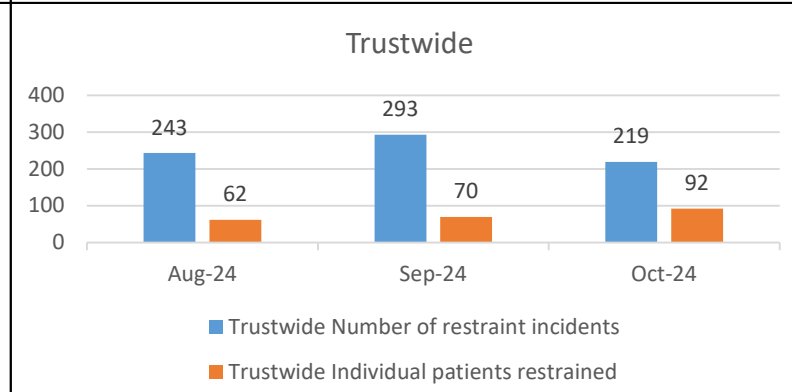
Incidents involving restraint – individual patients restrained

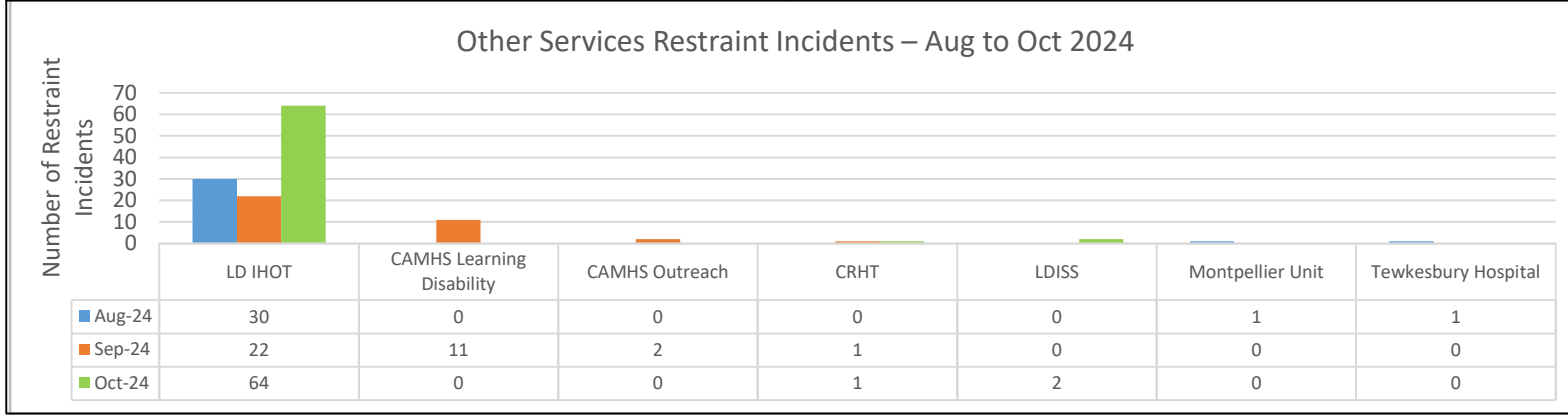












	LD IHOT	CAMHS Learning Disability	CAMHS Outreach	CRHT	LDISS	Montpellier Unit	Tewkesbury Hospital
Aug-24	30	0	0	0	0	1	1
Sep-24	22	11	2	1	0	0	0
Oct-24	64	0	0	1	2	0	0

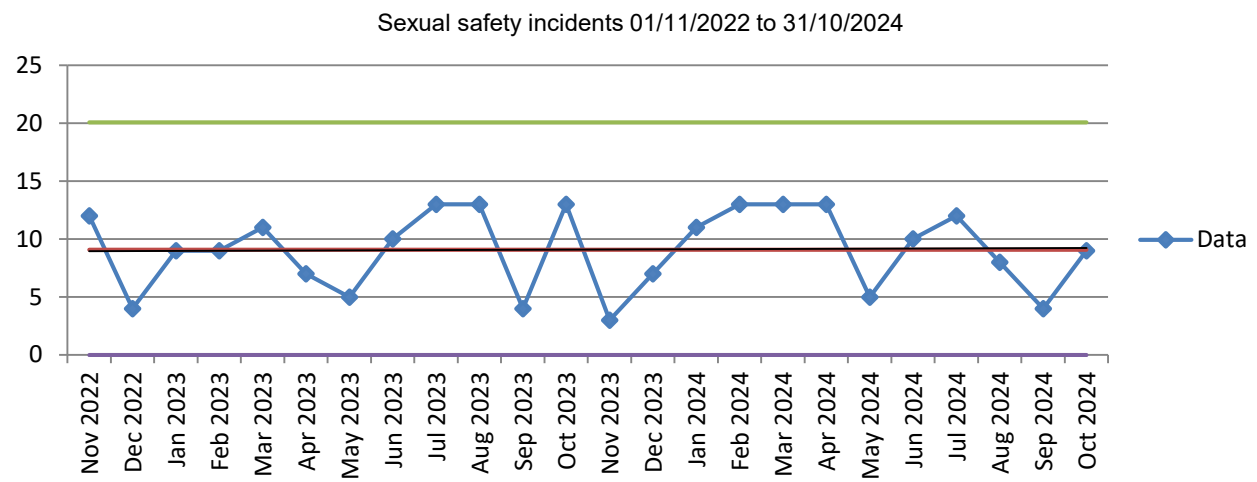
Mental health and learning disability inpatient services continue to account for the settings where individual patients are likely to have the highest frequence of restraints, although we note the seasonal variation attributed to the proactive work by IHOT in delivering the flu and covid vaccine programme. Looking more widely at other services:

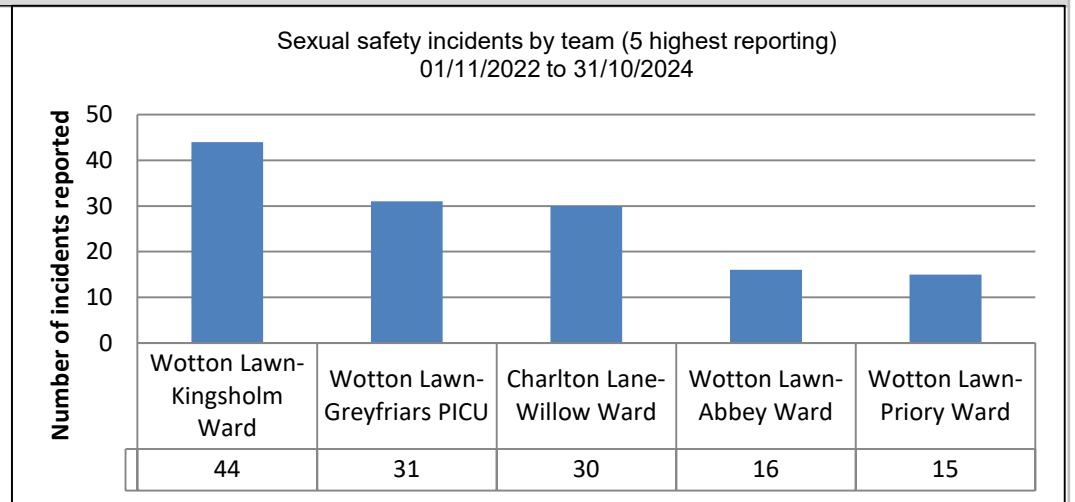
In October 2024 67 restraint incidents were reported across the other services of LD IHOT (64), LDISS (2) and CRHT (1). These involved 58 patients in LD IHOT, 1 patient in LDISS and 1 patient in CRHT.

32 of the 64 restraint incidents reported in LD IHOT in October 2024 related to the provision of seasonal vaccinations (Covid & Flu) in the best interests of the patients involved. , with the remainder associated with the delivery of physical healthcare needs such as phlebotomy or dentistry.

The impact on the overall increase in Trustwide data reflects the impact of the number of individual supported to have vaccines. Restraint in this context relates to safe and supporting holds

Sexual Safety Incidents

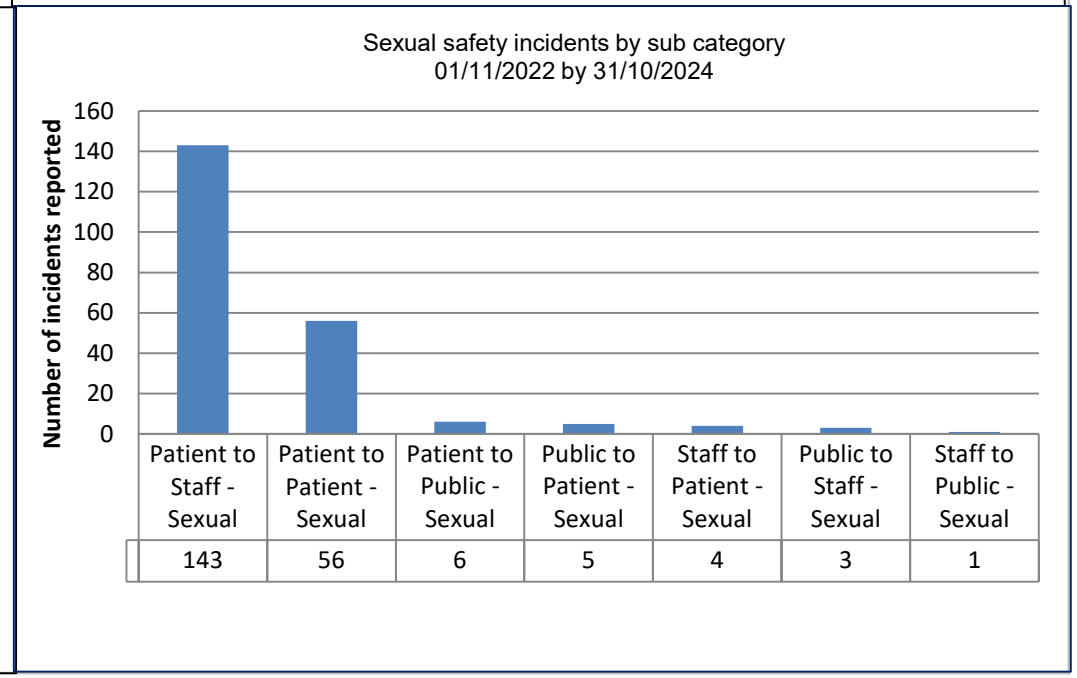




Sexual Safety update:

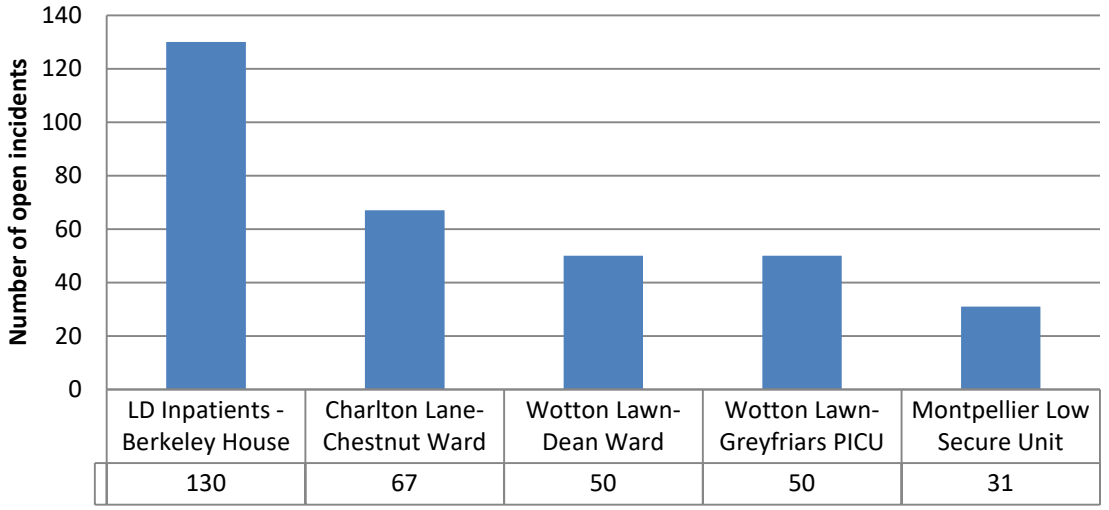
9 sexual safety incidents were reported in October, although 1 is being queried.

7 reported incidents occurred in mental health inpatient services, 4 occurring at WLH and 3 at CLH: Willow and Greyfriars Ward reported 2 incidents each, plus 1 incident each from Dean, Abbey, and Chestnut Wards. All 7 reported sexual safety incidents were patient on staff, as per the trend, and zero harm reported. The 'incidents by team' chart shows Willow and Greyfriars reporting a similar number of incidents over time. Both WLH & CLH report incidents of sexual disinhibition (3), sexual assault (2), and sexual harassment (2). Zero incidents involving AWOL or RP were reported.

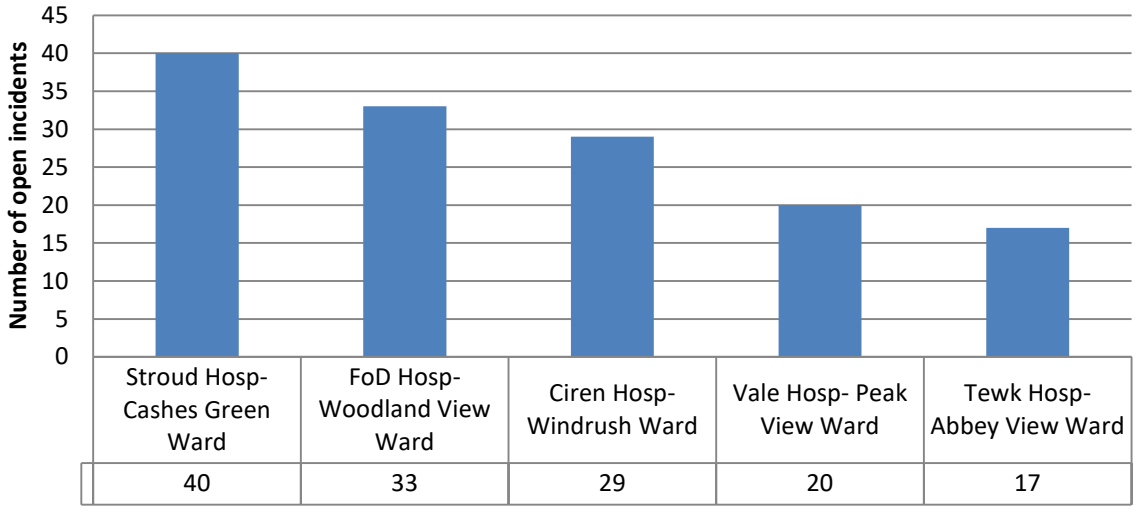


Incidents awaiting review and confirmation of level of harm: data priority areas and actions underway

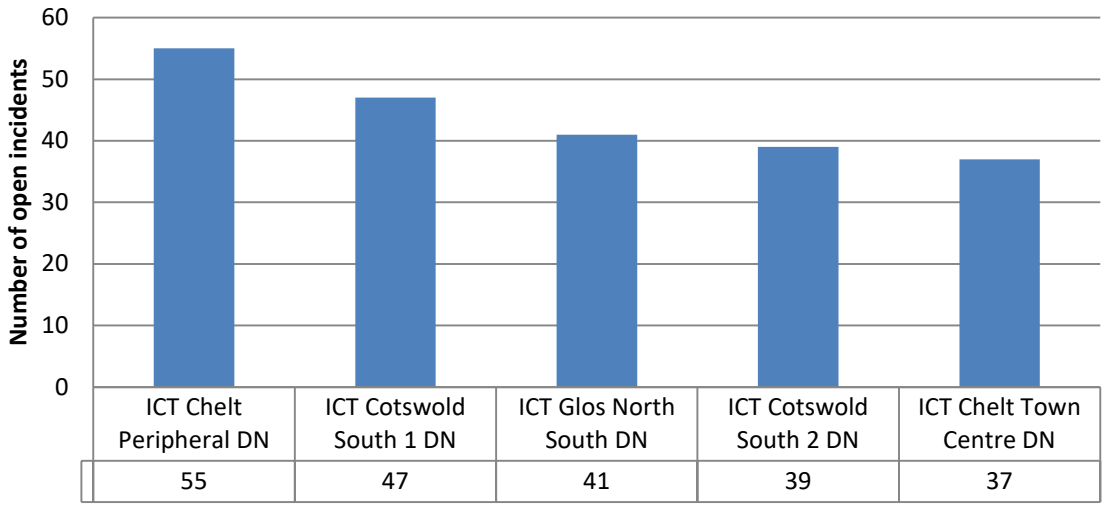
MH/LD inpatient wards/units (Top 5) –
Open incidents (awaiting review / being reviewed) as of 04/11/2024



Community hospitals (Top 5) –
Open incidents (awaiting review / being reviewed) as of 04/11/2024



ICT teams (Top 5) –
Open incidents (awaiting review / being reviewed) as of 04/11/2024



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

The total number of open incidents (awaiting review / being reviewed) that had yet to be closed was 1967 as of 04/11/2024. Of these:

- 1365 were incidents affecting patients
- 422 were incidents affecting staff
- 32 were incidents affecting visitors
- 148 were incidents affecting the Trust

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. 47 such incidents remain open as of 04/11/2024.

It has been agreed that this data will inform Operational Divisional Governance meetings from December as a mechanism to reduce the variance, timeliness of completion and target those over 40 days old.

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

Closed cultures – identification and risk factors (Sept 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 - We have 1 vacant post, out to advert, interviews 7th Nov. **Band 4 and 5** - Fully recruited! ***Band 3** - We have 1 vacant post, out to advert. Vacancy rates at 14%

Incidents: Familiar themes continue to remain present, majority of Datix incidents are for the management of disturbed patients (PMVA, RT administration and verbal abuse).

Training: Statutory and mandatory training rate 92.3% All training is on-going, with notable increase in the percentage rate of completion in most areas.

Issues: On-going challenges with regard to bed management and PICU beds being used for acute patients. This has impacted upon patients being moved to acute wards when they have met their PICU goals of admission. It is evident that this is impacting on the ability to consolidate patient's recovery in a less restrictive environment. However, there has been an improvement in patient flow, with a clear increase in patients being transferred to acute beds when deemed ready for transfer.

Other: Greyfriars ward is participating in the National Mental Health Act QI Programme, looking at change ideas to support reducing inequalities within mental health services.

Montpellier Unit

Staffing: Good staffing levels, 0.6WTE vacancy HCA which has gone out to advert. All other vacancies filled. Vacancy rate 4.7%

Incidents: 16 incidents in October which was less than last month. However, several were related to estates issues following a period of heavy rain. 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.

Training: Statutory and mandatory training compliance 96.6% overall. Relational security facilitators are starting to lead on projects including improving our empathy and trauma informed approach to care and improving our progress notes. Upcoming training for HCA's and EAP's regarding health outcomes, formulation, pathway plan and special arrangements, delivered in house by Unit Manager and Deputy Unit Manager. Staff have also been booked onto the ADDRESS: Working with personality disorder course, for which the current population at Montpellier consists of an ever-increasing proportion.

Issues: None to report, note that we are currently undertaking the RCP Quality Network for Forensic MH services peer review.

Other: CCQI day took place on 10th October – fantastic turnout of staff, patients and carers. Review teams were welcomed to the ward and had the opportunity to meet with staff, patients and carers. Awaiting final report. Daily activity with outside agencies and enhancing community focussed opportunities for patients.

Berkeley House

Staffing: Vacancy rates remain high at 28.1%. A new Registered Learning Disabilities Nurse started in October, another appointed and awaiting a start date. Interviewed and appointed 2 new HCAs. One has started, awaiting start date for the other.

Incidents: One major incident of note, a patient caused significant damage to their vehicle whilst returning from a trip out to see their mum. On their return to Berkeley House, their vehicle was damaged beyond safe use. A replacement vehicle was ordered and delivered in November.

Training and supervision: Statutory and mandatory training levels remain good at 94.4%. Supervision at 85%. Delivered some bespoke training to a partner agency to assist them in providing care to patients on their discharge.

Issues: None to report this month.

Other: Plans progress to discharge 4 of our patients, these are at various stages with the closest discharge planned for Dec.

Halloween party was a great success.

Charlton Lane Hospital, including Willow Ward

Staffing: Low **v**acancy rate, at 1.1% for whole of CLH.

Incidents: Slight reduction in incidents this month, 241 compared to 281 incidents in September - falls (96), violence and aggression patient to staff (49), restrictive interventions (40) and violence and aggression patient to patient or public (16) were the top 4 types of incident.

Training: Statutory and mandatory training compliance is good, currently 97.3%

Issues: None to report this month.

Other: Carers group attended well this month, 4 sets of carers present. Some of the feedback included- Willow relatives remarked on how caring the staff were and how great Ed was stating that he keeps them up to date regularly and is very professional. Mulberry relatives remarked how the staff were all very good, very caring, special shout out to Maxine, Sam, Mollie and Tracy.

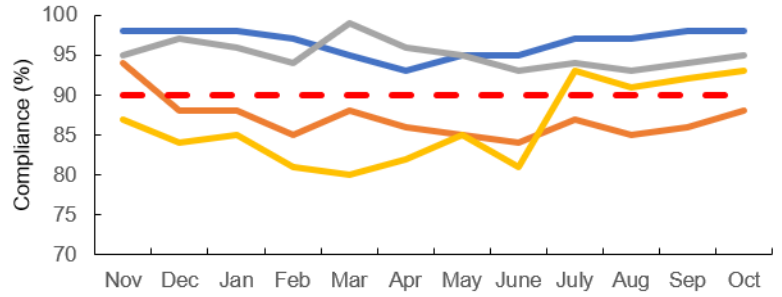
Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

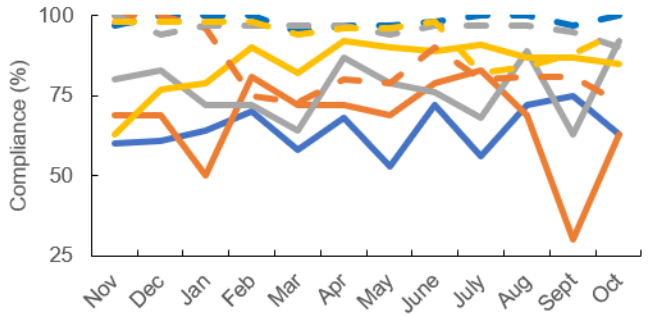
CQC DOMAIN - ARE SERVICES SAFE? Closed Cultures: eliminating the risk of our patients experiencing abuse

Closed cultures – Trust safeguards against risks

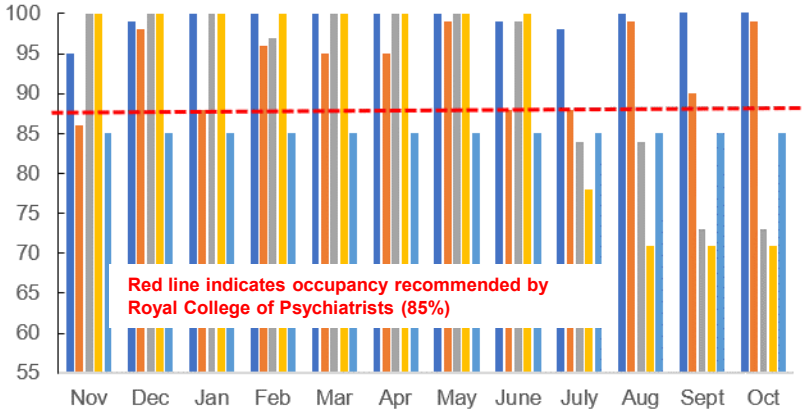
Safeguarding Training



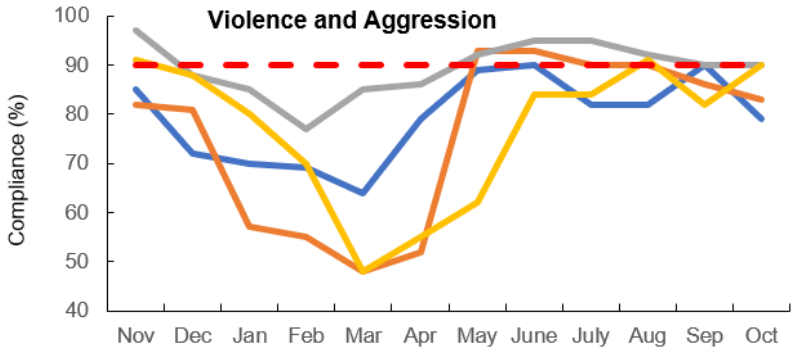
Supervision and Appraisals



Bed Occupancy (%)

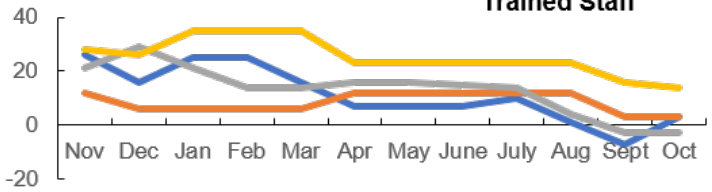


Violence and Aggression

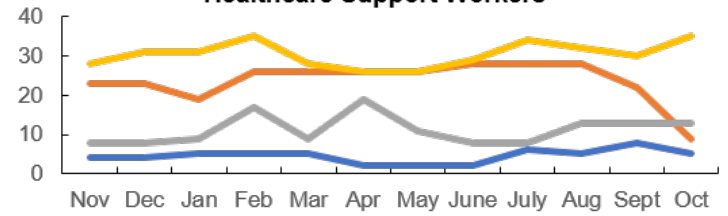


Staff vacancies (%)

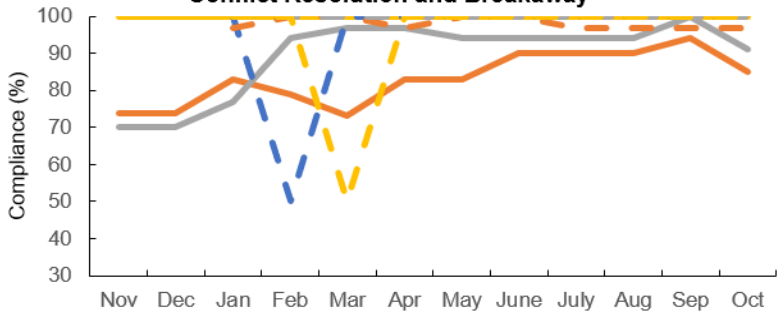
Trained Staff



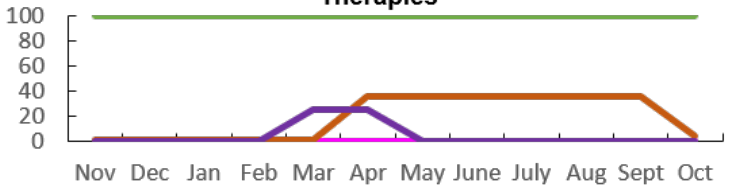
Healthcare Support Workers



Conflict Resolution and Breakaway



Therapies



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:

- Pink - CLH OT
- Brown - CLH physiotherapy
- Purple - Montpellier OT
- Green - Greyfriars OT

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.

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

		Nov	Dec	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct
Attempted assault	Willow W	4	3	3	4	1	4	5	5	2	4	2	2
	Greyfriars	0	0	0	1	2	3	0	0	0	0	3	5
	Montpellier	0	0	1	0	0	0	0	0	0	0	0	0
	Berkeley H	0	0	0	0	0	0	0	0	0	0	0	0
Physical	Willow W	8	3	3	7	8	1	14	8	3	3	9	6
	Greyfriars	3	2	2	3	2	13	2	4	0	4	10	10
	Montpellier	0	0	0	0	0	1	0	0	1	0	0	0
	Berkeley H	2	0	0	0	0	0	0	0	0	0	0	0
Verbal	Willow W	0	1	0	0	2	1	1	2	0	0	0	0
	Greyfriars	2	0	0	1	0	0	0	0	0	1	0	2
	Montpellier	0	0	1	1	1	1	0	0	0	0	0	2
	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	1	0	0	0	0	0	0	0	0	4	0	1
	Montpellier	0	0	1	1	2	0	0	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	8	6	7	28	56	5	30	4	2	18	12	13
	Greyfriars	9	27	26	31	18	54	20	19	16	38	65	48
	Montpellier	1	0	2	1	1	2	1	0	1	1	0	0
	Berkeley H	33	6	5	11	20	16	16	14	10	14	20	5
Total sexual safety incidents	Willow W	0	2	6	2	0	1	1	4	0	0	1	2
	Greyfriars	0	0	0	3	3	2	2	0	5	1	0	3
	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	2	4	4	6	0	3	3	4	2	0	0	3
	Greyfriars	4	3	1	1	1	2	2	3	3	0	0	2
	Montpellier	5	1	2	3	0	2	2	2	1	0	0	2
Enq/comment	Willow Ward	0	0	0		0	0	0	0	0	0	1	0
	Greyfriars	0	1	1	2	1	0	0	1	2	1	2	0
	Montpellier	1	0	0	0	0	0	0	0	0	0	0	0
	Berkeley House	0	0	0	0	0	0	0	0	0	0	0	0
Early resn	No new incidents												

Patient to staff incidents

	Nov	Dec	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct
Willow W	0	1	3	0	2	0	6	3	1	3	3	0
Greyfriars	2	3	5	2	1	5	0	1	2	4	8	3
Montpellier	1	0	0	1	1	0	0	0	0	1	0	0
Berkeley H	8	8	1	5	3	11	9	4	4	1	5	2
Willow W	17	6	7	3	6	4	8	5	1	13	8	19
Greyfriars	6	15	18	6	5	23	8	2	4	24	22	11
Montpellier	2	0	2	1	3	0	1	0	2	0	0	0
Berkeley H	46	29	15	11	14	30	18	21	10	19	29	7
Willow W	0	0	3	0	0	0	0	0	0	1	2	0
Greyfriars	1	4	6	4	1	1	1	0	1	2	8	4
Montpellier	1	3	1	2	3	2	3	1	1	1	2	0
Berkeley H	3	2	0	1	0	0	0	0	0	0	0	0
Willow W	1	0	1	2	0	0	0	0	0	1	0	0
Greyfriars	3	1	1	0	1	11	2	0	2	7	10	3
Montpellier	2	2	0	2	0	2	0	0	0	0	2	2
Berkeley H	0	0	0	0	0	0	0	0	0	0	0	0
Willow W	8	6	7	28	56	5	30	4	2	18	12	13
Greyfriars	9	27	26	31	18	54	20	19	16	38	65	48
Montpellier	1	0	2	1	1	2	1	0	1	1	0	0
Berkeley H	33	6	5	11	20	16	16	14	10	14	20	5
Willow W	0	2	6	2	0	1	1	4	0	0	1	2
Greyfriars	0	0	0	3	3	2	2	0	5	1	0	3
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
Willow W	2	4	4	6	0	3	3	4	2	0	0	3
Greyfriars	4	3	1	1	1	2	2	3	3	0	0	2
Montpellier	5	1	2	3	0	2	2	2	1	0	0	2
Willow Ward	0	0	0		0	0	0	0	0	0	1	0
Greyfriars	0	1	1	2	1	0	0	1	2	1	2	0
Montpellier	1	0	0	0	0	0	0	0	0	0	0	0
Berkeley House	0	0	0	0	0	0	0	0	0	0	0	0

Reported incidents of physical intervention and/or rapid tranquilisation in October, by individual.
Montpellier had 0 incidents in October

Willow Ward, 13 incidents

Greyfriars, 48 incidents

Berkeley House, 5 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

Safe Staffing Inpatient data October 2024

Ward Name	Code 1		Code 2		Code 3		Code 4		Code 5	
	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions
Gloucestershire										
Dean	7.5	1	0	0	0	0	0	0	0	0
Abbey	75	9	22.5	3	0	0	0	0	0	0
Priory	15	2	0	0	0	0	0	0	0	0
Kingsholm	15	2	0	0	0	0	0	0	0	0
Montpellier	20	2	22.5	3	0	0	0	0	0	0
Greyfriars	32.5	4	15	2	0	0	0	0	0	0
Willow	0	0	100	12	0	0	0	0	0	0
Chestnut	0	0	0	0	0	0	0	0	0	0
Mulberry	7.5	1	30	4	0	0	0	0	0	0
Laurel	195	25	22.5	3	0	0	0	0	0	0
Honeybourne	52.5	7	0	0	0	0	0	0	0	0
Berkeley House	0	0	527.5	59	0	0	0	0	0	0
Total In Hours/Exceptions	420	53	740	86	0	0	0	0	0	0

Key highlights:

The Director of Nursing, Therapies and Quality (NTQ) reviews safe staffing reports every month ahead of submission to NHS England (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 refenced highest exceptions with patient safety and patient experience data with no adverse trends being noted. Laurel House have reported the highest code 1 exception levels, followed by Abbey Ward. 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 on Abbey were attributable to RN vacancies on early and late shifts.

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

	Reporting Level	Threshold	2023/24 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2024/25 YTD	Notes
Number of Friends and Family Test Responses Received	N - R		30,519	2,471	3,093	2,638	2,274	2,314	1,960	2,443						17,193	Including 32 responses from carers (97% positive response)
% of respondents indicating a positive experience of our services	N - T	95%	94%	94%	93%	93%	93%	95%	94%	93%						94%	
Number of compliments received in month	L - R		2,506	151	241	156	203	211	173	241						1,376	As reported on last day of the month, noting compliments can be added retrospectively
Number of enquiries (other contacts) received in month	L - R		1,186	150	172	133	149	140	149	157						1,050	
Number of complaints received in month *Includes ALL complaints (closer look complaint / early resolution complaint)*	N - R		161	8	9	15	9	10	13	14						78	2 x MHUC/IP, 2 x CYPS, 9 x Comm (2 x MH and 7 x PH), 1 x Countywide
Of complaints received in month, how many were early resolution complaints	L - R			8	9	14	9	10	12	14						76	
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	30	28							
Percentage of complaints acknowledged within 3 working days	N - T	100%	100%	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	12	16						78	
Number of complaints closed within 3 months	L - I			9	9	7	4	5	11	13						58	We have adjusted our local KPIs in line with the NHS Complaints Standards targets
Number of re-opened complaints (not all opened within month)	L- R			3	1	1	1	0	2	1							
Number of external reviews (not all opened within month)	L - R			7	7	6	8	7	4	4							

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

Key Highlights:.

- We continue to see far more compliments than any other type of feedback and directorates now receive a full list of these each month.
- 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

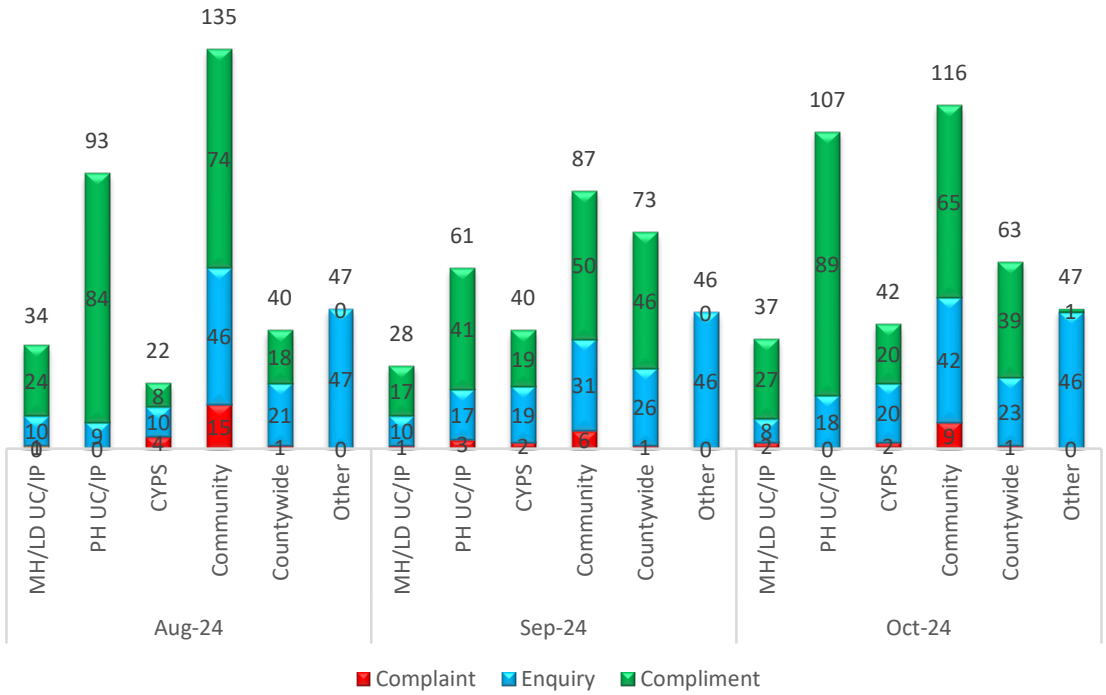
It is important to note that this is a snapshot and does not consider directorate size/footfall/caseloads/acuity of patients.

Directorate	Complaint			Enquiry	Compliment
MH/LD urgent care and inpatient	2	Early resolution:	**2**	8	27
		Closer look:	**0**		
PH urgent care and inpatient	0	Early resolution:	**0**	18	89
		Closer look:	**0**		
CYPS	2	Early resolution:	**2**	20	20
		Closer look:	**0**		
PH/MH/LD Community	9	Early resolution:	**9**	42	65
		Closer look:	**0**		
Countywide	1	Early resolution:	**1**	23	39
		Closer look:	**0**		
Other	0	Early resolution:	**0**	46	1
		Closer look:	**0**		
Totals	14	Early resolution:	**14**	157	241
		Closer look:	**0**		

Examples of complaints [as reported] for each directorate:

- **MH UC/IP:** Mother of patient still unhappy with lack of communication to her and is unhappy that the ward are discharging the patient.
- **Community:** Mother of patient feels the patient is being let down badly as she was referred to the team last December and still has not received any therapy.
- **CYPS:** Parents of patient unhappy with their occupational therapist.
- **Countywide:** Support worker very unhappy with the attitude of one of the dental team.

Directorate feedback over the past three months



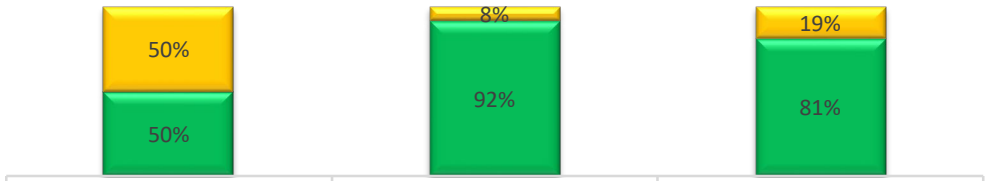
The above graph shows feedback by type and directorate over the past three months.
Whilst we continue to welcome complaints as an opportunity to improve our services, it is important to recognise good practice across all directorates.

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

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

Directorate	Upheld	Partially upheld	Not upheld	Withdrawn	Other	Total
MH/LD urgent care, inpatient	0	0	0	0	0	0
PH urgent care, inpatient	1	0	2	0	0	3
CYPS	0	0	2	0	0	2
PH/MH/LD Community	1	4	2	0	2	9
Countywide	0	1	1	0	0	2
Other	0	0	0	0	0	0
Totals	**2**	**5**	**7**	**0**	**2**	**16**

The below graph shows improvements in the length of time taken to close complaints.
This month, 81**%** were closed within three months (target = 50%), 100**%** closed within six months (target = 80%)

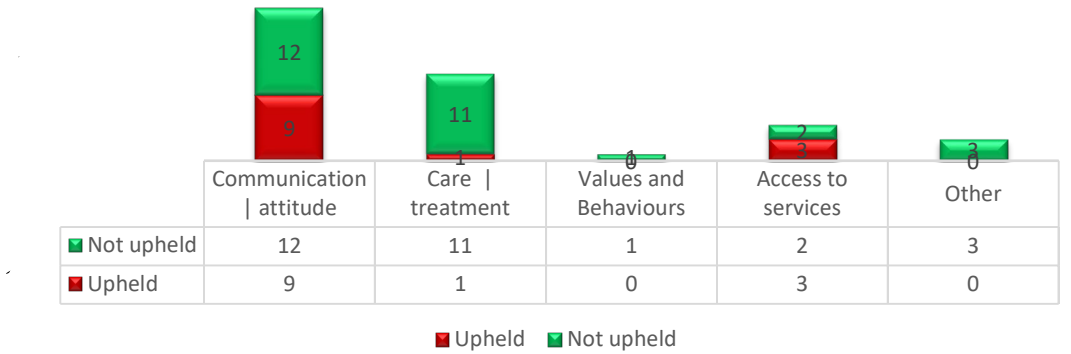


	Aug-24	Sep-24	Oct-24
7-12 months	0%	0%	0%
4-6 months	50%	8%	19%
1-3 months	50%	92%	81%

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
Countywide	Poor communication and advice given regarding a patient's weight. **Communication** Irrelevant comments made by clinician. **Communication**
PH UC/IP	Communication with relatives not documented. **Communication** IV procedure not delivered within safe time limits **Care|treatment**
Community	Call to family promised but not made. **Communication** Clinicians should communicate with other teams with further knowledge and specialism. **Communication** Unreasonable delays caused by poor decision making. **Access to services** Delayed referral to Tissue Viability Nurse**. Access to services** Confusion over delivery of equipment. **Communication** Incorrect information given in email**. Communication** Failure to provide requested information. **Communication** Suggestion that advocate not taking joined up approach. **Communication**

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



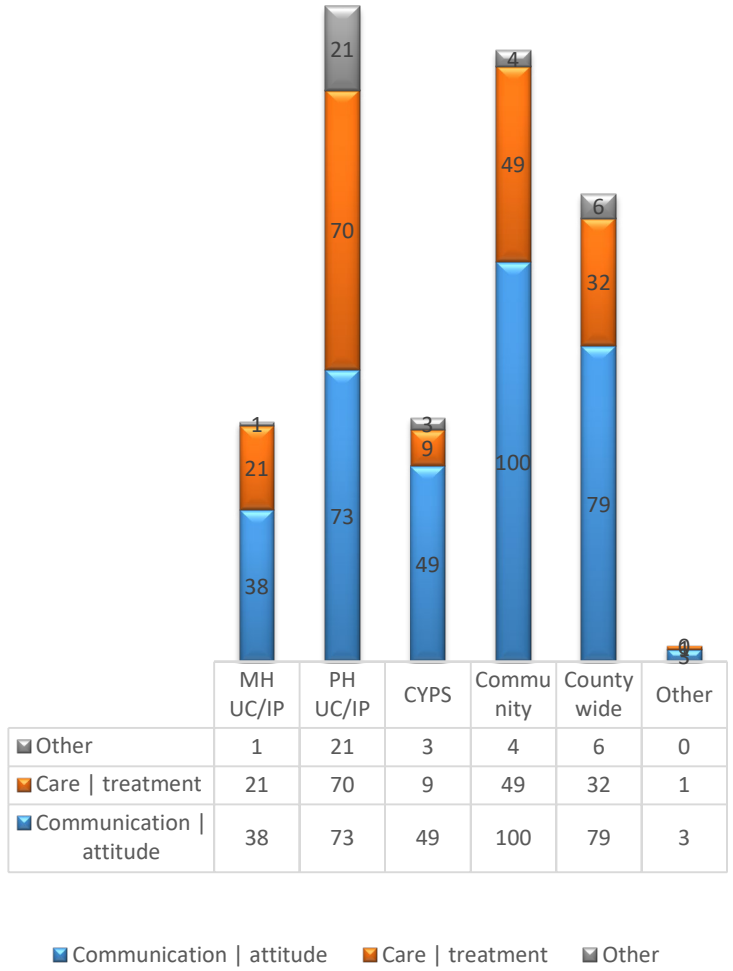
	Communication | attitude	Care | treatment	Values and Behaviours	Access to services	Other
Not upheld	12	11	1	2	3
Upheld	9	1	0	3	0

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

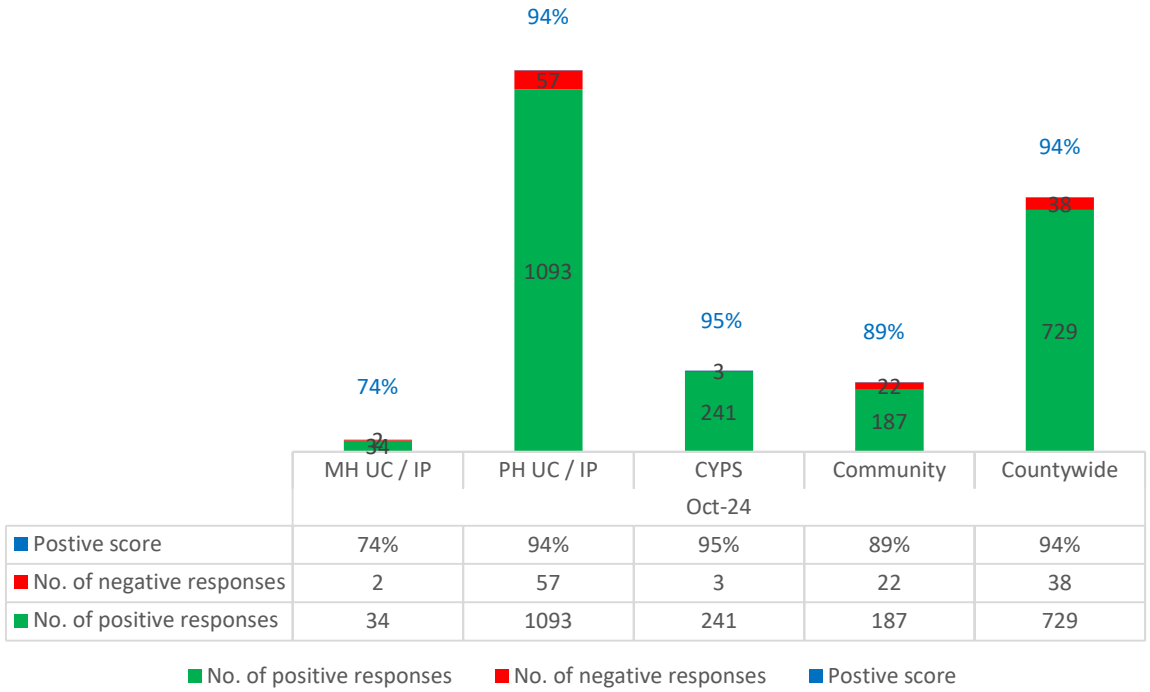
The table below is a sample of compliments received this month, and the chart opposite shows all COMPLIMENTS received this month by theme and directorate.

The 241 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
24/10/2024	16189	Charlton Lane-Mulberry Ward	As a family we are so grateful for her care and understand how precious a resource Mulberry ward is.
17/10/2024	16107	NC Hosp-Cotswold View Ward	Its as if they have picked all the best people, and they've come to work on this ward .
09/10/2024	16066	CYPS/PH-School Nursing	Initial phone call with a parent following referral in for sleep support. Thank you so much for calling earlier. I was very reassuring and just so nice to feel like we might actually be starting to tie all the things together. Thank you for the resources too!
14/10/2024	16042	Reablement Cotswolds	Thanks for everything you have done to support her. You're all so lovely. You talk to her and make her feel human.
29/10/2024	16256	Complex Care at Home FOD	With out your support I wouldn't have been able to attend my appointment, you have been a massive support to me and my husband.
09/10/2024	16050	Sexual Health Preg Adv PAS	Vulnerable patient stated how good the male student nurse was, "he's really good you should keep him", she said she felt he was kind to her.
29/10/2024	16228	Podiatry	It has been wonderful to have a week walking with no pain. Thank you.
18/10/2024	16139	Criminal Justice Liaison	Patient expressed gratitude for support given in Court. "Thank you so much for coming yesterday - it made a difficult day much easier knowing I had caring people around me. Thank you - again its the care, love and support around me that has kept me on track this far and I am so grateful."
28/10/2024	16213	Ciren Hosp-Windrush Ward	Daughter of pt wanted to thank the 'kind and gentle staff' for looking after her father for the past 10 weeks

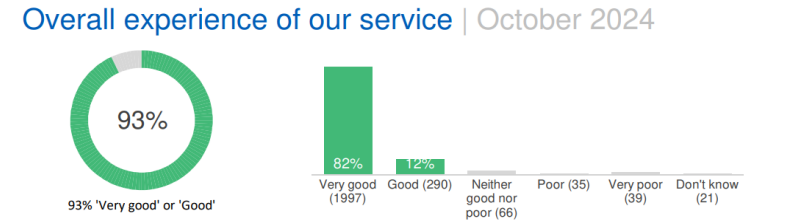


CQC DOMAIN - ARE SERVICES CARING? Patient and Carer Experience Team (PCET)

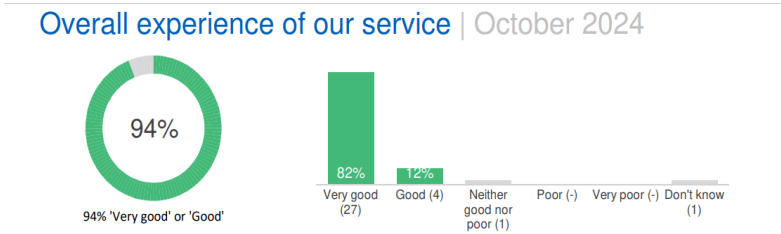


	MH UC / IP	PH UC / IP	CYPS	Community	Countywide
	Oct-24				
Postive score	74%	94%	95%	89%	94%
No. of negative responses	2	57	3	22	38
No. of positive responses	34	1093	241	187	729

Patient feedback



Carer feedback



Highlights for this month:

- The overall positive experience rating is 93% which is slightly lower than last month but in line with historic data.
- 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 90% from Inpatients (10 responses) and 95% for MIIU (63 responses).
- Evaluation of 'You Said, We Did' Boards pilot to be evaluated in Q3.
- Service users made 6 requests for contact/action through the FFT.
- FFT set up to support new OoH service (111 and remote CAS PRQs managed by IC24)

ARE SERVICES CARING? Non-Executive Director audit of complaints Q2 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 Q2 2024/25 audit provides **SIGNIFICANT** 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 Q2 2024/25

	Time scale of response	Quality of investigation	Accessibility, style and tone of letter	Learning actions identified	Comments
Complaint 1 Patient unhappy with lack of support from the Recovery and Crisis teams.	**SIGNIFICANT ASSURANCE** • Appropriate acknowledgement and clarification of issues • Formal response letter was sent slightly late due to line management changes in directorate	**FULL ASSURANCE** • Robust investigation • Good evidence of the support provided to the complainant	**FULL ASSURANCE** • Robust response in which an individual's expectations seem not to match what can realistically be offered	**FULL ASSURANCE** • No learning was identified but appropriate explanations were given	• Patient raised four concerns, which they later reduced to one key issue for investigation; however, the rationale for this is not clearly documented in the notes • Complaint was not upheld
Complaint 2 Estranged wife of patient felt he unduly influenced staff regarding his discharge from section. He then stopped taking his medication and she has been forced to leave home with their toddler and two dogs.	**FULL ASSURANCE** • Complaint was acknowledged appropriately • Lack of consent was discussed and explained • Response was sent within 3-month KPI	**FULL ASSURANCE** • Large volume of information and full investigation, which provided Trust assurance (despite not being able to share full response with complainant)	**FULL ASSURANCE** • Complex complaint with confidentiality constraints, which were appropriately communicated	**SIGNIFICANT ASSURANCE** • Relevant and appropriate information shared in relation to learning • No evidence that local learning around POhWER involvement in appeals was taken forward separately with teams	• No consent from patient • Complaint handled with a great deal of care and effort, and the notes evidence the thought given to providing an appropriate response • Good cross-team working with input of Safeguarding, Complaints, Security, etc. • Complaint was not upheld.
Complaint 3 Wife of deceased patient reported staff did not facilitate a telephone appointment with GHFT. The patient was later discharged from hospital with an infection which subsequently required inpatient care at GHFT.	**SIGNIFICANT ASSURANCE** • Good consultation with complainant to agree issues to investigate • Acknowledgement letter did not reference advocacy • Consent was discussed and explained • Response letter sent within 3-month KPI	**FULL ASSURANCE** • Thorough investigation into the care received both in community and acute hospitals • Very balanced and informed judgements made	**FULL ASSURANCE** • Sensitive letter, with appropriate information sharing and apologies	**SIGNIFICANT ASSURANCE**. • Very clear learning around use of ward phone, which has already been actioned	• Consent issue dealt with sensitively • Positive feedback from complainant for PCET: "thanks again for careful and lovely assistance…beautiful attitude' • Good documentation in notes regarding previous contacts • Complaint was partially upheld

CQC DOMAIN - ARE SERVICES EFFECTIVE? Community Hospital Delayed Patients

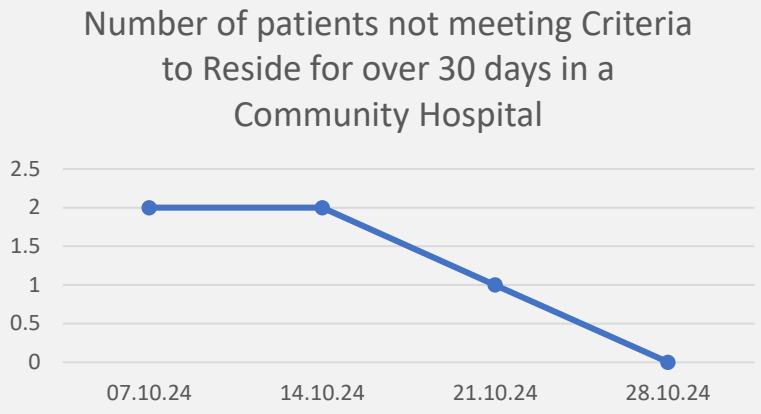
Long Length of Stay Patients – Community Hospitals

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.

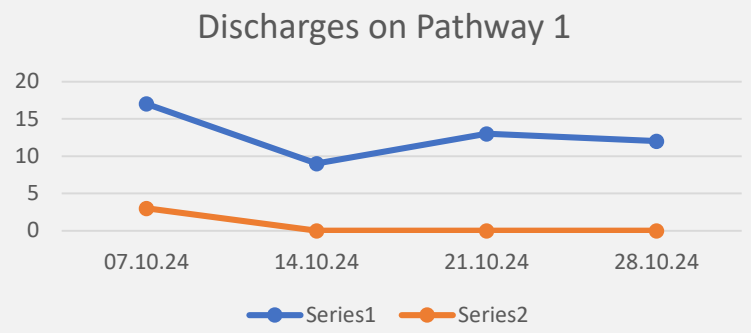
Headline Data - October 2024

- There has been an average of 32 patients that have Not Met the Criteria to Reside (nCTR) in a community hospital in October 2024
- There has been an average of 1.25 patients in total (nCTR) for over 30 days in October 2024.

- Overall, the number of patients that have not met the Criteria to Reside in a Community Hospital has reduced and averages occupying 19% of the Community hospital bed base.
- There has been a further decline in the number of patients who have not met the Criteria to Reside >30 days. There is a focus on these patients, during the weekly Community Hospital escalation call, to ensure no unnecessary delays.
- In general, there has been an increase in the number of patients that require ASC input across all community hospitals, which has increased the caseload for the hospital social care practitioners. Furthermore, there has been several patients requiring complex discharge planning, involving multiple professional's meetings, including safeguarding that has increased the length of stay.
- There is an increase in the number of patients discharged on Self- funded pathway 3, where delays with family's members sourcing the placement has delayed discharges.
- Patients that have a Non weight bearing status, and unable to progress with rehabilitation have caused discharge delays across a number of hospitals.



Showing the number of patients that do not meet the Criteria to Reside for > 30 days. Date ranges week commencing 07/10/2024 – 28/10/2024.



Showing the number of patients **discharges** on Pathway 1 who did not meet the criteria to reside for > 30 days. Date range: week commencing 07/10//2024 – 28/10/2024. 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.

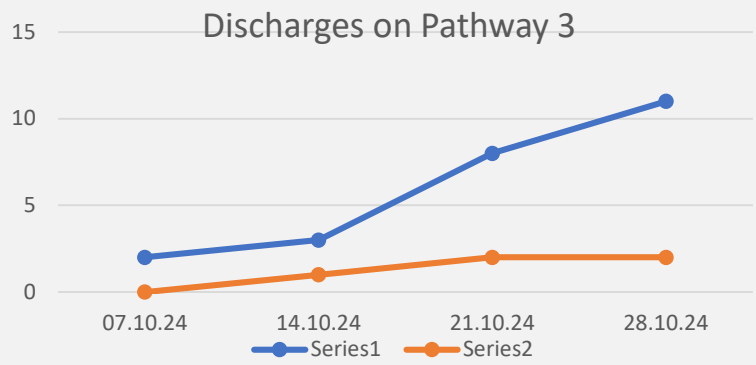


Chart 3 - Showing the number of patients delayed on Pathway 3 for over 30 days. Dat9 range: week commencing 07/10//2024 – 28/10//2024. Pathway 3 is defined as discharge to a Care home, either funded by the individual or through Social Care funding.

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

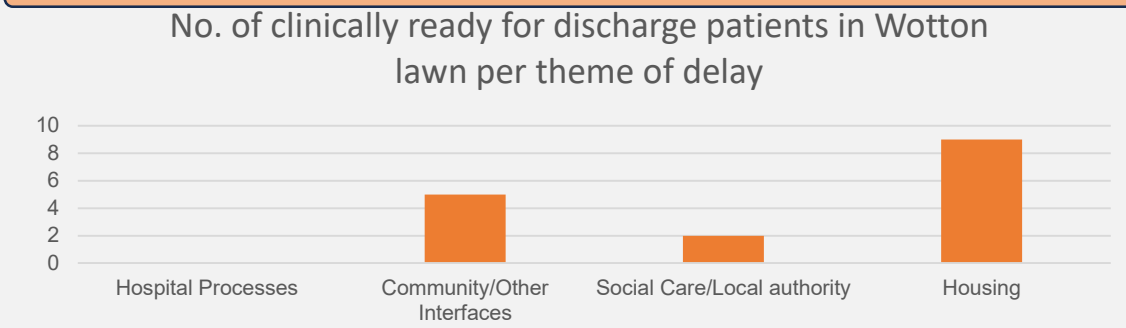
Long Length of Stay Patients- MH Hospitals.

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.

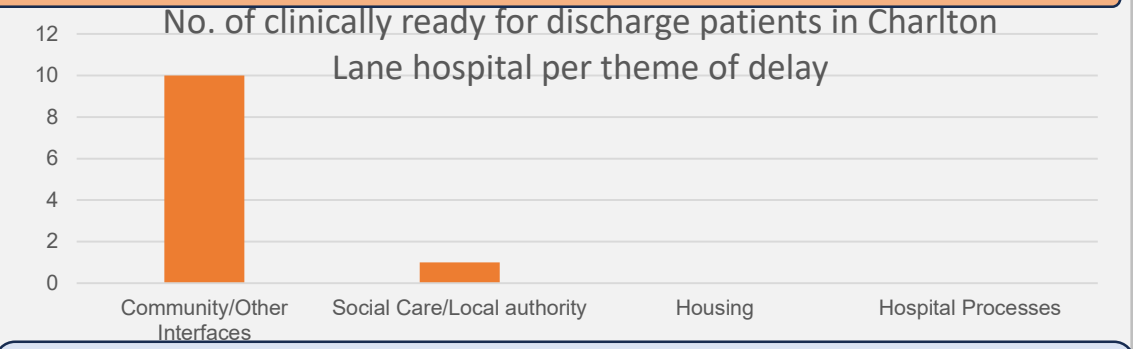
For reporting and descriptive purposes four high level sub-categories have been developed and these categories describe the reasons that a persons discharge is delayed.

- **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.

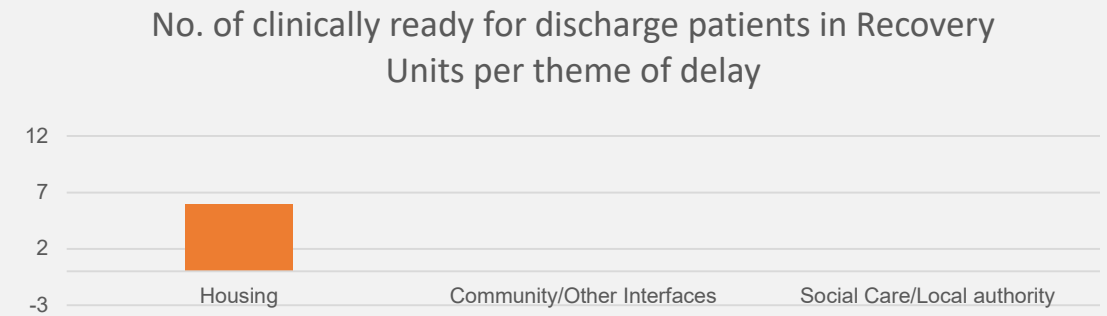
Headline Data - October 2024: Total of patients across WLH, CLH, Recovery, LD = 33 WLH = 16 CLH = 11 Recovery Units = 6 Learning Disability =0



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



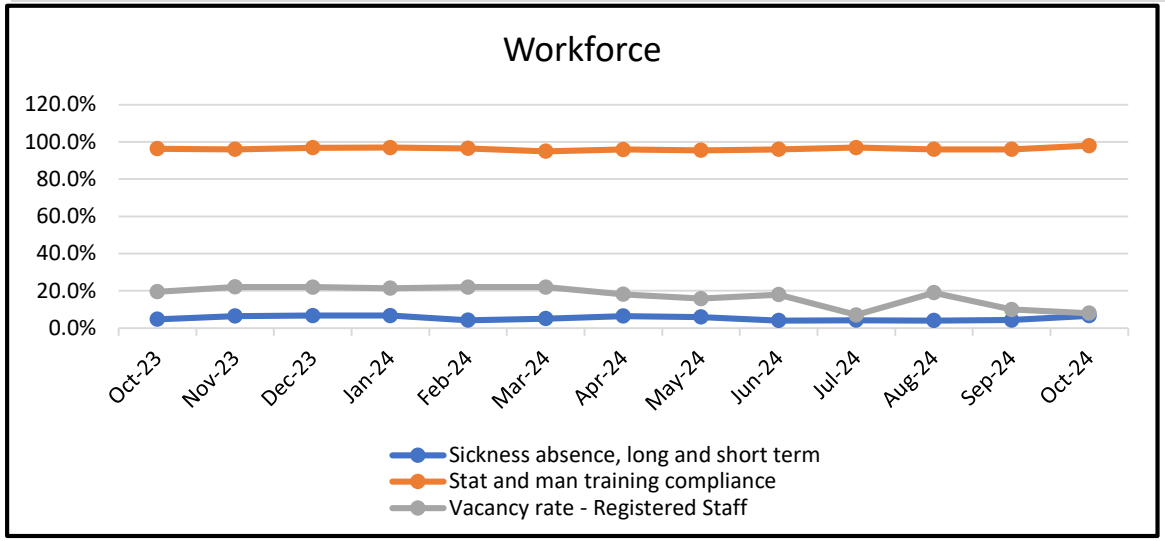
Themes related to delays:-
Community/Other Interfaces – awaiting care home placement (under care of hospital social work team)
Social Care/Local Authority – Awaiting care home through brokerage



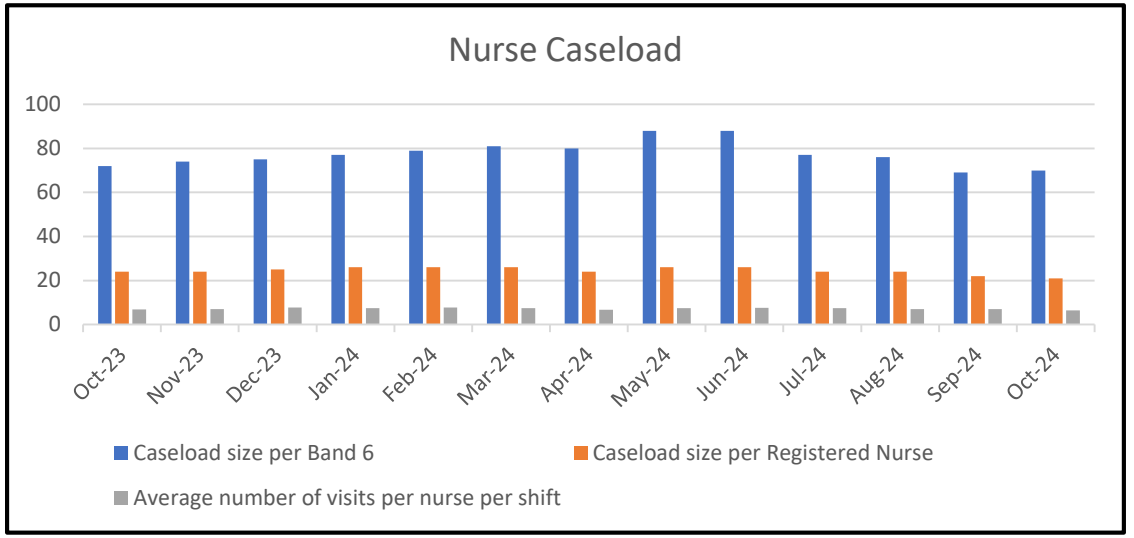
Themes related to delays:
Housing – homelessness, lack of appropriate supported accommodation

Themes related to delays:-

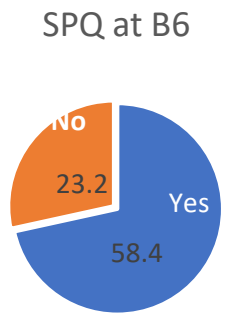
ICT Community Nursing Workforce - October 2024

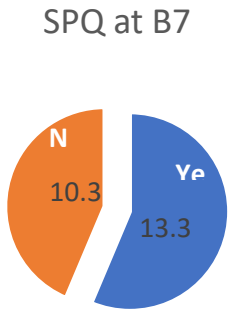


With a year's data now available vacancy rate has clearly been the most challenging for the community nursing teams. This month the data shows newly qualified nurses joining the ICT's, the sickness levels have increased in October which has impacted on teams .

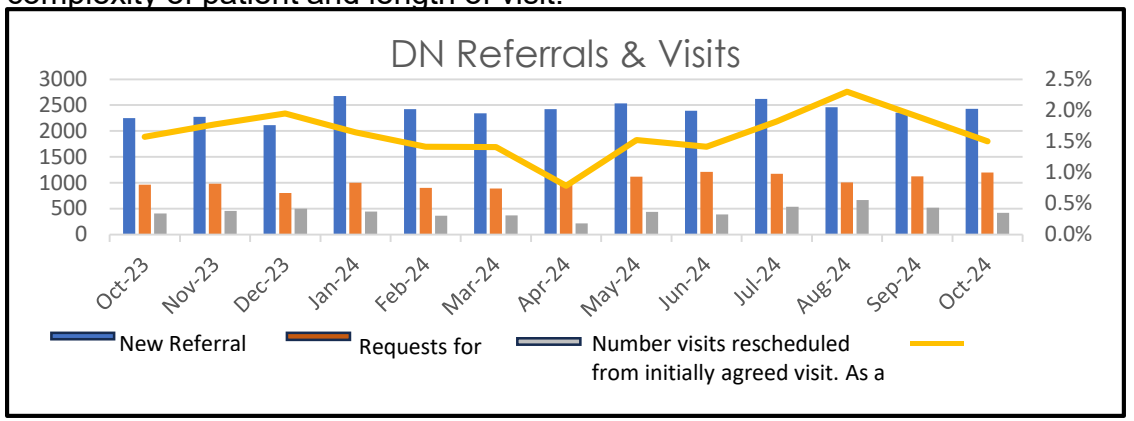


Caseload numbers peaked in summer but are now at their lowest together with the average number of visits. This does not take into account the complexity of patient and length of visit.





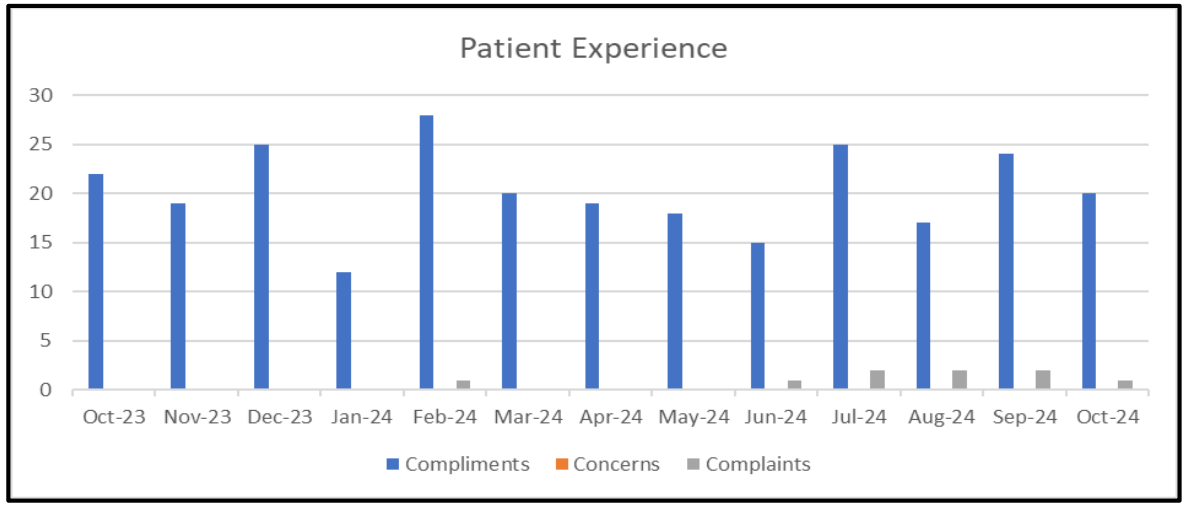
There are increased in SPQ qualified Senior Community nurses leading teams the Community nursing leads with an SPQ qualification has reduced due to staff movement however two newly recruited CNL's both hold the qualification.



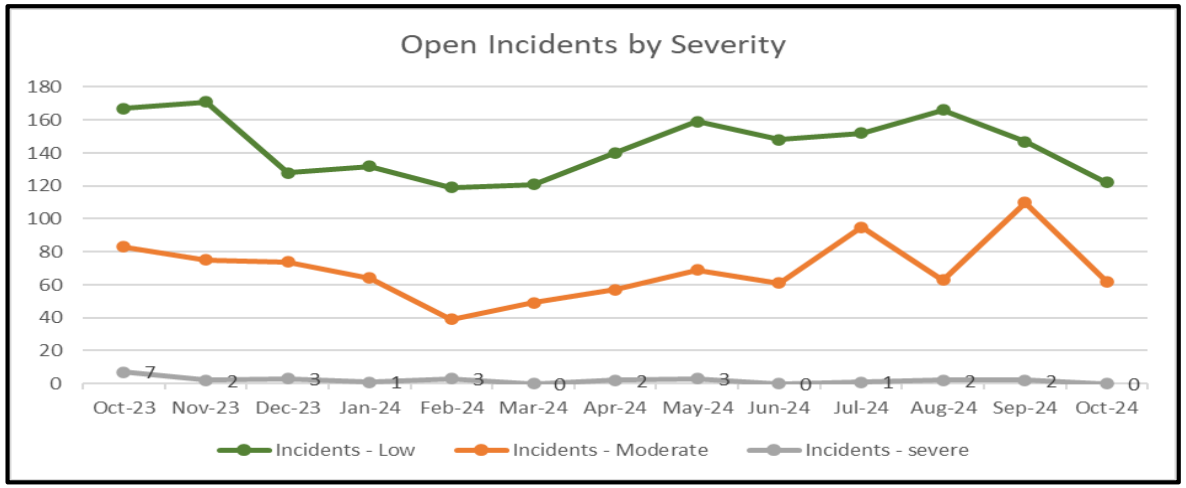
The years data shows a fluctuating picture with new referrals and requests for urgent visits increasing, this reflects the additional picture and is linked to increased acuity and complexity of patients on DN caseloads (QNI 2022)

27

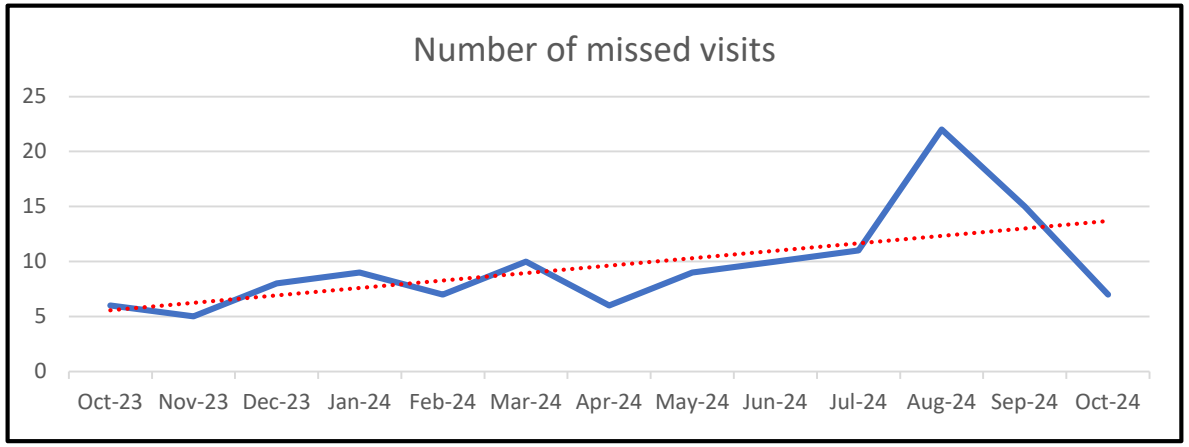
ICT Community Nursing – October 2024



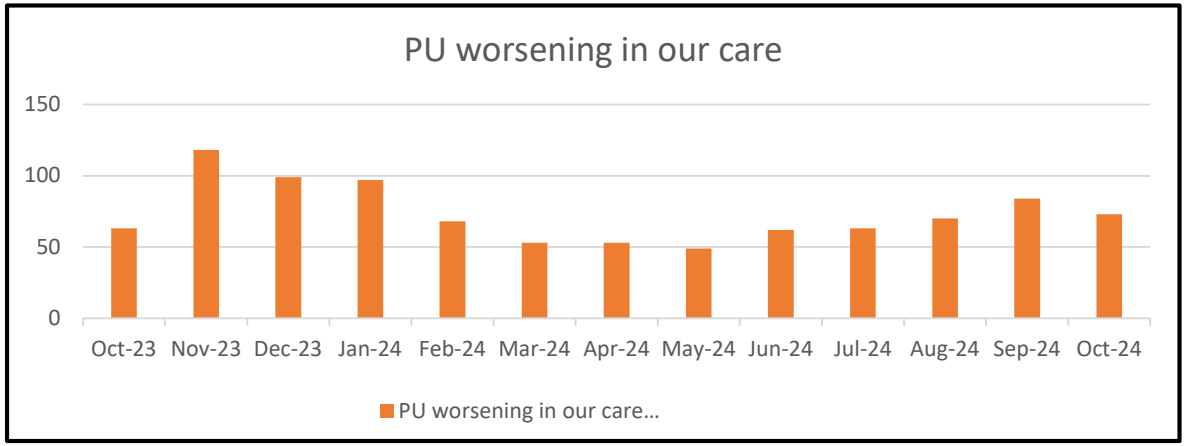
Compliments have increased over the summer and the new early resolution at local level have supported patients, their families and the nurses.



The reporting levels of all incidents have decreased this month following an increase in moderate harms in October.



The number of missed visits has reduced following AAR's and reminders to follow process.



The graph shows fluctuation in incidence which can be linked to seasonal variation and increased complexity of patients on ICT caseloads.

Quality Dashboard

Quality Improvement Hub Support along the Improvement Lifecycle

NHS
Gloucestershire Health and Care
NHS Foundation Trust

1. New improvement opportunity/concept/idea

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

- = (s) Gloves off - reducing PPE glove waste
- = (s) Streamlining triage process for adult SLT
- =Wrong site dental extractions
- =The Vale Stroke Unit
- =(s) Guidance on treatment of hyponatraemia and hypernatremia in the community
- = Culture of Care
- = Optimising staffing ADHD/ASD team band
- = Getting feedback from patients about MHA assessment
- + Improving assessment process in perinatal team
- +Reducing violence and aggression and complaints in MIIU

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
- = Transition from CAMHS to adult MH services
- = Improving access for mothers from ethnic minority into perinatal service
- ↑ CYPS collaborative information library
- ↑ (s) Local and national AAC pathways for children who may benefit from AAC
- + Developing a process for Observed Practice within AHPs

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
- = 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
- = 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
- = IPS project
- = People Promise - Learning from Leavers
- + Paper Care Certificate Workbooks
- + Booking Process Home Oxygen Service
- ↑ Clinical System Team Model

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
- = 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
- = Measuring effectiveness of new OATS service
- = 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
- = Improving access to ECT in WLH and community
- ↑ Weight management in SMI project

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
- = (s) Creating a sustainable placement offer for AHP Students in GHC
- = Single handed personalised care approach
- ↑ (s) Improving mouthcare standards in inpatient areas:

=Abbey view Ward
=Honeybourne
=Laurel House
=Mulberry ward
=The Vale
=Willow Ward
↑ Chestnut Ward
↑ Greyfriars
↑ Montpellier unit
↑ Woodland View ward

- ↑ (s) Homeward Assessment Team and ICT pathway

- 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.

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

Training data October 2024:
34 Silver – 0.7% workforce
685 Bronze (current trained taken from Care to Learn) - 14% workforce
975 Pocket QI, total trained overtime – 20% workforce

Directorate	No of Projects (QI and CI)
Countywide	10
MH Hospitals and UC	9
PH Hospitals and UC	5
Adult MH/PH/LD Community	12
CYPs	18
Corporate	8
Total: 62	

Quality Dashboard 2024/25

Appendix 1 Summary of Quality Priorities .

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

A summary of quality priority activity is provided below for information including examples of work being planned and undertaken., all workstreams are progressing well and full detail will be provided to QAG for assurance in December and flow through to Quality Committee and Board.

Priority	Description	Status H1 - 24/25
1	• **Tissue Viability (TVN)** – The recognition, reporting and clinical management of chronic wounds using QI methodology and educational resources including prevention and alignment with the National Wound Care Strategy.	• Progress has been made in implementing the National Wound Care Strategy with the review of the latest guidance/standards published on the NWCSP website being completed with links to the NWCSP videos and training/learning resources shared. • 24-25 Has included is the Development of business case to support a Trust wide wound care app, the Continuation of roll out of Face to Face training and progression of the standardised risk assessment process for pressure ulcers (Purpose T).
2	• **Dementia Education** - Initiatives to Increase staff awareness of dementia through training and education, improving the care and support that is delivered to people living with dementia and their supporters across Gloucestershire.	• Progress has been made with Training Baselines being established and reported, Gloucestershire 5 step approach now available on GCC website and joint working with Patient/Carer Experience Team to identify themes of concern and System working with GP practice. • 24-25 – has included targeted work to increase the number of staff completing Tier 2 and Tier 3 training and work within GP practice staff to include ARRS roles around early onset dementia and identification
3	• **Falls prevention** – with a focus on reduction in medium to high harm falls within all inpatient environments based on 2021/22 data.	• Excellent progress has been made at Charlton Lane trialling the Falls Action Plan. A falls leaflet and revised policy were also introduced.The Trust wide Falls group ensures consistency of practice, and strong focus on evidence-based falls prevention in all areas of GHC. • 24-25 **–** work has begun on the roll out of Falls Reduction Action plan to all inpatient units in GHC.
4	• **End of Life Care (EoLC)** – with a focus on patient centered decisions, including the extent by which the patient wishes to be involved in the End of Life Care decisions.	• Progress – The NACEL 2023 audit evidenced good compliance that patients, carers and families were involved in end of life care as much as they wanted to be. A training needs baseline has been established with the aim of Masterclasses being assigned as Essential to Role for certain groups. • 24-25 - A review of the training provision and alignment to essential to role training identified a shortfall in provision and as number of topics have been requested to become E2R, this has led to a wider review of E2R and therefore the EoL E2R proposals are part of that wider review.

Priority	Description	Status H1 - 24/25
5	• **Friends and Family Test (FFT)** – To deliver greater value for the data collected through patient surveys and demonstrate increased awareness of patient and carer feedback..	• Good progress has been made including silver QI FFT project where ccommunity services now use a variety of methods for collecting FFT responses, including electronic, paper and QR codes. Action to address the areas raised in the CQC Community MH Survey within Crisis and Talking Therapies. • 24-25 – Including evaluation of Friends and Family Test (FFT) QI Project using (Feedback analysis) and implementing the improvement measures arising from 2023 MH Community Survey.
6	• **Reducing suicides** – with a focus on incorporating the NHS Zero Suicide Initiative, developing strategies to improve awareness, support, and timely access to services.	• Progress **-** Self-assessment against the 10 key elements of the suicide prevention toolkit was completed during 2023/24 which evidenced that GHC has the majority of systems and processes in place and the recommended operational configuration. • 24-25 **-** The areas for focus in 2024/25 include staff turnover, family involvement in learning lessons, and multi-agency working by CAMHS health and social care, specialist drug and alcohol services and services for self-harm. Annual cycle of re-audit against the NCISH self – audit tool kit will recommence.
7	• **Reducing Restrictive Practice** - To Reduce Restrictive Interventions within Mental Health & Learning Disability Inpatient Services	• Progress – work undertaken in 4 key elements to reduce restrictive interventions, with a focus on continuing our strategy in line with the Southwest Patient Safety Strategy to include restraint and RT . • 24-25 **–** Work undertaken on focusing on reduction of blanket restrictions, Development of post restraint debrief process, monitoring of mandatory and required data fields within Datix .
8	• **Learning disabilities** – with a focus on developing a consistent approach to training and delivering trauma informed Positive Behavioral Support (PBS) Plans in line with National Learning Disability Improvement Standards. This includes training all learning disability staff in PBS by April 2025.	• A baseline of staff to be trained has been compiled and a comprehensive training pack is now available and has been successfully piloted.

Priority	Description	Status H1 - 24/25
9	• Children's services – with a focus on the implementation of the SEND and alternative provision improvement plan.	• Progress – Progressing towards SEND go live using 5 workstreams, examples being Digital reporting and Training. • 24-25 – To include SEND go live and the development of a SEND Operational Handbook
10	• Embedding learning following patient safety incidents – with a focus on the implementation of the Patient Safety Improvement Plan.	• Progress – Including the Implementation of the Patient Safety Incident Response Framework (PSIRF) which has seen new learning responses to patient safety incidents that have been met with positivity, embedding of Fidelity Testing and 168 Learning and Engagement Sessions taking place last year. • 24-25 – continuing work with the (PSIRF), Learning Assurance Framework (LAF) and Fidelity Testing.
11	• Carers – with a focus on achieving the Triangle of Care (ToC) Stage 3 accreditation.	• Progress – In early 2024 the Carers Trust reaffirmed our 1st and 2nd star status and gave approval for GHC to work towards the ToC 3rd star accreditation by engaging the principles of ToC with all teams across both MH and PH services • 24-25 - Progress with Triangle of care accreditation workstream continues including engagement with stakeholders and the development of a map of teams indicating their current compliance status with level 2 requirements by using a self-assessment methodology.

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Appendix Two

Non-Executive Directors Quality Visits
Q2 2024/25

Living our Trusts Values - Making a difference (Quarter 2 visits)

Positive Feedback from NED colleagues (as described in visit reports)

I was very impressed with the calm, friendly atmosphere of this Hospital. Everything looked sparkling and each colleague that I encountered appeared content and respected.
North Cotswolds Hospital

the EAP team are doing an incredible job, for incredible patient outcomes, with an incredibly challenging set of mental health presentations, and only the highest regard for their patients and service users
EAPs Greyfriars

I had previously visited Lydney and District Hospital to discover how colleagues were feeling about the changes. I was delighted by how settled it felt as though it had been open for years rather than a few months
Forest of Dean Hospital

The team appeared effective, cohesive and supportive, and are successfully delivering an extremely important service in a holistic and person-centred way.
Perinatal MH Service

Gloucestershire Health and Care NHS Foundation Trust

Visit Outcomes Update – completed visits Q2

Service	Recommendations/questions	Progress	Status
North Cotswolds Hospital	1. I recommend that we step up interaction with system partners to improve clinic utilisation. This could be included in our Green Plan as the travel reduction could be significant. If our Acute Trust colleagues are unable to provide clinicians, other NHS providers should be approached.	1. Work currently ongoing: ➢ Working with the ICB in relation to improved space utilisation across the county. ➢ There is ongoing dialogue within this space with all relevant partners across all sectors. ➢ Trying to secure other private providers such as Ramsay Health as an example use our space. ➢ Trying to obtain Oxfordshire and Warwickshire activity for NCH. ➢ Development of a dashboard that identifies all activity across all GHC sites	**Action closed as this is now embedded as BAU.**
	2. I recommend prompt action to help add appropriate templates to the clinical system for AHP assessments – if these do not exist within our Trust, colleagues elsewhere have templates which could be shared.	2. This is currently in development with appropriate colleagues across the Trust.	**Action closed as this is now embedded as BAU.**

Gloucestershire Health and Care NHS Foundation Trust

Visit Outcomes Update – completed visits Q2

Service	Recommendations/questions	Progress	Status
Forest of Dean Hospital	1. The ward showers don't drain properly so the bathrooms flood – efforts are being made to provide a remedy. The toilets are set near the wall so it is not possible for colleagues to assist patients from both sides. Colleagues are keen to complete a post project evaluation to improve learning for the future.	1. Efforts are being made to provide a remedy as quickly as possible alongside estates colleagues. Appropriate risk assessments are in place and highlighted on daily safety briefings. The organisation are leading a 'lessons learned' event follow the Hospital 'Go Live'.	**Actions 1,2,3 and 4 closed as this is now embedded as BAU.**
	2. The relative's room could be more welcoming.	2. Discussed with team, Matron will follow this up noting that this room is identified in bed escalation plan.	
	3. The continued uncertainty and lack of communication re endoscopy provision is difficult for senior colleagues to manage.	3. GHC executives remain in dialogue with the ICB.	
	4. The lack of CCTV cameras outside the main entrance creates risks out of hours when the hospital is locked. Once in the hospital, visitors have to ring a doorbell to be let into the ward with the release button a long way from the reception area.	4. Video intercom is due to be installed- awaiting date of this from estates	
	5. There is no ability to observe patients waiting for the Minor Injury/Illness service. I believe in the past, CQC raised concerns about this at the Dilke and Stroud?	5. Awaiting update from MIIU Matron	**Ongoing**
	6. The current cost of hiring 3 bariatric beds is apparently £9000 a month – would it be better to purchase when finance available?	6. This is explored through procurement routes.	**Actions 6 & 7 closed as this is now embedded as BAU.**
	7. Are there plans to launch a new Friends of the Hospital both to support fundraising and the provision of volunteers? Might FVAF help with that?	7. This is being explored through Strategy and Partnerships	

Gloucestershire Health and Care NHS Foundation Trust

Visit Outcomes Update – completed visits Q2

Service	Recommendations/questions	Progress	Status
AMHP Hub	1. Awaiting report from NED		

Gloucestershire Health and Care NHS Foundation Trust

Visit Outcomes Update – completed visits Q2

Service	Recommendations/questions	Progress	Status
EAPs Greyfriars Wotton Lawn Hospital	1. Lack of staff space leading to significant risks over patient privacy and staff wellbeing 2. Risk of discharge hub services not being used effectively 3. Missed opportunity to share learnings from recent incident at Berkeley House 4. Team's ambition to further improve quality of stay for patients hindered by shift administration processes	Director of Nursing, Therapies and Quality is leading the response to his NED visit and the areas that were identified.	**In Progress**

Gloucestershire Health and Care NHS Foundation Trust

Visit Outcomes Update – completed visits Q2

Service	Recommendations/questions	Progress	Status
Perimetral MH Service	1. The team have an Expert by Experience group but would like to recruit more and recognise that social media would help with this. Investing time in getting social media up and running (with advice around information governance) and a process for regularly posting would be great.	1. The team are liaising with the Trusts Communications Team and the Trusts IG lead to develop this.	**Ongoing as BAU**
	2. The team currently have to send texts to patient manually and queried whether things like appointment reminders could be automated. This is already possible with other systems used within the trust and would save a lot of time.	2. This is possible with IAPTUS and with other electronic patient record systems but not RiO currently.	**Ongoing as BAU**
	3. The issue of lack of confidential space for video calls is concerning as more appointments remain online. Could there be a policy change so that rooms can be booked for video appointments and not just face to face? Alternatively could soundproof booths be installed for video appointments?	3. The team are exploring a soundproof POD for the office.	**Ongoing as BAU**
	4. Is there any more we can do as a system to escalate the issue of lack of translators?	4. This has been raised and escalated by a number of system partners and a new provider has been identified and is embedding.	**Ongoing as BAU**

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Appendix Three
Quality Dashboard Development

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

The information below summarises the timescales for the development of the dashboard, current ownership of slides and any proposed developments agreed through committee.

Slide	Description	Ambitions for slide	Timescale	Slide Owner
0-3	Cover and Exec Summary	To remain.	N/A	Jane Stewart
3	Safeguarding Highlights and Challenges	Remain at present as not included in performance measures. Aim to redraft to include more narrative describing what this means for patients and future actions.	3 months	Paul Gray
4 to 13	Patient Safety Data	To be redrafted to concentrate on thematic findings over time rather than reporting on actual data and events . Notably to concentrate on Pressure Ulcers and Falls over time and to look for underlying reasons for emergent trends with one slide for each.	3 months	Nicola Mills
14 to 16	Closed Culture	To remain, with input to reflect organisational culture of care work programme.	3 months	James Wright
17	Safe Staffing	This slide needs to remain to fulfil statutory reporting requirements and is part of the BAF. Development required to align Physical Health and Mental Health data sets as Physical Health is captured in Tableau.	12 months	Nicola Hazle
18 - 24	PCET	To recognise pockets within the organisation where the patients' voices are not being heard and to shift away from presenting actual monthly data to themes reviews and trend analysis for both complaints and compliments. NEDS audit and Quality Visits to continue or be reported separately.	12 months	Kate Bowden
25 – 26	Long Length of stay MH and CoHo	Remove, as captured in the integrated report.	3 months	Jane Stewart
27-28	District Nursing Data	Remove – plan to revise ICT metrics.	3 months	Jane Stewart
29	QI Information	Primarily a list of projects – re draft to show the “what effect is this having” and what happens next elements of work streams – how they impact upon quality.	3months	Tanya Stacey

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AGENDA ITEM: 11/1124

REPORT TO: **TRUST BOARD PUBLIC SESSION – 28 November 2024**

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

AUTHOR: Chris Woon, Deputy Director of Business Intelligence

SUBJECT: **PERFORMANCE DASHBOARD OCTOBER 2024-25 M7**

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 October (Month 7 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 Records Working Group.

Recommendations and decisions required
The Trust Board are asked to:

- **NOTE** the Performance Dashboard Report for October 2024/25 as a **significant level of assurance** that the Trust's performance measures are being met or, Appropriate service improvement 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.

Chief Operating Officer & Director of Nursing, Therapies & Quality Perspective
Executive Updates are presented on page 2-5 of the performance dashboard.

Performance Update
The performance dashboard indicators are presented from page 6 within the Board's four domain format (*to note, the Operational Domain is only presented to Resources*

Committee). The Board's Performance Dashboard offers a lighter commentary format however members can be assured detailed exception narrative is reviewed within BIMG for each period.

- **Nationally measured domain** (under threshold)
  There were 4 indicators in exception this month. Specific focus was given in BIMG to understand the performance position, underlying issues and improvement planning on N03 Inpatient Follow-up within 72hrs and N11 Adolescent Eating Disorders referral to treatment.

- **Specialised & directly commissioned domain** (under threshold)
  2 health visiting indicators (S02 & S09) were slightly behind their thresholds for the period but these were significantly impacted by hospital NICU admissions.

- **ICS Agreed domain** (under threshold & outside of statistical control rules)
  There were 2 indicators in exception for the period. Eating Disorders Adult wait for adult assessments within 4 weeks (L07) and Perinatal routine referral to assessment within 2 weeks (L12). Performance improvement plans were presented to BIMG.

- **Board focus domain** (under threshold & outside of statistical control rules)
  7 indicators were in exception in October;
  - B01 Care Programme Approach - formal review within12 months
  - B08 Data quality maturity index (DQMI)
  - B19 MH PICU Inpatients - Percentage of discharges within LOS threshold (61 days), B20 MH Older Adult Inpatients - Percentage of discharges within LOS threshold (70 days) and B21 MH Rehab - Percentage of discharges within LOS threshold (480 days) are newly added KPIs in the dashboard having only previously been available operationally.
  - B25 PH Stroke Rehab (Vale) – Percentage of discharges within LOS Threshold (42 Days)
  - B30 Sickness absence average % is presented without e-Rostering data but its predicted to be above normal variation when available.

- **Performance to note**
  There are sometimes indicators that are not formally highlighted for exception, but they are useful for Board's wider awareness. These indicators are all routinely monitored by operational and support services within the online Tableau reporting portfolio and discussed in more detail within BIMG to evaluate trends. This month these highlights (from pg12) include the follow indicator that was within normal variation but under threshold:

  - B24 - PH CATU - Percentage of Discharges within LoS Threshold (10 days). The impact of patients with 'no criteria to reside' (nCTR) is presented. nCTR exclusion would reduce the LoS but not achieve indicator compliance.

  The following indicators are presented for the first time this month as they have been only recently developed so are just for Board awareness.

- N24 - Adults and older adults accessing select CMHSs, having their PROM recorded at least twice. It was compliant for the period.
- B18 - MH Acute Inpatients - Percentage of discharges within LOS threshold (26 days) was within normal variation but under threshold.

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 been discussed before?
BIMG Meeting on the 21 November 2024

Appendices:	Performance Dashboard October 24-25 Month 7

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

Gloucestershire Health and Care NHS Foundation Trust

Snapshot Month
October

Performance Dashboard Report & BI Update

Aligned for the period to the end October 2024 (month 7)

In line with the Performance Indicator Portfolio and the Trust's Performance Management Framework; this report presents to Board, performance indicators across four domains including **Nationally measured**, **Specialised & Direct Commissioning**, **ICS Agreed** and **Board Focus** domain. The **Operational** domain is only presented to Resources Committee, however this domain is still reviewed within Business Intelligence Management Group (BIMG) each period.

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) alongside specific service level improvement plans. An operationally led Patient Records Working 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) and the new Director of Nursing, Therapies & Quality (NQT) Update on page 5.

The Dashboard itself (on pages 6-11) 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 and governace structure 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 page 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.

Focused updates have been requested by October's BIMG around the recovery progress of Eating Disorders (1), Adult and Paediatric Speech & Language Therapy (2), Paediatric Physiotherapy services (3) and Perinatal (4) services. Focused time within BIMG in Quarter 3 will be centred around these services.

Business Intelligence Summary Update

Significant BI capacity has been focused over the last period to ensure a well supported implementation of the new Integrated Urgent Care Service (IUCS). In addition, further time has been invested into: designing a new reporting layout for Tableau users, improving waiting time indicator monitoring, a Mental Health Wait time Situational Report (SitRep) and an Occupational Therapy Scorecard.

Initial planning meetings have begun to map out the delivery of an Integrated Performance Quality Dashboard, beginning in 2025. A timeline with delivery phasing across the next few financial years is being prepared for presentation to Resources Committee in December 2024.

Within our Children and Young People Services, discussions have taken place around how we monitor patients who are waiting a long time for their first appointment. We have seen improvements for our patients who have been waiting over 52 weeks for their first appointment and at the time of writing, there were 8 children waiting for physical health appointments, who all have an appointment scheduled. The clinical services have been asked to ensure that they have plans and trajectories in place to monitor progress, with a particular focus now on patients who have been waiting 42 weeks.

For children who are waiting for our Child and Adolescent Mental Health Service (CAMHS), they continue to experience long waits for these services. We are reviewing our data so that we can truly understand the waiting times for children who are waiting for assessment and triage, or their first and second contact with the service. For our Core CAMHS Service, referral to assessment within the 4 week key performance indicator (KPI) was compliant. Colleagues are asked to note that the waiting list for cognitive behavioural therapy within the Core CAMHS service is long and it is projected that children will be waiting 52 weeks by the end of January 2025. The waiting list has been impacted by staff absence and the service has completed a number of actions which have included, caseload reviews, review staff skills, consider alternative interventions. Improvements are expected in the medium term when two new trainees will have a caseload from Spring 2025, and additionally, the service are looking to create a fixed term post.

As colleagues will be aware from previous reports, the 0-18 years Neuro Pathway continues to experience a high demand and at the time of writing, 3358 patients were waiting for an appointment. The service are is reviewing the waiting times for 9 patients who have been waiting 4-5 years and will then focus on those patients who have been waiting 2-3 years for an assessment. Ongoing discussions are taking place with our system partners.

In relation to immunisations for flu for children we achieved 56.4% against a target of 70%. The Service Director is analysing data and investigating this in order to develop an improvement plan.

I am pleased to report an improvement for our children's physiotherapy service for both our 4 week and 18 week targets, with a target of seeing 95% of patients. For the 4 week KPI, we met 87% which was an improvement from 82.1% in September. For the 18 week KPI we met 74%, which was an improved position from September at 67.1%. Further improvements were also seen in the children's occupational therapy service with our 18 week target, meeting 85.3% against a KPI of 95%, an improved position from September which was 70%. For the children's speech and language therapy service, we continue to see a high demand on this service, which outstrips the capacity of the team, seeing 60% of patients within 18 weeks, against our target of 95%. Updated position papers and updates on the children's physiotherapy service and speech and language therapy service will be discussed at the Business Intelligence Management Group in December 2024.

We achieved 91.3% of our target to see 95% of patients for their care programme approach (CPA) follow up contact within 72 hours of discharge from a mental health inpatient setting. We have reviewed the clinical records for the breaches and can confirm that all 5 people have been followed up post discharge and we are correcting how we record this in patient clinical records.

It was mentioned in last months report how we continue to review the length of stay that patients experience in the mental health inpatient settings. In our mental health adult inpatient wards, in October the average length of stay was 72.3 days, against a threshold of 26 days. For patients on our older adult mental health wards, the average length of stay was 85.1 days, against the threshold of 70 days. We have weekly meetings in place with our Patient Flow Team to undertake a line-by-line review to progress discharge plans as quickly as possible. We are identifying themes to work with system colleagues to reduce delays.

We have also noted an upward trajectory for patients being placed out of area since July 2024 and we are monitoring this area closely. In October we placed 4 patients in out of county beds, although 1 patient was an appropriate placement.

Last month we mentioned the increase in sickness absence rates at Charlton Lane Hospital and following a review, there are no identified trends at this time.

Narrative continued on next page.....

Continued from last page...

There are improvements with our Musculo Skeletal (MSK) service, meeting 93.7% of our target KPI of 95% of seeing patients within 18 weeks. We have triangulated this with our friends and family (FFT) feedback to understand the impact this has had on patient experience. These delays in appointments being offered related to the pelvic health element of the service and following successful recruitment, is expected to improve.

Similarly with our Podiatry Services, we have triangulated our performance with our FFT feedback. 89.3% were seen within 18 weeks, against a KPI 95%. Patient's experience was impacted by the availability of appointments. The demand for this service has increased and the service last month were able to offer the highest amount of patient appointments to meet the increased demand. We are working with staff to upskill them and are reviewing clinics accordingly to act on FFT feedback.

The Adult Speech and Language Therapy (SLT) Service met 80.5% against a KPI of 95% to see patients within 18 weeks. This relates to the voice caseload element of the service and is due to the absence of 2 staff members, although a locum is in place until March 2025. We are reviewing how we can increase the voice caseload clinics and discussions are ongoing with partners at Gloucestershire Hospitals NHS Foundation Trust (GHFT), particularly as we have some patients who have waited over 52 weeks and they require a review by the Ear, Nose and Throat Team at GHFT. We anticipate seeing improvements with this service from January 2025.

Previous reports have outlined a number of issues relating to the dental services. For the Special Care Paediatric Service element, we met 46% against our internal KPI of 95% for patient appointments within 18 weeks and I am pleased to report that the waiting list for this service is now coming down. The service has also undertaken some targeted work on new patient slots, including focussed work on the long waiting lists and reviewing how appointments are offered. There are further plans to skill mix the workforce, due to the lack of available dentists. Some further positive news for the Minor Oral Surgery Service which has now been commissioned to provide a service 5 days per week and we have successfully recruited staff to commence in post from December 2024. Previously this service was only commissioned to provide a service 1 day per week, so we anticipate improvements here.

For our Wheelchair Service, our exceptions related to the 18 week handover of wheelchairs for both adults and children, against a KPI of 92%. For adults, we met 67.3% which related to 16 people. We are looking at how we can improve our processes with key partners and additionally, we have successfully recruited to a vacancy that has been vacant for three years and we anticipate that this service will now recover and will be outlined in the recovery plan. For children, we met 83.3% against a KPI of 92%, relating to 2 children. To support us with improvements, we are looking at our standard operating processes and working with the administration team to identify solutions and prevent delays.

Colleagues will be aware of the previous reports around the GHFT ECHO performance which has been an ongoing concern for us, and I am pleased to report that meetings have now taken place with commissioner colleagues, who are looking at how the service is commissioned moving forward.

We have reviewed the risk regarding Telecare provision. The service has received further staff resignations and the current capacity does not meet demand. We are continuing to work with Gloucestershire County Council and will be working across Operations and the Nursing, Therapy and Quality Directorate to assess the clinical risk.

Colleagues may recall that we have been below our target KPI of 60% to treat new psychosis cases within 2 weeks of referral and I am pleased to report that in October we met our KPI target of 60%, achieving 100%.

Significant improvement has also been seen with the Perinatal routine referral to assessment within 2 weeks, meeting 48.3% against a KPI of 50%. A recovery plan is in place and continues to be reviewed and monitored via the Business Intelligence Management Group.

Narrative continued on next page...

Continued from last page...

We met 94.3% of offering patients a CPA formal review within 12 months against our KPI target of 95%. The service is embedding further improvements including proactively scheduling review appointments to ensure these reviews take place.

For our Integrated Care Teams (ICT) occupational therapy (OT) waits for our 18 week target, we saw 77.5% of patients against our KPI threshold of 95%. We have seen an improvement on the waiting times for this service and the mean waiting time now sits at 4 weeks. It is anticipated that once the backlog of patients who have been waiting has been worked through, this should improve. As part of the waiting list initiative, we are working with the third-party provider of OT services to make further improvements.

We noted improvements for the ICT community physiotherapy service which met 88.2% against the KPI of 95%, which is an improvement from 83.4% from September.

Within our community hospitals, the average length of stay had reduced from 35.7 days last month, to 34.8 days. Our bed occupancy rate is at 97.8% and has not been below 92% since August 2021. We consistently review patients who remain in hospital who are safe to be discharged. We have a number of processes in place to discuss these with system partners. 58% of people are discharged to their own home, we have seen a rising trend in the number of patients who are discharged to a nursing home over the last 12 months, which is around 13%. A quality improvement project is underway to understand the impact on patients and the related harms that are experienced when their discharge from hospital is delayed. The unplanned readmission rate is steady at 3.7% and we intend to benchmark this figure, which will be further explored.

Within the hospitals, we have noted an increased spend on bank and agency due to the increased clinical dependency of patient and the additional 1 to 1 nursing that is required. Additionally, as mentioned last month, the vacancy rate has reduced to 8.3% and will continue to be monitored.

Within our Rapid Response Team, the vacancy rate is currently at 32.1%. This will reduce as 8.2 whole time equivalent staff have been recruited and are in the pipeline to join the team. For September we shared that this team also showed as a breach for meeting their 2 hour target. On review this was due to late data entry. This was not a breach and the service were compliant at 72%. Compliance has continued and this month is 74%.

Performance in the Minor Injury and Illness Units (MIIU) remains very strong, seeing 99.5% of patients within the 4 hour target. Significant work has also taken place over the last 12 months to reduce the times that the MIIU is closed and this is currently sitting at around 2%, which is positive progress.

Mandatory and essential training for our staff is reviewed and monitored and the following areas have been particularly asked to plan improvements for the following areas; Clinical risks assessment training in the Crisis Team which is at 86.2%, Oliver McGowan training at Berkely House which is at 67.9%, Resuscitation training within our Mental Health and Learning Disability Directorate which is at 86.6%. Each of the Service Directors is now reviewing their training compliance in these areas to develop a trajectory for improvement.

Across the directorates, we also monitor and review clinical supervision compliance. Supervision levels within the Children and Young People Services has improved to 47.4%, although it is recognised that further improvements are required. This is also being further explored with the Nursing, Therapy and Quality Team as not all areas hold a caseload and therefore a clearer position is being sought. Additionally, other areas are not where we would want them to be in terms of clinical supervision, for example within Charlton Lane Hospital and further work is being undertaken with colleagues from the Nursing, Therapy and Quality Team to review the policy and practice of clinical supervision. Additionally, we have also looked at areas recording low compliance with supervision as one team revealed they were at 8.3% and on further review, this was due to the recording as the team were receiving supervision. It is however worth mentioning that our Countywide Services directorate met their clinical supervision rate in October, which has steadily increased since March 2024.

Director of Nursing, Therapies and Quality Report

Nicola Hazle, Director of NTQ

NTQ have reviewed the exceptions in this month's performance report with operational and BI colleagues and this reflects our developing approach to the integrated report.

At a development level, members of the quality team have contributed to the narrative updates in the report, with a focus on understanding any patient safety, clinical effectiveness and experience concerns. This has contributed to a widening narrative with an increased focus on the 'so what' aspect to performance data. We will continue to develop this month on month.

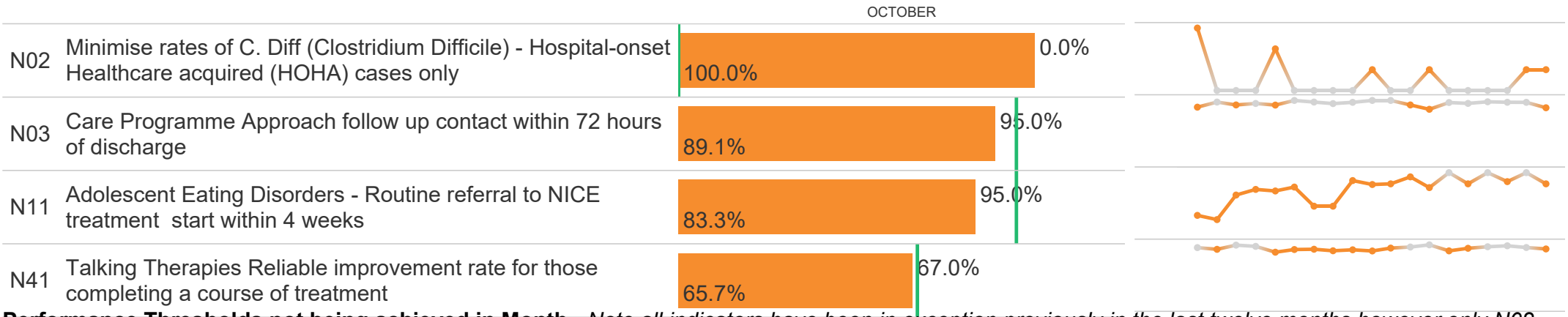
Activity centred around Echo, Community Dental, Eating Disorders and Perinatal services have had further in-depth discussion in the Quality Assurance Group and we assured at the plans in place to recover KPI's. We note in particular the escalation to the ICB regarding Echo Services and support the recovery plan. We also note that recent recruitment will improve capacity in the oral surgery pathway and will continue to monitor this with the team.

We have noted the areas of statutory and mandatory training that require improvement and have been assured this will be addressed in month. We will work with operational colleagues to support this as part of our routine quality monitoring at ward and team level.

KPI Breakdown

Compliant Non Compliant

National Contract Domain



Performance Thresholds not being achieved in Month - *Note all indicators have been in exception previously in the last twelve months however only N02 was in exception in September.*

N02 - Minimise rates of C. Diff (Clostridium Difficile) - Hospital-onset Healthcare acquired (HOHA) cases only
One patient started to show symptoms and tested positive four days after transfer from GHFT. Both patients have been treated with good effect.

N03 - Care Programme Approach follow up contact within 72 hours of discharge
October has been reported as 89.1% against the threshold of 95% with 5 out of 46 patients not contacted within 72 hours (September was 97.2%).

One patient was a data quality error which has subsequently been amended and current performance is 91.3%.

N11 - Adolescent Eating Disorders - Routine referral to NICE treatment start within 4 weeks
October performance is reported at 83.3% against a performance threshold of 95.0%. There were 2 patients not treated within 4 weeks in October out of 12. In the latest national data (MHSDS) for June to August, GHC achieved 72%, which is a lower than the England average of 75%. Statistical process control is not used for this KPI as performance is too variable.

N41 - Talking Therapies Reliable improvement rate for those completing a course of treatment
October performance is reported at 65.7% against a 67% threshold. There were 228 people who did not meet reliable improvement criteria in October out of 665. The performance is within normal variation.

Using the latest available month data, between 1 and 31 August 2024 from the monthly Talking Therapies (IAPT Dataset), GHC achieved 69%, which is a higher percentage compared to the England average, at 67.3%. Gloucestershire maintains a strong position on reliable improvement and reliable recovery regionally too in August, ranking 4th and 2nd out of the Southwest region trusts, respectively. Furthermore, Gloucestershire is also 2nd highest in the country on referral to first session wait times under 6 weeks.

Narrative continued on next page...

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The service has until the end of this financial year to consistently meet this KPI. In the last 7 months, the KPI has been over threshold in 4 out of the 7 months.

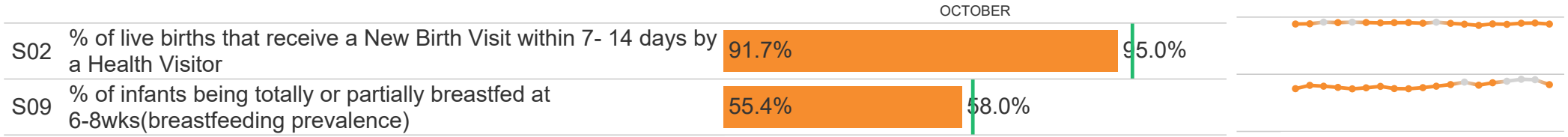
The service plans to improve the reliable improvement rate through clinical supervision. This will be supported by reports at a clinician and team level, which the Business Intelligence team has recently developed. During this year the service seeks to understand and address the areas affecting performance.

Performance Dashboard: *Specialised Commissioning Domain*

KPI Breakdown

Non Compliant

Specialised Commissioning Domain



Performance Thresholds not being achieved in Month - *Note all indicators have been in exception previously in the last twelve months, but only S02 was in exception in September.*

S02 - % of live births that receive a New Birth Visit within 7- 14 days by a Health Visitor
Performance in October is 91.7% (September was 93.6%) compared to a threshold of 95.0% with 42 out of 509 babies not seen within 14 days. Performance is within normal variation.

Neonatal Intensive Care Unit (NICU) admissions and hospital re-admissions accounted for 19 (45%) of the exceptions. NICU admissions and hospital re-admissions consistently continues to be the primary factor behind babies not being seen within timeframe.

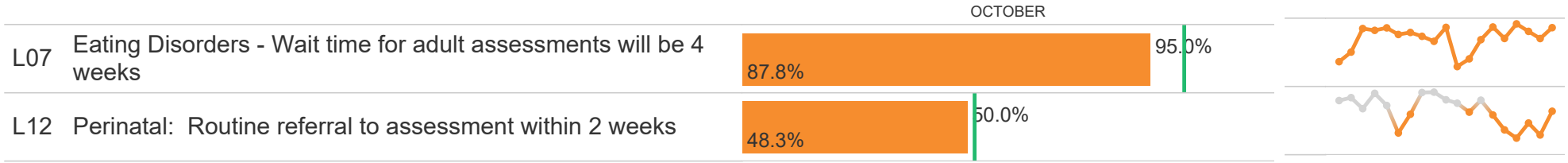
S09 - % of infants being totally or partially breastfed at 6-8wks(breastfeeding prevalence)
Performance in October is 55.4% (September was 60.8%) compared to a threshold of 58.0% with 239 out of 537 babies recorded as not being totally or partially breastfed at 6-8 weeks. Performance is within normal variation.

This is the first time performance has dipped below threshold since May 2024. Performance has been influenced by Neonatal Intensive Care Unit (NICU) admission and hospital re-admission, and staffing capacity issues across the Midwifery service.

KPI Breakdown

Non Compliant

ICS Agreed Domain



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

L07 - Eating Disorders - Wait time for adult assessments will be 4 weeks
October performance is reported at 87.8% against a 95.0% threshold. There were 4 patients not assessed within 4 weeks in October out of 33. Performance has increased from September, which was 71.7%. Statistical process control is not used for this KPI as performance is too variable.

The service continues to work with BEAT (an eating disorders charity) for adults on the momentum programme and with TIC plus for under 25's to refer patients to a counselling programme and then discharge from the caseload.

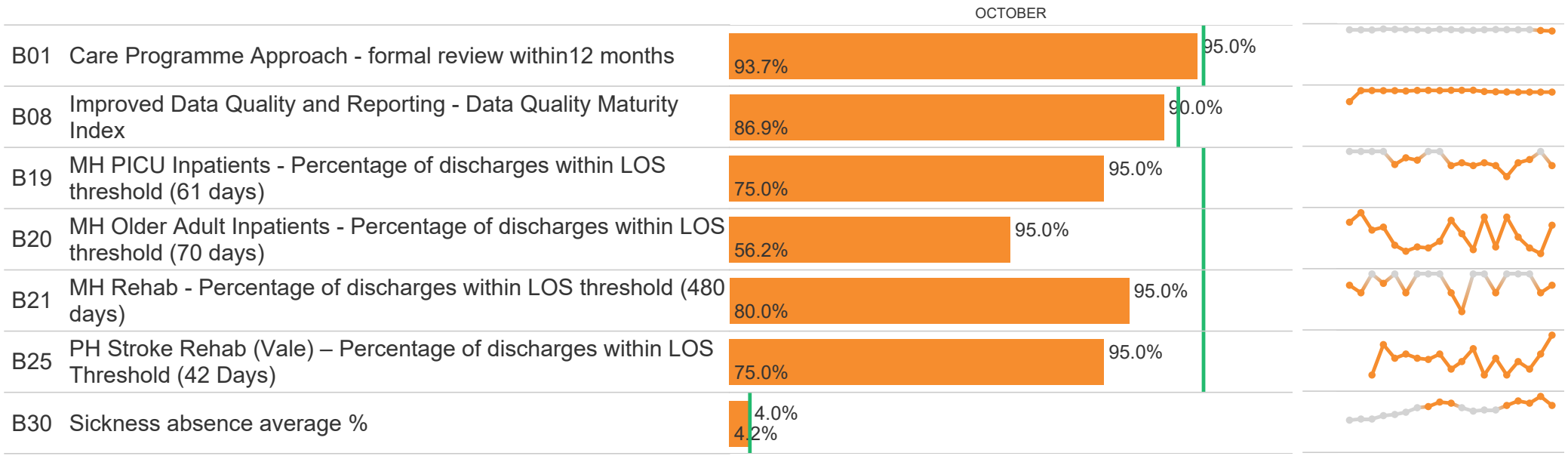
This set of indicators has a service improvement plan and is on the performance governance tracker. This is on the risk register ID 149 (score 16).

L12 - Perinatal: Routine referral to assessment within 2 weeks
Performance is reported at 48.3% against a performance threshold of 50%. There were 32 people not seen within 2 weeks out of 62. The performance for October is an improvement on 22.3% for September. Currently performance is too unstable to apply SPC limits. This will be reviewed as and when performance becomes stable.

There is a recovery plan in place and the service are reinforcing inclusion and exclusion criteria to ensure appointments are being offered to women who most need them. The recovery plan will be presented at BIMG in November 2024. The service estimates that recovery will be realised in February 2025.

KPI Breakdown

Board Focus Domain



<u>Performance Thresholds not being achieved in Month</u> - *Note all these indicators have been in exception previously in the last twelve months, however B01 only became in exception in September 2024.*

B01 - Care Programme Approach - formal review within12 months
October performance is reported at 93.7% against a performance threshold of 95.0%. There were 54 patients reviewed after 12 months in October. Performance is a low outlier and outside of normal variation.

Most of the patients that were reviewed after 12 months are within the Recovery teams, and Later Life teams.

There are ongoing operational pressures affecting the timely entry of reviews onto the clinical system. Since the snapshot was taken, the October performance has increased slightly and is currently at 94.1%.

B08 - Improved Data Quality and Reporting - Data Quality Maturity Index
The latest performance is 86.9% against a performance threshold of 90%. Performance is within normal variation. This indicator is an amalgamation of Data quality performance across national data sets:

Narrative continued on next page...

Continued from last page...

APC: Admitted patient care data set 98.8% (previous month 99.5%)
CSDS: Community services data set 88.8 % (previous month 88.7%)
ECDS: Emergency care data set 74.4% (previous month 74.2%)
IAPT: Talking Therapies data set 99.7% (previous month 99.8%)
MHSDS: Mental Health services data set 87.7% (previous month 88.3%)

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 Working Group and future action plans and updates will come from this Forum. To note, improved compliance will also come as a result of the Core Assessment work which is within the Clinical Systems Team workplan.

B19 - MH PICU Inpatients - Percentage of discharges within LOS threshold (61 days)
This is a new KPI this month,1 of the 4 patients whose PICU ward stay ended in October exceeded the threshold of 61 days, with a LOS of 93 days, in September there were 4 ward stay ends all within the threshold LOS. The average LOS for a PICU ward was 39.0 days (September was 37.8 days). Statistical process control is not used for this KPI due to the small number of cases.

B20 - MH Older Adult Inpatients - Percentage of discharges within LOS threshold (70 days)
This is a new KPI this month, 7 of the 16 patients whose Older Adult ward stay ended in October exceeded the threshold of 70 days. The average LOS for an Older Adult ward was 85.1 days (September was 126.2 days). For the patients who exceeded 70 days the average length of stay was 138.3 days. (Sep was 147.6). The maximum continuous LOS on an Older Adult Ward was 287 days. Statistical process control is not used for this KPI as performance is too variable.

B21 - MH Rehab - Percentage of discharges within LOS threshold (480 days)
This is a new KPI this month, 1 of the 5 patients whose MH Rehab ward stay ended in October exceeded the threshold of 480 days,with a LOS of 837.0 days (Sep also had one patient whose LOS exceed the threshold at 671 days). The average LOS on a MH Rehab ward was 229.0 days (September was 324.0 days). Statistical Process Control is not applied to this indicator due to the small number of cases.

B25 - PH Stroke Rehab (Vale) – Percentage of discharges within LOS Threshold (42 Days)
In October the average LOS for a stroke rehab patient was 37.5 days, compared to the threshold of 42 days, (September was 38.3 days). Of the 4 stroke rehab patients discharged from a community hospital stay, 1 exceeded the length of stay threshold of 42 days. Statistical process control is not used for this KPI as performance is too variable.

18.0% of beddays were lost to patients having no criteria to reside in our beds, with the highest percentage of days as nCTR for patients on pathway 3 (32.4%) with pathway 1 at 20.0%. On average this equates to 6.8 days nCTR for all patients and 22.0 days nCTR for each P3 patient. If patients were able to be discharged when they were clinically ready the average LOS would be 30.8 days, however performance would remain at 75%

B30 - Sickness absence average %
Sickness absence rate in October 2024 was 4.2%. This does not include data from the e-rostering system (Allocate) because it is not available at the time of reporting. The reported sickness absence rate in September 2024, including e-rostering, was 5% compared to a threshold of 4%; which was above normal variation and therefore it's likely October's position will be above normal variation.

This reflects the sickness absence information on Tableau on 01/11/2024.

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

- **N24 - Adults and older adults accessing select CMHSs, having their PROM recorded at least twice**

This is the first month this indicator has been reported. It is compliant at 12.4% against a 10% threshold.

- **B18 - MH Acute Inpatients - Percentage of discharges within LOS threshold (26 days)**

This is a new KPI this month, 17 of the 33 patients whose Adult Acute ward stay ended in October exceeded 26 day threshold. The average LOS for an Adults Acute wards was 72.3 days (September was 50.8 days). For the patients who exceeded 26 days the average length of stay was 127.2 days. (Sep was 83.9). The maximum continuous LOS on an Adult Acute Ward was 422 days. Performance is within expected variation.

- **B24 - PH CATU - Percentage of Discharges within LOS Threshold (10 days)**

In October, of the 16 patients discharged from a community hospital stay, who spent time in a CATU bed, 7 exceeded the CATU length of stay threshold of 10 days. For the patients who exceeded 10 days the average length of stay of these patients was 14 days. (Sep was 16.4). This is within normal variation.

9.2% of beddays were lost to patients having no criteria to reside in our beds, with the highest percentage of days as nCTR for patients on pathway 1 (17.4%) with pathway 3 at 9.1%. On average this equates to 1 day nCTR for all patients. If patients were able to be discharged when they were clinically ready the average LOS would be 8.7 days and performance would rise from 56.2% to 72.2%.

REPORT TO: **TRUST BOARD PUBLIC SESSION – 28 November 2024**

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

AUTHOR: Lavinia Rowsell, Director of Governance & Trust Secretary

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

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

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

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

Recommendations and decisions required

The Board is asked to:
- **Receive** and **consider** the BAF (Q2 review)
- **Note** the overarching risk profile for the Trust (Page 1, **Appendix 1** BAF)
- **Note** progress towards mitigating strategic risks

Executive summary

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

The Board Assurance Framework (BAF) for 2024/25 reflects the Trust's Strategic Aims and Objectives. For the assurance of the Board, throughout the year, the BAF has been reviewed and updated in line with Trust policy with the regular governance touchpoints (Executive risk owners, Executive Team and Governance Committees). The BAF is a dynamic in nature as demonstrated by the changes set out below.

<u>Key changes during Q1/Q2:</u>
- A summary key changes in Q2 set out on page 2 of **Appendix 1**.
- **Movements** in risk ratings in year can be seen in the dashboard on page 3 of the BAF with rationale contained within the main document. Changes to risk scores are reviewed by the relevant governance committee.

- One risk reached its target score and been **closed** – *Risk 7 - Sustainability*.
- A detailed review of assurances and mitigating actions have been undertaken for those risks overseen by the Great Place to Work and Quality Committee

A Board session on Strategic Risk will be scheduled for early 2025.

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

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

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

Appendices:	Board Assurance Framework Q2 Review

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

APPENDIX 1

BOARD ASSURANCE FRAMEWORK

April 2024 - March 2025

Q2 REVIEW

BOARD ASSURANCE FRAMEWORK - SUMMARY OF KEY CHANGES IN Q2

Strategic risks added or removed

Removed	No risks have been closed in this quarter. Following agreement through the Governance Committees as part of Q1 Review the risk relating to *Sustainability* has reached its target score and been removed from the strategic risk register and added to the corporate risk register.	
Revised	Risk 2 – *Services not meeting population needs.* The wording of this risk has been amended to remove reference to *Health Inequalities.* A separate strategic risk is being developed to ensure adequate focus on this important area in that there is a risk that the Trust does not fully factor in health inequalities into its approach to service development.	**12**

Movements in risk ratings

		Score
Risk 4 and Risk 9	*Internal Culture* and *Closed Culture* – the risk scores (likelihood ratings) of both of these risks have been raised from 9 to 16 to in light of the staff survey results which indicated an increase in colleagues Trust wide experiencing discrimination and specific feedback about experiences of colleagues which resulted in an external review. An enhanced Leadership and Culture Programme to bring together various existing and new strands of work that focus on improving our culture, leadership and, in particular, our determination to tackle racial and other forms of discrimination is being established.	**16 *(from 9)***
Risk 5	*Partnership Culture* – following consideration during the recent round of governance committee meetings, it was requested that the Executive reconsider the recommendation to close the risk relating to partnership culture as it had met its target risk score of 6. Following further consideration, it was agreed that the risk would remain open at a risk score of 9 until the completion of two key actions relating to partnership working firstly, the outcome of the evaluation of the CMHT programme and secondly, the conclusion of the review of the Working Together Advisory Group and associated report to Trust Board regarding assurance around progress in relation to the Trust's Working Together Advisory Plan.	**9**

Issues to note

		Score
Risk 8	*Cyber* – progress continues to be made in protecting the trust from Cyber attack however the external environment means that the threat continues to evolve and is likely to remain indefinitely. Further work on risk appetite/tolerance in relation to cyber risk will be undertaken.	**12**

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

<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="3">High Quality Care
Better Health</td><td>Exec Risk Owner</td><td>Dir NTQ</td><td>Date of review:</td><td>Oct 24</td></tr>
<tr><td>Risk ID:</td><td>01</td><td>Description:</td><td colspan="3" rowspan="8">Quality Standards:

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

will result in poorer outcomes for patients / service user and carers and poorer patient safety and experience.</td><td>Lead Committee</td><td>Quality</td><td>Date of next review:</td><td>Dec 24</td></tr>
<tr><td colspan="3">Risk Rating:
(Consequence x Likelihood):</td><td colspan="4" rowspan="7">Relevant Key Performance Indicators:
(taken from the Performance Report/ Quality Dashboard)
• Number of Complaints (and trends – including by site and service)
• Number of concerns and trends including by site & service)
• Timeliness of reviews into Concerns
• Patient Safety Incidents
• Friends & Family Test measures
• Safe Staffing Levels
• Embedding learning /Quality Improvement activity reporting
• Waiting times
• Vacancy rates – aggregate position</td></tr>
<tr><td colspan="2">Date Risk Identified/confirmed</td><td colspan="3">Updated Oct 2023 (Ongoing BAF Risk from 2019)</td></tr>
<tr><td colspan="2"></td><td>Likelihood</td><td>Impact</td><td>Overall</td></tr>
<tr><td colspan="2">Inherent Risk Score:</td><td>3</td><td>4</td><td>12</td></tr>
<tr><td colspan="2">Current Risk Score:</td><td>3</td><td>4</td><td>12</td></tr>
<tr><td colspan="2">Target Score</td><td>2</td><td>4</td><td>8</td></tr>
<tr><td>Date to Achieve Target Score</td><td>1st April 2025</td><td>Tolerance</td><td colspan="2">10</td></tr>
<tr><td colspan="3">Potential or actual origin of the risk:</td><td colspan="7">Recognising its core importance to the work of the Trust this has been confirmed as an area for ongoing monitoring on the BAF since 2019, confirmed 2023.</td></tr>
<tr><td colspan="10">Rationale for current score:
(What is the justification for the current risk score)
Established quality governance structures and processes through to Quality Committee provide partial assurance in relation to delivery of the Quality Strategy as well as the monitoring and response to trends and variability across quality standards and the embedding of learning and improvement; where the majority of indicators are within agreed parameters. There remains further development and improvement required to:
➢ Mature the analysis and triangulation of data available to demonstrate impact on clinical harm, safety and quality outcomes.
➢ Sustain improvement in safer staffing levels and the reductions in agency staffing use
➢ Continue the work to reduce closed cultures through triangulation of data from reviews, audits and FTSU alongside the quality priority programme in relation to reducing restrictive practice, pressure ulcers, clinical supervision, clinical risk assessment & management and PSIRF.
➢ Maintain progress on actions plans and internal assurance related to regulatory compliance, including the S31 at Berkeley House where there remains enhanced surveillance
➢ Assure on significant service transformation programmes, including the community MH services and integrated urgent care service</td></tr>
<tr><td colspan="10">Links to Risk Register
346 Estate - Berkeley House 387 - Berkeley House - Closed Culture 73 - Data Quality 107 - Ligature Points - Identification 109 -Safeguarding - System Recording of Patient Information 160 - Patient Record Document Storage & Access 194 - Non-NIHR Research and Development Funding 354 - Estate Maxwell Centre 372 - SARC Building and Accreditation 421 - CSSD - contaminated sets</td></tr>
</table>

Controls: (What do we currently have in place to control the risk?)		Last Review Date:	Next Review Date:	Reviewed by:	Gaps in Controls: (What additional controls should we seek?)
1.	Clinical policies, SOPs and clinical procedures			Dir of Ops & Dir NTQ	
2.	Clinical Compliance Programme including clinical audit, NICE guidance audit, clinical policy audit	Annual	Q4 2024/25	Dir NTQ/ Quality Committee / Board	
3.	Regulatory compliance including self-assessment and peer review, fidelity testing		Q4 2024/25		
4.	Effective local clinical governance processes operating in operational teams, services and directorates	Monthly	Q4 2024/25	Dir of Ops & Dir NTQ	
5.	Patient Safety Incident Response Framework e.g. Datix	As above	Q4 2024/25	Dir of NTQ	New framework is embedding and maturing
6.	Safer staffing including e-rostering and job planning	Monthly	Q4 2024/25	Dir NTQ	Safer staffing review in 2023/24 still under review
7.	Training and professional practice including stat man, essential to role, revalidation	Monthly	Q4 2024/25		

Sources of Assurance: (How do we know if the things we are doing are having an impact?)		Lines of assurance: L1 - Operational L2 - Board oversight L3 – Independent	Last Received	Received by	Assurance Rating	Gaps in Assurance: (What additional assurances should we seek?)
1	Reports on Quality Standards/Performance/Priorities	L1& L2	monthly	Qual/Res or Board	Satisfactory	
2	Reports on Service User Experience, Healthwatch etc, Annual Surveys	Includes L3	monthly	Qual Comm/Board	Satisfactory	
3	Reports on Staff Experience including staff survey, FTSU	L1 & L2 Includes L3	monthly	GPTW & Audit Committee	Satisfactory	
4	Compliance programmes including clinical audit, internal BDO audits	L1 & L2	Ad-hoc	Audit Committee	Satisfactory	
6	CQC inspections	L3	Ad-hoc	Qual/Board		Community MH services not inspected since 2016

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions:	Action Owner:	Deadline [revised deadline] Complete / In Progress / Delayed / Not Started
1.	Measuring What Matters Work Phase 2 to be progressed	Ongoing – Board Dev Session Aug 23	DoF	TBC - Priorities & focus to be agreed
2.	Embed PSIRF Programme	Patient safety panels now meeting 2 x weekly, quarterly updates, review of mortality/learning from deaths leadership and oversight	DoNTQ	In progress
3.	Integrated Performance and Quality Reporting	Integrated report in development as reported to Board. Review of quality dashboard and priorities.	DoNTQ	Dashboard being updated
4.	Quality Assurance mechanisms	Reliance on internal programme of self-assessment and peer reviews for community MH teams, recent Maturity Tool assessment via IAOT review by ICB	DoNTQ	
5.	Safer Staffing Review	Inpatient nursing safer staffing review - reassessment underway. Links to national work on AHP safer staffing in MH inpatients. National community safer staffing programme paused.	DoNTQ / DHR&OD	Ongoing
6.	Anti-closed culture activity and action plan in response to BDO internal audit	See Risk 9. Due for re-audit Sept/Oct 2024.	DoNTQ	In progress
7.	Evaluation and review of Quality Strategy		DoNTQ	Commence Q4 24/25

Strategic Aim:			**High Quality Care** **Better Health**	**Exec Risk Owner**	COO	**Date of review:**	Sept 24
Risk ID:	**2**	**Description:**	**Services not Meeting Population Need** There is a risk of demand out stripping supply for services and/or that services operate in a way which does not meet the needs of the population~~, potentially reinforcing health inequalities.~~ *[specific risk on health inequalities under development]*	**Lead Committee**	Resources	**Date of next review:**	Dec 24
Risk Rating: (Consequence x Likelihood):				**Relevant Key Performance Indicators:** (taken from the Performance Report)			
Date Risk Identified/ confirmed	Oct 2023 (Refocused from 2022 BAF risk)			• Waiting times • Referral and Access Reports • Length of Stay • No. Complaints and Compliments (also Trends – access, timeliness, E&D focus) • Out of Area Placements • Increased number of individuals with long term conditions – once available • Health Inequalities key metrics • User Satisfaction – by service, E&D characteristics • Quality Data			
	Likelihood	**Impact**	**Overall**				
Inherent Risk Score:	**5**	**4**	**20**				
Current Risk Score:	**3**	**4**	**12**				
Target Score:	**2**	**4**	**8**				
Target Date	**1st April 2025**	**Tolerance**	**10**				
Potential or actual origin of the risk:			Oct 2023 – Demand for Services Risk substantially revised and refocused to reinforce link to health inequalities and ensure reflects on way services delivered as well as demand.				

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

Demand for our services remains high and monitoring to reflect service operation meets the needs of the population continues to be in development. The Working as One diagnostic intervention identified areas for improvement which are currently being implemented (actions under our direct control are being taken forward and monitored through physical health transformation board). To date relationships with Commissioners remain supportive, but we need to ensure clear understanding of the volumes we are dealing with and how we are supporting Health & Care across the County through different services and different communities. We maintain a full suite of service improvement plans which are regularly reviewed at operational and governance level. We have developed a plan to reconfigure service around local partnerships considered by Board August 2023. Data monitoring of services against diversity characteristics to ensure needs of different communities being met requires further development. Recent change in reporting methodology has helped services to focus and drive delivery against 4 wk urgent and 18 week RTT which has demonstrably driven performance delivery performance, as demonstrated by podiatry, children's therapies and adult MSK. Whilst the majority of services are within national performance expectations it is acknowledged that improvements are required in some services (e.g. neurodiversity pathways), and this risk will continue to be kept under review.

Links to Risk Register

273 - Eating Disorder Service - Medical Resource 165 - CAMHS - Impact of high demand for specialist Core CAMHS treatment 196 - Mental Health Acute Inpatient Beds - Demand & Capacity Challenges 232 - Lengthening waiting times for CAMHS Neurodevelopmental Assessment Delivery 424 - Conveyance under the Mental Health Act (s6 (1)) - gap in secure transport commissioning 359 - Specialist Allocation Service Demand 398 - Speech and Language Therapy Staffing in General Medicine 180-Mental Health Act Changes 277-Telecare Provision 476 IUC - contract delivery IUC-mobilisation 449 – STOP Provision

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

Sources of Assurance: (How do we know if the things we are doing are having an impact?)		Lines of assurance: L1 – Operational L2 – Board oversight L3 – Independent	Last Received	Received by	Assurance Rating	Gaps in Assurance: (What additional assurances should we seek?)
1	Performance Report	L2	Monthly	Res Comm/Board	Satisfactory	
2	ICS Operating Plan	L2	Annual	Board	Limited	
3	Business Plan monitoring	L2	6 monthly	Board	Satisfactory	
4	Quality Account – including stakeholder feedback	L2/L3	Annual	Board	Satisfactory	
5	HoSC feedback	L3	Every other month	Chair/CEO/	Satisfactory	
6	Service User Feedback	L3	Annual	Board/Qual	Satisfactory	
7	Quality Report	L2	Monthly	Qual Comm/Board	Satisfactory	
8	Quality Dashboard	L2	Monthly	Qual Comm/Board	Satisfactory	Integrated reporting
9	Internal audit on Ops Governance	L3			TBC	

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions:	Action Owner:	Deadline [revised deadline] Complete / In Progress / Delayed / Not Started
1.	Continue work to build capacity and understanding of self-care and develop more admission avoidance schemes.	To be built into service reviews & developments. Focus on co-production for service developments to continue	COO DS&P	In progress –incremental adoption in conjunction with ILPs
2	Continue work to improve joined up working across the county to make best use of Gloucestershire pound	Ongoing work across ICS	Exec	Ongoing
3	Continue performance report monitoring & deep dives to focus on patient outcomes.	Established within agenda cycles	COO	Ongoing
4	Consider further how health inequalities can be measured and targeted as a system	Localisation discussed by Board. PLICS project targeting HE data from next iteration. Operationalisation of localisation plan with increased focus as a result. 24/25 business objectives with increased focus on localisation.	Exec/ICS	In progress. Progress Report end 24/25
5	Integrated reporting in newly configured performance report	Executive objective for ~~23/24~~ 24/25. Update provided to Resources Comm. Duplication between quality/performance reports removed.	Exec	In progress - date TBC
6	Quality Improvement Hub operation to be further developed to enable project consideration in relation to services meeting population needs	Resource and focus of QIH to be considered in line with meeting population needs.	DSP	In progress
7	Further work to develop integration of Working Together Advisory Committee within quality improvement processes	Regular meeting cycle to be put in place. Evaluation of WTAC underway.	DSP	In progress
8	GHC Health Inequalities objectives in place	CEO co-chair of system HI group. HI framework for the ICB developed - GHC specific actions/initiatives being development	CEO	Nov 2024 to ICB
9	Implement governance actions arising from internal audit	TBC		

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

There is a risk that we fail to recruit, retain and plan for a sustainable workforce to deliver services in line with our strategic objectives.

NB It is recognised that there is interrelation between BAF Strategic Risk Recruitment and Retention of the BAF Strategic Risks relating to Closed Culture and Inclusive Culture.</td><td>Lead Committee</td><td>GPTW</td><td>Date of next review:</td><td>Dec 24</td></tr>
<tr><td colspan="3">Risk Rating:
(Consequence x Likelihood):</td><td colspan="4">Relevant Key Performance Indicators:</td></tr>
<tr><td colspan="3">Date Risk Identified/confirmed</td><td colspan="3">October 23 (Updated from 2022)</td><td colspan="4" rowspan="8">• Staff Turnover & Stability Rate– inc wellbeing metrics
• Sickness Absence KPI
• Vacancy Rates
• Bank and Agency Usage
• Appraisal Compliance
• Stat & Man Training Compliance
• Staff FFT scores
• CPD Plan delivery
• Annual Staff and Pulse Surveys
• Recruitment & Retention Report – exit trends
• Education & Development Report
• Probationary periods
• Health & Wellbeing Report</td></tr>
<tr><td colspan="3"></td><td>Likelihood</td><td>Impact</td><td>Overall</td></tr>
<tr><td colspan="3">Inherent Risk Score:</td><td>4</td><td>4</td><td>16</td></tr>
<tr><td colspan="3">Current Risk Score:</td><td>4</td><td>4</td><td>16</td></tr>
<tr><td colspan="3">Target Score:</td><td>3</td><td>4</td><td>12</td></tr>
<tr><td colspan="2">Date to Achieve Target Score</td><td>1st April 2025</td><td colspan="2">Tolerance</td><td>12</td></tr>
<tr><td colspan="4">Potential or actual origin of the risk:</td><td colspan="4">Confirmed to be retained 2033-2025 BAF, now broadened to include workforce wellbeing.</td></tr>
<tr><td colspan="8">Rationale for current score: (What is the justification for the current risk score)
It is recognised that many aspects of supply, terms, conditions and competitive remuneration remain outside the Trust's immediate control, with continuing national shortages of staff across nursing, medical, AHP and health care. There is also increasing staff demand to meet increasing service needs and changes to standards, for example safer staffing levels. Due to these factors recruitment and retention will remain a significant risk, with delays in the current registered staff pipeline continuing to significantly impact our ability to reduce this risk in the short or medium term. However, quarter 2 has seen an improvement on bank and agency usage (consistently overachievement of the NHSE target of 3.2%), reduced staff turnover, increased stability rate and establishment over last 12-month period, following recruitment campaigns Trust wide. This risk incorporates workforce and wellbeing metrics to ensure holistic oversight of recruitment and retention.</td></tr>
<tr><td colspan="8">Links to Risk Register
273 - Eating Disorder Service - Medical Resource 247 - Agency & Bank Staff – Reliance to deliver services 320 - CAMHS – Medical Workforce Vacancies 398 - Speech and Language Therapy Staffing in General Medicine</td></tr>
</table>

Controls: (What do we currently have in place to control the risk?)		Last Review Date:	Next Review Date:	Reviewed by:	Gaps in Controls: (What additional controls should we seek?)
1.	Recruitment and Retention Strategic Framework	July 23	Nov 24	Exec and GPTW	Recruitment of underrepresented communities (geographic, demographic & protected characteristics) and potential links to voluntary sector.
2.	International Recruitment & Retention Programme (includes revalidation, visas etc).	July 24	July 25	Exec	
3.	Relationships with universities to build supply. New Programmes developed Uni of Glos (UoG) and Three Counties Medical School.	Ongoing	Quarterly	Exec	Lead times to completion and under recruitment to Learning Disability Nursing Courses
4.	Recruitment Policy and SOPs in place	Ongoing	Ongoing	Exec/HR	Ongoing review of impact of changes to time to hire.
5.	System wide inclusive workforce recruitment Plan	01/06/24	Quarterly	Exec/ ICS Workforce Steering Group	ICS Strategy and Recruitment & Retention Plan to be agreed
6.	Health & Wellbeing Strategic Framework - (maximise support for colleagues)	Quarterly	Quarterly	Exec and GPTW	

Sources of Assurance: (How do we know if the things we are doing are having an impact?)		Lines of assurance: L1 - Operational L2 - Board oversight L3 – Independent	Last Received	Received by	Assurance Rating	Gaps in Assurance: (What additional assurances should we seek?)
1	Monthly Recruitment Activity Reports to SSOG	L1	Monthly	Exec	Work in progress	Recruitment from underrepresented communities.
2	Staff Survey and Staff FFT	Ls 1,2 and 3	August 2023	GPTW	Satisfactory	Includes wellbeing metrics. Action plan to address gaps
3	Retention Data	Ls 1 and 2	Ongoing	GPTW	Satisfactory	
4	Sickness Data	Ls 1 and 2	Ongoing	GPTW	Work in progress	
4	Turnover Data	Ls 1 and 2	Ongoing	GPTW	Satisfactory	
5	Annual Action Plan Recruitment & Retention Strategic Framework Review	L1 L2	Annual	GPTW	Satisfactory	
5	Annual Working Well Assurance Report	L2	June 2024	GPTW	Satisfactory	Sustainability and funding post March 2025 of wellbeing line.

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions:	Action Owner:	Deadline [revised deadline] Complete / In Progress / Delayed / Not Started
1	International Recruitment Partnership Activity – (RMNs, AHPs)	Programme of nurse and AHP international recruitment (focused to ICTs) including local domestic recruitment of overseas candidates. Retention actions progressed and agreed e.g. VISA renewal.	DHR&OD/ DNTQ	In progress
2	Return to practice Opportunities	Review opportunities to increase RTP recruits for 2023, 2024 cohort	D HR&OD	In progress -Sept 24 - review
3	Remuneration Review	2022 pay review paid at end Sept. Band 2-3 transition programme completed.	D HR&OD	In progress -
4	ICB Improved long term nursing workforce supply modelling being developed to support NHSE People Plan.	ICB, GHT, primary care and GHC colleagues work through exercise to support modelling development. To identify future workforce gaps.	DHR&OD	In progress

5	People Promise Workstream Implementation Plan	6 areas of focus, national programme.	DHR&OD	In Progress – December 24 & May 2025 review
7	Review Recruitment & Retention Framework impact	Increase in establishment over last 12-month period, following recruitment campaigns trust wide.	DHR&OD	In Progress – End Q4
8	Increase careers, widening access and apprenticeship engagement – Be in Gloucestershire Campaign.	GHC Careers and Engagement Officer connecting with schools, DQP, communities and diversity groups including recruitment to apprenticeship talent pool	DHR&OD	In Progress
9	Retention within Trust – facilitation of movement between Teams/services opportunities to be supported.		DDHR&OD	In Progress Q1 project
10	Violence and Aggression Strategic Plan	V&A Strategic Framework stakeholder engagement sessions ran through Nov 2023 (summary to GPTW Dec 2023) and work is underway to build the themes into the strategic framework.	DDHROD	To commence again Oct 2024
11	Industrial Relations /Staff Engagement Activities to support collaborative and open culture way of working.		Exec	In Progress
12	New Agency rate cards and cessation of off framework agency use. (start date July 24)	Implementation across the South West may encourage further uptake of substantive recruitment.	DDHROD	In progress
13	Use of targeted task and finish groups and/or cultural reviews for areas of concern.	Undertaken Mental health service areas, integrated community team.	Exec	In progress

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Strategic Aim:			**Great Place to Work** **Better Health**		**Exec Risk Owner**	N Savage, DHR&OD	**Date of review:** Sept 24
Risk ID:	**4**	**Description:**	**Inclusive Culture (Internal)** There is a risk that we fail to deliver our commitment to having a fully inclusive and engaging culture with kind and compassionate leadership, strong values and behaviours which negatively impacts on retention and recruitment, colleagues experience and engagement and on our ability to address inequalities in service delivery (access, experience and outcomes). *NB It is recognised that there is interrelation between this risk and Risk 8: Closed Culture.*		**Lead Committee**	GPTW	**Date of next review:** Dec 24
Risk Rating: (Consequence x Likelihood):					**Relevant Key Performance Indicators:**		
Date Risk Identified/confirmed		Oct 2023 (Updated from 2022)			• Staff Survey and Pulse Surveys • HR Formal Casework report • E-learning compliance - Equality, Human Rights Just & Learning Culture • Diversity levels at Band 8 and above – area of ongoing work • FTSU, WRES and WDES Data • Pay Gap Data • Service User Equality Access Data – when available • Recruitment metrics from underrepresented communities		
		Likelihood	**Impact**	**Overall**			
Inherent Risk Score:		**3**	**3**	**9**			
Current Risk Score:		**~~3~~ 4**	**~~3~~ 4**	**16**			
Target Score:		**3**	**2**	**6**			
Date to Achieve Target Score	**1st April 2025**	**Tolerance**		**6**			
Potential or actual origin of the risk:					Updated format for 2023-25 BAF (previously in 2021 BAF)		

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

Co-development of Trust Values & Behaviours work is agreed and embedded within key policies, reward/award process, recruitment, induction and appraisals to reflect Trust and Board commitments and our culture. Freedom to Speak Up Policy, updated in line with the new national template, plus the developing Diversity Networks are used to inform and develop practice provide assurance that the values and behaviours are being lived throughout the organisation. The Civility Saves Lives programme is now implemented alongside a Restorative, Just & Learning Culture approach with a second cohort of trainees commencing in Q3. 2023 Staff Survey indicators for 'compassionate and inclusive culture' places our Trust 2nd in South West Provider Trusts and above the average score for all trust wide indicators, with 73.9% of colleagues stating they would recommend the organisation as a place to work. However, feedback indicators continue to show less good experience for some colleagues related to protected characteristics. This remains an area of ongoing focus. The survey reports a 9% increase in discrimination on the grounds of ethnicity, combined with feedback from IEN Council in Q4 and the completion of an externally facilitated Culture Review, the score of this risk was increased. A programme of work is in place to address this including the launch of the Anti-Abuse Roadmap in March and an action plan following the externally commissioned culture review is being developed. A Board EDI session was held in June 2024 with resulting Board objectives and focused Board discussion in July. It is recognised that the external climate is currently more challenging in terms of racism and diversity and that partnership work is of increasing importance to ensure all staff feel supported.

Links to Risk Register

Controls: (What do we currently have in place to control the risk?)		Last Review Date:	Next Review Date:	Reviewed by:	Gaps in Controls: (What additional controls should we seek?)
1	Local Resilience Forum Partnership Meetings	Quarterly		Exec (Board as necessary)	Ongoing development of comms and projects to improve local relationships
1	Co-developed & Embedded Values & Behaviours	01/11/23	1/11/24	Board	
2	Just culture and appreciative enquiry processes included in performance management & Disciplinary Processes	01/12/23	1/12/24	Executive	
3	Valuing Difference Leadership Strategy in place	01/12/23	1/12/24	Executive	
4	Diversity and Inclusion Policy	26/04/22	31/12/24	WOMAG	
5	Freedom to Speak Up, Speaking up at work policies	01/12/23	1/12/24	Board	
6	Co-production commitment to service design	Ongoing		Board	
7	Learning and Development Strategic Framework	01/12/23	1/12/24	GPTW	
8	Inclusive Employer Status	Ongoing	Ongoing	GPTW	
9	EQIA and EIA to monitor policy & service changes	ongoing	Ongoing	Exec	

Sources of Assurance: (How do we know if the things we are doing are having an impact?)		Lines of assurance: L1 – Operational L2 – Board oversight L3 – Independent	Last Received	Received by	Assurance Rating	Gaps in Assurance: (What additional assurances should we seek?)
1	Feedback from appraisals and reward award processes	L1	Ongoing	Exec	Satisfactory	Gap between colleagues reported uptake and internal ESR records. Reported usefulness.
2	Disability Confident Leader Accreditation	L3	Aug 2023	Exec	Satisfactory	Re- accreditation process starts autumn 2024 for re-accreditation Aug 2025
3	Annual Workforce Race Equality Standard & Action Plan	Ls 2 and 3	July 2024	Board	Satisfactory	
4	Annual Workforce Disability Equality Standard & Action Plan	Ls 2 and 3	July 2024	Board	Satisfactory	
5	Patient & Staff Surveys	Ls 1,2 and 3	Mar 2024	Board	Satisfactory	
6	Freedom to Speak Up 6 monthly report	Ls 1,2 and L3	May 2024	Board	Satisfactory	
7	Diversity Networks with Lead NED in place	L2	Ongoing	Board/Exec	Satisfactory	Evaluation of impact and outcomes of networks - co-production with members, exit interviews.
8	Diversity Pay Gap Reporting	Ls 2 and 3	Mar 2024	Board	Satisfactory	Increased to incorporate diversity gaps
9	Internal Audit on Barriers to Raising Concerns	L3	Nov 2024	Comm	TBC	
10	External Review – (2024)	L3	Sept 24	Board	Limited	Action plan to be developed

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions:	Action Owner:	Deadline [revised deadline] Complete / In Progress / Delayed / Not Started
1.	Senior management diversity – Bands 8 and above to be developed.	Reciprocal Mentoring and Flourish Leadership Development programmes in place and ongoing.	D HR&OD	In progress
2	Equality &Diversity Training to be updated.	Equality and Human rights Level 1 training 99% compliance. 'safer recruitment' EDI training implemented. "Dignity at Work practice review – Restorative Just and Learning Culture". Initial cohort complete, second cohort in train. Case studies being developed. EDI recruitment / interviewer programme in place for Board-level appointments.	D HR&OD	In progress
3	Annual EDI action plan formalised, which includes key statutory requirements and stretch milestones.	Work towards a single EDI action plan continues against priorities raised through the staff surveys, and 6 'high impact actions' specified by NHSE. Board seminar June 24, Governor session TBC	D HR&OD	In Progress – single EDI implementation plan in place end 2024
4	Review of Apprenticeship (widening access) policy and pay	Commenced Q4	ADELD	In progress

5	Recruitment metrics to be reviewed	Focus on underrepresented communities – geography, demographics & protected characteristics. Monthly review of inclusive recruitment metrics,	D HR&OD	Sustainable Staffing Oversight Group commenced reviewing Aug 24
6	External Culture review commissioned	Expert review commissioned - targeted in-patient areas. Conclude end July, report September.	COO	Q2
7	Anti-racism campaign	Launch of campaign and roll out. Roadmap, resources, video and training workshops. Cultural Competence and Anti-Bullying & Harassments workshops are being delivered to all band 6's and above at our MH and PH sites. Ensure colleagues know how to support each other and respond to concerns relating to colleagues or service users. Encouragement to use Working Well for support.	DHR&OD	In progress
8	Wider Community Networking to be developed	Sharing good practice and providing support	DHR&OD	In progress
9	Leadership and Culture Programme in place and associated action plan	High level findings of external review shared with Board. Establishment of Leadership and Culture programme	CEO/ DHR&OD	In progress
10	Diversity Network Reviews	Network Chairs and Senior Leader Network Day held. Follow up required. Network maturity toolkit under consideration.	DHR&OD	In progress

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<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="3">Better Health</td><td>Exec Risk Owner</td><td>Dir of Strategy & Partnerships</td><td>Date of review:</td><td>Sept 24</td></tr>
<tr><td>Risk ID:</td><td>5</td><td>Description:</td><td colspan="3" rowspan="6">Partnership Culture

There is a risk that the Trust is not seen as, and does not maintain focus on being, an organisation which actively engages with its patients, staff and wider community partners impacting on our ability to deliver co-produced, personalised, high-quality services and address inequalities in health service delivery (access, experience and outcomes).</td><td>Lead Committee</td><td>Board</td><td>Date of next review:</td><td>Dec 24</td></tr>
<tr><td colspan="3">Risk Rating:
(Consequence x Likelihood):</td><td colspan="4" rowspan="5">Relevant Key Performance Indicators:
(taken from the Performance Report)

• Number of Engagement Partners
• Number of services redesigned using co production
• Number and breadth of services covered by Experts by Experience?
• Staff Diversity data reflects our community
• Patient Diversity Data reflects our community – available but needs to be more widely promoted and used
• Working Together Advisory Committee feedback</td></tr>
<tr><td colspan="2">Date Risk Identified/confirmed</td><td>Oct 2023 (updated from 2022)</td></tr>
<tr><td colspan="2"></td><td>Likelihood</td><td>Impact</td><td>Overall</td></tr>
<tr><td colspan="2">Inherent Risk Score:</td><td>3</td><td>3</td><td>9</td></tr>
<tr><td colspan="2">Current Risk Score:</td><td>3</td><td>3</td><td>9</td></tr>
<tr><td colspan="2">Target Score:</td><td>2</td><td>3</td><td>6</td></tr>
<tr><td>Date to Achieve Target Score</td><td>1st April 2024</td><td colspan="2">Tolerance</td><td>12</td></tr>
<tr><td colspan="4">Potential or actual origin of the risk:</td><td colspan="6">Similar risk on BAF since 2019. Refined Oct 2023.</td></tr>
<tr><td colspan="10">Rationale for current score: (What is the justification for the current risk score)
Partnership working, co-production and personalised care are central to the Trust's ways of working. There is clear leadership around the personalisation agenda through the Improvement and Partnership Team providing a consistent approach to how the Trust is taking forward co-production and working with stakeholders to achieve this. The Working Together Advisory Committee established in 2022 advises the Board on the way the Trust involves and includes people in its work, including progress with carrying out the Working Together plan. An evaluation of the Committee and its governance arrangements is underway in addition to a review of the Trust's approach to Peer Support Worker roles. CMHT programme has partner engagement throughout and an evaluation will take place to review all aspects including engagement with will inform our approach to future partnership working. CMHT Partnership Board extended to March 25 to allow us to continue to build the ongoing relationship with VSE and wider system partners.

All actions proposed have now been completed and the experts by experience cohort is growing. Work is ongoing to further embed co-production & personalisation within the organisation with clear work plans in place.</td></tr>
<tr><td colspan="10">Links to Risk Register
424 - Conveyance under the Mental Health Act (s6 (1)) - gap in secure transport commissioning</td></tr>
</table>

Controls: (What do we currently have in place to control the risk?)		Last Review Date:	Next Review Date:	Reviewed by:	Gaps in Controls: (What additional controls should we seek?)
1	Directorate for Strategy and Partnership with engaged team embedded in the communities we serve	Agreed as part merger	-	Board	
2	Joint Director with GCCG to support working with GP Network	Agreed as part merger	-	Board	
3	Expert by Experience Programme	22/23	23/24	D S&P	EbE policy under review
4	Governor Membership & Engagement Strategy	June 23	June 24	Council of Governors/Board	

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

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		Update since last reviewed (this should be high-level actions – the detail of the actions part of regular committee discussions:	Action Owner:	Deadline [revised deadline] Complete / In Progress / Delayed / Not Started
1.	Experts by Experience Review	EBE numbers continue to increase – focus on recruiting young experts and those with physical health conditions. Policy review underway.	D S&P	In progress – Dec 2025
2.	Governor Membership & Engagement Action Plan	To be implemented – partners and members to be put in place. Action plan reviewed by Governors end June 24. Governor engagements QI session held July 24.	Dir CG	Ongoing
3.	Patient Access and Involvement Data to be developed	BI have developed a range of data tools to enable understanding of our cohorts at team and patient level and demographic data is being introduced into reporting. Building into Measuring What Matters Phase 2 to raise profile and utilisation across ops teams. Plan for roll out to be developed.	DD of BI	In Progress – monitored via WTAC
4.	CMHT Evaluation process	Mechanism through which evaluation will be delivered under consideration including procurement approach.	DoS&P	TBC – 31 March 2025
5.	Review of Working Together Advisory Group	Workshop taking place in October to review form and function and relationship with other governance committees	DoS&P	31 March 2025
6.	Annual Report to Trust Board – Progress against WT Plan	To be delivered as part of report on evaluation of WTAG review.		31 March 2025
7.	Review of Peer Support Worker Roles	Research and benchmarking undertaken. Co-production/design of draft framework with EbE and Peer Support workers and Ops colleagues.		Jan Trust Board
8.	Explore VCS partner engagement	Meeting to develop the mutual relationship between the Trust and VCS	DoS&P	Dec 2025

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<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="3">High Quality Care
Better Health
Great Place to Work</td><td>Exec Risk Owner</td><td>Sandra Betney D of F</td><td>Date of review:</td><td>Sept 2024</td></tr>
<tr><td>Risk ID:</td><td>6</td><td>Description:</td><td colspan="3" rowspan="8">Funding for Transformation
There is a risk that funding constraints impact the ability of commissioners to commit to long term transformation of services to meet the needs of the populations we serve.</td><td>Lead Committee</td><td>Board</td><td>Date of next review:</td><td>Dec 2024</td></tr>
<tr><td colspan="3">Risk Rating:
(Consequence x Likelihood):</td><td colspan="4" rowspan="7">Relevant Key Performance Indicators:
• NHS Funding Settlement
• ICS Funding Settlement
• Access waiting times</td></tr>
<tr><td colspan="2">Date Risk Identified/confirmed</td><td>2023</td></tr>
<tr><td></td><td>Likelihood</td><td>Impact</td><td>Overall</td></tr>
<tr><td colspan="2">Inherent Risk Score:</td><td>4</td><td>4</td><td>16</td></tr>
<tr><td colspan="2">Current Risk Score:</td><td>4</td><td>3</td><td>12</td></tr>
<tr><td colspan="2">Target Risk:</td><td>3</td><td>3</td><td>9</td></tr>
<tr><td>Date to Achieve Target Score</td><td>March 2025</td><td>Tolerance</td><td>9</td></tr>
<tr><td colspan="4">Potential or actual origin of the risk:</td><td colspan="6">Discussion at Executive and Resources Committee to refocus finance risk June 2024</td></tr>
<tr><td colspan="10">Rationale for current score:
(What is the justification for the current risk score)</td></tr>
<tr><td colspan="10">The Trust's ability to directly impact on national funding is limited, but the Trust is active nationally in NHS Providers, the ICS and in community and mental health networks to support understanding of the roles of these services in supporting the population of the community and recognition of the need for their distinct funding. Gloucestershire submitted a balanced plan for 24/25, however the 24/25 financial outlook for the system and the Trust is challenging with system deficit risk sharing arrangements in place. The nature of growing demand for unplanned services impacts on longer term commitment for transformational planning/funding. The impact of the new government on NHS funding is as yet unclear and the additional focus on prevention and community services from the Darzi review.</td></tr>
<tr><td colspan="10">Links to Risk Register</td></tr>
<tr><td colspan="10">391 FINANCIAL RISK - Non-delivery Recurrent CIP Savings 390 - FINANCIAL RISK - ICS risk share mechanism will lead to financial impact on GHC</td></tr>
</table>

Controls: (What do we currently have in place to control the risk?)		**Last Review Date:**	**Next Review Date:**	**Reviewed by:**	**Gaps in Controls:** (What additional controls should we seek?)
1	Active Member NHS Providers	Ongoing	Each Board	Board	
2	Membership ICS Strategic Executive Meetings	Ongoing	Exec	Exec	
3	Membership of System Resources Committee	Ongoing	Exec	Exec	
4	Membership of ICB	Ongoing	Each Board	CEO – ongoing	
5	ICS pathway planning	Ongoing	Exec	Board	
6	ICS Joint Forward Plan	June	Annual	Board	
7	Working as One programme	Ongoing	Exec	Exec	

Sources of Assurance: (How do we know if the things we are doing are having an impact?)		**Lines of assurance:** L1 – Operational L2 – Board oversight L3 – Independent	**Last Received**	**Received by**	**Assurance Rating**	**Gaps in Assurance:** (What additional assurances should we seek?)
1.	Funding allocations achieved with commissioners	L2	Annual – Jan- Mar	Exec/Board	Satisfactory	
2.	Updates on relationships – commissioners, GCC, GCCG, MPs, Councillors.	L2	Every other month	Board	Satisfactory	
3.	ICS System Reporting	L2	Every other month	Board	Satisfactory	
4.	Joint Forward Plan					
5.	Benchmarking data					Population Health Management info

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		**Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions:**	**Action Owner:**	**Deadline** [revised deadline] Complete / In Progress / Delayed / Not Started
1	Continue to work with community and mental health networks	Ongoing	CEO/COO	Ongoing
2	Continue to be active ICS Partner making best use of Gloucestershire pound	Ongoing	CEO/DoF/Chair	Ongoing
3	Partnership in Working as One Programme		COO	Ongoing
4	Build knowledge base to demonstrate quantifiable results of investment in non-acute services		DoF	
5	Contribution to system discussion on – how funding is spent / allocated	ICB workshop on 'how do we/how should we spend our money'	CEO/DoF	Sept

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<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="3">Sustainability</td><td>Exec Risk Owner</td><td>Director of S&P</td><td>Date of review:</td><td>Aug 24</td></tr>
<tr><td>Risk ID:</td><td>7</td><td>Description:</td><td colspan="3" rowspan="2">Sustainability (environment)

There is a risk that responding to the climate emergency is not prioritised resulting in the failure to transform and deliver the Green Plan.</td><td>Lead Comm</td><td>Resources</td><td>Date next review:</td><td>Closed</td></tr>
<tr><td colspan="3">Risk Rating:
(Consequence x Likelihood):</td><td colspan="4" rowspan="6">Relevant Key Performance Indicators:

• Green Plan in Place on track
• Green Plan Targets/KPIs</td></tr>
<tr><td colspan="3">Date Risk Identified/confirmed</td><td colspan="3">2023 Reviewed & 2022 Risk maintained</td></tr>
<tr><td colspan="3"></td><td>Likelihood</td><td>Impact</td><td>Overall</td></tr>
<tr><td colspan="3">Inherent Risk Score:</td><td>4</td><td>3</td><td>12</td></tr>
<tr><td colspan="3">Current Risk Score:</td><td>2</td><td>3</td><td>6</td></tr>
<tr><td colspan="3">Target Score:</td><td>2</td><td>3</td><td>6</td></tr>
<tr><td>Date to Achieve Target Score</td><td>March 2025</td><td>Tolerance</td><td colspan="3">6</td></tr>
<tr><td colspan="3">Potential or actual origin of the risk:</td><td colspan="7">Recognition of need to keep a holistic oversight on Trust’s approach to sustainability which helps drive change.</td></tr>
<tr><td colspan="10">Rationale for current score:
(What is the justification for the current risk score)</td></tr>
<tr><td colspan="10">Sustainability (environment) has been identified as an area of ongoing focus for the Trust. A Green Plan, with Board input, was developed to support this work. (Green Plan Guidance (A three-year strategy towards net zero) has been issued by NHSE/I with Trust plans required by January 2022 and system-wide plans by end March 2022). The focus of the risk has moved from set up to taking forward of breadth of actions. Progress is being made in overall carbon reduction and the Sustainability Steering Group in place to bring together a wider Trust wide focus to the broader issues of sustainability development including workforce, procurement, anchor institution work. External funding bid for the works to upgrade the Charlton Lane boilers has now been secured and work is now being scheduled which means we are now on line to deliver the key net zero activities.</td></tr>
<tr><td colspan="10">Links to Risk Register</td></tr>
<tr><td colspan="10"></td></tr>
</table>

Controls: (What do we currently have in place to control the risk?)		Last Review Date:	Next Review Date:	Reviewed by:	Gaps in Controls: (What additional controls should we seek?)
1	Estates Environment Measures monitoring	Ongoing	Mar 24	Head of Sustainability	Annual Monitoring in Place
2	Management structure to support sustainability in place – Directorate responsibility DSP and Head of Resources in Place	Nov 2020	-	DSP	
3	Relationships in place to support joint working on this issue	Ongoing	-	DSP	
4	Commitment to sustainability within Trust Business Plan	Mar 24	Mar 25	Board	Need to embed the sustainability culture further
5	Commitment to sustainability within Trust Strategy	Mar 22	Mar 24	Board	

Sources of Assurance: (How do we know if the things we are doing are having an impact?)		Lines of assurance: L1 - Operational L2 - Board oversight L3 – Independent	Last Received	Received by	Assurance Rating	Gaps in Assurance: (What additional assurances should we seek?)
1	Estates Reporting on environmental measures within annual report	L2	May 24	Board	Satisfactory	Reporting in progress for 2024 report
2	Procurement processes in place which include high level consideration of sustainability	L1	2023	Resources	Satisfactory	Embed sustainability within procurement at all levels.
3	Sustainability Annual Report at Board level to contextualise this work.	L2	Nov 2023	Board	Satisfactory	
4	Resources Committee Review	L2	April 2024	Resources	Satisfactory	
5	Sustainability Maturity Internal Audit	L3	2023	Resources	Satisfactory	Environmental maturity assessment completed – 1 domain assessed as mature, 3 as defined and 1 Amber – all actions being taken forward

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

<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="3">High Quality Care
Better Health</td><td>Exec Risk Owner</td><td>Sandra Betney DoF</td><td>Date of review:</td><td>Sept 24</td></tr>
<tr><td>Risk ID:</td><td>8</td><td>Description:</td><td colspan="3" rowspan="6">Cyber
There is a risk that we do not adequately maintain and protect the breadth of our IT infrastructure and software resulting in a failure to protect continuity/ quality of patient care, safeguard the integrity of service user and colleague data and performance/monitoring data.</td><td>Lead Committee</td><td>Audit</td><td>Date of next review:</td><td>Dec 24</td></tr>
<tr><td colspan="3">Risk Rating:
(Consequence x Likelihood):</td><td colspan="4" rowspan="2">Relevant Key Performance Indicators:
(taken from the Performance Report/ Quality Dashboard)
Cyber Essentials Plus Certification
Colleague Cyber Training</td></tr>
<tr><td colspan="3">Date Risk
Identified/confirmed</td><td colspan="3">2023 (originated 2022)</td></tr>
<tr><td colspan="3"></td><td>Likelihood</td><td>Impact</td><td>Overall</td></tr>
<tr><td colspan="3">Inherent Risk Score:</td><td>4</td><td>5</td><td>20</td></tr>
<tr><td colspan="3">Current Risk Score:</td><td>3</td><td>4</td><td>12</td></tr>
<tr><td colspan="3">Target Score:</td><td>2</td><td>4</td><td>8</td></tr>
<tr><td colspan="2">Date to Achieve Target Score</td><td>1 April 2025</td><td colspan="2">Tolerance</td><td>6</td></tr>
<tr><td colspan="3">Potential or actual origin of the risk:</td><td colspan="7">Risk identified at Board Risk Seminar March 2022, informed by the growing risks in the corporate risk register relating to cyber security. Confirmed ongoing 2023 with additional recognition of risks to service user and colleague data and performance monitoring data.</td></tr>
<tr><td colspan="10">Rationale for current score: (What is the justification for the current risk score)</td></tr>
<tr><td colspan="10">[redacted – full review by Audit and Assurance Committee Nov 2024]</td></tr>
<tr><td colspan="10">Links to Risk Register</td></tr>
<tr><td colspan="10">[redacted – full review by Audit and Assurance Committee Nov 2024]</td></tr>
</table>

<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="3">High Quality Care
Better Health
Great Place to Work</td><td>Exec Risk Owner</td><td>DNTQ/ DHR</td><td>Date of review:</td><td>Sept 24</td></tr>
<tr><td>Risk ID:</td><td>9</td><td>Description:</td><td colspan="3" rowspan="6">Closed Culture
There is a risk of closed cultures existing within the organisation, where problems and concerns are not openly shared and acted on, either locally and/or at a Trust level, resulting in vulnerable and isolated patient groups being at risk of harm.

NB It is recognised that there is interrelation between this risk and Risk 4: Inclusive Culture.</td><td>Lead Committee</td><td>Board</td><td>Date of next review:</td><td>Dec 24</td></tr>
<tr><td colspan="3">Risk Rating:
(Consequence x Likelihood)</td><td colspan="4">Relevant Key Performance Indicators:
(taken from the Performance Report/ Quality Dashboard)</td></tr>
<tr><td colspan="2">Date Risk
Identified/confirmed</td><td>2023</td><td colspan="4" rowspan="5">Independent advocate activity data (TBC)
Training Compliance
Vacancy rates
Clinical supervision rates
Complaints and compliments
Reported incidents</td></tr>
<tr><td></td><td>Likelihood</td><td>Impact</td><td>Overall</td></tr>
<tr><td colspan="2">Inherent Risk Score:</td><td>3</td><td>4</td><td>12</td></tr>
<tr><td colspan="2">Current Risk Score:</td><td><s>3</s> 4</td><td>4</td><td><s>12</s> 16</td></tr>
<tr><td colspan="2">Target Score:</td><td>2</td><td>3</td><td>6</td></tr>
<tr><td>Date to Achieve Target Score</td><td>March 2025</td><td>Tolerance</td><td>10</td><td colspan="5"></td></tr>
<tr><td colspan="3">Potential or actual origin of the risk:</td><td colspan="7">Identified following reflection on Edenfield case, alongside previous and current culture reviews in some services across the Trust.</td></tr>
<tr><td colspan="10">Rationale for current score:
(What is the justification for the current risk score)</td></tr>
<tr><td colspan="10">The Trust has in place a range of processes to support an open culture, such as Freedom to Speak Up, Civility at Work, options to raise concerns confidentiality or via CEO or Board member, however this is an area where vigilance is required to reduce the likelihood and ensure that staff feel confident to report harm to vulnerable and/or isolated patient groups. Previous culture reviews and an internal audit in 2023 resulted in greater reporting on closed culture in higher risk areas. Further work to review the approach to identifying and monitoring closed cultures and determining the impact on patient care will be considered as part of the Leadership and Culture Programme.</td></tr>
<tr><td colspan="10">Links to Risk Register</td></tr>
<tr><td colspan="10">346 Estate - Berkeley House 387 - Berkeley House - Closed Culture</td></tr>
</table>

Controls: (What do we currently have in place to control the risk?)		Last Review Date:	Next Review Date:	Reviewed by:	Gaps in Controls: (What additional controls should we seek?)
1.	Current clinical policies, SOPs and clinical procedures	As required	As required	DoNTQ/COO	
2.	Clinical Compliance Programme including clinical audit, NICE guidance audit, clinical policy audit	Annual	Q4	Qual Comm/Board	
3.	S31 Regulatory compliance requirements for Berkeley House	Monthly			
4.	Effective local clinical governance processes operating in operational teams, services and directorates	Monthly	As above	Dir of Ops & Dir NTQ	
5.	Patient Safety Incident Response Framework e.g. Datix	As above	As above	Dir of NTQ	New framework is embedding and maturing
6.	Safer staffing including e-rostering and job planning	Monthly	As above	Dir NTQ	Safer staffing review in 2023/24 still under review
7.	Training and professional practice including stat man, essential to role, revalidation	Monthly			

Sources of Assurance: (How do we know if the things we are doing are having an impact?)		Lines of assurance: L1 - Operational L2 - Board oversight L3 – Independent	Last Received	Received by	Assurance Rating	Gaps in Assurance: (What additional assurances should we seek?)
1	Quality Reporting – including safeguarding, PCET, patient safety through to quality dashboard	L1	Annual	Annual	Satisfactory	Review if the approach is able to identify, monitor and assure as intended
2	Clinical audit programme and self-assessment and peer reviews	L1	Ongoing	Ongoing	Satisfactory	Frequency of these being undertaken internally
3	Non-Exec Quality Visits	L2	Ongoing	Ongoing	Satisfactory	
4	Internal/ external audits and reviews – BDO FTSU audit 2023	L3	Aug 23	Audit Comm/Qual Comm	Satisfactory (FTSU) Limited (Culture)	Completion and impact of learning/action plans Learning from repeat of 2023 audit
6	External review 2024	L3	Sept 24	Board	Limited	Action plan to be developed
7	Staff survey	L1-3	March 34	Board	Satisfactory	

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions:	Action Owner	Deadline [revised deadline] Complete / In Progress / Delayed / Not Started
1.	Improvement Plan Berkeley House following management reviews and CQC unannounced inspection Sept 23	Review & Development of improvement plan with focus on culture ongoing. Positive feedback from CQC on progress. Trust to apply to CQC to have s31 notice rescinded. Continuation of ICB enhanced surveillance and monthly catch ups.	DNTQ	**In progress**
2.	Reviews of practice ongoing to identify improved ways of working & options to identify & then share good practice.	RCP invited review will no longer take place due to timeline and cost. Alternative peer review process to be considered	DNTQ/MD	**Delayed**
3.	Ensure workforce data: clinical supervision, T&D, appraisal, length of service in one area, staff vacancies and safety incidents and complaints/concerns for areas with vulnerable or isolated patient groups regularly triangulated.	Appropriate frequency and reporting mechanism to Board committee/operational groups to be considered – potential for regular deep dives focused on closed culture risks to be assessed. Closed culture dashboard presented to Quality Committee May 24.	Exec	**In progress**
4.	Action plan in place against internal audit recommendations	Action plan in place with review at Quality Committee in September. Follow up audit scheduled to commence Sept.	DoNTQ	In progress - November
5.	Leadership and Culture Programme in place and associated action plan	High level findings of external review shared with Board. Establishment of Leadership and Culture programme	CEO/ DHR&OD	In progress

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<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="3">High Quality Care
Better Health
Great Place to Work</td><td>Exec Risk Owner</td><td>COO/ DHR</td><td>Date of review:</td><td>July 24</td></tr>
<tr><td>Risk ID:</td><td>10</td><td>Description:</td><td colspan="3" rowspan="6">Workforce Transformation – Skill Mix & New Roles
There is a risk the Trust does not invest strategically and sufficiently in colleague's development, meaning that colleagues do not develop the new skills or have the ability to undertake the transformational roles needed for the future, do not have a long-term relationship with the trust and that productivity is below target.</td><td>Lead Committee</td><td>GPTW</td><td>Date of next review:</td><td>Sept 24</td></tr>
<tr><td colspan="3">Risk Rating:
(Consequence x Likelihood):</td><td colspan="4">Relevant Key Performance Indicators:
(taken from the Performance Report/ Quality Dashboard)</td></tr>
<tr><td colspan="2">Date Risk Identified/confirmed</td><td>2023</td><td colspan="4" rowspan="4">• Staff Survey outcomes (L&D)
• Retention rates
• Number of advance practice roles developed
• CPD investment Plan Delivery</td></tr>
<tr><td></td><td>Likelihood</td><td>Impact</td><td>Overall</td></tr>
<tr><td colspan="2">Inherent Risk Score:</td><td>3</td><td>4</td><td>12</td></tr>
<tr><td colspan="2">Current Risk Score:</td><td>3</td><td>3</td><td>9</td></tr>
<tr><td colspan="2">Target Risk:</td><td>3</td><td>2</td><td>6</td><td colspan="4" rowspan="2"></td></tr>
<tr><td>Date to Achieve Target Score</td><td>March 2025</td><td>Tolerance</td><td>12</td></tr>
<tr><td colspan="3">Potential or actual origin of the risk:</td><td colspan="7">Reflection of need to ensure focus on transformation of staffing roles and practice.</td></tr>
<tr><td colspan="10">Rationale for current score:
(What is the justification for the current risk score)</td></tr>
<tr><td colspan="10">The NHS long term workforce plan sets out the strategic direction required to address current workforce challenges with a key priority area being 'reform' i.e. working differently in different ways to build teams with more flexible roles. However, the government stated that while it would invest circa £2.4 billion to fund the 27% expansion in training places by 2028/29, on top of current education and training budgets, there is a suggestion that related funding for the plan will not be forthcoming until 2025. Funding required to implement the entire plan beyond 2028/29 is also unclear. Workforce transformation is key to the delivery of the Trust's strategic objectives as is the need to equip colleagues for transformed ways of working to support the Trust's long term operation. The development of a Trust strategic workforce plan is a priority for the current financial year and reflected in Executive objectives</td></tr>
<tr><td colspan="10">Links to Risk Register</td></tr>
<tr><td colspan="10">248 - Great Place to Work – Just & Learning Culture & Strong Voice</td></tr>
</table>

Controls: (What do we currently have in place to control the risk?)		**Last Review Date:**	**Next Review Date:**	**Reviewed by:**	**Gaps in Controls:** (What additional controls should we seek?)
1.	Executive Review of Transformation Programme	Bi monthly	June 24	Exec	Trust strategic workforce plan in place
2.	Exec Prioritisation of transformation Programme	Annually	July 24	Exec	
3.	Strategic Oversight Group	Ongoing	Ongoing	Exec/Board	
4.	Board Development Time – review of Strategy Progress	March	Annual	Board	

Sources of Assurance: (How do we know if the things we are doing are having an impact?)		**Lines of assurance:** L1 - Operational L2 - Board oversight L3 – Independent	**Last Received**	**Received by**	**Assurance Rating**	**Gaps in Assurance:** (What additional assurances should we seek?)
1	Board Strategy Reporting	L2	Every other month	Board	Satisfactory	
2	Quality, Finance & Workforce Reporting	L2	Monthly	Board/Related Committee	Satisfactory	Integrated reporting
3	Digital Strategy	L2	Annual	Board	Satisfactory	

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		**Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions:**	**Action Owner:**	**Deadline** [revised deadline] Complete / In Progress / Delayed / Not Started
1.	Strategic long term plan in place, mapped to strategic service changes, defining GHC workforce requirements of the future.	Identified priority area for Dir HR&OD	DHR&OD	**In progress** (date TBC)
2.	Gaps in workforce supply to meet requirements		DHR&OD	(date TBC)
3.	Strategy in place to develop advanced practitioner role (AHP, ACP and Physician Associates)	AHP strategy in place, 5 year AHP strategy in development	DNTQ DHR&OD/ MD	**In progress**
4.	Implementation plan and monitoring in place.		DHR&OD	(date TBC)
5.	T&D budget commitment to developing future roles.		DHR&OD	(date TBC)
6.	Local Workforce Optioneering completed with the support of the SW NHSE team, with further support and ICS plans to develop further in Qs 2 to 3 2024/25.		DHR&OD	**In progress**

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Strategic Aim:			**High Quality Care, Sustainability** **Better Health, Great Place to Work**	**Exec Risk Owner**	Dir of Gov.	**Date of review:**	July 24
Risk ID:	**11**	**Description:**	**Board Stability** There is a risk that transition of Board members over the next 12 months, Executive and Non-Executive, leads to loss of board capacity (both executive and non-executive) whilst appointment and induction processes are ongoing, which impacts on strategic focus leading to a failure to deliver strategic objectives within planned timescales.	**Lead Committee**	Board	**Date of next review:**	Sept 24
Risk Rating: (Consequence x Likelihood):				**Relevant Key Performance Indicators:** (taken from the Performance Report/ Quality Dashboard)			
Date Risk Identified/confirmed	Jan 2024						
	Likelihood	**Impact**	**Overall**				
Inherent Risk Score:	**4**	**4**	**16**				
Current Risk Score:	**3**	**3**	**9**				
Target Risk:	**2**	**3**	**6**				
Target Date to Achieve Target Score	**April 25**	**Tolerance**	**6**				
Potential or actual origin of the risk:			Risk considered as potential BAF risk in September 23. Further unscheduled resignations of Executives and Non-Executives meant the risk was reviewed and agreed to be raised to a BAF risk.				
Rationale for current score: (What is the justification for the current risk score)							
There has been a change of approximately 50% of the overall Board in the past 8 months (including 3 execs and 3 NEDs). This has put additional pressure on ongoing Board members, with them holding additional responsibilities and also additional demands on time, to build the new team once appointments made. Corporate memory held prior to April 2023 continues to be significant, but a number of key roles will be developing knowledge of the Trust, and potentially this region. As of November, the recruitment for the final NED appointment (clinical focus) has concluded with appointee commencing in January 25. The new Director of Nursing is in post and the new COO & DoIP will commenced in post in early Nov 2024. The board development programme for the reminder of the calendar year is in place focussing on ways of working. There is no change to risk score during the quarter, noting that capacity issues still remain, particularly at Executive level.							
Links to Risk Register							

Controls: (What do we currently have in place to control the risk?)		Last Review Date:	Next Review Date:	Reviewed by:	Gaps in Controls: (What additional controls should we seek?)
1.	Appointment Processes – Chair – comprehensive process supported by NHSE and stakeholder engagement	15/03/24	-	Nom and Rem	
2.	Executive Appointment Processes overseen by ATOS	15/03/24	01/08/24	ATOS	
3.	Planned appointment processes NEDS – timing staggered	15/03/24	15/09/24	Nom and Rem	
4.	Induction Processes for new Executive and Non-Executive members	15/03/24	15/09/24	Chair/CEO	
5.	Board Development Planning	15/03/24	15/06/24	Chair/ ATOS	24/25 development programme in development
6.	Succession Planning process – Deputy Executive Directors	15/03/24	01/11/24	ATOS	
7.	Board Relationship Building Planning	15/03/24	01/11/24	ATOS	Targeted programme required to ensure focuses on key aspects to avoid overload
8.	Delivery of Strategic Goals	Board	Board		Monitoring to see if on track

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

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions:	Action Owner:	Deadline [revised deadline] Complete / In Progress / Delayed / Not Started
1	Acting up by Current Deputy Executives	To be part of development programme – in place for Strategy and Partnerships	CEO	Complete
2	Executive Development Coaching Programme	Ongoing – targeted to provide support	CEO/Chair	In progress
3	Non-Executive Development & Coaching	Targeted programme to be developed. Objective setting meetings being held and develop needs identified as part of induction.	Chair/N&R	In progress
4	New CEO /Chair Coaching	Coaching sessions commenced	Dir of Gov	In progress
5	Review of Non-Executive activities to maximising use of time	Director of Governance assessing frequency of meetings, quality visits etc to ensure best use made of NED and ED time.	Dir of Gov	Dec 2024
6	Refocussed board development programme 24/25 in place	Board Seminar and Development Programme Cycle for 2024-25 finalised. Full day board development held in October focussing on ways of working and including new Exec Appointment. Further session planned Dec 2024	Dir of Gov	In progress

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

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

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

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

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

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REPORT TO: **TRUST BOARD PUBLIC SESSION – 28 November 2024**

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

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

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

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

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

The purpose of this report is to:

To update the Trust Board, capturing activity of the Freedom to Speak service from April - September 2024.

To provide assurance to the Trust Board that:

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

Recommendations and decisions required:

Following consideration by the Great Place to Work Committee at its meeting in November 2024, the Board is asked to **RECEIVE, REVIEW** and **NOTE** the information and assurance provided in relation to Freedom to Speak Up activity from April-September 2024.

Executive summary

This six-monthly update report is an update from the previous report presented to the Trust Board in May 2024, which covers Freedom to Speak Up activity of colleagues speaking up, national and regional updates and the proactive work undertaken by the Freedom to Speak Up Guardian.

This is a summary of a report presented to the Great Place to Work Committee on 8th November 2024. In addition to the information presented in the report, the Committee considered further detail in relation to barriers to speaking up. The Committee took

assurance from the information presented on Freedom to Speak Up activity.

From April 2024 there have been a further 41 speak up cases raised to the Freedom to Speak Up Guardian. There was a notable increase in the 2023-24 year of colleagues speaking up to the Guardian, a total of 96 cases, more complex in nature and has impacted on the proactive time including visibility with teams across the Trust. Previous years data is 77 cases in 2022-23, compared to 54 cases 2021-22, 120 cases in 2020-21 and 60 in 2019-20. This year is a similar picture.

Anonymous reporting is highlighted by the National Guardian's Office as an indicator of staff potentially feeling a lack of trust in their organisation and a fear of suffering detriment. Anonymous reporting this year in the first two quarters is currently at 7% and for the year 2023-24 was 3%, nationally was 9.5%. Those colleagues that feel they have suffered disadvantageous and/or demeaning treatment because of speaking up, that has been reported to the Guardian is just under 10%. Those that have declared a protected characteristic is 12%.

For those colleagues that access the Freedom to Speak Up service feedback continues to be positive. 19 people provided feedback, 16 said that they would speak up again, 2 maybe and 1 said no. This includes speaking up to and sign posting on from our growing network of Freedom to Speak Up Champions, 106 to date. In July 2024, our Champion away day was very positive with planning and engagement for a new Freedom to Speak Up Strategy which is underway, 2025-28.

On a quarterly basis, Freedom to Speak Up Guardians are expected to share non-identifiable information with the National Guardian's Office (NGO) about the speaking up cases raised with them. This information provides invaluable insight into the implementation of Freedom to Speak Up and the national full year consolidated data for 2023-24 is available here and our benching marking as an organisation is shared in the PowerPoint appendices.

The BDO Barriers to Raising Concerns internal audit of December 2023 has recently been re-audited. The auditor shared some very positive feedback. They had seen improvements in all areas audited. In particular, they highlighted the improved communications, teamwork and attitudes of staff and acknowledged the work that had been undertaken around Freedom to Speak Up.

To support year-on-year improvement in raising the bar, in embedding our positive speaking up culture, we will continue to actively analyse the data through the NHS staff surveys, Pulse surveys and Networks. Further analysis has highlighted service areas to focus more visibility, champion development and enhancing the proactive speaking up culture work.

Since my last update various National reports have been published and as a Trust gives us an opportunity to reflect on these and capture some learning. The mandated Guidance for Boards reflection tool from NHS England continues to be a working document evaluating how healthy the Trust's speaking up culture is.

October was National Speak Up Month and our theme for this year focused on the power of listening, and the important part which listening plays in encouraging people

to speak up. Through 'Listening events' with teams, colleagues shared their experiences and how we can embed this further into our positive speaking up culture.

Dr Jayne Chidgey-Clark the National Guardian for Freedom to Speak Up in the NHS in England visited the Trust on the 10th October as part of National Speak Up Month. She led a session at our Senior Leadership Network, and we discussed how we can all be part of creating a positive environment to listen up, and barriers that our colleagues can face or perceive to face. The feedback will feed into the new strategy and priorities moving forward. She also spent the afternoon with our patient safety team, sharing insights into the Patient Safety Incident Response Framework (PSIRF) and the NHS Patient Safety Strategy.

Risks associated with meeting the Trust's values
All risks are clearly identified within the paper.

Corporate considerations	
Quality Implications	Processes are aligned to the guidance NHE/I and the National Guardian's Office embedded in the NHS Contract. A positive speaking up culture within our workforce will ensure that patient safety matters are heard and that colleagues are supported. Freedom to Speak Up arrangements are reviewed within the Well Led domain. NHS contract (2016/17) the requirement of a Freedom to Speak Up Guardian.
Resource Implications	Continued monitoring of the workload and demand on the Freedom to Speak Up service.
Equality Implications	Colleagues have spoken up regarding their experiences of racial discrimination. Colleagues disclose to the Freedom to Speak Guardian their protected characteristics.

Where has this issue been discussed before?
• Workforce Management Group 11th September 2024 • Great Place to Work Committee 8th November 2024 • Quality Assurance Group 15th November 2024

Appendices:	PowerPoint Slide deck Freedom to Speak Up Six Monthly Update.

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

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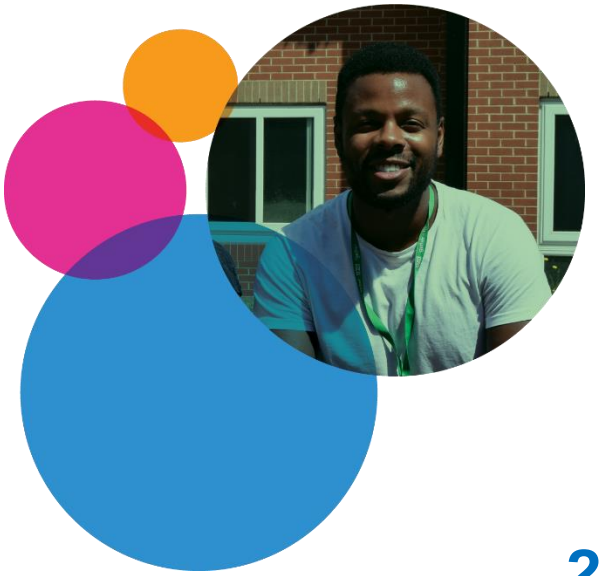

Freedom to Speak Up Update

Trust Board
28th November 2024

Freedom to Speak Up Guardian

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Colleagues Speaking Up

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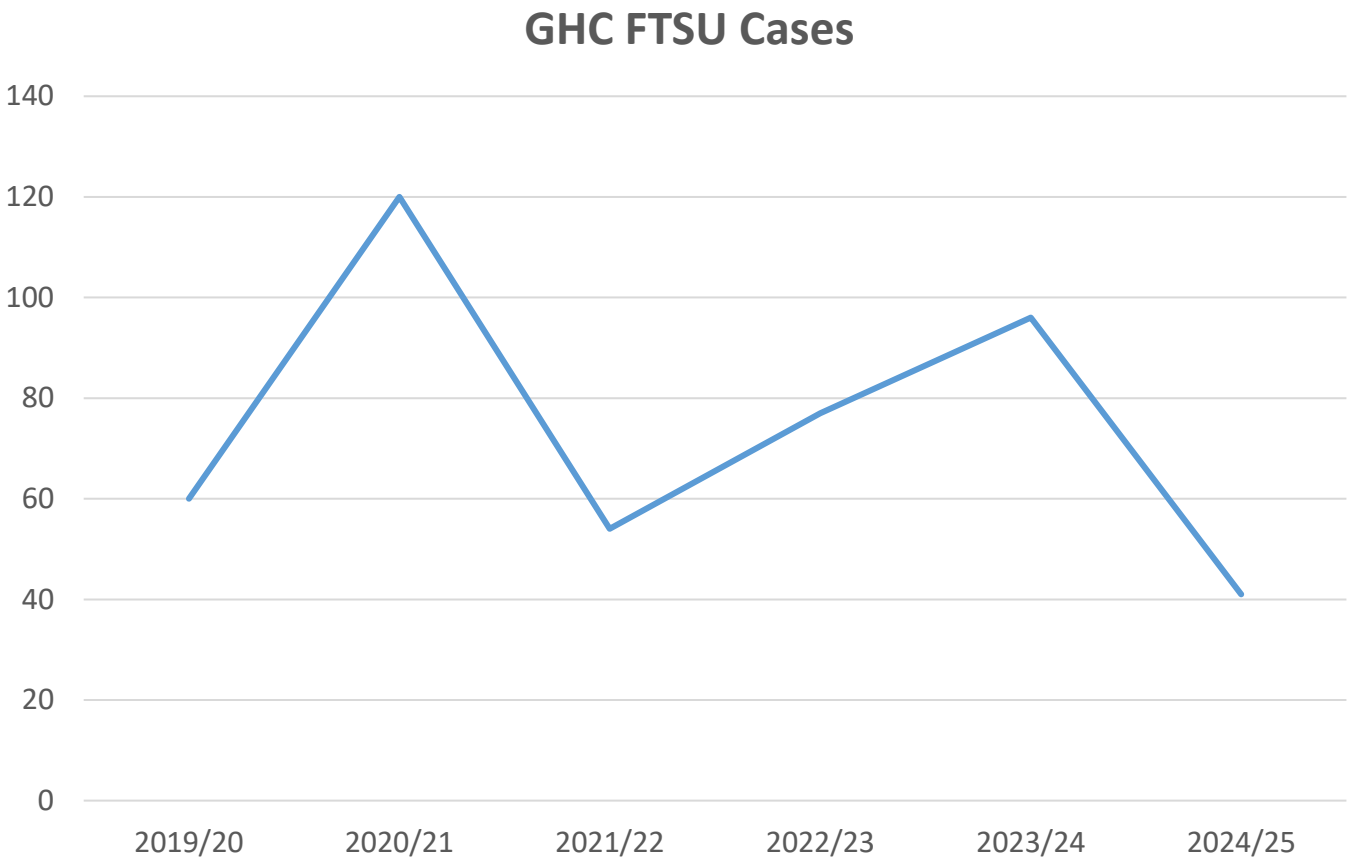
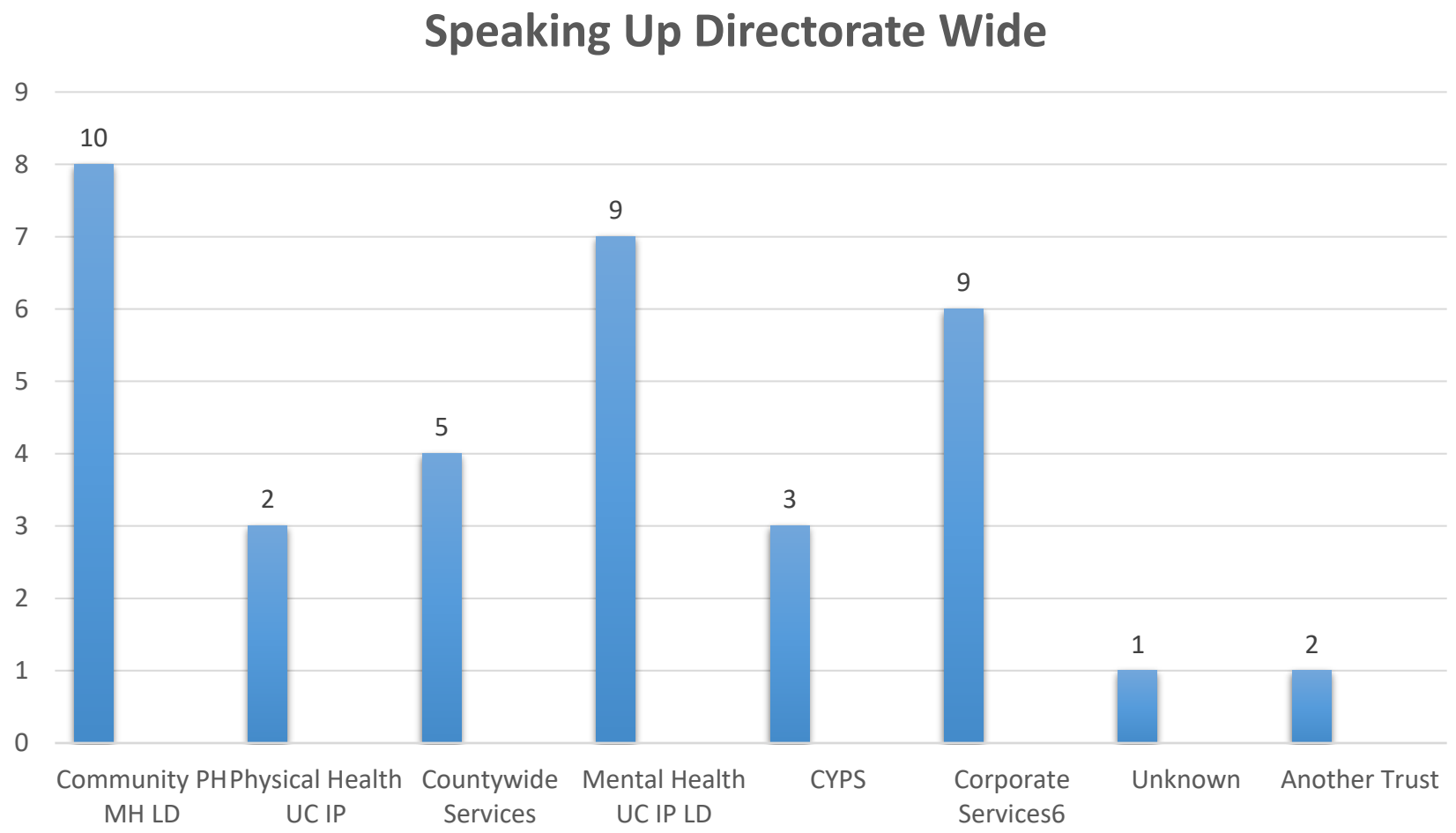


Colleagues Speaking Up

Gloucestershire Health and Care
NHS Foundation Trust



Colleagues Speaking Up

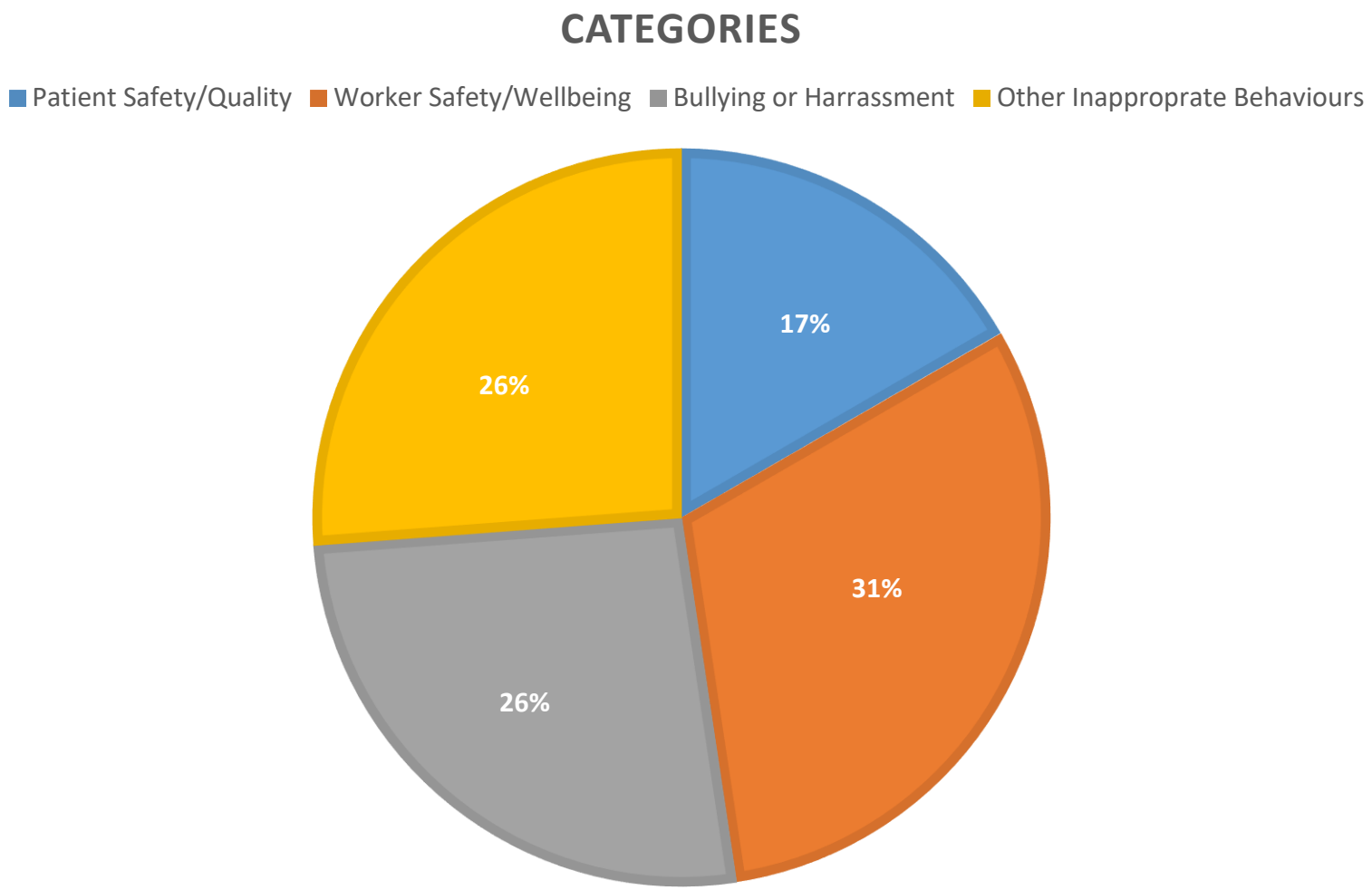
Gloucestershire Health and Care
NHS Foundation Trust

Count of 'Professional Group'

Professional Group	Count of Professional ...
Nursing and Midwifery	21
Allied Health Professionals	7
Additional Clinical Services (includes any colleagues ...	6
Administrative and Clerical	4
Estates and Facilities	2
Unknown	1
Grand Total	**41**

Colleagues Speaking Up

Gloucestershire Health and Care
NHS Foundation Trust



Colleagues Speaking Up

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Category of Speaking Up	Examples
Examples with an element of patient safety/quality	▪ Patient safety issue connected to care ▪ Undermined and professional judgement of patient care dismissed ▪ Allegations of fraud ▪ Concerns regarding unfair recruitment practices and nepotism ▪ Concerns regarding professional practice
Examples with an element of worker safety/wellbeing	• Poor experience when speaking up to their line manager • Not feeling valued by their team • Colleague reporting being fearful in relation to speaking up and the potential retaliation due to team culture • Colleague seeking advice regarding the mental health and behaviours of a colleague in another team and how to raise this as worried

Colleagues Speaking Up

Gloucestershire Health and Care
NHS Foundation Trust

Category of Speaking Up	Examples
Examples with an element of bullying or harassment	▪ Colleague feeling bullied by a senior member of their team ▪ Colleague experiencing racial discrimination
Examples with an element of other inappropriate attitudes or behaviours	• Unprofessional behaviours of a senior colleague • Unprofessional behaviours of team members • Being treat as an ‘inferior’

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Feedback

The platform gave me the confidence to approach you and the meet up Thanks

Thank you for your support at such a difficult time for me. You allowed me the time to share how I was feeling, and your support and advice was what I needed

You gave me the confidence to respond to incivility using a variety of techniques

As soon as i spoke up, I went from not being listen to, to being completely heard. I felt like someone rather than someone invisible

My issue could not be resolved

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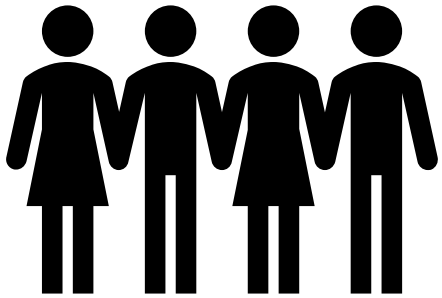
Analysis of cases in GHC against the national picture 2023/24



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BULLYING AND HARRASSMENT

19.8% of cases reported included an element of bullying or harassment.

A 2-percentage point fall compared to 2022/23.

GHC - 12.5%

PATIENT SAFETY AND QUALITY

18.7% of cases raised included an element of patient safety/quality

a marginal drop compared to 2022/23 (19.4%).

GHC - 14.5%

Headlines 2023/24

TOTAL CASES

32,167 cases

were raised with Freedom to Speak Up Guardians In 2023/24

The highest number of cases recorded – a 27.6% increase from 2022/23.

GHC - 96 cases

INAPPROPRIATE BEHAVIOURS

Two in every five cases (38.5%) involved an element of inappropriate behaviours and attitudes.

The most reported theme in 2023/24.

GHC - 23%

WORKER SAFETY AND WELLBEING

One in every three cases raised (32.3%) involved an element of worker safety or wellbeing.

An increase from one in every four cases (27.6%) in 2022/23.

GHC - 42% The most reported theme in 2023/24

DETRIMENT

Detriment for speaking up was indicated in 4.0% of cases.

This is the same as in 2022/23.

GHC - 7%

FEEDBACK

Four-fifths (79.8%) of those who gave feedback said they would speak up again.

GHC - 95% of those that gave feedback would speak up again

ANONYMOUS CASES

The percentage of cases which were raised anonymously is ten percent (9.5%).

This was similar to the percentage raised anonymously in 2022/23 (9.4%).

GHC - 3%

PROFESSIONAL GROUPS

Workers from a range of professional groups spoke up to Freedom to Speak Up Guardians.

Nurses and midwives accounted for the biggest portion (28.3%) of cases raised.

GHC - Nurses accounted for the biggest proportion at 44%

GOOD PRACTICE – CULTURES AND BARRIERS

Culture

- Several proactive projects and initiatives which incorporate FTSU and aim to create a culture of psychological safety to benefit both colleagues and patients (CSL/RJLC/OD) Civility Saves Lives - Interact (ghc.nhs.uk)

- FTSU Strategy - Alongside the policy, a new FTSU Strategy for 2025-28. This will be a three-year strategy to feed into the quality and people strategies

- Workshops – the Guardian attends various events across the Trust to deliver relevant sessions related to FTSU, behaviour and cultural change.

- NHS England » Verdict in the trial of Lucy Letby sent by NHS England to Integrated Care Boards (ICBs) and NHS Trusts the organisation

GOOD PRACTICE – CULTURES AND BARRIERS

Barriers

- Networks - the Guardian is visible with the Chairs for each of the diversity networks including the Internationally Educated Nurses Council and Junior Doctor's Forum.

- Temporary Staff - FTSU also extends to temporary staff and contractors. The Guardian has links with the local Universities and is a visiting lecturer at both the University of Gloucestershire and the University of Worcester, thereby raising the profile of FTSU and supporting students who may wish to access the service.

- Closed Culture - Barriers to Raising Concerns Audit October 2023 Response Action Plan.

- FTSU Speak Up, Listen Up and Follow up training is available to access. Not currently mandated and uptake to be reviewed.

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#ListenUpPledge

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Freedom to Speak Up Champion

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[Freedom to Speak Up Away Day - Interact (ghc.nhs.uk)]

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Freedom to Speak Up Champion

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Highlight of the day?

Meeting everyone I loved meeting everyone face to face for the first time was really my highlight! I met so many really inspiring and interesting people.

+ 4

neeting Nicola and hearing what she represents. Energy from the whole network.

+ 2

Nichole Bullock presentation - Very honest and insightful

+ 0

From the day I have gained....

A passion to find out more about a learning just culture and do more as an active bystander

+ 2

All the speakers were interesting . I especially liked hearing from Nicola on how she managed to change things at WLH. Very inspiring lady!

+ 2

Selfcare is not selfish

+ 1

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Patient Safety Incident Response Framework (PSIRF)

CIVILITY SAVES LIVES

Creating and maintaining a restorative 'Just and Learning' culture

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NATIONAL UPDATES

- NHS England published their cultural review of ambulance trusts following a review by the National Guardian's Office found that the culture in ambulance trusts was having a negative impact on workers' ability to speak up.
  Action: How does this intelligence support Sexual Safety work?

- The Guidance on Recording Cases and Reporting Data has been updated. The new guidance came into effect for cases received on or after Monday 1 April 2024 (Q1, 2024/25).
  Action: Closed GHC reporting in line with national guidance.

- The National Guardian's Office (23 February 2023) published Listening to Workers following its Speak Up review of NHS ambulance trusts in England.
  Action: Progress actions

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NATIONAL UPDATES

- The National Guardian's Office is conducting a Speak Up review on the experiences of overseas-trained workers
  Action: Invited GHC colleagues to partake - complete. FTSU Guardian as part of the review.

- Board Guidance Tool - Together with NHS England, the National Guardian's Office also published new and updated Freedom to Speak Up guidance and a Freedom to Speak Up reflection and planning tool. All trust boards are to be able to evidence this by the end of January 2024.
  Action: Working document with Board review 6 monthly

- Updated guidance for NEDS **Action: Shared with GHC NED for FTSU**

REPORT TO: **TRUST BOARD PUBLIC SESSION – 28 November 2024**

PRESENTED BY: Dr Amjad Uppal, Medical Director

AUTHOR: Andrew Telford, Deputy Director, Adult Community Services and Sadie Trout Gloucestershire ICB

SUBJECT: **INTENSIVE AND ASSERTIVE MENTAL HEALTH CARE REVIEW**

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

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

The purpose of this report is to:
Provide a brief overview of the full report on Gloucestershire ICB and GHC response to the NHSE National Intensive and Assertive Community Mental Health Care.

Recommendations and decisions required
GHC Trust Board is asked to: • **NOTE** the initial key findings of the completion of the ICB Maturity Matrix Tool, led by the Intensive & Assertive Task & Finish Group. • **SUPPORT** the next steps outlined to develop an Intensive and Assertive Community Mental Health Action Plan. The paper outlines the next steps to engage with those with lived experience and the wider public. The system aims to coproduce an action plan with system partners, relevant stake holders and those with lived experience of serious and enduring mental illness.

EXECUTIVE SUMMARY

ICBs were required by NHS England (NHSE) 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.' The ICB and GHC are working together and have completed a self-assessment using the ICB Maturity Index Self-Assessment Tool. Key priorities and areas of focus have then been summarised in the ICB Intensive and Assertive Community Mental Health Treatment Review which was submitted to NHSE in September 2024.

The review has been an opportunity to reflect on the community provision in place for people with severe and relapsing mental illness, highlighting the strengths of our current community mental health service offer, but also the opportunities to make improvements via the development of a coproduced action plan for focused development in 2025/26.

Key Issues to Note:

Safety is a key consideration in completing the review. The system and GHC has confirmed that DNAs (did not attends) are never exclusively used as a reason for discharge from care for this vulnerable patient group. As per national guidance the ICB has rapidly checked that existing service polices, and practice are clear on this issue and confirmed this to NHS England regional mental health team. The system must now produce a comprehensive action plan that addresses any areas identified for improvement in addition the final discharge process.

Risks associated with meeting the Trust's values

The following system risks were identified during the review:

There is insufficient robustness in our psychosis care pathway to prevent future serious incidents involving this client group: 12

Mitigation: Assessment of the current pathway and its interfaces provided assurance of safety, quality and that adequate policies were embedded and adhered to. Development of the action plan will identify actions and/or initiatives that can enhance the robustness of the pathway, support colleagues and interfaces across pathways and improve service user experience and outcomes. This includes work to review the internal interfaces between GHC services and resources i.e. Recovery and AOT and exploring opportunities with VCSE partners. This is a significant issue, as service users move across services as clinical presentation changes. ***Residual Risk****: **9***

From a GHC perspective, we will work with system partners and stakeholders in the task and finish group to coproduce a robust pathway which addresses our identified inequalities and improves health outcomes.

There is insufficient workforce to deliver the intensity and expertise required to safely manage people with psychosis who do not wish to engage with services: 12

The review and supporting guidance from NHSE identified steps that will need to be considered that could result in additional staffing being required within the community mental health workforce. The system will explore how current workforce, and roles could be utilised differently and/or how training could support new ways of working. This work will need to be scoped further to mitigate the risk beyond its current score. **Residual Risk: 12**

In terms of implications for GHC this is likely to require more investment which may or may not be available from NHSE. This risk will be difficult to mitigate without investment being

prioritised in this area. New structure of 'neighbourhood teams' and use of 'My Care Plan' will enable clearer communication of service user needs and risks.

The Dartmouth Fidelity Scale and ICB Maturity Index Self-Assessment Tool are based on 1990's frameworks and will not provide sufficient improvement detail for a Transformed CMHT service: 12

GHC clinical and operational leads are reviewing the Dartmouth Fidelity Scale tool and have completed the ICB Maturity Matrix. The Dartmouth Tool is specific to AOT, and not to other teams treating psychosis. Locally we have developed a template that enables the tool to be utilised for a local clinical review, removing ambiguity, whilst ensuring a comprehensive review against the core principles of the tool/protocols. ***Residual Risk****: **9***

As noted in the system narrative, we are actively involved with NHS SouthWest to collate our findings from the ICB Maturity Matrix to develop consensus across our region. We participate in the fortnightly regional meetings.

Corporate Considerations	
Quality Implications	
Resource Implications (Financial)	The paper outlines the next steps to develop an action plan in response to the priority areas identified from the review. The system will prioritise mitigations, actions and assess financial impact, considering the potential additional resources i.e., workforce and investment in training that will be likely identified. NHSE have noted that additional investment has not currently been identified by the national team, but systems should share resource requirements with their regional team as the action plan is developed. Noting the key risks associated with the Maturity and Dartmouth tools, we may need a more suitable review methodology for modernised services.
Equality Implications	The review highlights the need to ensure whole population data is available to support the self-assessment tool. We are aware that our current caseload ethnicity profile is not in keeping with our community population profile. Initial work has been started within the Community Mental Health Team Transformation team and will require funding from April 2025 to continue. Assertive Outreach Teams are often tasked with minimising potential harms including harms to the individual and to others within the local community. Clinical decision making requires balancing each of these to find an optimal solution. Development of the action plan will therefore consider the impacts of our psychosis pathway, service delivery and balancing safety, with a person's Human Rights.

Impact on Health Inequalities	At a national level, it is noted that there is a risk that those with serious and enduring mental illness such as Schizophrenia (particularly with predominately negative symptoms) can be less visible to services and therefore often suffer poorer health outcomes. It is acknowledged that it is not possible to report true counts of psychosis for individuals in England. However, the 'Adult Psychiatry Morbidity Survey 2014' estimated a prevalence of psychotic disorders in the year prior of 0.7% in adults aged 16 and over. The 'Psychosis Data Report' (2017) outlines data that individuals from ethnic minority groups are statistically more likely to be diagnosed with psychosis. 14% of individuals newly diagnosed with psychosis will require rehabilitation services (Craig et al. 2004). The review highlights the need to ensure whole population data is available to support the self-assessment tool. The review also links to the Community Mental Health Transformation Programme and the work that has been undertaken with system partners to coproduce engagement and embed lived experience within codesign and decision making.
Regulatory & Legal Issues	None identified. Review via ICB Maturity Matrix aligned to core values of NHS Constitution.

Where has this issue been discussed before
26/09/2024 GHC Executive Committee 12/11/2024 ICB Operational Executive 19/11/2024 GHC Executive Committee 28/11/2024 Scheduled for ICB Board Meeting

Appendices:	

Acronyms used within this report	
ICS	Integrated Care System
ICB	Integrated Care Board
GHC	Gloucestershire Health & Care Foundation Trust
GHFT	Gloucestershire Hospitals NHS Foundation Trust
GCC	Gloucestershire County Council
VCSE	Voluntary, Community and Social Enterprise

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

1.0 BACKGROUND

NHSE requires all ICB's to review their community services by Q2 2024/25 to ensure that they have clear policies, practice, and right care provision in place for patients with serious mental illness, who require intensive community treatment and follow-up particularly where engagement is a challenge. The group under consideration includes individuals who:

- Are presenting with psychosis (but not necessarily given a diagnosis of psychotic illness)
- May not respond to, want or may struggle to access and use 'routine' monitoring, support and treatment that would minimise harms
- Are vulnerable to relapse and/or deterioration with serious related harms associated (esp. but not limited to violence & aggression)
- Have multiple social needs (housing, finance, self-neglect, isolation etc)
- Likely present with co-occurring problems (e.g. drug and alcohol use/dependence)
- May have had negative (e.g. harmful and/or traumatic) experiences of mental health services or other functions of the state (e.g. the criminal justice systems)
- Concerns may have been raised by family / carers

The collaborative approach by a multi-disciplinary task and finish group, including a range of system colleagues from across commissioning, community mental health teams, specialist services and including clinical and operational leaders, has provided a broad, honest and open review of intensive and assertive mental health community provision provided by GHC across the county. Whilst it provides assurance to the ICB and NHSE regarding the comprehensive and safe service offered, it does highlight areas of improvement and opportunity that should be prioritised both in the short and longer term.

2.0 KEY THEMES FROM TASK & FINISH REVIEW

The Intensive & Assertive Task and Finish Group completed the self-assessment over several workshops during September 24. Some of the sections are specific to Assertive Outreach Team(s) and other sections are applicable to all GHC services that treat people with psychosis (Recovery, GRIP, Specialist Community Forensic Team, Specialist Rehab and MHICT.) Overall the initial self-assessment provided assurance that the cohort (outlined above) were well managed and able to support the complexities of treating people with severe and enduring mental illness, with no concerns or significant issues identified with regards to safety or quality of care.

2.1 Identified Strengths

Dedicated AOT	Community Rehabilitation Offer	Relevant Criteria in Place in Policy & Pathways
Assessment Risk Assessment & Care Planning	Improving Recruitment Picture	

Unlike other systems, Gloucestershire benefits from a dedicated Assertive Outreach Team(s) delivered by GHC, that provides a recovery focussed, personalised approach. Operating across the county in 3 teams (North, South & West), the teams work with people with SMI, who require more regular professional help than mainstream mental health services, to help improve health and social function and achieve the best quality of life possible.

The system also benefits from a broad community rehabilitation offer, including a Specialist Treatment and Rehabilitation (STAR) Team, Supported Accommodation Service (SAS) and Specialist Community Forensic Team. Where our AOT Teams provide an 'assertive' function, the Community Rehabilitation Team offers the opportunity to work 'intensively' with individuals.

The clinical and operational review also identified that the relevant criteria in policy and pathways for the assertive outreach / intensive case management function in community service provision were in place across key patient pathways i.e., significant risk of persistent self-harm or neglect, high use of inpatient or intensive home-based care, difficulty in maintaining lasting and consenting contact with services.

Team awareness, knowledge, approach and delivery of assessment, care planning, risk assessment and safety planning were also considered a strength. The review particularly highlighted the positive impact of the roll out of My Care Plan to community services, further embedding coproduction with the individual and where possible their friends and family.

The review also noted, that although community mental health services continued to face clinical workforce recruitment and retention challenges, recruitment was improving, and vacancies were attracting good levels of interest from suitable candidates.

2.2 Areas of Opportunity

Improving Interfaces across pathways and between services	Intervene more quickly and prevent relapse	Discharge Processes
Local Community Demographics	Diversity Profile	Embedding Lived Experience

Interfaces within GHC services and across our pathways i.e., Learning Disabilities & Autism, Drugs & Alcohol is an area of opportunity that will be prioritised. Whilst the review identified clear pathways and processes within services, staff identified areas that could improve with sharing of information and clinical and/or operational practice. The review also highlighted the need to strengthen the interface with wider system partners i.e., VCSE, which will be supported by the roll out of community mental health neighbourhood teams but would benefit from a focus within the action plan.

The review also noted that there is opportunity to intervene quicker and prevent relapse. Strengthening interfaces, could go some way to support this, but revisiting our current team functions and dedicated service offers may identify solutions to assess and intervene more quickly and aim to reduce the length of time an intervention may be needed e.g., building on the strength of our community rehabilitation offer. There are opportunities to extend the psychological intervention offer by upskilling of workforce in Family Intervention, Motivational Interviewing etc.

Discharge (both step up and step down) was highlighted as an area of focus and is supported by the Community Mental Health Framework and the CQC recommendations following the Nottingham report. We have assured the system and NHSE that DNA should never be used as a reason for discharge, but we can improve our policies by strengthening trust internal

assurance processes, data sharing and building on the opportunities of embedding My Care Plan, ensuring discharge plan is also coproduced and information shared appropriately.

The review identified the need to develop plans that would provide further insight to our diversity pattern and local community demographics. As noted, developing a profile of people with psychosis where engagement is a challenge, is complex, but the action plan should explore opportunities with population health analytics and current caseload profiles, that could help staff to consider someone's history of using mental health services alongside changes in a range of factors around potential and additional support and drives decision making for people in need of intensive support.

The review acknowledged how lived experience was welcomed and pivotal to the codesign of pathways and services, but also was an opportunity in supporting how our services are delivered. It was suggested that the role of Peer Support Workers, those who have recovered from psychosis, could be key in developing our approach and management to those individuals who engagement is a challenge.

3.0 NEXT STEPS

Following clinical review and in line with national guidance, the next step for the system will to be complete a detailed action plan that responds to the areas of opportunity outlined above. Coproduction of the action plan is key, to maintain a person-centred perspective and system ownership. The current Intensive & Assertive Task & Finish Group is currently developing an engagement plan that will ensure wider system partner representation, both lived experience and extended professional representation, to ensure the action plan is developed during Q4 24/25.

To further support the review and provide a comprehensive clinical review, staff from the Assertive Outreach Team will also engage with completion of the Dartmouth Assertive Community Treatment Scale (DACTS Fidelity Scale) which supports organisations to develop assertive community treatment through evidence-based review and improve outcomes for people with severe mental illness who are most vulnerable within our local communities. Completion of the DACTS Fidelity Scale will be undertaken concurrently across AO Teams within the county (North, South & West) during November/December 24.

The Intensive and Assertive Review remains a national priority and systems continue to report progress via their regional NHSE Team. The work programme will continue to report as per the ICB and GHC trust governance structures but will report directly to the ICS System Quality Committee for oversight and assurance.

3.1 Timeline

The high-level timeline below identifies the proposed next steps to developing a system Intensive & Assertive Community Mental Health Action Plan:

Completion of Dartmouth Assertive Community Treatment Scale (DACTS Fidelity Scale) across Assertive Outreach Teams.	October – December 2024
Intensive & Assertive Task & Finish Group Engagement Workshops	November – January 2024
Appoint dedicated clinical leadership resource for the GHC psychosis clinical pathway	December 2024
Implement Diversity and Inclusion Task and Finish group for psychosis within our communities	January 2025

Specify business intelligence requirements to identify those at risk of relapse or incident according to our clinical systems profile	February 2025
Intensive & Assertive Community Mental Health Action Plan developed and shared with system partners.	March 2025
I & A Community Mental Health Action Plan operational.	Expected delivery through Q1-2 2025/26.

GLOUCESTERSHIRE HEALTH AND CARE NHS FOUNDATION TRUST
COUNCIL OF GOVERNORS MEETING

Wednesday 18 September 2024
Via MS Teams

PRESENT:	Graham Russell (Chair)	Kizzy Kukreja	Bob Lloyd-Smith
	Steve Lydon	Peter Gardner	Andrew Cotterill
	Penelope Brown	Mick Gibbons	Chris Witham
	Ismail Surty	Sarah Nicholson	Cath Fern
	Neil Hubbard	Tussie Myerson	

IN ATTENDANCE: Douglas Blair, Chief Executive
Anna Hilditch, Assistant Trust Secretary
Sumita Hutchison, Non-Executive Director
Nicola de Iongh, Non-Executive Director
Jason Makepeace, Non-Executive Director
Jan Marriott, Non-Executive Director
Kate Nelmes, Head of Communications
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: Chas Townley, Alicia Wynn, Alison Hartless, Paul Winterbottom, Jenny Hincks, Rebecca Halifax, and Laura Bailey. Apologies had also been received from Steve Alvis, Bilal Lala, and Vicci Livingstone-Thompson, Non-Executive Directors.

1.3 Graham Russell welcomed newly appointed Public Governors for Cheltenham, Tussie Myerson and Neil Hubbard. Both had commenced in post on 1 September 2024.

1.4 The Council noted that Dr Paul Winterbottom had been re-appointed unopposed for a second term as a Staff Governor representing Medical Dental & Nursing colleagues.

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 10th July were agreed as a correct record.

4. MATTERS ARISING AND ACTION POINTS

4.1 The actions from the previous meetings were complete or progressing to plan.

4.2 In response to a question from Steve Lydon, Graham Russell informed the Council that a meeting would be taking place later that week with one of the new Gloucestershire MPs. Meetings for the Chair and Chief Executive with all local MPs had now been scheduled in the diary.

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 meeting held on 4th September 2024, for information.

5.2 Those items covered within the summary included an update on NED (Non-Executive Director) recruitment, confirmation that objective setting had now been completed for the NEDs and Chair, an update on the appointment of an Associate NED representing the University of Gloucestershire, and an update on discussions around NED remuneration.

5.3 The Council was asked to note that it is within the Nominations and Remuneration Committee terms of reference to review the pay and conditions of the NEDs annually. The Committee considered remuneration in 2019 at the point of merger, and it was agreed in November 2019 to increase NED remuneration to £14k per annum. There had been no further increase since that time despite inflation and cost of living increases for other NHS colleagues. Despite being anticipated there had also been no further national guidance published on which to guide Trusts. The annual NHS Providers Remuneration Survey had now been completed and the Committee agreed to receive a more detailed NED remuneration report at its next meeting for consideration. It was confirmed that any matters relating to NED remuneration, terms and conditions, and appointments would be brought to the full Council for final approval, following Committee consideration and scrutiny.

5.4 This report was **noted** by the Council of Governors.

6. CHAIR'S REPORT

6.1 Graham Russell said that he wanted to use this time for Governors to raise any questions they may have.

6.2 Andrew Cotterill asked for an update on Berkeley House. Graham Russell said that the Board had received good assurance on the progress taking place. Douglas Blair advised that the Trust continued to provide regular updates to the CQC (Care Quality Commission) on progress, and a further inspection was being scheduled. The testing and learning around the development of community-based services was continuing and a full review of this was due shortly.

6.3 Andrew Cotterill welcomed receiving the schedule of visits undertaken by the Chair. He asked whether it would be possible for Governors to participate in some of those visits. Graham Russell said that he would be happy to be joined by Governors and invited colleagues to make contact either with himself directly, or with Anna Hilditch to express an interest.

6.4 The Governors discussed the publication of the Darzi Review. Lord Darzi's report provided an expert understanding of the current performance of the NHS across England and the challenges facing the healthcare system. Graham Russell said that GHC was trying to look at how it could become a better designer of services, rather than just a provider. More was needed to push the commissioning of mental health services higher up the ICS (Integrated Care System) agenda and to get the right levels of investment. It was noted that the County Council had a new leader in post and meetings had been scheduled for the Chair and Chief Executive to meet with them. It was hoped that this would offer a good opportunity to develop the relationship. Douglas Blair said the Trust had a different type of relationship with the Council, however, at a senior level he said that colleagues did have honest and open discussions about key issues which was positive.

7. CHIEF EXECUTIVE'S REPORT

7.1 Douglas Blair provided a verbal update on key matters to the Governors, including the publication of the Darzi Review, the proposal for a 10-year health plan, and the lessons learned from Nottingham.

7.2 Douglas Blair said that NHSE had carried out and published 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. All ICBs (Integrated Care Boards) have been asked to carry out a full review of the care and treatment of people requiring Assertive Outreach treatment and it was noted that GHC would be receiving the output from this review at its November Board meeting.

7.3 In response to this, Bob Lloyd-Smith said that people with paranoid schizophrenia had been given the label of being violent and a danger to others which was untrue, and he asked whether the Trust planned to send out any form of public messaging about this to help in tackling the stigma and inaccurate messages. Douglas Blair agreed that all patients needed to be viewed on a case-by-case basis and there certainly should not be one approach to all. However, he said that the Trust had not felt the need to issue a statement at this time but was very supportive of the review taking place.

7.4 Neil Hubbard said that it felt as though people with mental health needs could only access services when they got very ill and said that more needed to be done nationally around the development of preventative services.

7.5 Penelope Brown said that she had experience of people being discharged too quickly from inpatient mental health services, who had then been involved in an incident. Douglas Blair said that the Trust, as well as all other Trust's with inpatient provision, had a Length of Stay metric that was reported upon. This was used to ensure we could manage our bed base and was monitored to ensure appropriate use. He said that the Trust kept a balanced approach to meet capacity requirements and was clear that the clinical need of the patient was always the top priority.

7.6 Douglas Blair provided an update on Board member changes. David Noyes, the Chief Operating Officer would be retiring at the end of September. Two new Executive Directors would be commencing on 4th November, Rosanna James (Director of Improvement and Partnership) and Sarah Branton (Chief Operating Officer). Douglas Blair advised that the Director of Primary Care and Locality Development had been a joint Director role with GHC and the ICB. The decision had been made that this joint role would cease at the end of September, with the postholder, Helen Goodey focussing on her work at the ICB.

8. WAYS OF WORKING

8.1 Following the appointment of a new Chair in May 2024, it was agreed that it would be helpful to take some time for the Council of Governors to carry out a review of ways of working in order to understand how best to maximise the contribution of Governors to the Trust. These discussions commenced at the May 2024 Council of Governors meeting, with two further discussions subsequently taking place at a Staff Governors meeting (20 June), and at the Membership & Engagement Committee (25 June).

8.2 This paper summarised those most recent discussions, highlighting the key themes arising and looking at what might be put in place to achieve these.

8.3 The Council of Governors supported this report and the proposed way forward. It was noted that work would be carried out to shape the proposals further, and Governors would be consulted on different elements of this over the coming months.

9. INTEGRATED URGENT CARE SERVICE (IUCS)

9.1 The Council of Governors welcomed Nicola Moore, IUCS (Integrated Urgent Care Service) Programme Director to the meeting who was in attendance to provide a presentation on the new Integrated Urgent Care Service.

9.2 The new service will launch on 19th November 2024 and will include:

- NHS 111 – telephone and online support
- A new Clinical Assessment Service (CAS) giving the public access to general and specialist clinical advice
- An out of hours face to face service – Clinicians seeing people in person either at a local hospital/treatment centre or in their own homes

The service will be provided by Gloucestershire Health and Care NHS Foundation Trust in a partnership with social enterprise organisation Integrated Care 24 (IC24).

9.3 The key aims of the Integrated Urgent Care Model were presented, and included:

- Reducing ambulance response times and handover delays
- Reducing long waits in the ED (Emergency Department)
- Improving patient experience
- Stream Mental Health Calls to GHC's MH Urgent Care Services via IVR
- Locally defined outcomes required
  - Increased use of NHS 111
  - A clear and concise patient experience
  - Reduced duplication of triage
  - Effective navigation through the urgent care system

9.4 Nicola Moore advised that the service would employ approximately 100 people and will be managed out of GHC's Headquarters, Edward Jenner Court, in Brockworth, Gloucester. NHS 111 colleagues will be employed by IC24. CAS (Clinical Assessment Service) and out of hours clinicians will work for GHC and be based either at EJC or work in hospital sites, such as Gloucestershire Royal Hospital, Cheltenham General Hospital, or Stroud, Cirencester and Forest of Dean. Out of hours home visits will also be available. NHS111 and the CAS will operate 24 hours a day, seven days a week.

9.5 Chris Witham said that this was an exciting opportunity. He said that there had been a real decline in the number of people using the NHS111 service so there needed to be a push on the communications of this new service, promoting it and getting people to use it.

9.6 The Council noted that work was still underway as part of the consultation around staffing and TUPE arrangements.

9.7 Nicola Moore said that KPIs and performance thresholds were currently in development for the service, for things such as call volumes, answer times etc to be able to monitor performance going forward.

9.8 Douglas Blair said that it was not common for a community trust like GHC to provide these services, but it was fully in line with the Trust's values. This was a brand-new service providing things such as 24/7 GP triage which did not currently exist in Gloucestershire. A lot of the key

benefits had been set out within the presentation, but Douglas Blair said that it was important to acknowledge that there would be bumps in the road and the Trust would address these as and when they may arise. He said that it was really helpful to have Governors sighted on the new service, and it was agreed that a follow up presentation would be brought back to a future Council meeting once the service had gone live. **ACTION**

10. GOVERNOR DASHBOARD

10.1 The Council of Governors received the Governor Dashboard for information and assurance. The purpose of the Governor Dashboard is to provide a high-level overview on the performance of the Trust through the work of the Board and Committees, with particular focus on the core responsibilities of governors in holding the NEDs to account for the performance of the Board and ensuring that people that use our services are receiving the best possible care.

10.2 Chris Witham made reference to the workforce indicator presented in the dashboard for vacancy rates, noting that performance had remained at approx. 10% for some time. However, he noted that the threshold for this indicator was 20% and he suggested that this didn't reflect individual teams and therefore queried whether a 20% threshold was helpful. Sandra Betney suggested that turnover would be a more helpful indicator to monitor as what was manageable in terms of vacancies within one team wouldn't be in another. It was agreed that future Dashboard reports would include the measure for staff turnover rather than vacancy rates. **ACTION**

10.3 The Council **noted** the content of the Dashboard report.

11. BOARD COMMITTEE UPDATES

11.1 Due to time pressure at the meeting, Graham Russell suggested that it would be helpful for Governors to receive the Board Committee summary reports which would be issued later in the week as part of the board paper pack. This would provide Governors with the most up to date summary of activity.

12. COUNCIL OF GOVERNOR MEMBERSHIP AND ELECTION UPDATE

12.1 The Council **received** and **noted** this report which provided an update on changes to the membership of the Council of Governors and an update on progress with any upcoming Governor elections.

13. GOVERNOR QUESTIONS LOG

13.1 The Governor Questions Log is presented at each Council meeting, and any questions received between meetings are presented in full, alongside the response for Governors' information.

13.2 It was noted that no new questions had been received since the last meeting in July.

14. ANY OTHER BUSINESS

14.1 Governors were reminded that the Trust's Annual General Meeting would be taking place on Thursday 19th September and all colleagues were invited to attend.

14.2 Chris Witham made Governors aware that the GHC Charity had recently been rebranded and relaunched. It was agreed that further information would be circulated to Governors providing an update on what the Charity was, how people could donate and any fundraising activities coming up. **ACTION**

15. DATE OF NEXT MEETING

15.1 The next meeting would take place on Wednesday 13th November 2024 at 10.30 – 1.00pm via MS Teams.

PRIVATE SESSION

16. EXTERNAL AUDITOR APPOINTMENT

16.1 The Council welcomed Sandra Betney, Director of Finance who was in attendance to provide an update to the Governors on the provision of External Audit services and the need for the Trust to carry out a competitive tendering process. The Council of Governors are responsible for the appointment of the Trust's External Auditors and a Governor task and finish group was proposed to ensure Governor involvement in the process. It was agreed that a follow up invitation would be sent out after the meeting to all Governors inviting expressions of interest in participating in the process. **ACTION**

COUNCIL OF GOVERNORS – ACTION LOG

Date	Ref	Action	Update
18 Sept 2024	9.8	Follow up presentation on the IUCS to be scheduled for a future Council meeting once the service had gone live	**Complete**. Provisionally booked for March 2025 meeting.
	10.2	Future Governor Dashboard reports to include the measure for "staff turnover" rather than vacancy rates	**Complete**.
	14.2	Information would be circulated to Governors providing an update on what the GHC Charity was, how people could donate and any fundraising activities coming up.	**Complete.** Information emailed out to Governors on 7 November
	16.1	Invitation to be sent to all Governors inviting expressions of interest in participating in External Auditor tendering process.	**Complete.** 3 Governors selected to participate, with the first meeting having taken place on 6 Nov to agree timeline and specification

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 16/1124

REPORT TO: **TRUST BOARD PUBLIC SESSION – 28th November 2024**

PRESENTED BY: Jan Marriott, WTAC Committee Chair, Non-Executive Director

AUTHOR: Julie Mackie, Head of Partnerships
Dominika Lipska-Rosecka, Service Development Manager

SUBJECT: **WORKING TOGETHER ADVISORY COMMITTEE REVIEW**

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

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

The purpose of this report is to:

Present the Board with a summary report setting out the progress and outcomes of the first (of two) workshops taking place with the aim of reviewing the Working Together Advisory Committee purpose, function and structure.

Recommendations and decisions required

The Board is asked to **note** the content of this report for information.

Executive summary

Following recommendations from the WTAC meeting on 25th July 2024, the Board agreed with a proposal to host workshops to enable a comprehensive review of the purpose and membership of the WTAC alongside setting objectives to inform an implementation plan working towards the strategic goal.

On October 17, 2024, the WTAC core members were invited to a workshop at Gloucestershire Deaf Association. The group evaluated the WTAC purpose, using several System Thinking methods and tools to reflect and critically appraise progress over the past two years. Outcomes from the group work are summarised in the paper to highlight emerging themes, proposals, and recommendations.

These themes will be further explored at the second planned workshop taking place on 5 December 2024. The Trust will engage a wide range of stakeholders at the next workshop to co-design a working together mechanism and set objectives, and present this to the Board for consideration and approval in 2025.

Risks associated with meeting the Trust's values
Aligns with the Trusts approach and strategic goal to embed a culture of working together with the people and communities we serve throughout the Trust.

Corporate considerations	
Quality Implications	Governance process for a re-designed Working Together Advisory Committee to be considered.
Resource Implications	None identified
Equality Implications	A new model aims to improve equity – by increasing opportunity for community involvement and inclusion.

Where has this issue been discussed before?
• Trust Board – regular summary reports • Council of Governors – presentation received at November meeting

Appendices:	None

Report authorised by: Jan Marriott	**Title:** Committee Chair, Non-Executive Director

WORKING TOGETHER ADVISORY COMMITTEE
SUMMARY REPORT FROM WORKSHOP 1

1.0 INTRODUCTION

The Working Together Advisory Group (WTAC) was established in October 2022 and became a Committee from April 2023 reporting to the Trust Board. The Working Together Advisory Committee purpose is to advise, influence and organise activities to achieve the Trust's strategic goal to embed a culture of working together with the people and communities we serve throughout the Trust. The WTAC oversees the aims and objectives outlined in GHC's Working Together Plan, including reporting on improvement, partnership and participation activity, highlighting best practice, and ensuring that co-production principles are implemented across all levels of business as usual, improvement and transformation work. Following recommendations from the WTAC meeting on 25th July 2024, the Board agreed with a proposal to host workshops to enable a comprehensive review of the purpose & membership of WTAC alongside setting objectives to inform an implementation plan working towards the strategic goal. This paper highlights emerging themes and recommendations from Workshop 1 for awareness, noting that Workshop 2 would be taking place on 5th December.

2.0 WTAC WORKSHOP 1 SUMMARY

On October 17, 2024, the WTAC core members were invited to a workshop at Gloucestershire Deaf Association. We evaluated the WTAC purpose, using several System Thinking methods and tools to help us reflect and critically appraise our progress over the past two years. We identified what worked well, exposed barriers, challenges, and areas for further development, and considered ideas for the Trust's future direction to embed a working together culture. Emerging themes and recommendations are summarised below:

What worked well that we want to further develop:

- The Working Together Plan has a clear vision, goal, aims and approach. We recommend keeping the plan but updating objectives focused on key issues and represent local needs, such as access to services, equity, and joined-up working. We recognised a need to be more proactive, reflect local needs, and demonstrate how we act on feedback. with a stronger focus on building trust and relationships with communities we serve.

- The WTAC has increased our awareness of coproduction activity, progress of our objectives, and helped drive forward change that may not have been prioritised, including: GHC's Carer's approach the Triangle of Care; the Patient and Carer Race Equality Framework; the Lived Experience Peer Support Worker Framework; and the Children and Young People strategy, etc. We need a mechanism to help us embed a culture of working together that connects the population we serve and community of partners we work with and can drive change.

What we identified as obstacles to achieving our vision:

- **Process driven:** While becoming a committee added authority to drive our co-production agenda, the WTAC has become dominated by GHC colleagues, processes, and activity reporting that is a barrier to involvement and discussion.

- **Voice of the People:** The voice of the people we serve and partners we work with are under-represented in the membership, agenda, and objective setting.

- **Duplication:** We acknowledged a variety of forums and partnership boards available across Gloucestershire that GHC, community groups, lived experience experts, and partners we work with attend. This can lead to duplication of effort and siloed working.

- **Measuring culture change:** We noted that embedding co-production requires a cultural shift, time, and change in attitudes and behaviours. We need to explore ways to gather data to effectively measure the impact of co-production and change.

- **Capacity and change fatigue:** The executive, operational, medical, quality, and corporate teams are working on multiple priorities. We recognised the challenge for leadership to actively listen to and value community input while empowering GHC colleagues to proactively seek opinions and test co-production ways of working.

Emerging ideas and recommendations:

- **Rename and Re-design the WTAC**: We recognise we still need a mechanism to support and drive change agendas that reflect internal GHC objectives and local community priorities and concerns. We propose a more radical format that fosters more listening and discussion, including proactively reaching out to our lived experience groups, Trust membership and community groups for advice and opinions, to support Trust decision making, and pulse check on key issues. We recommend renaming the Committee and changing membership, to reflect the purpose of a more vibrant and intentional group that fosters stronger partnership working.

- **Co-production is Trust wide agenda**: We propose that co-production should be an agenda item on all on established governance structures and Committee's, not just the remit of one group. The Trust will need a mandate for all Committee's, leaders and teams to demonstrate how coproduction featured as part of the work undertaken. This dispersed leadership approach aims to support coproduction cultural change and spread understanding of the benefits of meaningful involvement of the people and communities we serve**.**

- **Involving Governors and Members**: We propose finding innovative ways to better engage our governors and members, ensuring they play a more active role as representatives of the communities represented. For example, we propose that we ask people to identify levels of membership involvement, for example: Information & Update; Consultation; and Collaboration, so that we can engage with people on key issues in a range of ways.

- **Working more closely with VSCE:** We propose the group membership supports an increase in the ways we collaborate with the voluntary sector to enhance our impact and reach, learn and share good practice, and improve service delivery.

- **Developing Mechanisms for Feedback**: We need to explore how we can influence the connections between Gloucestershire's network of forums and partnership boards to seek feedback and align with our new working together group's role.

- **Measuring the benefits of co-production**: We need to measure the impact and benefits of coproduction. We are testing the maturity matrix that has been developed to understand where improvement activity can make a difference. We propose using Artificial Intelligence to support evaluation, for example to analyse qualitative information and quantitative data, including engagement, workshops, feedback and survey checking at the locality level, with appropriate human oversight, guidance and ethics in place.

3.0 NEXT STEPS: PROPOSAL FOR WORKSHOP 2 – 5TH DECEMBER 2025

In preparation for our second workshop, we plan to expand our engagement from the WTAC membership to include a broader group of stakeholders to gain deeper insights. The workshop will be based on the recommendations identified in workshop 1 and include:

1) Explore options for a mechanism to enable a broader approach to engage with the people and communities we serve, proactively identify change objectives, and drive forward GHC's ambition to embed working together.
2) Identify key objectives and topics for future focus areas to ensure that our approach is fully aligned to support our agenda of embedding co-production across the trust.
3) Agree a new name for the WTAC that reflects its new purpose and approach.
4) Identify how and what the group advises, reports, and receives feedback from the Trust Board, GHC groups and committees, and community Partnership Boards.

ASSURANCE REPORT TO TRUST BOARD

REPORT TO:	**TRUST PUBLIC BOARD – 28 NOVEMBER 2024**
COMMITTEE:	**MHLS COMMITTEE – 16 OCTOBER 2024**
AUTHOR:	Trust Secretariat
PRESENTED BY:	Steve Alvis, Chair of 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

The Committee was informed of the update to the Mental Health Act and was advised that a task and finish group had been set up to consider the implications and to prepare the Trust for the proposed changes.

ADVISE: Advise of areas of ongoing monitoring or development

The Committee received an update on the waiting times of Second Opinion Appointed Doctors (SOAD) and was informed of the increase in the use of section 62 due to the delay in SOAD reviews. It was **noted** that this was a national issue.

The Committee received an update from the Mental Health Act Manager's (MHAM) Forum and it was reported the Mental Health Act Manager had changed status from volunteer to worker, and the implications of this with regards to MHA Manager training requirements would be explored further.

The Committee received an update on the development of the Patient and Carer Race Equality Framework (PCREF) and was advised on the progress made and the further engagement to be sought from internal and external diversity networks.

ASSURE: Inform the Board where positive assurance has been achieved

The Committee received the Receipt and Scrutiny of Mental Health Act Documents policy audit and was assured that no errors which could have invalidated applications for detentions had been identified.

The Committee received the Renewal of Detention and Extension of CTO policy audit and was assured that the RC had examined all patients (reviewed in the audit) within the designated timeframe and also that the second professional had met the criteria in the Code of Practice; showing a high compliance with the Mental Health Act.

APPROVALS: Decisions and Approvals made by the Committee

The Committee **received** the Mental Health Act Managers Policy and **approved** the recommended changes.

RISK & BOARD ASSURANCE FRAMEWORK (BAF) UPDATE

The Committee **noted** the Risk Report and was informed of the following two risks for the Committee's oversight:

Risk ID	Risk Title	Current Score	Target Score
180	Mental Health Act Changes	**12**	**5**
424	Conveyance under the Mental Health Act (s6 (1)) - gap in secure transport commissioning.	**12**	**4**

CELEBRATE: Share any practice innovation or action that the Committee considers to be outstanding

The Committee **noted** the positive progress made in relation to the Mental Capacity Act (MCA) and the improvement with compliance since the previous audit, noting that progress was still being made with work undertaken across the Trust.

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

- Mental Health Legislation Operational Group Update
- Review of CQC Monitoring Visits
- Reports of Issues Arising at Mental Health Act Managers Reviews
- AMHP Update Report

ASSURANCE REPORT TO BOARD

REPORT TO:	**TRUST PUBLIC BOARD – 28 NOVEMBER 2024**
COMMITTEE:	**RESOURCES COMMITTEE – 22 OCTOBER 2024**
AUTHOR:	Trust Secretariat
PRESENTED BY:	Jason Makepeace, Chair of 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

The Committee received the Finance Report for month 6 and **noted** that the Trust continued to use Off Framework Agency to maintain safe service provision. There had been a slight upward trend in the usage of off framework agency in the previous two months, when compared with the downward trend seen in July.

ADVISE: Advise of areas of ongoing monitoring or development

The Committee **noted** that the action plan for the Off-Framework Agency was being progressed through the GPTW Committee.

It was agreed that the Chair and Executive Lead of the Resources Committee would meet and discuss Performance Report improvements with other Executives.

The Committee received the Business Planning Report for Quarter 2. It was flagged that the Trust may not continue to meet its milestones due to the pressure from the IUC Mobilisation, noting the continuing pressure on capacity whilst in mobilisation.

The Committee received an update on Transforming Care Digitally and **noted** the potential risk of challenge to comms of the programme due to the current interdependencies associated with JUYI 2.

ASSURE: Inform the Board where positive assurance has been achieved

The Committee received assurance that the Trust's agency usage remained below the agency ceiling, despite the upwards trend seen in September.

The Committee received the Performance Report for month 6, and received a significant level of assurance that the Trust's performance measures were being met or that appropriate service action, improvement or recovery plans were being developed, or were in place to address areas requiring improvement.

The Committee received the Performance Indicator Portfolio Review which set out the review of the overall portfolio for the Trust, encapsulating over 200 compliant indicators monitored at different levels within the organisation. This review would happen on an annual basis ahead of each new financial year.

The Committee **agreed** that Transforming Care Digitally needed to be a Trust priority and there was a need to ensure that the necessary comms were in place to explain the benefits and outcomes of the programme.

The Committee received an update on the progress that had been made towards the Green Plan Strategy and **noted** the interdependency with the Estates Strategy, and clinical strategies.

APPROVALS: Decisions and Approvals made by the Committee

The Committee **endorsed** the draft ICS Cyber Security Strategy and **noted** that the first draft would be submitted to NHSE by 18th December and the final version would be submitted April 2025.

RISK & BOARD ASSURANCE FRAMEWORK (BAF) UPDATE

The Committee noted the quarter 2 Risk Report and **noted** the two BAF risks for the Committee's oversight, noting no changes were made to the scores.

Risk ID	Risk Title	Current Score
Risk 2	Services not meeting population need	**12**
Risk 6	Funding for Transformation	**12**

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

The Committee was informed that good progress had been made with progressing the Trust Business Plan.
The Committee **acknowledged** the progress that had been made in delivering the Trust's Transforming Care Digitally Programme.
The Committee **celebrated** the good progress made in implementing the Trust's Green Plan Strategy.

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

- Service Development Report
- Summary Reports from:
  - → Digital Group
  - → Capital Management Group
  - → Business Intelligence Management Group
  - → Strategic Oversight Group
  - → Community Mental Health Transformation Programme

ASSURANCE REPORT TO BOARD

REPORT TO:	**TRUST PUBLIC BOARD – 28 NOVEMBER 2024**
COMMITTEE:	**QUALITY COMMITTEE – 7 November 2024**
AUTHOR:	Trust Secretariat
PRESENTED BY:	Jan Marriott, Chair of 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

The Committee received an update on Berkeley House and was informed that the Section 31 notice would not be lifted for a further three months due to wider work in the pathway and a delay in discharges.

Crisis Management and access to services when in a crisis was raised in a number of items discussed by the Committee during the meeting.

ADVISE: Advise of areas of ongoing monitoring or development

The Committee received the Quality Assurance Group (QAG) Summary Report, which referred to waits for autism diagnosis by the Social Communication and Autism Assessment Service (SCAAS) team, and raised that some people were only seeking a diagnosis so that they were eligible for certain services. Discussion took place as to how this would fit in with the wider system approach to meeting patients needs, as well as the national work in this area.

The Committee discussed the utilisation of Community Hospitals and how services can be maximised in these spaces, also being aware of the quality implications of this.

The Committee **noted** that this was the second Committee meeting without an Expert by Experience in attendance, and that this did change the dynamic of the meeting. It was acknowledged that work was taking place to determine future co-production arrangements.

ASSURE: Inform the Board where positive assurance has been achieved

The Committee received a deep dive on Restrictive Practice and received good assurance around the level of *no harm* or *low harm* incidents. Assurance was received from a review of individual interventions, wider management practice, and from looking at training compliance and considerations of both psychological harm and physical harm.

The Committee received the Integrated Urgent Care (IUC) Service Clinical Governance Structure and the IUC Service Clinical Safety Report and Risk Management Plan, in preparation for the future service; and was assured that mechanisms would be flexible post the go live date of 19 November. Discussion took place about the need to ensure that clear and measurable Board level metrics could be developed. The Committee **noted** the

following risks: 1) The clinical CAS and OOH night shifts for the first three weeks & the midnight to 8am slots were still to be filled, 2) The TUPE process was being worked through for go live and 3) developing training for colleagues using the systems, including e-learning for clinical systems, YouTube videos and step by step guides.

The Committee received the Medicines Optimisation Annual Report, which outlined the progress made during 2023-24, and **accepted** the contents for assurance.

APPROVALS: Decisions and Approvals made by the Committee

The Gloucestershire Suicide Prevention Strategy 2024-29 was received and presented to the Committee, and **approved** to be adopted as part of the Trust's Policy Framework. The action plan will be received at a future Trust Board meeting.

RISK & BOARD ASSURANCE FRAMEWORK (BAF) UPDATE

The Committee received the quarter 2 Risk Report and **noted** the two BAF risks for the Committee's oversight, noting no changes to risk scores were made in the meeting.

Risk ID	Risk Title	Comment	Current Score
Risk 1:	Quality Standards		12
Risk 4 & 8:	*Internal Culture and Closed Culture Risks*	The Committee was informed that this risk was under review	16

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

The Committee **recognised** the influential work of the Trust taking place in regards to the Gloucestershire Suicide Strategy 2024-29.

The Committee **acknowledged** the huge contribution by Gordon Benson, Quality Lead over his time within the Trust ahead of him retiring (for the second time).

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

No other items were received.

ASSURANCE REPORT TO BOARD

REPORT TO:	**TRUST PUBLIC BOARD – 28 NOVEMBER 2024**
COMMITTEE:	**GPTW COMMITTEE – 8 NOVEMBER 2024**
AUTHOR:	Trust Secretariat
PRESENTED BY:	Sumita Hutchison, Chair of 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

The Committee received the Board Assurance Framework report, **noting** that risks 4 and 8 - *Internal Culture and Closed Culture Risks* had increased from a score of 9 to 16. Board members of the Committee reviewed the Culture and Leadership Programme as part of their review of the risks.

ADVISE: Advise of areas of ongoing monitoring or development

The Committee received and **noted** the NHS Quarterly People Pulse Survey, which provided the results from the most recent survey.

The Committee received and discussed updates to the People Strategy, which provided a pilot report designed to rationalise related activity and provide a more comprehensive single report overview of progress made in delivering our strategic intent to be a 'Great Place to Work.' The Committee **welcomed** the report.

ASSURE: Inform the Board where positive assurance has been achieved

The Committee received the Freedom to Speak Up 6 monthly report, and was assured of the progress made and that processes were in place to raise concerns, seek advice and support. The Committee explored reviewing feedback from the roadshows, better triangulation of the data and the future review of this on a more granular level. It also sought assurance on developing additional ways to emphasise the service's importance to line managers for embedding a speaking up culture.

The Committee received the BDO Internal Audit on Health and Wellbeing and contributed to discussions relating to this. The Committee **noted** the partial assurance for this and the action plans for development, especially in relation to governance and better data.

The Committee received the Leadership and Culture Programme report and was assured on the initial progress of actions and debated the future plan and timelines set out; including the development of the Board Oversight Committee which would be formed shortly.

APPROVALS: Decisions and Approvals made by the Committee

No approvals were made during this meeting.

RISK & BOARD ASSURANCE FRAMEWORK (BAF) UPDATE

The Committee received the Quarter 2 risk Report and discussed the risks included below which the Committee has oversight for:

Risk ID	Risk Title	Comment	Current Score
Risk 3:	Recruitment and Retention		**12**
Risk 4 & 8:	Internal Culture and Closed Culture Risks	The Committee was informed that these risks were under review and had a range of mitigations and action plans in place	**16**
Risk 10:	Workforce Transformation	No change in risk score	**12**

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

Nichole Bullock, Ward Manager at Montpellier Unit attended the meeting and shared her staff story on Freedom to Speak Up and promoting change, in which the Committee congratulated her for her inspirational leadership.

The Committee received the Performance Report, which provided strong workforce KPI scores and positive benchmarking when compared to other similar organisations.

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

Summary Reports of Management Groups & ICS Meetings:

- Workforce Management Group
- Joint Negotiating and Consultative Forum
- LNC (Medical Staff) Committee
- NHS Gloucestershire People Committee

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NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 21/1124

ASSURANCE REPORT TO BOARD

REPORT TO:	**TRUST PUBLIC BOARD – 28 NOVEMBER 2024**
COMMITTEE:	**AUDIT & ASSURANCE COMMITTEE – 21 NOVEMBER 2024**
AUTHOR:	Trust Secretariat
PRESENTED BY:	Bilal Lala, Chair of 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

Nothing to report.

ADVISE: Advise of areas of ongoing monitoring or development

Directorate Governance Internal Audit Report: rated limited for design and moderate for effectiveness. The audit identified areas of improvement in governance relating to meeting structure, sequencing of meetings and timeliness of information. The resulting action plan is delayed, to enable the new Chief Operating Officer to address the recommendations, in collaboration with Service Directors.

Cyber Security Report: the Committee was assured by the Trust's own actions taken to prevent cyber-attacks, however noted the ongoing threat environment remained high.

GMS Sterilisation Action Plan: The Committee was assured of the clinical teams' actions which were in place to ensure non-compliance would be spotted, but requested ongoing work with GMS to have a better understanding of the issues raised and subsequent remediation.

ASSURE: Inform the Board where positive assurance has been achieved

BDO Internal Audit Progress Report and Follow Up Report: positive progress made with a focus on timely completion of recommendations by year end.

Barriers to Raising Concerns Internal Audit Follow Up: positive assurance provided on progress made in implementing the recommendations from the 23/24 audit with a marked improvement across sites visited. Work underway to address the further suggested considerations within the report.

Counter Fraud, Bribery and Corruption Report: The Committee **noted** the good progress made within the Progress Report.

Patient Safety Incident Reporting Framework (PSIRF) Update Report: provided a review of the process. Ongoing governance oversight of PSIRF would be provided through the Quality Committee.

The Committee received and noted the *Finance Compliance Report*.

APPROVALS: Decisions and Approvals made by the Committee

The Committee **approved** the changes to the *Managing Conflicts of Interest policy*.

RISK & BOARD ASSURANCE FRAMEWORK (BAF) UPDATE

Quarter 2 Risk Report was considered. An ongoing focus on setting and meeting target dates was requested. The Committee considered and confirmed the following strategic risk from the Board Assurance Framework:

Risk ID	Risk Title	Current Score
Risk 8	Cyber – risk score remains appropriate.	**12**

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

The Committee received the *Counter Fraud, Bribery and Corruption Single Tender Waiver Benchmarking Report*, which confirmed that the Trust performs extremely well when compared with similar Trusts in the country and its use of single tender waiver procedures is limited appropriately.

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

KPMG External Audit Progress Report & Technical Update, noting the additional Taskforce on Climate-related Financial Disclosure (TCFD) requirements for the 2024/25 Annual Report process.

Freedom of Information Compliance Update.

Approach to the Committee Annual Effectiveness.

Review of the external Audit Effectiveness for 2024 and the future provision of External Audit update.

Summary Reports from Management Groups:

- Health & Safety & Security Management Group
- Risk Management Group
- Information Governance Group
- BEME Management Group