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NHS
Gloucestershire Health and Care
NHS Foundation Trust

TRUST BOARD MEETING - PUBLIC SESSION

Thursday, 23 January 2025

10:00 – 13:00

The Board Room, Edward Jenner Court

AGENDA

TIME	Agenda Item	Title	Purpose	Comms	Presenter
OPENING BUSINESS					
10:00	01/0125	Apologies for absence and quorum	Assurance	Verbal	Chair
	02/0125	Declarations of interest	Assurance	Verbal	Chair
10:05	03/0125	Patient Story Presentation	Assurance	Verbal	MD
10:30	04/0125	Draft Minutes of the meeting held on 28 November 2024	**Approve**	**PAPER**	Chair
	05/0125	Matters arising and Action Log	Assurance	**PAPER**	Chair
10:35	06/0125	Questions from the Public	Assurance	Verbal	Chair
10:45	07/0125	Report from the Chair	Assurance	**PAPER**	Chair
10:55	08/0125	Report from Chief Executive	Assurance	**PAPER**	CEO
PERFORMANCE AND PATIENT EXPERIENCE					
11:05	09/0125	Finance Report M9	**Approve**	**PAPER**	DoF
11:15	10/0125	Quality Dashboard Report	Assurance	**PAPER**	DoNTQ
11.35 – BREAK - 10 Minutes (Cleeve Room)					
11:45	11/0125	Performance Report M9	Assurance	**PAPER**	DoF
STRATEGIC ISSUES					
12:05	12/0125	Leadership & Culture Programme • Terms of Reference	**Approve**	**PAPER**	CEO
12:20	13/0125	Lived Experience Practitioner Framework Update	Assurance	**PAPER**	DoIP
12:35	14/0125	Sustainability: Carbon Footprint and Green Plan Delivery Report	Assurance	**PAPER**	DoIP
GOVERNANCE					
TO NOTE	15/0125	Council of Governor Minutes – Nov 24	Information	**PAPER**	DoCG
BOARD COMMITTEE SUMMARY ASSURANCE REPORTS (REPORTING BY EXCEPTION)					
TO NOTE	16/0125	Charitable Funds Committee (18 December 2024)	Information	**PAPER**	CF Chair
TO NOTE	17/0125	Resources Committee (19 December 2024)	Information	**PAPER**	Resources Chair
TO NOTE	18/0125	Quality Committee (9 January 2025)	Information	**PAPER**	Quality Chair

TIME	Agenda Item	Title	Purpose	Comms	Presenter
TO NOTE	19/0125	Mental Health Legislation Scrutiny Committee (15 January 2025)	Information	**PAPER**	MHLS Chair
TO NOTE	20/0125	Great Place to Work Committee (16 January 2025)	Information	**PAPER**	GPTW Chair
CLOSING BUSINESS					
12:55	21/0125	Any other business	Note	Verbal	Chair
	22/0125	**Dates of future 2025 Trust Board Meetings** • Thursday, 27th March • Thursday, 29th May • Thursday, 31st July • Thursday, 25th September • Thursday, 27th November	Note	Verbal	All

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AGENDA ITEM: 04/0125

MINUTES OF THE TRUST BOARD MEETING

Thursday, 28 November 2024
Trust HQ, Edward Jenner Court, Gloucester

PRESENT:
Graham Russell, Trust Chair
Steve Alvis, Non-Executive Director
Sandra Betney, Director of Finance
Douglas Blair, Chief Executive
Sarah Branton, Chief Operating Officer
Nicola Hazle, Director of Nursing, Therapies & Quality
Sumita Hutchison, Non-Executive Director
Nicola de Iongh, Non-Executive Director
Rosanna James, Director of Improvement & Partnership
Cathia Jenainati, Associate Non-Executive Director
Bilal Lala, Non-Executive Director
Vicci Livingstone-Thompson, Associate Non-Executive Director
Jason Makepeace, Non-Executive Director
Jan Marriott, Non-Executive Director
Neil Savage, Director of Human Resources (HR) & Organisational Development
Amjad Uppal, Medical Director

IN ATTENDANCE:
Anna Hilditch, Assistant Trust Secretary
Millie Holmes, Corporate Governance Apprentice, GHNHSFT
Bob Lloyd-Smith, Appointed Governor/Healthwatch (via MS Teams)
Bren McInerney, Member of the Public
Alan Metherall, Member of the Public
Louise Moss, Assistant Director of Corporate Governance (via MS Teams)
Moiz Nayeem, NED Insight Programme
Kate Nelmes, Head of Communications
Lavinia Rowsell, Director of Corporate Governance/Trust Secretary
Rosi Shepherd, Non-Executive Director (from 6 January 2025)

1. WELCOME AND APOLOGIES

1.1 The Chair welcomed everyone to the meeting. No apologies had been received.

1.2 The Chair welcomed Sarah Branton (Chief Operating Officer) and Rosanna James (Director of Improvement and Partnership) to their first Trust Board meeting. Sarah and Rosanna both commenced in post on 4 November 2024.

1.3 Graham Russell also welcomed Rosi Shepherd who was in attendance observing the meeting. Rosi had been appointed as a Non-Executive Director and would be commencing in post on 6 January 2025.

2. DECLARATIONS OF INTEREST

2.1 There were no new declarations of interest.

3. SERVICE STORY PRESENTATION

3.1 The Board welcomed Debbie to the meeting, who was supported by Dominika Lipska-Rosecka (Service Development Manager).

3.2 Debbie was initially diagnosed with joint hypermobility syndrome and fibromyalgia in 2013 and then hypermobile Ehlers Danlos syndrome in 2022. Debbie had served in the RAF in the 1990s as a dental officer.

3.3 Debbie first self-referred to podiatry over a decade ago after struggling with very painful feet, difficulties walking, and ankles rolling. She discovered hypermobility by accident and once she read up about it she mentioned it to her podiatrist and he examined her feet in a new light and agreed that she did have hypermobile feet and ankles. Debbie said that having this reflected back to her was really important in terms of learning and growing about something she was unsure of, and it improved her own sense of who she was and why she was struggling.

3.4 In 2019 Debbie went to podiatry again and was referred to the MSK team, where she was subsequently cast for a Richie brace. Debbie said that wearing the Richie brace alongside a custom orthotic in her other shoe seemed to really improve her walking ability and improved the slight vertigo / dizziness that she had been experiencing when walking.

3.5 Debbie's GP had mentioned the need to strengthen her quads after a knee operation and after a bit of research Debbie found out about recumbent trikes and there was a charity called Wheels for All in Gloucester, and they were going to be at the Trust's Big Health Day in June 2017. After trialing the trikes Debbie started to go to sessions in the Forest of Dean. Debbie said that this was significant for her, being out in nature and moving, and that small start had set her on a path to becoming a para athlete in her late 50s. As well as this, Debbie discovered that open water swimming was fantastic for temperature regulation issues and health issues generally. She completed the Superhero Series triathlon at Dorney Lake, ridden Ride London and the Princes Trust Palace to Palace sportive.

3.6 In terms of key takeaways from Debbie's story and experiences, Debbie said that MSK services could do more to identify and help hypermobile patients, and more joined up working between therapies and linking with charities potentially through and with peer support would also be welcomed. People with multiple symptoms can get a bit lost and that is hard to cope with, so joined up healthcare would really help. With reference to physiotherapy, Debbie said that she had received great care but telephone calls and pieces of paper with exercises on them did not work for some people, with more support to learn how an exercise is done and to be motivated to do it. Debbie had received private physiotherapy services whilst waiting for her NHS referral to start and they had used video calls and she could show the physiotherapist what was happening and was also sent a link to an app with a number of exercises to do.

3.7 Debbie also said that she would push for better understanding of trauma informed care. Several very traumatic experiences which largely happened due to her Hypermobility not having been seen or understood as a risk factor, had led to

significant mental health issues that could have been dealt with in a more effective and compassionate way.

3.8 Jan Marriott thanked Debbie for attending and speaking to the Board about her experiences. She said that Debbie was a real expert and the Trust was very lucky to have her expertise and knowledge.

3.9 Steve Alvis said that it was frustrating to hear about the time taken to get a diagnosis, and therefore agreed that more training and education was needed to help teams and services recognize the potential symptoms of hypermobility.

3.10 In regard to receiving physio exercises on paper, Nicola Hazle said that the Trust was set up to hold video calls and agreed that services needed to move forward and use the technology available. She added that the Therapies Service had a real interest in exploring the types of app available for patients. Sandra Betney advised that Gloucestershire already had a library of authorized apps that could be sent to patients so it may be more about publicizing this library and getting people to use it. Nicola Hazle agreed to speak to the Head of Therapies to progress this. **ACTION**

3.11 Neil Savage said that this story had demonstrated the fantastic use of charitable organisations, third sector and support groups. Debbie had highlighted that one of the nearest support groups for her was in Swindon, with no support available in Gloucestershire which could potentially be explored further.

3.12 Graham Russell thanked Debbie for attending and presenting her extraordinary journey to the Board.

4. MINUTES OF THE PREVIOUS BOARD MEETING

4.1 The Board received the minutes from the previous Board meeting held on 26 September 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 Jan Marriott said that she was disappointed that the Peer Support Worker Framework had been delayed and she was therefore very keen to see this at the January meeting, as advised.

6. QUESTIONS FROM THE PUBLIC

6.1 The Board **noted** that two questions had been received in advance of the meeting.

6.2 The first question had been received from Bren McInerney and related to the provision of services to the Sudanese community in Gloucestershire. Rosanna James provided a verbal response, and the full written response would be sent directly to Bren McInerney following the meeting.

6.3 The second question had been received from Alan Metherall and related to the plans for the Gym space at Wotton Lawn hospital in Gloucester. Sandra Betney provided a verbal response, and the full written response would be sent directly to Alan Metherall following the meeting.

6.4 The Board **noted** that the full questions and responses would be included as an annex to the meeting minutes, for the record.

6.5 Bren McInerney expressed his thanks to Graham Russell for the inclusive way that the Board was chaired, and for allowing time to receive questions from the public.

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 Graham Russell informed the Board that this had been an interesting period with many announcements at a national level about what needs to be done to improve the health and care sector. Graham Russell highlighted four key areas to the Board within his report.

7.3 Firstly, Graham Russell said 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 the Trust was in an excellent position to make a real gear change and a real difference. Graham Russell said that he hoped GHC could play an important role in designing the services, rather than just providing them.

7.4 The second reflection related to the need to ensure that we make the very best use of our community hospitals. Graham Russell had recently visited all of the Trust's community hospitals and said that these were fantastic facilities with brilliant colleagues. Our community hospitals mean that people can access health and care close to home. However, there is scope for even better use of these spaces and this will be an important focus for the Trust as we continue to develop our offer to local communities.

7.5 Graham Russell said that we should never underestimate the power of partnership. Collaborative working with others helps us to provide better services than if we were working on our own. Our appetite as a Trust is to work closely with partner organisations in order to better address the health needs of everyone in

Gloucestershire. Graham Russell stressed the importance of working with the voluntary sector and he noted that a working lunch had been scheduled with colleagues from the Gloucester VCS in December to discuss how we can work better together

7.6 Graham's final reflection related to the importance of culture. Culture is how we operate; how we interrelate; how we work together; how we provide services; and how we behave. A tolerant and inclusive culture does take time to create but is easily lost and we should be mindful of that. More diverse organisations are better performing organisations and better able to serve all communities in Gloucestershire. A programme of work had commenced focussing on Leadership & Culture, and a further update would be provided as part of the Chief Executive's report.

7.7 Vicci Livingstone-Thompson noted that two Public Governors had recently tendered their resignation from the Council of Governors, and she asked whether exit interviews took place to see if there were any underlying issues or learning that could be taken on board. Anna Hilditch said that conversations did take place with any Governor who had advised that they wished to resign and confirmed that all recent resignations related to either health concerns or caring considerations. Discussions did take place to ensure that the individual Governors received the necessary advice or support if they required it, and also about other opportunities to get involved with the Trust if appropriate.

7.8 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.

Integrated Urgent Care Service (IUCS)

8.2 The Trust's 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 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.

8.3 Douglas Blair informed the Board that the IUCS was a great opportunity, but it was important to acknowledge that it could be a bumpy start, and a huge amount of work had taken place to assess the potential risks and to mitigate against these. It was

important that the Trust was able to offer a responsive service as well as ensuring a smooth transition from the existing provider.

Leadership and Culture Programme

8.4 As highlighted within the Chair's report, 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.

8.5 This new programme will include the following areas of focus:

- Support for concerns about individual behaviour and attitudes.
- Targeted training, awareness raising and support.
- Continued delivery of the NHS England Culture of Care programme.
- Long term culture and leadership improvement support.

8.6 The programme will be led by Douglas Blair 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.

Leadership & Management Framework: Code of Practice

8.7 Douglas Blair informed the Board that he had 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. Douglas Blair had 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.

Change NHS

8.8 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, which was intended to start an open and honest conversation about the state of our health service and the reforms needed. The review revealed the scale of the challenge faced.

8.9 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. Douglas Blair said that the Trust was working with system partners to develop a response to this. Nicola de longh said that she would encourage people to respond to the Change NHS consultation as it was a real opportunity as individuals to feedback priorities. It was noted that information about this would be included in the next Membership newsletter due to be sent out in early December.

New Mental Health Bill

8.10 The Board **noted** that on 6th November the new Mental Health Bill was introduced in Parliament by the government to reform the Mental Health Act 1983 (MHA). Full implementation of the 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. Douglas Blair advised that the Bill would have major implications for GHC in terms of how we work and the need for additional resources. The Trust's Mental Health Legislation Scrutiny Committee would lead on the oversight of this work.

8.11 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 7.

9.2 At month 7 the Trust had a surplus of £0.210m compared to a plan of £0.198m

9.3 The 2024/25 Capital plan was £10.704m with £4m of disposals leaving a net £6.704m programme. Spend to month 7 was £2.1m against a year-to-date budget of £4.176m. Cash at the end of month 7 was £44.754m compared to plan of £49.881m.

9.4 It was reported the Cost Improvement Programme had delivered £3.658m of recurring savings at month 7 compared to plan of £3.997m. The target for the year is £7.319m of which £1.848m is currently unidentified. In total, the Trust has 15% of its savings target unidentified, a reduction of 2% from last month. Sandra Betney reported that this was classified as a risk and details were included within the report.

9.5 The Board **noted** however, that £4.818m of non-recurring savings had been delivered at month 7 against plan of £4.534m. The target for the year is £5.661m, and all have been identified.

9.6 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.

9.7 Sandra Betney advised that the Better Payment Policy performance showed 90% 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. The 7-day performance at the end of October was 63.8% of invoices by value paid.

9.8 Sandra Betney informed the Board that the 2025/26 capital plan was not yet finalised and discussions would be taking place over the coming months at the Resources Committee as there was a need to take account of the system capital position. A number of amendments to the Capital Plan were proposed and these were approved by the Board, as follows:

- 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.

9.9 Steve Alvis noted that the target for off framework agency usage was zero, and he asked how the launch of the new IUCS service might impact on this. Sandra Betney advised that the zero target was a nationally set target, but it was felt that this was unrealistic. GHC used agency staff to maintain patient and clinical safety and would continue to do so if it was required. However, it was reported that all agency used as part of the IUCS was “on” framework which was positive, and demonstrated a huge amount of work carried out by Trust colleagues to achieve this.

9.10 Nicola de Iongh said that there were huge complexities in the NHS, especially with regard to finance and she expressed her thanks and congratulations to all colleagues involved in maintaining a strong and stable position.

9.11 Bilal Lala noted that the Trust was behind on its capital spend and asked for some assurance on this position, noting that we were over half way through the financial year. Sandra Betney advised that the Capital Management Group met regularly and reviewed each capital scheme and carried out discussions on when each scheme would be progressed or identifying any challenges. She said that through this process, she remained confident that the Trust’s outturn position would be achieved at year-end.

9.12 The Trust Board **noted** the month 7 financial position and **approved** the changes to the capital programme.

10. QUALITY DASHBOARD REPORT

10.1 Nicola Hazle introduced the Quality Dashboard Report (October 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.

10.2 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 was now complete and would be presented at the next Safeguarding Group. The Board noted that overall compliance was 65% (previous year 41%). Nicola de longh noted that 65% was better than 41%, however, this was still not at the level it should be for such an important area. Nicola Hazle agreed. As the dashboard summarised there have been a number of developments during 2024/25 including using the new template, increased training and supervision opportunities and improved data sharing with the Local Authority that should support improvement in compliance. Nicola Hazle confirmed that further discussion would be taking place at the Safeguarding Group and robust action plans would be put in place.

10.3 There were a total of 1,231 patient incidents reported 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 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.

10.4 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). Nicola Hazle confirmed that the management of pressure ulcers was a Trust priority and work was underway to review the incidents and learning.

10.5 There is a decrease in the rates of rapid tranquilisation (RT) and this is attributable to a reduction in NG feeding, however, an increase in clinical holds has been recorded which is attributable to the seasonal vaccination and Covid 19 Booster Programme.

10.6 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. The Board noted that 100% of complaints were acknowledged within the national 3-day requirement. The Non-Executive Director (NED) Audit of complaints for Q2 2024/25 was included within the dashboard report and assurance was given that the Trust is investigating and responding to complaints appropriately. Vicci Livingstone-Thompson noted that many of the complaints received were categorised as “Communication issues” and she sought further information on this. Nicola Hazle said that this was very broad and the PCET team had been asked to explore this further to look at what was being said and what we could do to address this on a trust wide level.

10.7 Nicola Hazle advised that the Quality Dashboard was currently under development and a slide had been included within the report which highlighted the planned

programme of improvement for the dashboard, a high-level summary of the changes and proposed timeframes.

10.8 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 said that the Committee had discussed the increase in pressure ulcers and the need for this to be addressed as a systemwide issue. The Committee had also welcomed the BDO internal audit report on Berkeley House, noting the improvements made. Over the past few meetings, the Quality Committee had received a number of reports/sources of information related to crisis services and has sought further detail on the services and assurance related to quality and safety.

10.9 The Board **received, noted** and **discussed** the October 2024 Quality Dashboard.

11. PERFORMANCE DASHBOARD

11.1 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 October (Month 7 2024/25).

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

11.3 The Board **noted** those indicators that were in exception for the period within the nationally measured, specialised and directly commissioned, ICS agreed, and Board Focus domains. Performance improvement plans for those indicators in exception were received and considered at the BIMG.

11.4 Sarah Branton presented the Chief Operating Officer Report to the Board, highlighting some key areas to note.

11.5 The Board **noted** an improvement for our children's physiotherapy service for both the 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.

11.6 Sarah Branton noted that the Trust had been below our target KPI of 60% to treat new psychosis cases within 2 weeks of referral. Sarah was pleased to report that in October we met our KPI target, achieving 100%.

11.7 The Board **noted** that meetings have now taken place with commissioner colleagues around the concerns with GHFT ECHO performance, and work will now be taking place to look at how the service is commissioned moving forward. Steve Alvis welcomed this news and asked how we could assure that this continued to be an area of focus. Sandra Betney advised that it was now on the agenda and would be monitored through system working groups.

11.8 In relation to immunisations for flu for children it was reported that the Trust achieved 56.4% against a target of 70%. The Service Director is analysing data and investigating this in order to develop an improvement plan. Sarah Branton added that in terms of flu vaccination take up by Trust colleagues, this currently stood at 35% which was low. A push on communications out to colleagues to encourage the vaccination would take place over the coming weeks.

11.9 Within our Rapid Response Team, the vacancy rate was currently at 32.1%. This would reduce as 8.2 whole time equivalent staff have been recruited and are in the pipeline to join the team. Sarah Branton advised that this would continue to be monitored closely.

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

12. FREEDOM TO SPEAK UP (FTSU) REPORT

12.1 The Board welcomed Sonia Pearcey, FTSU Guardian to the meeting who was in attendance to present the six-monthly FTSU update report, which provided an update on the Speaking Up processes that were in place across the Trust and assurance that the processes were in line with the national guidance. The Board noted that this report had been received and reviewed by the Great Place to Work Committee on 8th November 2024. In addition to the information presented in the report, the Committee had considered further detail in relation to barriers to speaking up.

12.2 From April 2024 there had been 41 speak up cases raised to the Freedom to Speak Up Guardian. There was a notable increase in 2023/24 of colleagues speaking up to the Guardian, a total of 96 cases. These were more complex in nature and has impacted on the proactive time including visibility with teams across the Trust.

12.3 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% (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%.

12.4 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 from our growing network of Freedom to Speak Up Champions. The Board noted that there were currently 115 FTSU Champions across the Trust which was excellent.

12.5 The BDO Barriers to Raising Concerns internal audit of December 2023 has recently been re-audited and 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.

12.6 To support year-on-year improvement in embedding our positive speaking up culture, Sonia Pearcey advised that the Trust would continue to actively analyse the data captured through the NHS staff surveys, Pulse surveys and Networks. Further analysis to date has highlighted those service areas to focus more visibility, champion development and enhancing the proactive speaking up culture work.

12.7 The Board **received** and **noted** this report, and the assurance provided. It was agreed that the ability for colleagues to have the Freedom to Speak Up and the mechanisms and support in place was so important for the culture of the organisation. Thanks were given to Sonia Pearcey and to all those FTSU Champions across the organisation.

13. BOARD ASSURANCE FRAMEWORK

13.1 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.

13.2 A summary of the key changes to the BAF in Quarter 2 and movements in risk ratings in year could be seen within the dashboard, with rationale contained within the main document. The Board was assured that any changes to risk scores were reviewed by the relevant governance committee.

13.3 The Board **noted** that one risk had reached its target score and had been closed (Risk 7 – Sustainability). It was also **noted** that a detailed review of assurances and mitigating actions has been undertaken for those risks overseen by the Great Place to Work and Quality Committees.

13.4 Sandra Betney wanted to flag to the Board that discussions would be taking place to review the Cyber risk and aspiration of target.

14. INTENSIVE AND ASSERTIVE MENTAL HEALTH CARE REVIEW

14.1 The purpose of this report was to provide an overview of the Gloucestershire ICB and GHC response to the NHSE National Intensive and Assertive Community Mental Health Care review.

14.2 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.

14.3 Amjad Uppal reported that 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.

14.4 The Board **noted** the initial key findings of the completion of the ICB Maturity Matrix Tool, led by the Intensive and Assertive Task & Finish Group, and **supported** the next steps outlined to develop an Intensive and Assertive Community Mental Health Action Plan. The Board **noted** that the system aims to coproduce an action plan with system partners, relevant stakeholders and those with lived experience of serious and enduring mental illness.

15. COUNCIL OF GOVERNOR MINUTES

15.1 The Board **received** and **noted** the minutes from the Council of Governors meeting held on 16 September 2024.

16. WORKING TOGETHER ADVISORY COMMITTEE REVIEW

16.1 The Board received 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. This was **noted**.

17. BOARD COMMITTEE SUMMARY REPORTS

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

- Mental Health Legislation Scrutiny Committee (16 October)
- Resources Committee (22 October)
- Quality Committee (7 November)
- Great Place to Work Committee (8 November)
- Audit Committee (21 November)

18. ANY OTHER BUSINESS

18.1 The Board **noted** that former Chief Executive, Paul Roberts had received an Honorary Fellowship from the University of Gloucestershire.

19. DATE OF NEXT MEETING

19.1 The next meeting would take place on **Thursday, 23 January 2025**.

APPENDIX

Questions from the Public – Received at 28 November 2024 Board Meeting

Question 1

It was very concerning to read about the imminent closure of the gym at Wotton Lawn Hospital and the proposal that an exercise room is a suitable alternative. I am not sure closure of a large department in a community hospital would have proceeded without a public Board decision or scrutiny by the HOSC. I could find no record of the Board discussing the closure of the gym in previous board papers.

When were the inpatients and their representatives; staff and the public formally consulted about the closure of the gym?

Follow up if permitted - If no formal consultation took place, when will inpatients, staff, carers and the public be able to participate in a meaningful consultation? ***Alan Metherall***

Trust Response

The proposed capital scheme to which you are referring (which has not yet been approved) is related to much needed improvements to our Health Based Place of Safety (Section 136 suite). The risks of the current environment are clear and respond to issues being raised by Executive Directors, NED quality visits, complaints, feedback to the Chief Executive and via the staff survey. The difficulties of refurbishing it whilst in use have led to the development of a potential scheme in the Capital Programme which has examined how best to make the best use of space on the Wotton Lawn Hospital site, balancing our aims of providing high quality therapeutic support to inpatients while also improving the environment at our S136.

We are exploring modifications of an initial proposal to reduce any potential impact on the gym area and a Quality Equality Impact Assessment of the scheme will be prepared for any scheme that might impact on the gym area.

A complete closure of the gym space is neither imminent nor likely. There is expected to be a positive impact on the access to therapeutic activity undertaken at the hospital as a result of related capital works. We will of course include experts by experience and colleagues in the project to remodel both the S136 and the therapeutic areas once we have established viable options to improve both. Once a viable option has been identified the capital scheme will be considered by our Capital Management Group unless the financial value of the scheme requires Chief Executive (over £1m) or Board signoff (over £2m) which is unlikely given limited capital funds available.

Sandra Betney
Director of Finance / Deputy CEO

Question 2

What data driven insights does Gloucestershire Health and Care NHS Foundation Trust have when planning, delivering, and monitoring services to the Sudanese community in Gloucestershire? What assurance and re assurance does this Trust have that their services to the Sudanese community are culturally appropriate and trauma informed? What robust evidence does the trust have to consistently ensure itself that access is equitable, experiences are exceptional, and there are optimal outcomes for the Sudanese community in Gloucestershire. ***Bren McInerney***

Trust Response

Thanks so much for your question; currently we do not have separate mechanisms to gather information for this specific group. According to the Census data 2021, 1.4% of the Gloucestershire population is from African countries, however, the Census data does not provide a specific breakdown for the Sudanese community.

Gloucestershire Health and Care Foundation Trust is committed to delivering culturally appropriate and trauma informed services to all communities, and whilst we don't currently engage directly with Sudanese community as a distinct group, we're actively developing relationships with African communities across Gloucestershire to address shared cultural and health needs.

We are aware, through work with (GARAS) Gloucestershire Action for Refugees and Asylum Seekers that many of the local Sudanese community may have experienced conflict, or other traumatic events. Our Trust is committed to embedding trauma-informed approaches, with training packages already co-delivered with Experts by Experience and Lived Experience Practitioners as part of our mandatory training programme for front line staff. Furthermore, our Complex Emotional Needs Service works systemically across the county to support individuals and agencies to understand and deliver trauma informed approaches within their work, recent examples of their work include:

- A 3-day Multi-Agency Training event called 'Knowledge and Understanding Framework' which attends to all aspects of Trauma informed approaches. Participants include a broad range of agencies from housing providers, education, the voluntary care sector and GHC staff from a broad array of services. We have now reached over 320 staff through this training, with another 8 cohorts planned over 2025.

- Supporting the Friendship café through a series of workshops specifically for the Islamic Community including a session around understanding complex emotional needs as a response to Trauma.

Outside of our trauma informed approaches, GHC also has a number of strategies & transformation programmes to ensure our services meet diverse needs (culturally competent and trauma-informed care delivery, personalisation), some of these are detailed below:

- Community Mental Health Transformation programme - focusing on co-production and engagement with people who have lived experience and their carers, including community members from Diverse Research Network.
- Patient and Carer Race Equality Framework - GHC is actively working on adopting and implementing a nationally recognised framework utilising data driven approaches to identify disparities, improve patient outcomes, and ensure that communities we serve receive equitable and culturally competent care.

Rosanna James
Director of Improvement and Partnership

AGENDA ITEM: 05/0125

TRUST BOARD PUBLIC SESSION: Matters Arising and Action Log – 23 January 2025

- 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 / Rosanna James	Jan 2025	Scheduled for January 2025 Board meeting.	
28 Nov 2024	3.10	Nicola Hazle agreed to speak to the Head of Therapies about exploring the types of technology and apps available for patients to receive virtual appointments and onward care (such as physio exercises)	Nicola Hazle	Jan 2025	Email sent following the Board meeting in November linking up the Head of Therapies, to see how the reflections/learning points from the patient story item in relation to MSK and podiatry services might be developed further within the existing AHP structures. Verbal update to be provided at the January meeting.	

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 07/0125

REPORT TO: **TRUST BOARD PUBLIC SESSION – 23 January 2025**

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 Trust 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 Directors Summary of Activity For November and December 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.

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:

    - **Montpellier Unit, Wotton Lawn** where I met with Unit Manager Nichole Bullock and colleagues.
    - **Elmbury Suite, Tewkesbury Hospital Theatres** where I was accompanied by the Chief Executive. Douglas and I met with Gemma Arkell, Staff Nurse, and James Willetts, Theatre Manager.
    - **Digital Services Clinical Systems Team** who are based at Edward Jenner Court. I was invited by Amanda Linley, Deputy Head of Clinical Systems to join their Team meeting.
    - **Stroud Therapy Department**, where I met with Sarah Nicholson, Lead Physiotherapist.

    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 during 2025 and I look forward to meeting further teams and service users.

- On 4th December, I, along with Douglas Blair, Chief Executive, Rosanna James, Director of Improvement and Partnerships, and Vicci Livingstone-Thompson, Associate Non-Executive Director had the pleasure of meeting with members from

the **Gloucestershire Voluntary Sector**. This in person 'getting to know you' session was an opportunity to develop a stronger mutual relationship between the Trust and the voluntary sector. Following the session, I was delighted to be invited to visit Sunflowers Suicide Support by Abbie Warren, Chief Executive and Founder.

- On 19th December I met with **Dame Gill Morgan, Chair, NHS Gloucestershire** and **Deborah Evans, Chair of Gloucestershire Hospitals NHSFT** where we discussed matters of mutual interest.

- I attended on 8th January the virtual **ICB Gloucestershire Neighbourhood Transformation Steering Group** meeting.

- Moiz Nayeem's placement with the Trust as part of the **GatenbySanderson's Insight South West Programme** ends on 31st January and I wish Moiz every success with his future Non-Executive Director career.

Always improving

- The Chief Executive and I met with **MP for South Cotswolds, Dr Roz Savage** on 19th December and **MP for North Cotswolds**, **Sir Geoffrey Clifton-Brown** on 17th January. These virtual meetings were an opportunity to introduce newly elected Roz to the many services provided by the Trust and both Roz and Sir Geoffrey to ask any specific questions.

- Along with the Chief Executive, I attended the in person **South West 10 Year Plan System Leadership Engagement Workshop** on 5th December. NHS England South West brought together local authority leaders from the ICB, NHS Trusts and senior system partners to gather insights, feedback and ideas on the 10 Year Plan for Health (10YP) which is due to be published in the Spring.

- To discuss the **Trust strategic priorities and key milestones**, a meeting took place on 8th January with Douglas Blair, Chief Executive, Rosanna James, Director of Improvement and Partnership and Lavinia Rowsell, Director of Corporate Governance and Trust Secretary.

- To establish working together goals for during 2025, I attended the second **Working Together Advisory Committee workshop** on 5th December. Working together is important to the Trust as we recognise the essential role it plays in supporting our responsibility to improve health equity, deliver quality services, and contribute to wider determinants of health in Gloucestershire. At our last Working Together Advisory Committee workshop we identified the need to be more outward-facing, impactful, proactive and innovative in our working together and co-production approach to ensure the voice of the people we serve and community partners we work with is obtained, listened to, and acted upon. During the workshop we:

  - explored options and identified an approach which will enable us to engage effectively with the people and communities we serve, proactively identify change objectives, and drive forward the Trust's ambition to embed a culture of co-production across the organisation.
  - Identified key objectives and areas for development to focus on.
  - Re-shaped and re-named our Working Together Advisory Committee so that it can be an effective delivery mechanism for our approach and objectives.
  - Thought about how we can communicate and improve how we work with our Trust Board, groups and committees, and as part of a network of community groups and Partnership Boards.

Respectful and kind

- I participated in the judging panel for the **Better Care Together Awards** on 16th January. There were more than 160 nominations across the eight categories, and the panel spent a whole day at Churchdown Community Centre carefully considering and choosing a shortlist of 3 entries per category. The panel felt that the standard of nominations was incredibly high, and it was very difficult to shortlist some categories. We hope that the final shortlist reflects the breadth and depth of our services, and we look forward to the awards event itself, on 9th April at Hatherley Manor Hotel.

Making a difference

- Following a really positive meeting on 1st October where **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, Mary and I met to discuss next steps on 15th January.

- On 7th January, I met in person with Barbara Piranty, Chief Executive of **Gloucestershire Rural Community Council** where we discussed housing and health within Gloucestershire.

3. BOARD UPDATES

- I am delighted to congratulate Vicci Livingstone-Thompson, Associate Non-Executive Director, on being awarded the British Empire Medal (BEM) in the **King's New Year Honours for 2025**. This prestigious recognition celebrates Vicci's remarkable contributions to mental health and the rights of Disabled people in Gloucestershire and beyond.

- As referred to in my previous Board report, I am delighted to advise Rosi Shepherd, joined the Trust on 6th January as **Non-Executive Director**. Introduction meetings with the Board will take place over the coming weeks. I am sure you will all join me in welcoming Rosi to the Trust.

- On 4th December, a **Board Seminar** took place where the topic for discussion was Sustainability – Green Plan. The seminar which was led by Rosanna James, the Director of Improvement and Partnership, reviewed the status of our NHS carbon footprint emissions and identified areas for improvement, enabling us to identify actionable strategies for our Green Plan Refresh and ensure alignment with national NHS Sustainability goals and carbon reduction targets.

- A **Board Development session**, facilitated by The Value Circle, took place on 17th December. This face-to-face session focused on the forward plan and Board fundamentals for 2025 along with next steps for development.

- 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.

- A meeting of the **Nominations and Remuneration Committee** took place on 8th January. The committee discussed Non-Executive Director remuneration and endorsed the recruitment process for a new Non-Executive Director.

- On 22nd January we held our in-person **Council of Governors meeting** where the meeting was dedicated to a development session. At the meeting we were joined by colleagues from NHS Providers (Governwell) who delivered a bespoke training package on Governor and NED Development focussing on Board relationships, Accountability, Effective Questioning and Challenge and Holding to Account.

- **Election to the Council of Governors** have now closed for our vacant Governor positions. We have received some fantastic nominations. Voting will open on 14th January with new Governors declared on 3rd February.

- Sadly, for us, Rebecca Halifax, appointed Governor for Gloucestershire County Council and Cath Fern, Staff Governor, Medical, Dental & Nursing have resigned. I would like to thank Rebecca and Cath for their contributions to the Trust. We look forward to receiving a new nomination from the County Council over the coming months.

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 November and December 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 November – 31st December 2024

NED Name	Meetings with Executives, Colleagues, External Partners	GHC Board / Committee meetings
Dr Stephen Alvis	Council of Governors GGI Webinar ICS Non-Executive Director's Network Pre-Meet Mental Health Act Manager Personal Review Mental Health Act Managers Forum NHS Providers Non-Executive Network Non-Executive Directors Meeting Quality Visit to Community Neurology Service Quarterly Staff Governor Meeting Senior Leadership Network	Appointments and Terms of Service Committee Board Development: thevaluecircle Board Seminar: Sustainability Quality Committee Resources Committee Trust Board: Private Trust Board: Public
Sumita Hutchison	GHC Colleague Diversity Network Meeting Health and Wellbeing Guardian Role with NHS England Meeting with Clinical Psychologist and Clinical Lead Meeting with Karen Clements, ICB Non-Executive Director NHS Annual Providers Conference Non-Executive Directors Meeting Quarterly Staff Governor Meeting	Audit & Assurance Committee Great Place to Work Committee Trust Board: Private Trust Board: Public
Nicola de longh	Council of Governors Non-Executive Directors Meeting 1:1 with Trust Chair	Appointments and Terms of Service Committee Board Development: thevaluecircle Board Seminar: Sustainability Charitable Funds Committee Great Place to Work Committee Resources Committee Trust Board: Private Trust Board: Public
Jan Marriott	1:1 with Forest of Dean Health Forum 1:1 with Freedom to Speak Up Guardian 1:1 with Service Development Manager (Involvement, Inclusion, Engagement) Agenda Planning for Quality Committee Introduction Meeting with Chief Operating Officer	Appointments and Terms of Service Committee Audit and Assurance Committee Board Development: thevaluecircle Board Seminar: Sustainability Quality Committee Trust Board: Private Trust Board: Public

NED Name	Meetings with Executives, Colleagues, External Partners	GHC Board / Committee meetings
	Introduction Meeting with Director of Improvement and Partnerships Meeting with Non-Executive Director and Director of Nursing Therapies and Quality Non-Executive Directors Meeting Quality Assurance Group Quality Committee Follow Up Meeting Quality Committee Pre-Meet with Director of Nursing, Therapies and Quality Quality Visit to First Point of Contact Centre Quality Workshop System Quality Committee	
Vicci Livingstone-Thompson	NHS Annual Providers Conference Gloucestershire Voluntary Sector Getting to Know You Session Non-Executive Directors Meeting Quality Visit to Wheelchair Service 1:1 with Director of Nursing, Therapies and Quality	Board Development: thevaluecircle Trust Board: Private Trust Board: Public
Bilal Lala	1:1 with Trust Chair 2-day NHS Providers Non-Executive Director Induction Audit & Assurance Committee Pre-Meet Audit & Assurance Committee Process Evaluation Meeting External Audit Evaluation Workshop Introduction meeting with Operational Governance & Performance Lead Meeting with Aspiring Non-Executive Director Meeting with Counter Fraud Lead Non-Executive Directors Meeting Quality Visit to Community Neurology Service	Audit & Assurance Committee Board Seminar: Sustainability Trust Board: Private Trust Board: Public
Jason Makepeace	2-day NHS Providers Non-Executive Director Induction Audit & Assurance Committee Introduction meeting with Chief Operating Officer Introduction meeting with Director of Improvement and Partnership	Board Development: thevaluecircle Board Seminar: Sustainability Charitable Funds Committee Trust Board: Private Trust Board: Public

NED Name	Meetings with Executives, Colleagues, External Partners	GHC Board / Committee meetings
	Meeting with Aspiring NED Non-Executive Directors Meeting Oliver McGowan Training Post Resources Committee Catch Up Quarterly Staff Governor Meeting Resources Committee Agenda Setting Meeting Resources Committee Assurance Report Resources Committee Pre-meet	

REPORT TO: **TRUST BOARD PUBLIC SESSION – 23 January 2025**

PRESENTED BY: Douglas Blair, Chief Executive Officer

AUTHOR: Douglas Blair, Chief Executive Officer

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

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

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

The purpose of this report is to

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

Recommendations and decisions required

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

Executive Summary

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

- Chief Executive Overview
- System Updates
- National / Regional Updates
- Events
- Achievements / Awards

Risks associated with meeting the Trust's values

None identified

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

Where has this issue been discussed before?
N/A

Appendices:	Report attached

Report authorised by:	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

In December and early January, I have completed the following service visits:

- A visit to Young Gloucestershire, where I discussed how best we work together with them as a key partner of the Trust

- Nelson Trust, to meet the team as we work in partnership with the trust generally and, in particular, in relation to our responsibilities in relation to the integrated non-custodial service.

- Tewkesbury Hospital (in particular the theatre team, where we discussed some of the challenges related to the changing shape of demand for the work of our theatres in community hospitals)

- I met with the Community Rehabilitation Team. We were also joined by an Expert by Experience to talk about the team and the work they have been undertaking along with team members from STAR and Supported Accommodation Service.

1.2 Integrated Urgent Care Service

The new Integrated Urgent Care Service, which includes NHS 111, a new Clinical Assessment Service, operating 24 x 7, as well as Out of Hours primary care appointments in treatment centres and Home Visits, has continued to build and establish itself over the last few weeks. This has included the festive period, which is traditionally one of the busiest times for this service given the number of bank holidays. Through December, over 23,000 calls were handled by NHS 111, resulting in over 2,500 out of hours appointments, which was above the regional forecast level of activity.

The service performed well during this period, demonstrating clear benefits related to the additional triage resources within the Clinical Assessment Service. Clinical validation of calls to NHS 111 potentially requiring a Category 3 or 4 ambulance dispatch or Emergency Department attendance has performed at a high level and has been really effective in routing appropriate patients to other urgent/unplanned care services across our system – helping to alleviate pressure on our already stretched partners in the Ambulance and Acute Trusts. We are continuing to work with our partners IC24 to embed and improve the service, including a focus on Pharmacy First referrals from NHS 111 and to enhance our referral pathway into GHC's Minor Injury and Illness Units.

1.3 South West Provider Collaborative

I attended, on 15 November 2024, a meeting with fellow mental health Chief Executives across the South West. While there are regular opportunities to connect

with these colleagues, this session acted as the first meeting of a Chief Executive Strategy and Oversight Group in relation to the activities of the South West Provider Collaborative.

This is part of some reshaping of the oversight arrangements for the South West Provider Collaborative. GHC is a member of this collaborative in terms of the delivery of Low Secure services (Montpelier Ward) and, more recently, collaboration in relation to perinatal mental health services. We continue to also be members of the Thames Valley provider collaborative in relation to access to specialist Children and Young People Mental Health and Eating Disorder services.

There is likely to be a period of change in relation to these specialised services as it is proposed that the commissioning responsibility for these type of services is delegated to Integrated Commissioning Boards from NHS England with one lead ICB identified for each region. It will be important that the clear advantages of collaborating across larger geographies in provider collaboratives is maintained during this time.

2.0 SYSTEM UPDATES

2.1 Winter Plan

The Gloucestershire Integrated Care System Winter Plan Health and care partners publish Winter Plan : NHS Gloucestershire ICB was published on 11 December 2024 and set out how services are working more closely than ever to plan ahead and make best use of all available resources.

The plan contained profiles of each service area across the health and care system, with pledges detailing how they will work together to support patients and the public this winter.

It focuses on keeping people safe and well at home, ensuring people can access the right care at the right time in the right place and supporting people to leave hospital and return home when safe to do so, with additional support in place if needed.

2.2 Joint Forward Plan - Governance and Approvals - 2025/26 – 2029/30

Integrated Care Boards (ICB) and their partner NHS Trusts have a statutory / legal responsibility (as defined by the Health and Care Act 2022) to publish and refresh a 5-year Joint Forward Plan on an annual basis. The purpose of the plan is to set out how the NHS plans to exercise its functions over the next five years and will require Board sign off in March to meet national expectations.

Systems have flexibility to determine the scope, structure and content of their plan, but are required to: collaborate as partners on the plan; engage the Health and Wellbeing Board in development of the plan to take proper account of the local Health and Wellbeing Strategy; set out how the system intends to provide services to meet the mental health needs of their population; how 17 legislative requirements are met and that it is a shared delivery plan for the Integrated Care Strategy.

The system has received positive feedback on our Joint Forward Plan for the last two years from NHS England. Therefore, our approach is focused on strengthening clarity in the plan rather than changing the overall structure. In addition, with the NHS 10 Year Plan being published in Spring 2025 we are anticipating there will be a need for a wider refresh ahead of 2026/27 rather than for this year, aligning well with our own Trust Strategy refresh and a similar process happening in Gloucestershire Hospitals NHS Foundation Trust.

It is important that the plan reflects our performance, quality and financial ambitions as a system and provides specificity regarding delivery. Given the financial pressures, the plan needs to provide the framework for how transformation activity will release capacity / avoid cost / reduce expenditure.

The intention is to structure the detail of the plan around a set of Portfolios (draft at this stage):

- Long-Term Conditions (Physical Health) including a focus on people living with multiple long-term conditions.
- All Age Mental Health, Neurodiversity and Learning Disabilities
- Urgent and Emergency Care including intermediate care
- Planned Care and Diagnostics
- System Quality and Sustainability including maternity, medicines optimisation and sustainability/green programme.
- System Enablers (will include programmes such as Digital and Data; Estates; Integrated Locality Partnerships; Integrated Neighbourhood Teams; Workforce and the work to embed a framework for health inequalities).

The Executive team have reviewed the draft content of the plan in January and the full plan will come back to Board for approval in March 2025.

2.3 Integrated Care Board (ICB) Development Meeting

The NHS Gloucestershire ICB Board Development meeting took place on 18 December, which I attended along with Graham Russell, Chair and Rosanna James, Director of Improvement and Partnerships. The meeting included a focus on further developing the approach in Gloucestershire to working in neighbourhoods. This aligns to emerging Government policy surrounding a neighbourhood health service and will be a key focus for GHC in planning for the next delivery year and beyond.

3.0 NATIONAL / REGIONAL UPDATES

3.1 National Elective Reform Plan

The Elective (planned care) Reform Plan, which outlines priorities to cut the number of patients waiting more than 18 weeks for NHS treatment was published by the Government on 6 January 2025.

The plan focuses on three key areas: improving waiting times so more people receive a quicker diagnosis and treatment; more convenient access to care through direct access to tests, scans, operations or procedures; and improving patient experience

through greater choice and control over when and where they will be treated. The overall ambition is to ensure 92% of patients wait no longer than 18 weeks from referral to treatment by March 2029.

Much of this work is already well underway in Gloucestershire, with significant progress made in reducing the longest waiting times for diagnostic tests and planned operations and procedures as we continue to focus on improving efficiency and increasing the capacity of our services.

While the majority of this plan will be focused on the efforts of colleagues in Gloucestershire Hospitals NHS Foundation Trust, there will be implications for some of our services. Equally, keeping a focus on waiting times for community services which fall outside this plan will be an important feature.

4.0 EVENTS

4.1 Mental Health Trust CEO Event

I attended a meeting of all Mental Health Trust Chief Executives with NHS England on 3 December. This was a good opportunity to discuss some of the common issues across the sector and shape some of the future thinking in relation to long term plans. It was the first time that mental health Chief Executives had met nationally in a face to face format since 2022, and the feedback was that it had been very helpful, particularly as there has been a number of new colleagues joining the group (including me) during this time.

5.0 ACHIEVEMENTS / AWARDS

5.1 Apprenticeships

Congratulations on the achievements of our apprentice who has recently successfully completed their apprenticeship:

Ellis Vernon,
Level 5 Operations/Departmental Manager Apprenticeship,
achieving a Distinction.

5.2 Congratulations to the Wotton Lawn Hospital ECT Team, who received Accreditation with the Royal College of Psychiatrists.

Wotton Lawn in Gloucester was reviewed against the Quality Standards for Electroconvulsive Therapy Services – Sixteenth Edition (2023). To achieve accreditation, a service must meet 100% of type 1 standards, at least 80% of type 2 standards and at least 60% of type 3 standards:

The service completed a self-review whereby they rated their procedures, policies and practices against the published standards. Data was also collected from a staff questionnaire, a case

note audit, patient questionnaire, referrer questionnaire and a family and carers questionnaire.

This was followed by a peer-review visit in June 2024. The visit was an opportunity for the peer-review team to validate the service's self-review data by collecting information through interviews with staff, patients and their family, friends and carers.
This service was accredited by the Royal College of Psychiatrists and this is valid from 26 September 2024 until 25 September 2027.

6.0 CONCLUSION AND RECOMMENDATIONS

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

Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 09/0125

REPORT TO: **TRUST BOARD PUBLIC SESSION – 23 January 2025**

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

AUTHOR: Stephen Andrews, Deputy Director of Finance

SUBJECT: **FINANCE REPORT FOR PERIOD ENDING 31st DECEMBER 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 9 position.
- Formally **APPROVE** the accuracy and robustness of the capital forecast as submitted including the charge against capital allocations, the impact of IFRS 16, and the total CDEL charge

Executive summary

- At month 9 the Trust has a surplus of £0.123m compared to a plan of £0.112m
- 24/25 Capital plan is £10.704m with £4.000m of disposals leaving a net £6.704m programme. Spend to month 7 is £3.196m against a budget of £6.26m.
- Cash at the end of month 9 is £44.754m compared to plan of £48.292m
- Cost improvement programme has delivered £4.191m of recurring savings at month 9 compared to plan of £5.168m
- £6.264m of non-recurring savings have been delivered at month 9 against plan of £5.287m
- The Trust spent £3.865m on agency staff up to month 9. This equates to 2.13% of total pay compared to the agency ceiling of 3.2%.
- The Board is asked to formally record approval of the accuracy and robustness of the capital forecast

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

Corporate considerations	
Quality Implications	
Resource Implications	
Equality Implications	

Where has this issue been discussed before?

Appendices:	Finance Report

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

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Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 09.1/0125

Finance Report Month 9

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

Overview

Gloucestershire Health and Care NHS Foundation Trust

- At month 9 the Trust has a surplus of £0.123m compared to a plan of £0.112m.
- 24/25 Capital plan was £10.704m with £4.000m of disposals leaving a net £6.704m plan. Spend to month 9 is £3.196m against a ytd budget of £6.26m.
- Revised Plan is £8.174m including disposals of £2.0m and FOT is expected to meet this plan.
- Cash at the end of month 9 is £44.754m, an increase of £4.11m on last month. FOT is £51.458m.
- Cost improvement programme has delivered £4.191m of recurring savings at month 9 compared to plan of £5.168m. Target for the year is £7.319m of which £1.332m is currently unidentified.
- £6.264m of non recurring savings have been delivered at month 9 against plan of £5.287m. Target for the year was £5.661m, and has been fully delivered.
- In total the Trust has 6% of its savings target unidentified. FOT is to fully meet the savings target, with additional non recurring savings making up any shortfall in recurring savings.
- Worked WTEs were 67 below the budgeted WTEs in December.
- The Trust spent £3.865m on agency staff up to month 9. This equates to 2.13% of total pay compared to the agency ceiling of 3.2%. There were 93 off framework agency shifts in December.
- IUC agency temporarily increased agency spend and offset the decrease in November seen elsewhere
- Better Payment Policy shows 90.7% of invoices by value paid within 30 days, the national target is 95%.
- The 7 day performance at the end of December was 64.5% of invoices by value paid.
- The Board is asked to formally approve the accuracy and robustness of the capital forecast as submitted including the charge against capital allocations, the impact of IFRS 16, and the total CDEL charge.

GHC Income and Expenditure

Gloucestershire Health and Care NHS Foundation Trust

	2024/25 NHSE Plan	2024/25 Revised budget	2024/25 YTD revised budget	2024/25 YTD Actuals	2024/25 Variance - ytd actual to ytd revised budget
Operating income from patient care activities	272,338	300,951	223,423	223,551	128
Other operating income	16,993	19,313	14,485	15,411	926
Employee expenses - substantive	(198,597)	(242,633)	(181,275)	(163,705)	17,570
Bank	(17,771)	(2,587)	(1,940)	(14,217)	(12,277)
Agency	(7,152)	(1,165)	(874)	(3,866)	(2,992)
Operating expenses excluding employee expenses	(63,887)	(74,062)	(54,273)	(57,454)	(3,182)
PDC dividends payable/refundable	(2,624)	(2,624)	(1,968)	(1,939)	29
Finance Income	825	2,932	2,515	2,397	(118)
Finance expenses	(212)	(212)	(159)	(169)	(10)
Surplus/(deficit) before impairments & transfers	**(87)**	**(87)**	**(65)**	**9**	**74**
Gains/ (losses) from disposal of assets				(26)	(26)
Remove capital donations/grants I&E impact	87	87	65	140	75
Surplus/(deficit)	**0**	**0**	**0**	**123**	**123**
Adjust (gains)/losses on transfers by absorption/impairments	0	0	0	0	0
Remove net impact of consumables donated from other DHSC bodies	0	0	0	0	0
Revised Surplus/(deficit)	**0**	**0**	**0**	**123**	**123**
WTEs	4702	4784	4784	4717	67

NHSE plan did not include full impact of pay award or introduction of IUCS but revised budget does.

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	-314,094	-317,298	-319,925	-331,077	-334,029	-336,117
Pay	235,460	242,337	242,727	251,621	252,019	252,420
Non Pay	82,049	76,600	77,760	78,839	80,108	80,801
Total Recurring Deficit/ (surplus)	**3,415**	**1,639**	**562**	**-616**	**-1,902**	**-2,896**
Non Recurring						
Income	-10,133	-6,116	-6,118	-6,131	-6,143	-6,156
Pay	4,514	3,930	3,620	3,350	3,350	3,350
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)	**187**	**1,023**	**-256**	**-1,572**	**-2,921**	**-3,977**
Depreciation on donated assets	-187	-127	-127	-127	-127	-127
Performance Deficit / (surplus)	**0**	**896**	**-383**	**-1,699**	**-3,048**	**-4,104**
Recurring savings	-7319	-8,054	-7,239	-7,308	-7,328	-7,352
Savings as % of budget	2.5%	2.56%	2.28%	2.28%	2.27%	2.26%
Non recurring savings	-5662	-2,411	-2,270	-2,125	-2,175	-2,225
Savings as % of budget	2.0%	0.8%	0.72%	0.66%	0.67%	0.68%
Total savings	-12,981	-10,465	-9,509	-9,433	-9,503	-9,577
TOTAL Savings %	4.5%	3.33%	3.00%	2.9%	2.9%	2.9%

Inflation assumptions in line with NHSE guidance.

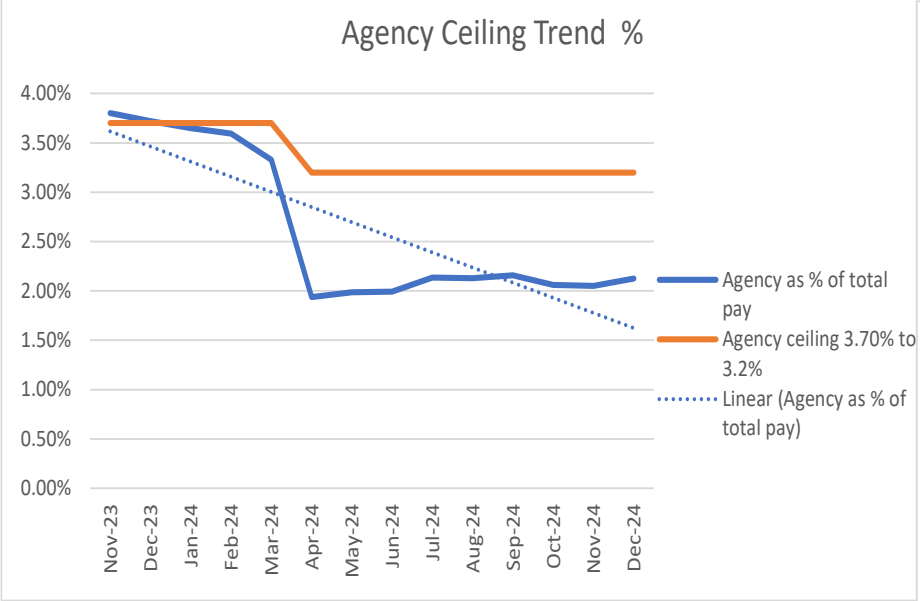
Income and Pay include c.£9.5m for employers contribution of nationally funded pensions.

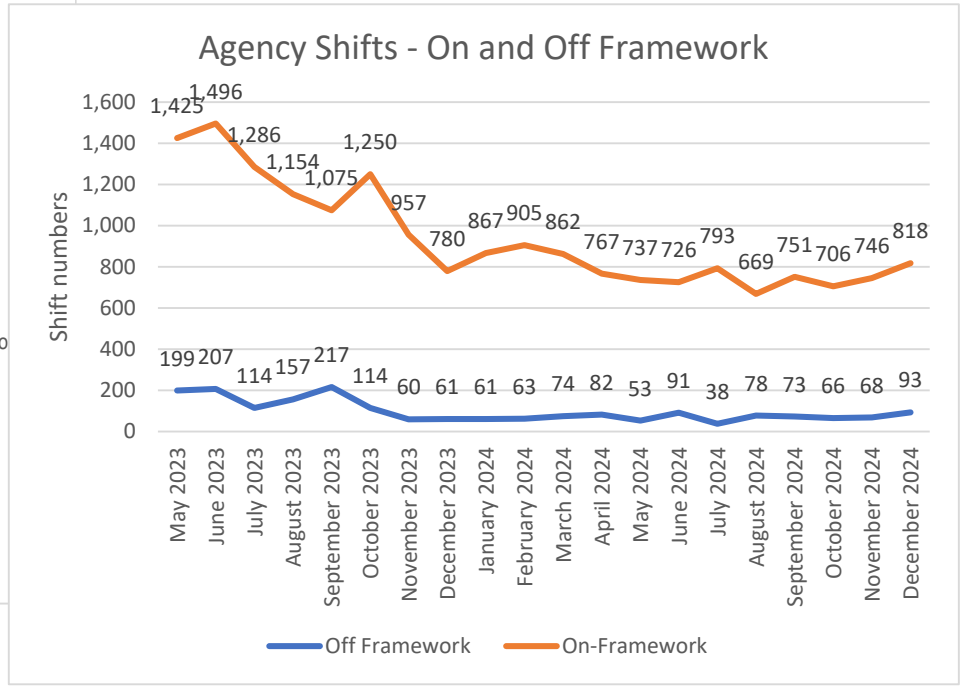
Pay analysis

Gloucestershire Health and Care
NHS Foundation Trust

Pay analysis month 9						
	Plan WTE Month 9	Budget WTE Month 9	Budget ytd £000s	Actual WTE Month 9	Actual ytd £000s	Actual ytd £ as % of Total £
Substantive	4,227	4,768	181,275	4,294	163,705	90.1%
Bank	368	16	1,940	364	14,217	7.8%
Agency	53	0	874	59	3,866	**2.13%**
Total	**4,648**	**4,784**	**184,089**	**4,717**	**181,788**	**100.0%**

- Trust WTE budget 82 higher than plan +35 IUC, +28 IAPT trainee posts, 19 other devts
- 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
- the Trust used 93 off framework agency shifts in December. The target is 0.
- 2.13% of pay bill spent on agency year to date. System agency ceiling 3.2%





From Mar 24 pay costs include nationally funded pension costs.

Balance Sheet

NHS
Gloucestershire Health and Care
NHS Foundation Trust

STATEMENT OF FINANCIAL POSITION (all figures £000)		2023/24	2024/25			
		Actual	NHSE Plan	YTD revised budget	YTD Actual	Variance
Non-current assets	Intangible assets	1,618	2,106	1,932	1,527	(405)
	Property, plant and equipment: other	120,401	120,161	119,315	117,605	(1,710)
	Right of use assets	17,358	16,886	16,224	16,280	56
	Receivables	1,013	1,013	1,013	321	(692)
	Total non-current assets	**140,390**	**140,166**	**138,483**	**135,734**	**(2,750)**
Current assets	Inventories	356	356	356	343	(13)
	NHS receivables	3,184	3,184	3,184	9,814	6,630
	Non-NHS receivables	9,248	9,248	9,248	15,738	6,490
	Credit Loss Allowances	(1,565)	(1,565)	(1,565)	(1,637)	(72)
	Property held for Sale	5,025	1,201	3,025	3,024	(1)
	Cash and cash equivalents:	51,433	54,152	48,292	44,754	(3,538)
	Total current assets	**67,681**	**66,576**	**62,540**	**72,036**	**9,496**
Current liabilities	Trade and other payables: capital	(2,743)	(2,743)	(243)	(1,174)	(931)
	Trade and other payables: non-capital	(35,320)	(35,319)	(32,319)	(36,860)	(4,541)
	Borrowings	(1,454)	(1,385)	(1,402)	(1,414)	(11)
	Provisions	(8,464)	(7,464)	(7,831)	(8,033)	(202)
	Other liabilities: deferred income including contract liabilities	(1,086)	(1,086)	(1,086)	(2,271)	(1,185)
	Total current liabilities	**(49,067)**	**(47,997)**	**(42,882)**	**(49,751)**	**(6,870)**
Non-current liabilities	Borrowings	(14,925)	(14,752)	(14,014)	(13,978)	36
	Provisions	(2,510)	(2,510)	(2,510)	(2,489)	21
	Total net assets employed	**141,569**	**141,482**	**141,617**	**141,552**	**(66)**

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)	(2,839)	(2,888)	(49)
	Income and expenditure reserve (current year)		0	0	(17)	(17)
	Total taxpayers' and others' equity	**141,569**	**141,482**	**141,617**	**141,551**	**(66)**

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

Balance Sheet Forecasts

NHS
Gloucestershire Health and Care
NHS Foundation Trust

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	2,138	2,699	2,606	2,236	1,834
	Property, plant and equipment: other	121,346	124,360	124,417	124,546	124,539
	Right of use assets*	16,357	15,550	14,240	12,953	11,666
	Receivables	322	322	322	322	322
	Total non-current assets	**140,162**	**142,930**	**141,584**	**140,056**	**138,360**
Current assets	Inventories	343	343	343	343	343
	NHS receivables	3,814	3,764	3,734	3,704	3,674
	Non-NHS receivables	9,783	9,683	9,633	9,583	9,533
	Credit Loss Allowances	(1,637)	(1,637)	(1,637)	(1,637)	(1,637)
	Property held for Sale	3,124	381	881	381	381
	Cash and cash equivalents:	51,458	51,059	51,064	52,343	54,073
	Total current assets	**66,885**	**63,593**	**64,018**	**64,717**	**66,367**
Current liabilities	Trade and other payables: capital	(3,174)	(3,174)	(3,174)	(3,174)	(3,174)
	Trade and other payables: non-capital	(35,126)	(35,126)	(35,126)	(35,126)	(35,126)
	Borrowings*	(1,414)	(1,322)	(1,244)	(1,231)	(1,231)
	Provisions	(8,033)	(8,033)	(8,033)	(8,033)	(8,033)
	Other liabilities: deferred income including contract liabilities	(1,271)	(1,271)	(1,271)	(1,271)	(1,271)
	Total current liabilities	**(49,018)**	**(48,926)**	**(48,848)**	**(48,835)**	**(48,835)**
Non-current liabilities	Borrowings	(14,051)	(13,747)	(13,032)	(12,344)	(11,628)
	Provisions	(2,489)	(2,489)	(2,489)	(2,489)	(2,489)
	Total net assets employed	**141,489**	**141,361**	**141,233**	**141,105**	**141,775**

Taxpayers Equity	Public dividend capital	131,976	131,976	131,976	131,976	131,976
	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	(3,068)	(3,196)	(3,324)	(3,452)	(2,782)
	Income and expenditure reserve (current y	0				0
	Total taxpayers' and others' equity	**141,488**	**141,360**	**141,232**	**141,104**	**141,774**

Cash Flow Summary

Gloucestershire Health and Care
NHS Foundation Trust

Statement of Cash Flow £000	YEAR END 23/24		YTD ACTUAL 24/25		FULL YEAR FORECAST 24/25		2025/26 Forecast £000s	2026/27 Forecast £000s	2027/28 Forecast £000s	2028/29 Forecast £000s
Cash and cash equivalents at start of period		**48,836**		**51,433**		**51,433**	**51,458**	**51,059**	**51,064**	**52,343**
Cash flows from operating activities										
Operating surplus/(deficit)	475		(282)		(764)		**1,835**	**1,697**	**2,218**	**3,016**
Add back: Depreciation on donated assets	189		140		186		28	28	28	28
Adjusted Operating surplus/(deficit) per I&E	**664**		**(142)**		**(578)**		**1,863**	**1,725**	**2,246**	**3,044**
Add back: Depreciation on owned assets	9,856		7,722		9,180		8,100	8,121	8,286	8,454
Add back: Depreciation on Right of use assets	0				1,659		1,796	1,810	1,787	1,787
Add back: Impairment	277		0		0		0	0	0	0
(Increase)/Decrease in inventories	50		14		13		0	0	0	0
(Increase)/Decrease in trade & other receivables	8,262		(13,182)		(402)		150	80	80	80
Increase/(Decrease) in provisions	502		(452)		(452)		0	0	0	0
Increase/(Decrease) in trade and other payables	(3,556)		913		(194)		0	0	0	0
Increase/(Decrease) in other liabilities	(21)		1,185		185		0	0	0	0
Net cash generated from / (used in) operations		**16,034**		**(3,943)**		**9,411**	**11,909**	**11,736**	**12,399**	**13,365**
Cash flows from investing activities										
Interest received	2,843		2,394		3,401		998	1,237	820	820
Interest paid	0		(7)		(11)		(7)	(7)	(7)	(7)
Asset Held for Sale							0	0	0	0
Purchase of property, plant and equipment	(15,371)		(4,609)		(10,487)		(11,703)	(13,613)	(8,073)	(8,073)
Sale of Property	1,356		1,974		1,974		2,743	5,000	500	0
Net cash generated used in investing activities		**(11,172)**		**(248)**		**(5,123)**	**(7,969)**	**(7,383)**	**(6,760)**	**(7,260)**
Cash flows from financing activities										
PDC Dividend Received	1,710				100		**0**	**0**	**0**	**0**
PDC Dividend (Paid)	(2,409)		(1,179)		(2,624)		**(2,790)**	**(2,890)**	**(2,990)**	**(2,990)**
Finance lease receipts - Rent	230		4		4		**0**	**0**	**0**	**0**
Finance lease receipts - Interest	(8)		(3)				**0**	**0**	**0**	**0**
Finance Lease Rental Payments	(1,559)		(1,156)		(1,534)		**(1,385)**	**(1,293)**	**(1,201)**	**(1,216)**
Finance Lease Rental Interest	(229)		(158)		(209)		**(164)**	**(165)**	**(169)**	**(169)**
		(2,265)		**(2,491)**	**0**	**(4,263)**	**(4,339)**	**(4,348)**	**(4,360)**	**(4,375)**
Cash and cash equivalents at end of period		**51,433**		**44,752**	**0**	**51,458**	**51,059**	**51,064**	**52,343**	**54,073**

Capital – Five year Plan

NHS
Gloucestershire Health and Care
NHS Foundation Trust

Capital Plan	Full Year Revised Plan	Plan ytd	Actuals to date	Forecast Outturn	Plan	Plan	Plan	Plan
£000s	2024/25	2024/25	2024/25	2024/25	2025/26	2026/27	2027/28	2028/29
Land and Buildings								
Buildings	2,197	1,178	265	2,197	4,021	3,000	3,000	3,000
Backlog Maintenance	1,612	1,612	1,007	1,612	1,879	1,393	1,393	1,393
Buildings - Finance Leases	420	0	0	420	796	1,900	250	250
Vehicle - Finance Leases	239	130	156	239	250	250	250	250
Other Leases	0	0	0	0	0			
Net Zero Carbon	645	518	144	645	2,643	1,400	1,800	500
LD Assessment & Treatment Unit					0	2,000	0	0
Cirencester Schemes					0	5,500	0	0
Medical Equipment	903	451	302	903	1,780	602	930	1,030
IT								
IT Device and software upgrade	880	200	624	880	320	600	600	600
IT Infrastructure	1,865	1,199	66	1,865	1,300	1,300	1,300	1,300
Transforming Care Digitally	770	735	15	770	1,260	790	250	250
NHS Net Transition					500			
Digital Innovation							500	500
Sub Total	**9,531**	**6,023**	**2,579**	**9,531**	**14,749**	**18,735**	**10,273**	**9,073**
Forest of Dean	617	237	617	617	0	0	0	0
Total of Updated Programme	**10,148**	**6,260**	**3,196**	**10,148**	**14,749**	**18,735**	**10,273**	**9,073**
Disposals	(2,176)	0	0	(2,000)	(3,265)	(6,500)	(500)	0
Total CDEL spend	**7,972**	**6,260**	**3,196**	**8,148**	**11,484**	**12,235**	**9,773**	**9,073**
Funded by;								
Anticipated System CDEL	**4,239**			**4,239**	**11,562**	**9,073**	**9,073**	**9,073**
IFRS 16	**659**			**659**	**1,046**	**2,150**	**500**	**500**
Additional CDEL	**3,250**			**3,250**				
Frontline Digitisation funding	**0**			**0**				
CDEL Shortfall / (under commitment)	**(176)**	**6,260**	**3,196**	**0**	**(1,124)**	**1,012**	**200**	**(500)**

Risks

Gloucestershire Health and Care
NHS Foundation Trust

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	1284	1284		3	3	9
447	Gloucestershire County Council (GCC) are reviewing their budgets to identify significant savings which could affect the Trust's finance position	0	950	-950	1	1	1
180	Mental Health Act White paper reforms (8 year programme)	100	1400	-1300	3	1	3
	Total of risks	1384	3634	-2250			

Risk No.	Risks 25/26	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	2500	2500		3	4	12
443	There is a risk that the costs of the Safer staffing project are greater than expected	1029	1029		2	3	6
447	Gloucestershire County Council (GCC) are reviewing their budgets to identify significant savings which could affect the Trust's finance position	950	950		2	3	6
	System balance discussions lead to Trust taking share of deficit as reduction in Trust income or increased CIP	3488	3488		3	4	12
180	Mental Health Act White paper reforms (8 year programme)	1400	1400		3	3	9
	Total of risks	9367	9367	0			

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NHS Foundation Trust

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REPORT TO: **TRUST BOARD PUBLIC SESSION – 23 January 2025**

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

AUTHOR: Jane Stewart, Quality Team

SUBJECT: **QUALITY DASHBOARD REPORT – DECEMBER 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) Board with a summary assurance update on progress and achievement of quality priorities and indicators across Trust Physical Health, Mental Health, and Learning Disability services.

Recommendations and decisions required.

The Trust Board are asked to **RECEIVE, NOTE** and **DISCUSS** the December data 2024 Quality Dashboard.

Executive summary

This dashboard provides an overview of the Trust's quality activities for November 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 the Business Intelligence team have initiated a programme of work to develop an integrated performance report that will reduce duplication of reported data 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 held on the 4th of November which clarified the Executive/ Board expectations around developing the new Integrated Quality and Performance Report. A paper containing the proposed implementation plan and actions was

presented at the Executives meeting on 17th December and Resources Committee on 19th December where the planned phases and timescales were outlined and agreed. The reporting lines will be back into the Business Intelligence Management Group (BIMG)

Quality issues showing positive improvement:

- Progress is being made to improve safeguarding performance involving the provision of training (such as the first sessions of older person's Domestic Abuse (DA) training for Charlton Lane Hospital), supervision, the development of guidance and shared learning.

- Analysis work concentrating on special cause variations and themes rather than individual events continues to be developed within Patient Safety narratives.

- The developments of the integrated performance report continue with proposed plans being presented to Executives and agreed at Resources Committee in December.

- The development work being undertaken on the dashboard will look to bring through from QAG assurance related to clinical effectiveness.

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 in conjunction with the integrated reporting project.

- The 78 incidents reported by MIIUs related to the pathway from the NHS 111 service and wider IUCS service are subject to a task and finish group review led by the GHC IUCS Governance Lead.

- There is a sustained trend of high use of Rapid Tranquilisation (RT), the Positive and Safe Group have confirmed this relates to care of specific patients for which individualised care plans are in place. Quality Committee received a deep dive into restrictive practices in November 2024 but has sought a further overview of details related to rapid tranquilisation given the sustained levels.

- The Guardians of Safe Working report is included this month. A work schedule review is underway to evaluate working patterns and intensity whilst on call to address the recent breaches and exception reports made.

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 - December 2024 Data

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

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NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 10.1/0125

QUALITY DASHBOARD 2024/25

Physical Health, Mental Health and Learning Disability Services

Data covering December 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

Gloucestershire Health and Care NHS Foundation Trust

Are our services SAFE?

- Ongoing progress is being made to improve safeguarding performance involving the provision of training (such as the first sessions of older person's Domestic Abuse (DA) training for Charlton Lane Hospital), supervision, the development of guidance and shared learning.
- There were a total of 1377 patient incidents reported in November. Zero new Patient Safety Incident Investigations were declared in December and three After Action Reviews (AAR) were undertaken in December.
- The upward trend of no harm incidents has a special cause variation but no specific trends across the categories (for December Priory Ward reported an increase of 50 incidents in relation to one patient).
- Moderate harms: There is no significant difference in the overall number of incidents between November and December with a minor decrease of two incidents to 95.
- The 78 incidents reported by MIIUs related to the pathway from the NHS 111 service and wider IUCS service are subject to a task and finish group review led by the GHC IUCS Governance Lead. All incidents where harm is unknown/suspected are subject to an end-to-end pathway review with input from the IUCS Clinical Lead.
- The sustained trend of high use of Rapid Tranquilisation (RT) has seen a rise to 110 incidents in December 2024. The Positive and Safe Group have confirmed this relates to care of specific patients at Wotton Lawn Hospital, for which individualised care plans are in place. Quality Committee received a deep dive into restrictive practices in November 2024 but has sought a further overview of details related to rapid tranquilisation given the sustained levels.
- QAG is holding greater oversight of open and outstanding incident data on Datix due to the volume of incidents that remain open. Operational governance meetings from December will facilitate discussions and improvement plans across the directorates to reduce variance and timeliness of completion, with specific focus on incidents over 40 days old.
- We continue to report against the agreed set of metrics for closed cultures as this is strategic risk 9 on the Board Assurance Framework (rating of 16). Work is underway to develop our approach in this area with engagement in national work on early warning signs in mental health.
- The Guardians of Safe Working report is included this month evidencing that there were 8 exception reports in time period, with 4 being breaches of contractual working conditions resulting in fines being levied. A work schedule review is underway to evaluate working patterns and intensity whilst on call to address the recent breaches and exception reports made by Higher Residents.

Executive Summary

Are our services CARING?

- 94% of Friends and Family Test (FFT) respondents reported a positive experience. Across the Trust there were 1934 FFT responses last month.
- 33 formal complaints were received in December, with 19 of these relating to the IUC. 100% of complaints were closed within 3 months and 100% of complaints being closed within six months (against targets of 50% and 80% respectively). Two complaints were re-opened in December and the PCET continue to work collaboratively with patients and carers to ensure post-complaint actions are completed.
- The number of complaints acknowledged within the national 3-day requirement dropped to 93% due to a delay in NHS 111 complaints being shared with PCET. This reflects the mobilisation period for the new service and additional support has been provided to ensure the new governance processes dovetail with existing procedures. At the end of December, there were 51 open complaints. There are 4 complaints that remain with the Parliamentary and Health Service Ombudsman (PHSO). There were 199 compliments recorded in month. PCET visits continue at Berkeley House. Feedback from the new Forest of Dean hospital shows a positive rating of 92% for MIIU (79) responses) however no responses were received for inpatients.

Are our services EFFECTIVE?

- 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.
- The development work being undertaken on the dashboard will look to bring through from QAG assurance related to clinical effectiveness .

CQC - Berkeley House update/Under 18 admission

- We have submitted 2 cycles of information to the CQC under the revised reporting structure. The template is a focused version of the previous format which the CQC agreed would be suitable for reporting. The feedback from the CQC remains positive and they are assured and reassured by the information and narrative provided around the key areas of interest, namely quality of life indicators, visits by external advocates and discharge planning. This is part of our stepped approach to the application for the removal of conditions under the section 31 notice which is due for review in March 25.
- Under 18-year-old admitted to Wotton Lawn on 20th December. Young person was 16 days from his 18th birthday, and it was agreed that local admission was preferable. CQC notification completed and under 18 policy applied to support the young person who went to a single sex ward. A review of the escalation pathway is underway.

Appendix two Learning From Deaths

- A positive message and assurance comes from our Learning from deaths report which indicates that 0, representing 0.0% of the patient deaths reviewed during Q2 2024-25, were judged more likely than not to have been due to problems in the care provided to the patient.

Summary
Trust Safeguarding Data December 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:

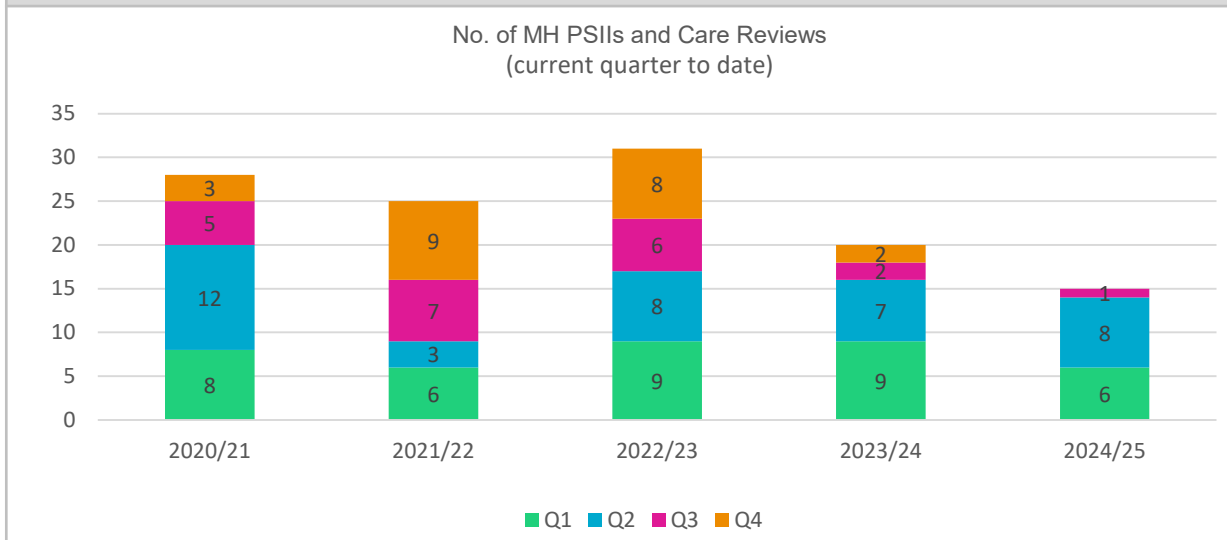
Progress is being made to improve performance and increase patient safety, examples of this are detailed below**:**

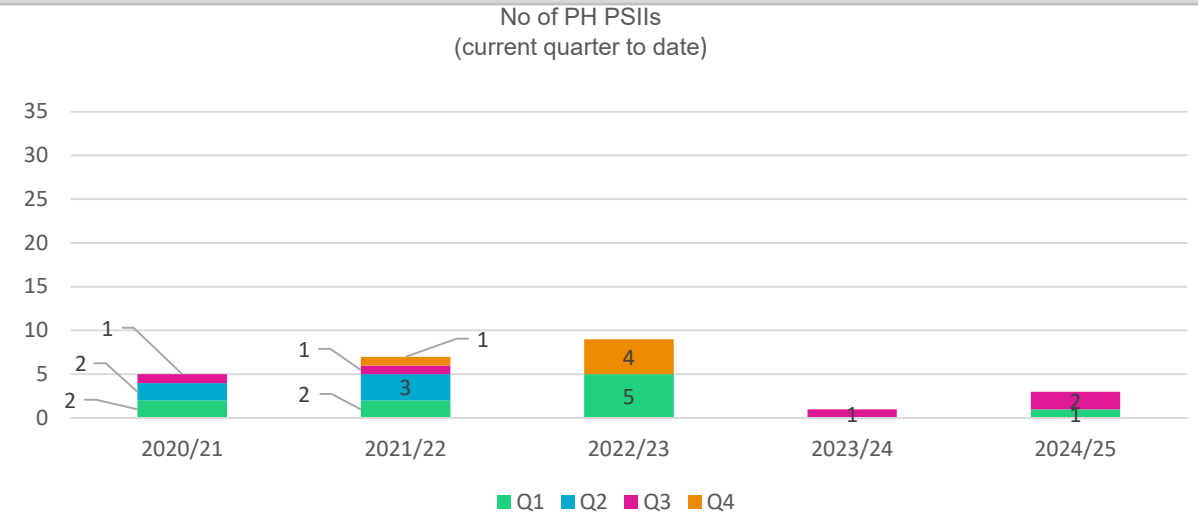
- The first of the older person's Domestic Abuse (DA) training for Charlton Lane Hospital (CLH) took place in December, with a further 4 sessions planned to take place in Jan and Feb.
- The team wrote & published a guide to effectively completing a Multi Agency Referral Form (MARF) - Top tips on how to complete a good MARF - Interact
- The team has a member trained to deliver the NSPCC course : "Developing an understanding of Child sexual Abuse" . Details of how this can be accessed will follow in due course.
- Against the Mental Capacity Assessment workplan, our Leads have completed the data gathering for the MCA assessments audit, which should help demonstrate how the new forms are working; a report will be completed in the next few weeks. (Risk 416)
- The Safeguarding team will be commencing Adult Supervision sessions in January New safeguarding adult supervision offer – Interact
- December's safeguarding monthly focus topic was 'When Should I Raise an Adult Safeguarding Referral to Adult Safeguarding'. 2024 Monthly Focus - Interact

Challenges/risks:

- Whilst we are receiving data regarding our safeguarding referrals to the Local Authority, there is further work to understand what this is telling us. The picture regarding children's safeguarding referral activity remains less clear. We are continuing to work with the Local Authority to support that we have the best possible data (risk 298).
- Despite work recommencing to introduce the new Childrens Safeguarding template on System1, there is still no clear delivery date agreed (Risk 299).
- There remains a challenge in terms of engaging teams around MCA work. As an example, a recent audit of MCA in community hospitals found that only 18 of 43 cases reviewed had a capacity assessment on Systm1. This and other issues are being followed up at DSD level. (risk 416).

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





- **Key Highlights**

- **New Patient Safety Incident Investigations (PSIIs) and Care Reviews**
  No new PSIIs were declared in December 2024.

- **Post incident learning activity – After Action Reviews**
  We have held 3 After Action Reviews (AARs) in December (one from Swindon and two from Gloucestershire) from which there has been post incident learning activity relating to supervision and training, equipment enhancement and electronic clinical record system review.

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

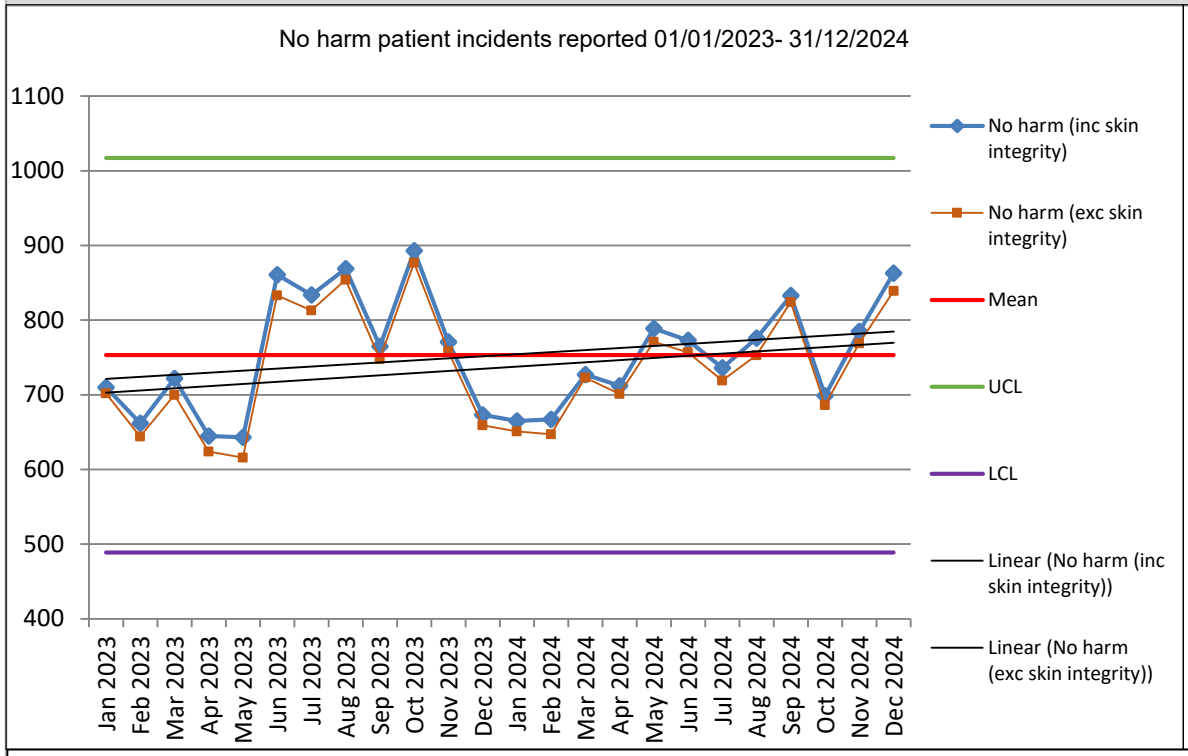
Learning Assurance Update:

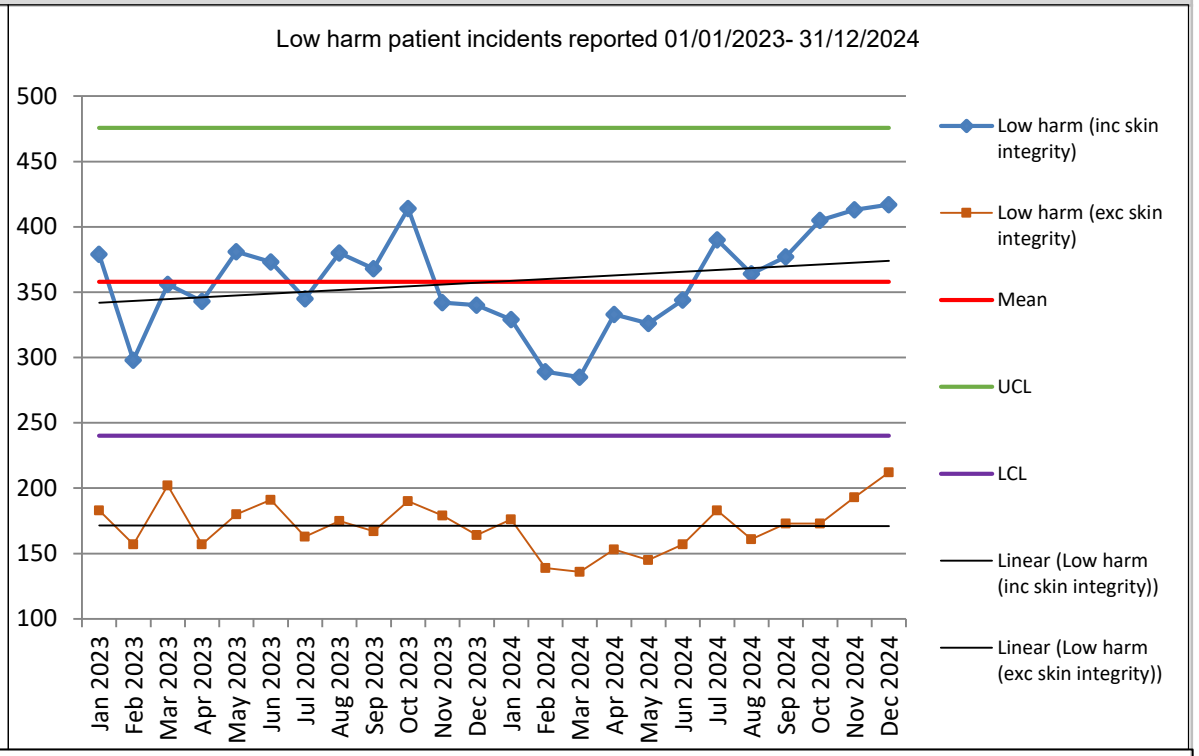
- During December, the Learning Assurance (LA) Team attended 21 Learning and Engagement sessions, including directorate governance meetings, internal review meetings, After Action Reviews, quality meetings with matrons, and presentations at the Trust's preceptorship training. These sessions provided valuable opportunities to share key insights from recent incidents.

- Each month this team share insights from incidents across the organization, which for December included
  - sharing learning via the Medical and Dental Staffing Committee and the Community Hospitals Medic and AP Forum through detailed learning summaries,
  - distributing monthly learning information packs for the Patient Safety and Quality of Care noticeboards,
  - participating in the bi-weekly Learning Opportunities Group meetings, which invites attendance from PCET, QI, Safeguarding Team, CQC Lead, Trusts Legal Team, Mortality Team and Quality Managers.

- The Homicide Action Plan (March 2022) is nearing completion, with assurance gained on actions, several of which have undergone fidelity testing to ensure they are being implemented effectively and as intended. In January, we will meet with managers from other inpatient mental health and learning disability units to benchmark their progress against these actions. This benchmarking exercise will help identify any gaps in current practices and enable us to address these gaps by implementing necessary changes. The goal is to further reduce the risk of preventable harm within our services. Additionally, this process underscores our commitment to sharing learning and best practices across the Trust, fostering a culture of continuous improvement and safety.

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





Key Highlights from No and Low harm incidents:

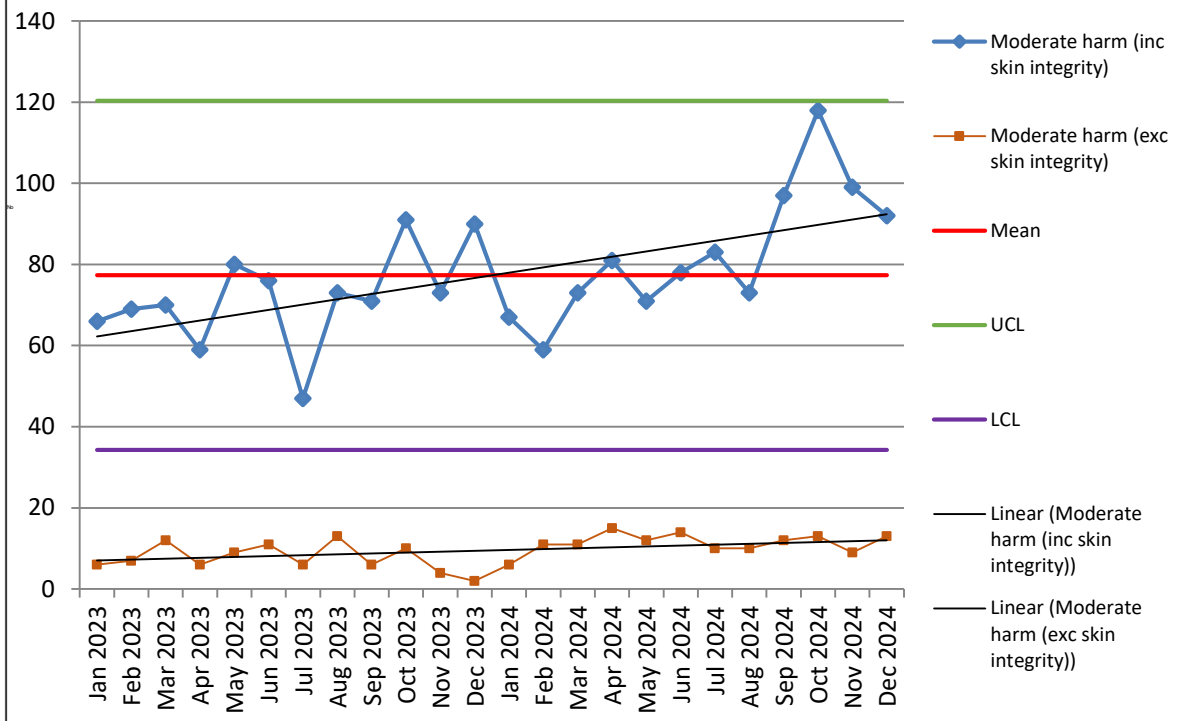
In December, there was an increase of 81 no and low harm incidents compared to the previous month, with 1,279 incidents reported in December versus 1,198 in November. The most significant rise occurred at Wotton Lawn Hospital, which reported an increase of 45 incidents overall. Priory Ward alone reported an increase of 50 incidents compared to November which on investigation is largely attributed to 51 additional restraint incidents involving one patient.

The Minor Injury and Illness Units (MIIUs) reported an increase in incidents, with 78 incidents recorded in December, a rise of 33 incidents to November. The highest increases were at the Forest of Dean and Tewkesbury MIIUs. The category of 'Appointments, Follow-ups, and Referrals' had 17 additional incidents attributed compared to the previous month. These incidents indicate issues with the pathway through to the MIIUs from the NHS 111 service and wider Integrated Urgent Care Service (IUCS). A task and finish group has been established between these services to review the incidents and pathway led by the GHC IUCS Governance Lead. All incidents where harm is unknown/suspected are being reviewed with input from the IUCS Clinical Lead. End to End reviews to be arranged to review the patient journey through the Urgent Care system where harm is unknown.

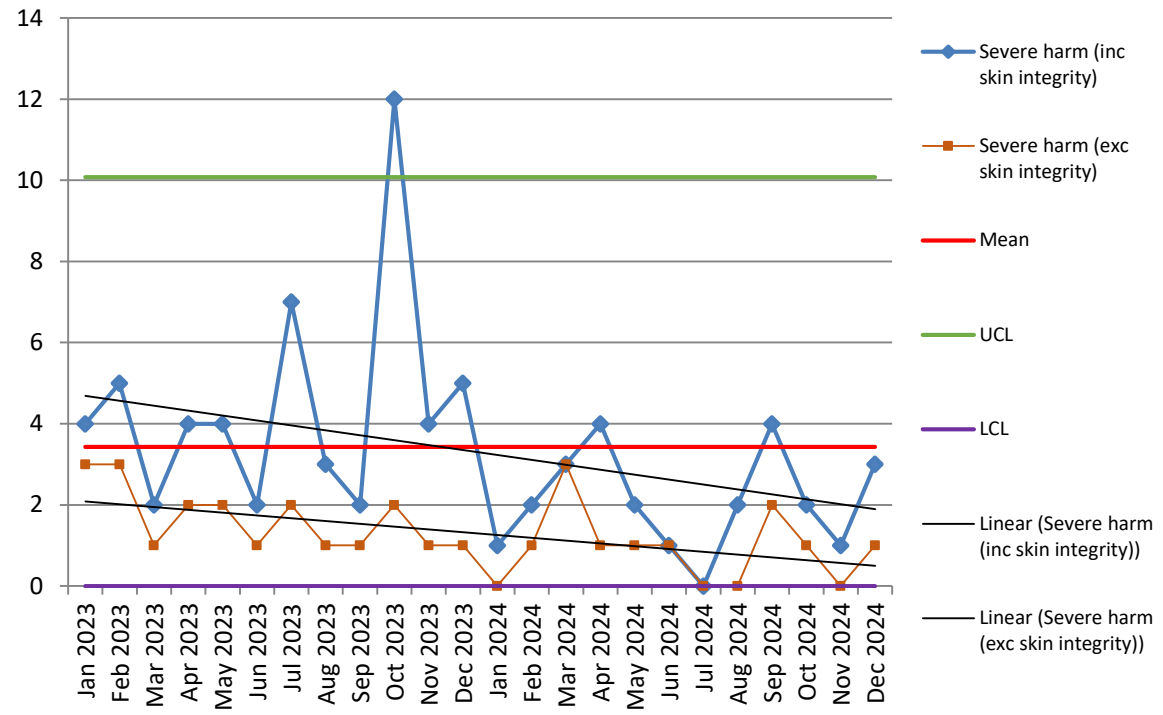
Low and no harm incidents of violence and aggression towards staff saw a reduction in December, with 80 incidents reported compared to 104 in November. Despite this overall decrease, Willow Ward at CLH and Dean Ward at WLH experienced a slight increase in incidents, with an additional 5 and 6 incidents, respectively. These incidents primarily involved low-level verbal abuse and minor assaults, often linked to the patients' mental health conditions. This trend highlights the ongoing challenges faced by staff in managing patients with complex needs.

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

Moderate harm patient incidents reported 01/01/2023- 31/12/2024



Severe harm patient incidents reported 01/01/2023- 31/12/2024



Moderate harms: Review of the data indicates that there is no significant difference in the overall number of incidents between November and December. Within categorisation there are changes include slight increases in incidents related to communication and handover, falls, clinical care, treatments and procedures, medication incidents, and self-harm. However, these increases are marginal, rising by no more than 2 incidents in each category. Slight decreases were observed in categories such as accidents and injuries, equipment and medical devices, and suicide attempts, each reducing by 1 incident.

The most substantial change occurred in the skin integrity category, which saw a decrease of 6 incidents, to 82 in December. The overall data reflects stability, with no major shifts or notable trends between the two months.

Severe Harm: Three severe harm incidents were reported in December. One incident involved a young person, the other two incidents involved Category 4 pressure ulcers.

Quality Dashboard

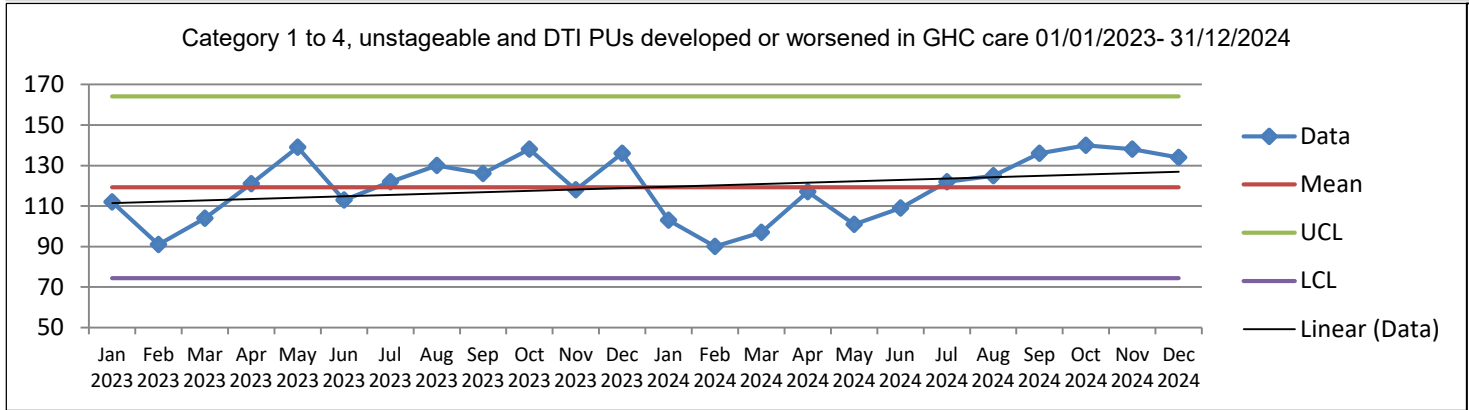
Gloucestershire Health and Care NHS Foundation Trust

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%	98.0%				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	1	0				5	G		
Number of MRSA Bacteraemia	N	0	0	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	122	125	136	140	138	134*				1122			
Number of Category 1 & 2 pressure ulcers developed or worsened within our care.	L - R		912	87	70	72	72	81	82	80	80	80*				704			
Number of Category 3 pressure ulcers developed or worsened within our care.	L - R		44	4	4	4	5	2	8	5	11	11*				54			
Number of Category 4 pressure ulcers developed or worsened within our care.	L - R		16	4	1	1	2	3	1	0	2	2*				16			
Number of unstageable and deep tissue injury (DTI) pressure ulcers developed or worsened within our care.	L - R		461	22	26	32	43	39	45	55	45	41*				348			

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

HCAI: There were 0 post 48-hour Clostridium Difficile,0 (C. Diff), and 0 MRSA infections recorded in December 2024 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.

*December 2024 data has not been fully validated so PU classification may alter after review. 54.5% of category 1 to 4, unstageable and DTI PUs developed or worsened in GHC care, and reported in December 2024, had been reviewed and closed by 02/01/2025.

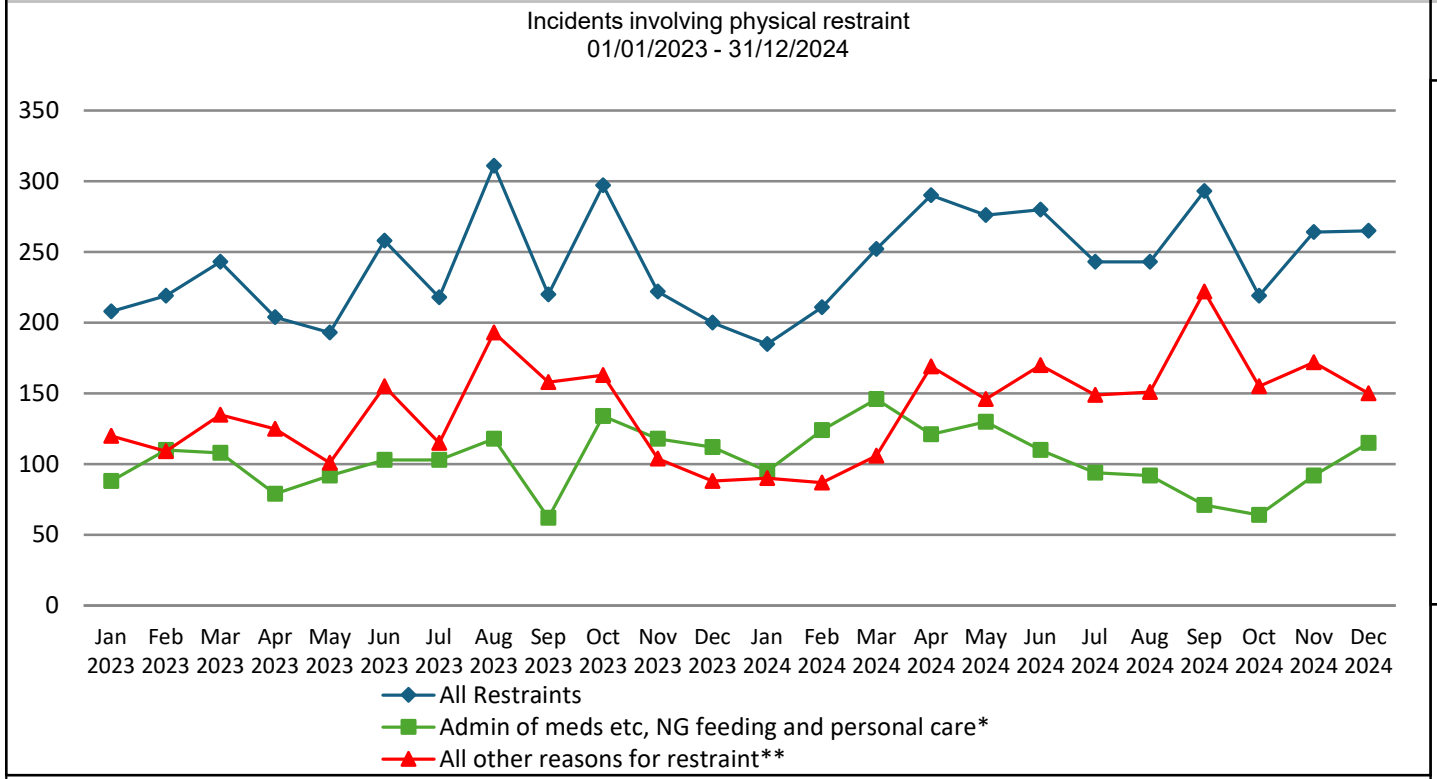
Following clinical review of the November data, Category 3 Pressure Ulcers reduced from 12 incidents to 11 incidents and the number of Unstageable and deep tissue injury (DTI) reduced by 3 incidents (44 to 41 incidents).

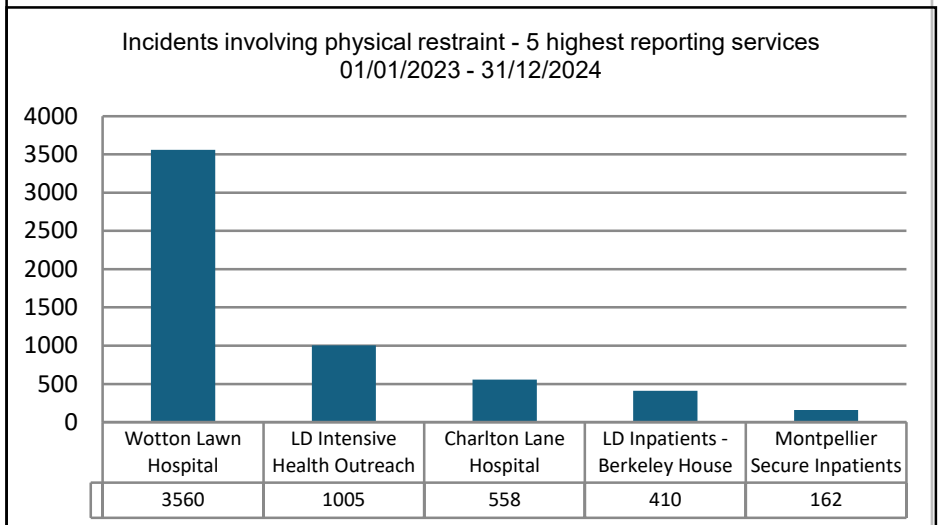
A deep dive into community nursing was presented to January's Quality Committee with good assurance taken on the work in relation to pressure ulcers.

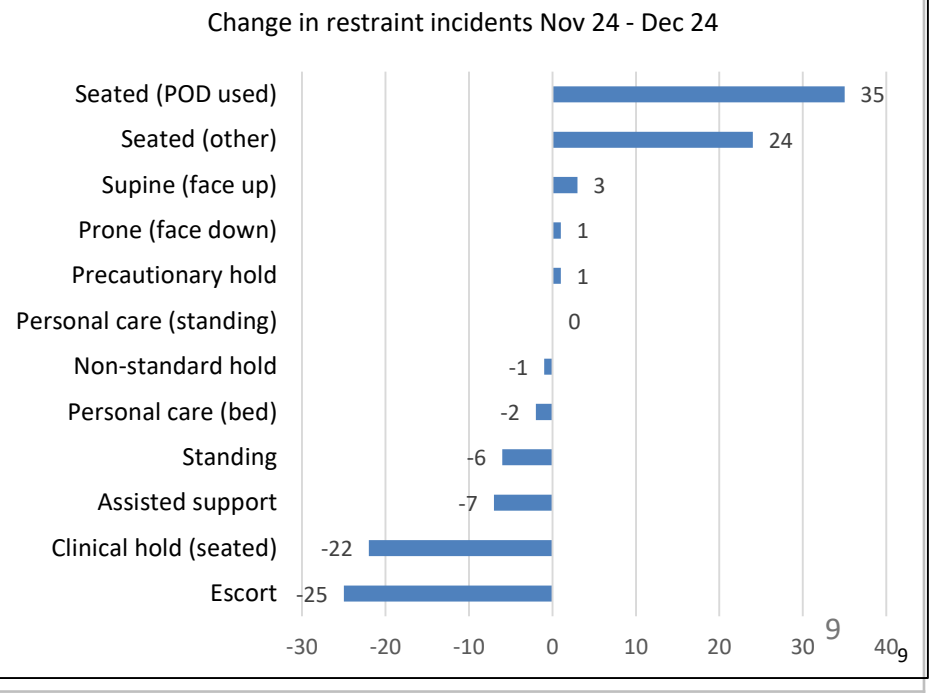
Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

Incidents involving restraint







*Lawfully administer medicines or other medical treatment, Facilitate nasogastric (NG) feeding & Facilitate personal care

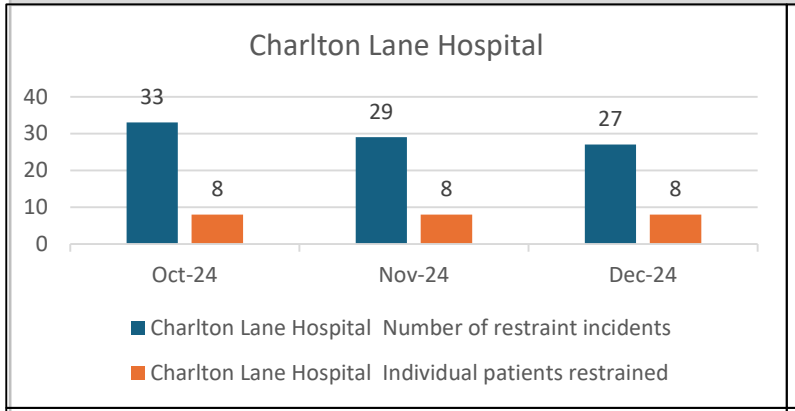
**Prevent a patient being violent to others, Prevent a patient causing serious intentional harm to themselves, Prevent a patient causing serious physical injury to themselves by accident, Prevent the patient exhibiting extreme and prolonged over-activity, Prevent the patient exhibiting otherwise dangerous 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.

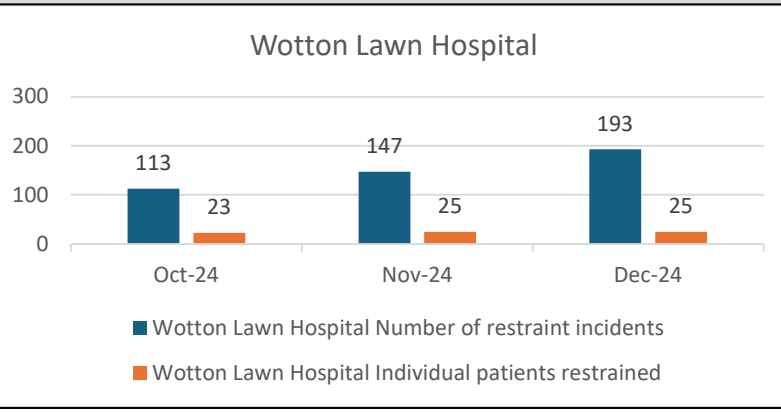
The overall number of incidents involving physical restraint has been consistently in a range between 200-300 during 2024/25. Within this there are very low levels of the most restrictive floor based prone and supine restraints (6% of restraints in December 2024), with most restraints being seated (80% of restraints in December 2024).

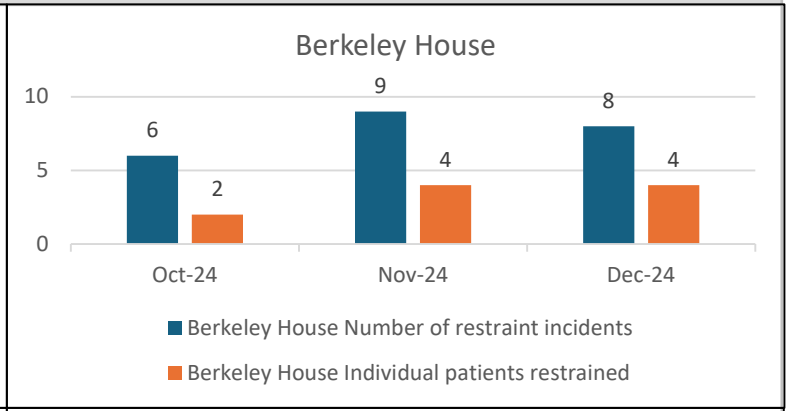
The trend of increased use of Rapid Tranquilisation (RT) remains, which has risen to 110 incidents in December 2024. The Positive and Safe Group have confirmed this relates to care of specific patients at Wotton Lawn Hospital, for which individualised care plans are in place. Quality Committee received a deep dive into restrictive practices in November 2024 but has sought a further overview of details related to rapid tranquilisation given the sustained levels. Low levels of RT were reported at Charlton Lane. Berkeley House continued to report no RT use.

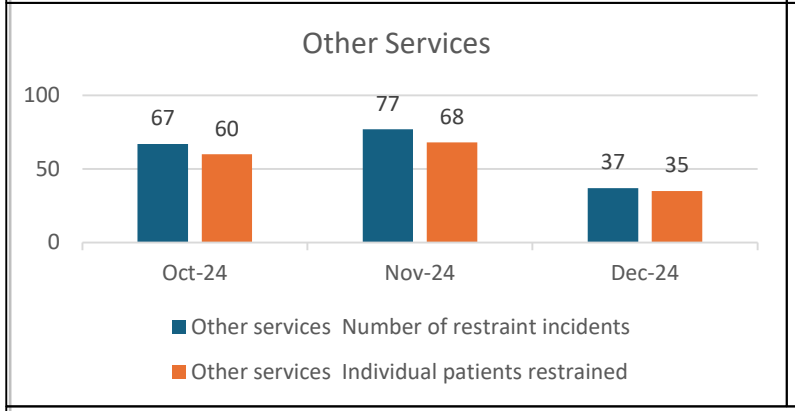
Restraints to facilitate NG feeds had reduced during 2024 up until November. In December this returned to 51 incidents to facilitate NG feeds, in line with the trend before August 2024. This is the result of changes in patient population at Wotton Lawn Hospital.

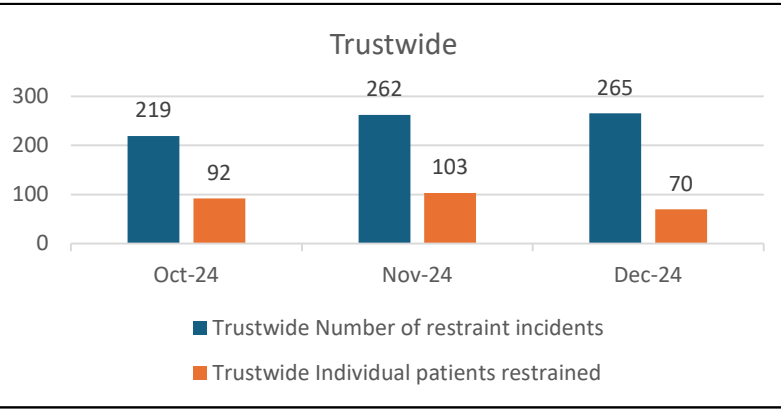
Incidents involving restraint – individual patients restrained





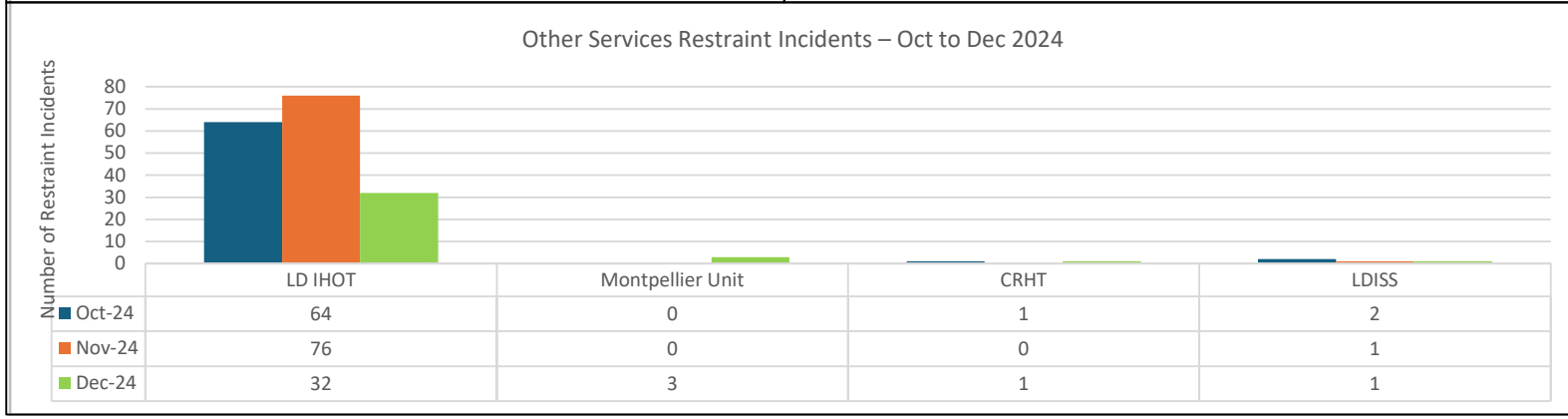






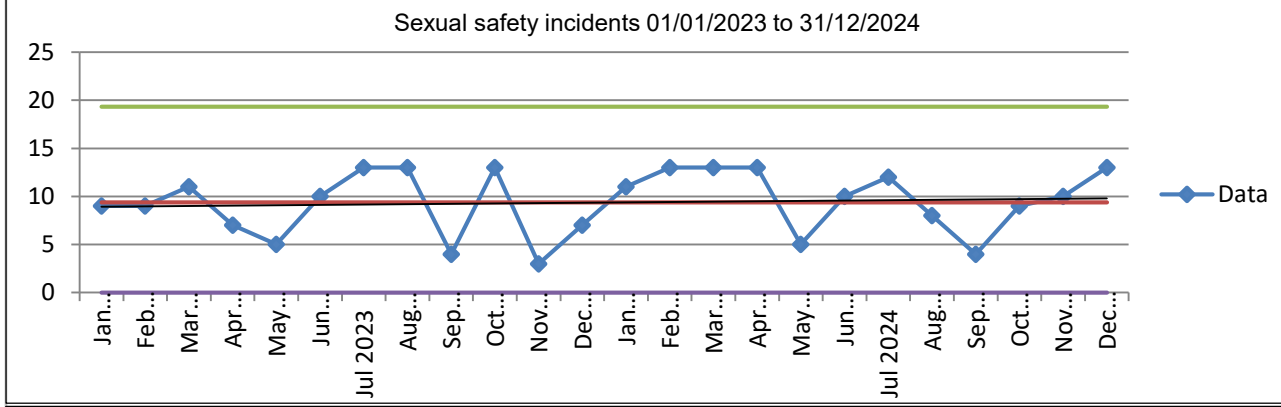
Mental health and learning disability inpatient services continue to account for the settings where individual patients are likely to have the highest frequence of restraints. Looking more widely at other services:

In December 2024 37 restraint incidents were reported across other services of LD IHOT (32), Montpellier Unit (3), CRHT (1) and LDISS (1).
The number of restraints in LD IHOT reduced in December 2024 (32) which aligns to the slowing down of the covid and seasonal flu vaccination campaigns (flu continues until March 2025).



	LD IHOT	Montpellier Unit	CRHT	LDISS
Oct-24	64	0	1	2
Nov-24	76	0	0	1
Dec-24	32	3	1	1

Sexual Safety Incidents

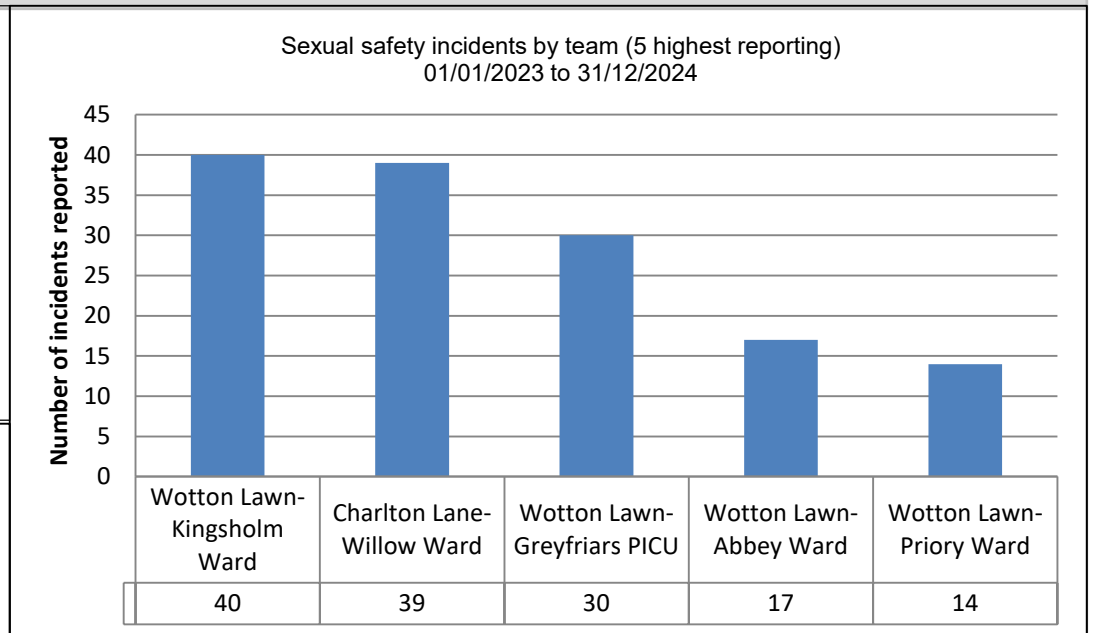


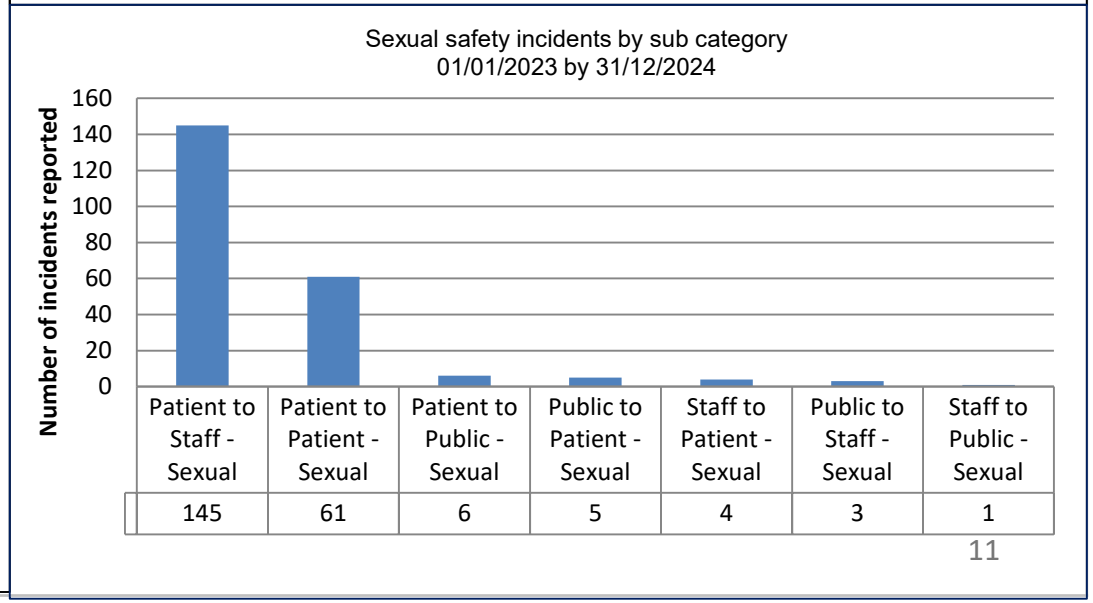
Sexual Safety update:

In December, 13 sexual safety incidents were reported:

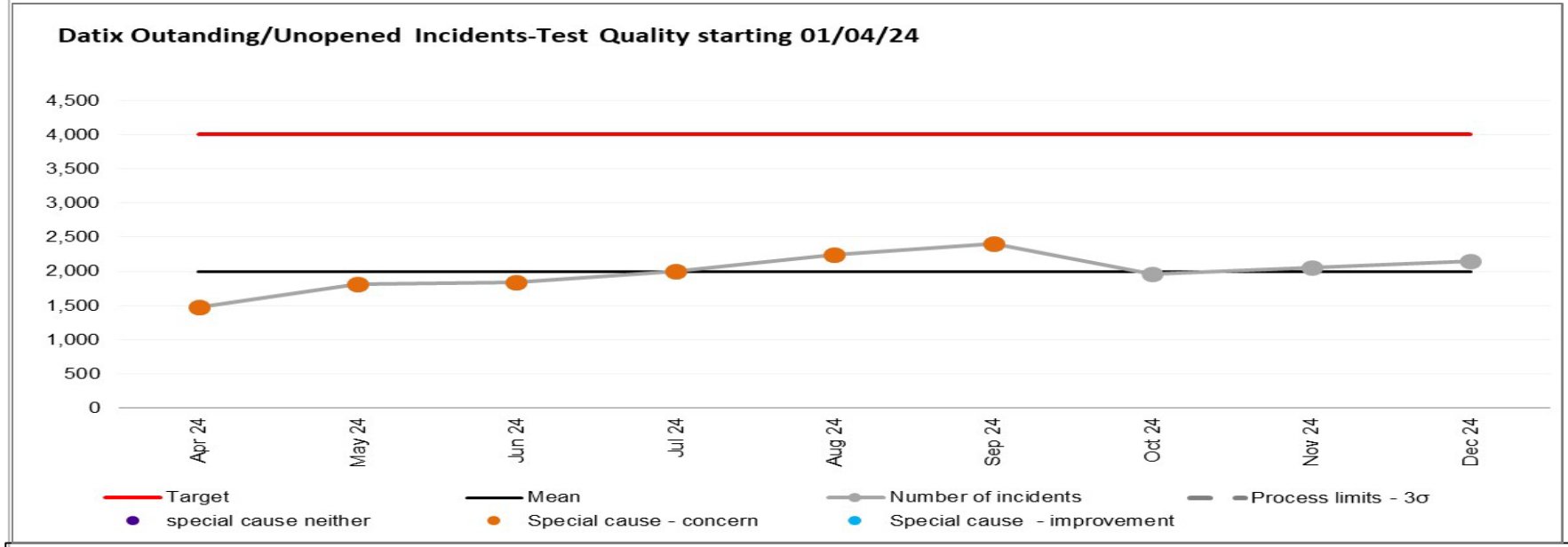
- **77%** of incidents occurred in mental health inpatient services, predominantly at Charlton Lane Hospital **(62%)** and Wotton Lawn Hospital **(15%).**
- **23%** involved ICT teams, with incidents reported by lone workers. All these incidents involved male service users on attending clinicians, regardless of the clinicians' gender. There is evidence of good practice, care planning, and safeguarding was observed where appropriate, and **100%** of the incidents resulted in zero harm.
- An increase in patient-to-patient incidents was noted, with perpetrators of both genders.
- Three incidents were categorized as 'other.' One incident has been requested for recategorization as a sexual assault due to reported touching. The remaining two involved observations of potential sexual behaviours.
- One sexual harassment incident reported by Willow Ward prompted Positive Behaviour Management (PBM) interventions.
- No incidents were linked to reported absconding (AWOL).
- Specific incident types included two affectionate activity incidents, three sexual harassment incidents, and five sexual disinhibition incidents.

Additionally, eLearning sexual safety training has been updated in alignment with NHS England's sexual Misconduct resources to enhance awareness and prevention efforts. Incidents are patient specific and care plans are in place to manage. Willow ward completed the eLearning sexual safety awareness training as part of the training pilot in 2022, which has most likely increased their awareness regarding reporting.





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



We are trialling using NHSE recommended software to display data in a more informative manner highlighting special cause variations. The data opposite shows orange data points (concerns) as there are 6 data points showing a worsening position , there are not yet any SPC levels established.

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 2143 as of 03/01/2025, an increase of 94 since the start of December. Of these:

- 1547 were incidents affecting patients, an increase of 118 since 03/12/2024 (1429)
- 414 were incidents affecting staff, a decrease of 26 since 03/12/2024 (440)
- 35 were incidents affecting visitors, an increase of 9 since 03/12/2024 (26)
- 147 were incidents affecting the Trust, a decrease of 7 since 03/12/2024 (154)

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. 38 such incidents remain open as of 03/01/2025.

** Note: there is a current issue with DatixWeb preventing 36 of these 38 incidents from being uploaded to LFPSE. A support ticket has been opened with RLDatix and the issue is under investigation by their development team. Until this issue is resolved these incidents will continue to be closed locally on the GHC DatixWeb system once Patient Safety investigations are complete, but they cannot be reported via LFPSE.

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

Closed cultures – identification and risk factors (Dec 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 substantial governance review of the Manchester Edenfield Unit, published by the Good Governance Institute (2023), to develop a governance approach and implement anti-closed culture interventions.

Close cultures is strategic risk 9 on the Board Assurance Framework with a risk rating of 16.

Montpellier Unit

Staffing: Good staffing levels, 0.4WTE vacancy HCA. All other vacancies filled. Vacancy rate 3.4%
Incidents:. The team are taking a person-centred systems-based approach to learn from incidents. Staff are encouraged to use the SEIPS model to learn, reduce blame culture and encourage staff to speak up.

Training: Statutory and mandatory training compliance good and 98.3% 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. Training for HCAs and EAPs 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: Daily activity with outside agencies and enhancing community focussed opportunities for patients

Greyfriars Ward
Staffing: Vacancy rate 17.3%. **Band 6**- Successfully recruited to band 6 position with one of the band 5 nurses being successful at interview. **Band 5**- Fully recruited.. **Band 3**- three new HCAs starting in the new year.
Incidents: Familiar themes continue to remain present with the majority of Datix reportable incidents being completed are surrounding the management of disturbed patients (PMVA, RT administration and verbal abuse)..

Training: Statutory and mandatory training rate is good at 93% All training is on-going, with notable increase in the percentage rate of completion in most areas.
Issues: On-going challenges with bed management and PICU beds being used for acute patients. This impacts on 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 evident improvement in patient flow, with a clear increase in patients being transferred to acute beds when deemed ready for transfer. This is due to significant pressures for beds across the county.
Other Greyfriars ward is participating in the National Mental Health Act Quality Improvement Programme, which is a programme looking into change ideas to support reducing inequalities within mental health services. This project is now in full flow, with the team involved having weekly coaching session to support. We have now completed some work with the staff team, collecting feedback, which has been thematically analysed to support the creation of a patient feedback form. We are currently in the process of collecting this feedback to gain a steer on change ideas.

Berkeley House

Staffing: Vacancy rates remain high at 30.8%. A Registered Learning Disabilities Nurse has been recruited - awaiting a start date. Two HCAs recruited - one has started, awaiting start date for the other.
Incidents: 61 incidents in December. The majority were self-harm/self-injurious behaviour (50) and restrictive interventions (7).
Training and supervision: Statutory and mandatory training levels remain good at 95.7%.
Issues: None to report this month.
Other: Plans progress to discharge 4 of our patients, these are at various stages.

Charlton Lane Hospital, including Willow Ward

Staffing: Vacancy rate low at 1.5% for whole of CLH.

Incidents: Reduction in incidents this month, 105 for December. Falls were the highest (53), restrictive interventions (19) and violence and aggression patient to patient or public (11) were the top 3 types of incident.

Training: Statutory and mandatory training compliance is good, currently 98.2%

Issues: None to report this month.

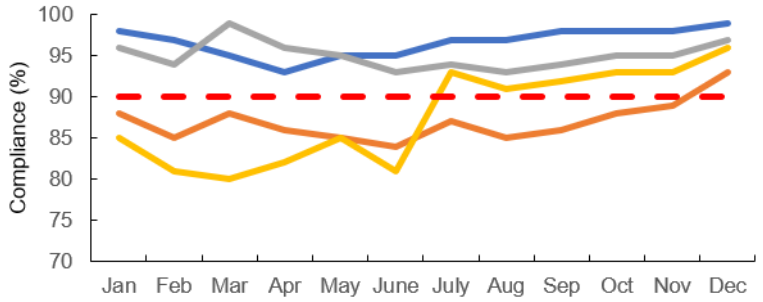
Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

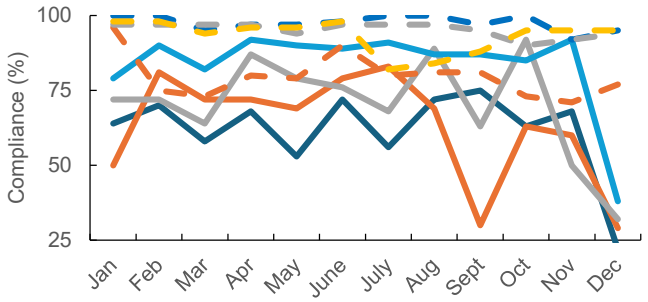
CQC DOMAIN - ARE SERVICES SAFE? Closed Cultures: eliminating the risk of our patients experiencing abuse

Closed cultures – Trust safeguards against risks

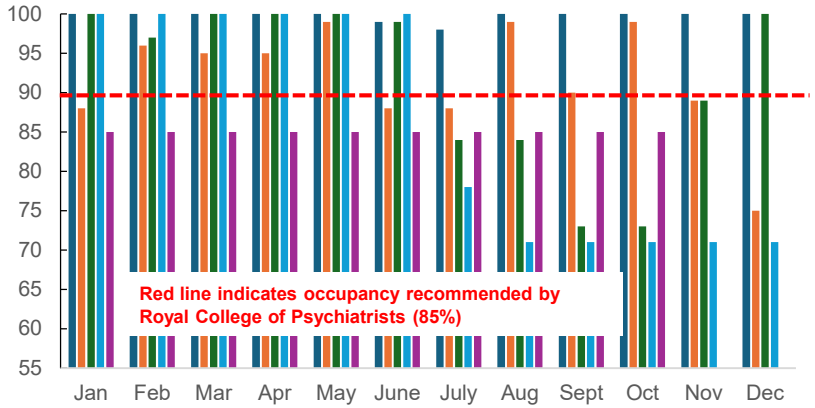
Safeguarding Training



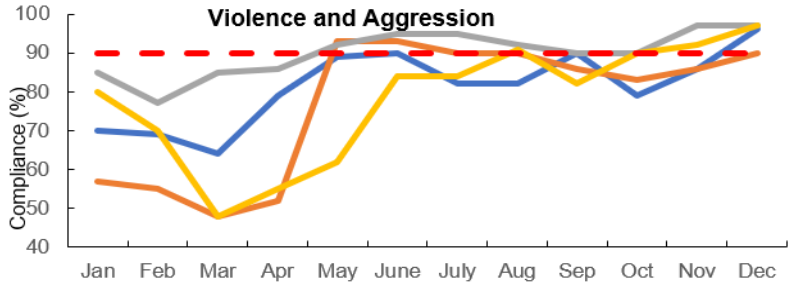
Supervision and Appraisals



Bed Occupancy (%)

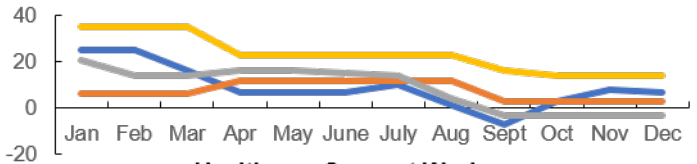


Violence and Aggression

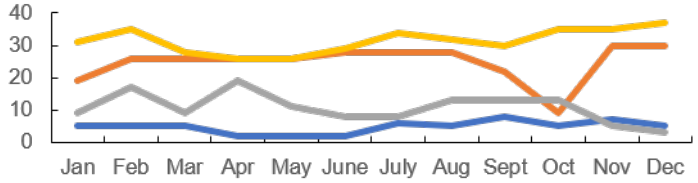


Staff vacancies (%)

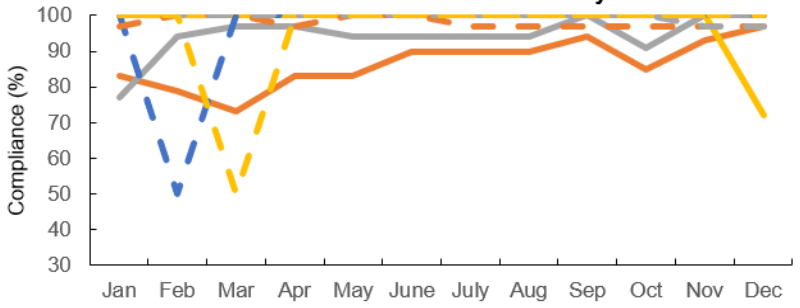
Trained Staff



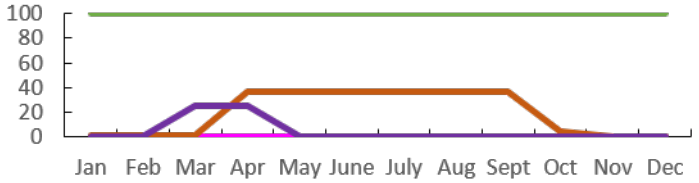
Healthcare Support Workers



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.

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

Patient to patient incidents

		Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Attempted assault	Willow W	3	4	1	4	5	5	2	4	2	2	1	2
	Greyfriars	0	1	2	3	0	0	0	0	3	5	2	0
	Montpellier	1	0	0	0	0	0	0	0	0	0	0	0
	Berkeley H	0	0	0	0	0	0	0	0	0	0	1	0
Physical	Willow W	3	7	8	1	14	8	3	3	9	6	17	9
	Greyfriars	2	3	2	13	2	4	0	4	10	10	2	4
	Montpellier	0	0	0	1	0	0	1	0	0	0	0	0
	Berkeley H	0	0	0	0	0	0	0	0	0	0	1	0
Verbal	Willow W	0	0	2	1	1	2	0	0	0	0	0	0
	Greyfriars	0	1	0	0	0	0	0	1	0	2	0	0
	Montpellier	1	1	1	1	0	0	0	0	0	2	2	3
	Berkeley H	0	0	0	0	0	0	0	0	0	0	0	0
Racial abuse	Willow W	0	0	0	0	0	0	0	0	0	0	0	0
	Greyfriars	0	0	0	0	0	0	0	4	0	1	0	0
	Montpellier	1	1	2	0	0	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	7	28	56	5	30	4	2	18	12	13	19	17
	Greyfriars	26	31	18	54	20	19	16	38	65	48	33	15
	Montpellier	2	1	1	2	1	0	1	1	0	0	0	3
	Berkeley H	5	11	20	16	16	14	10	14	20	5	10	7
Total sexual safety incidents	Willow W	6	2	0	1	1	4	0	0	1	2	6	6
	Greyfriars	0	3	3	2	2	0	5	1	0	3	0	0
	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	4	6	0	3	3	4	2	0	0	3	1	0
	Greyfriars	1	1	1	2	2	3	3	0	0	2	3	0
	Montpellier	2	3	0	2	2	2	1	0	0	2	1	1
Enq/comment	Willow Ward	0	0		0	0	0	0	0	0	1	0	0
	Greyfriars	1	1	2	1	0	0	1	2	1	2	0	0
	Montpellier	0	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	1 new early resolution for Greyfriars in December												

Patient to staff incidents

	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Willow W	3	0	2	0	6	3	1	3	3	0	3	0
Greyfriars	5	2	1	5	0	1	2	4	8	3	2	0
Montpellier	0	1	1	0	0	0	0	1	0	0	0	0
Berkeley H	1	5	3	11	9	4	4	1	5	2	3	1
Willow W	7	3	6	4	8	5	1	13	8	19	25	30
Greyfriars	18	6	5	23	8	2	4	24	22	11	8	9
Montpellier	2	1	3	0	1	0	2	0	0	0	1	1
Berkeley H	15	11	14	30	18	21	10	19	29	7	4	5
Willow W	3	0	0	0	0	0	0	1	2	0	0	0
Greyfriars	6	4	1	1	1	0	1	2	8	4	8	6
Montpellier	1	2	3	2	3	1	1	1	2	0	4	1
Berkeley H	0	1	0	0	0	0	0	0	0	0	3	1
Willow W	1	2	0	0	0	0	0	1	0	0	0	0
Greyfriars	1	0	1	11	2	0	2	7	10	3	2	4
Montpellier	0	2	0	2	0	0	0	0	2	2	3	0
Berkeley H	0	0	0	0	0	0	0	0	0	0	0	0

Reported incidents of physical intervention and/or rapid tranquilisation in December, by individual.

Willow Ward, 17 incidents

Greyfriars, 15 incidents

Montpellier, 3 incidents

Berkeley House, 10 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 December 2024

Exception Summary Gloucestershire

	Code 1		Code 2		Code 3		Code 4		Code 5	
Ward Name	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions
Gloucestershire										
Dean	25	3	17.5	2	0	0	0	0	0	0
Abbey	45	6	75	10	0	0	0	0	0	0
Priory	97.5	13	0	0	0	0	0	0	0	0
Kingsholm	0	0	0	0	0	0	0	0	0	0
Montpellier	7.5	1	50	5	0	0	0	0	0	0
Greyfriars	30	4	85	11	0	0	0	0	0	0
Willow	7.5	1	37.5	5	0	0	0	0	0	0
Chestnut	0	0	0	0	0	0	0	0	0	0
Mulberry	0	0	67.5	9	0	0	0	0	0	0
Laurel	120	16	37.5	4	0	0	0	0	0	0
Honeybourne	112.5	14	7.5	1	0	0	0	0	0	0
Berkeley House	0	0	487.5	61	0	0	0	0	0	0
Total In Hours/Exceptions	445	58	865	108	0	0	0	0	0	0

	Code 1	Min Staff numbers met – skill mix non-compliant but met needs of patients
	Code 2	Min staff numbers not compliant but met needs of patients
	Code 3	Min staff numbers met – skill mix non – compliant and did not meet needs of patients
	Code 4	Min staff numbers not compliant and did not meet needs of patients
	Code 5	Other

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 Honeybourne House. The Matrons report no adverse impact on care delivery or patient experience. Code 1 exceptions at Laurel and Honeybourne were attributable to HCA vacancies on early and late shifts. The noted code 2 exceptions (61) at Berkeley House were attributable to HCA vacancies on early and late shifts.

Guardian of Safeworking Hours Committee Report Part 1

- **Reporting time period July 2024 – September 2024**

- GoSWH – Dr Sally Morgan

- **Number of mental health resident doctors** - Doctors rotated posts at end of July 2024, (figures not including Drs on maternity leave)
- 47 resident posts during July (15 HTs, 3 CT3s, 5 CT2s, 5 CT1s, 5 GP residents, 4 FY2s, 7 FY1s)
- 52 in August, September (17 HTs, 5 CT3s , 7 CT2s, 4 CT1s, 4 GP residents, 8 FY2s, 7 FY1s)
- **24 gaps during this period due to residents not completing on-calls as normal.**

- **Reasons for gaps –** gaps from part time residents, pregnancy related reasons and some short notice sickness.
- 24 on-calls shifts covered by Locums. 5 were covered by specialty doctors in our bank, 16 by our resident doctors (core and foundation 2), 1 by a consultant stepping down and 1 by a higher resident stepping down. 1 was covered by an agency Locum.
- **JDF** held via MS Teams on 18 October 2024 which was well attended.
- GOSWH attended the annual national GOSWH conference and is now a member of the national GOSWH Group.

- There are **2 Resident Wellbeing Reps** who are helping develop the next **Wellbeing Days** planned for next year.
- **GOSWH with the support of a Higher Resident is developing a GOSWH webpage** for the intranet to improve awareness of this role and to provide a central location for information regarding exception reporting.

Guardian of Safeworking Hours Committee Report Part II

- **There were 8 exception reports** in this time period , 5 related to the number of hours worked and 3 related to patterns of work, of these, 4 were breaches of contractual working conditions which resulted in fines being levied:
- 2 fines issued when Higher Residents did not achieve five hours of continuous rest between 22:00 and 07:00 during a non-resident on-call period.
- 2 fines issued when a shift exceeded more than 13 hours in length, the first occurred due to acute clinical work needing to be undertaken at time of handover, the second occurred due to last minute sickness of the rostered night duty resident meaning the daytime resident had to stay on until the consultant on call was able to step down to provide cover.
- **Outcomes agreed for all 8** : Compensatory rest or TOIL, Fines for the breaches.
- **A work schedule review for Higher Residents is underway to evaluate working patterns and intensity whilst on call to address the recent breaches and exception reports made by Higher Residents. It is not thought that any harms were caused by breaches.**
- **Fines:**–
- interrupted rest on call non residential rota – breach = **FINE – to be calculated**
- interrupted rest on call non residential rota – breach = **FINE – to be calculated**
- Exceeding 13 hours shift (1 ½ hrs at WLH/CLC) – breach = **FINE £280**
- Exceeding 13 hours shift (3 ½ hrs WLH/CLC) – breach = **FINE** – to be calculated
- **The Junior Doctors Forum (JDF) are considering how to use this money which will need be spent before the end of this financial year.**
- The money raised through fines must be used to benefit the education, training and working environment of residents.
- These funds must not be used to supplement the facilities, study leave, IT provision and other resources that are defined by HEE as fundamental requirements for resident doctors and which should be provided by the employer/host organisation as standard.

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	2,195	1,934				21,322	
% of respondents indicating a positive experience of our services	N - T	95%	94%	94%	93%	93%	93%	95%	94%	93%	93%	94%				94%	
Number of compliments received in month	L - R		2,506	151	241	156	203	211	173	241	182	199				1,757	
Number of enquiries (other contacts) received in month	L - R		1,186	150	172	133	149	140	149	157	157	122				1,331	
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	13	33				122	
Of complaints received in month, how many were early resolution complaints	L - R			8	9	14	9	10	12	14	13	33				120	
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	29	51					
Percentage of complaints acknowledged within 3 working days	N - T	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	93%				99%	
Number of complaints closed in month *Includes ALL complaints (closer look complaint / early resolution complaint)*	L - R			11	13	9	7	10	12	16	13	11				1022	
Number of complaints closed within 3 months	L - I			9	9	7	4	5	11	13	7	11				58	
Number of re-opened complaints (not all opened within month)	L- R			3	1	1	1	0	2	1	3	2					
Number of external reviews (not all opened within month)	L - R			7	7	6	8	7	4	4	4	4					

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

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

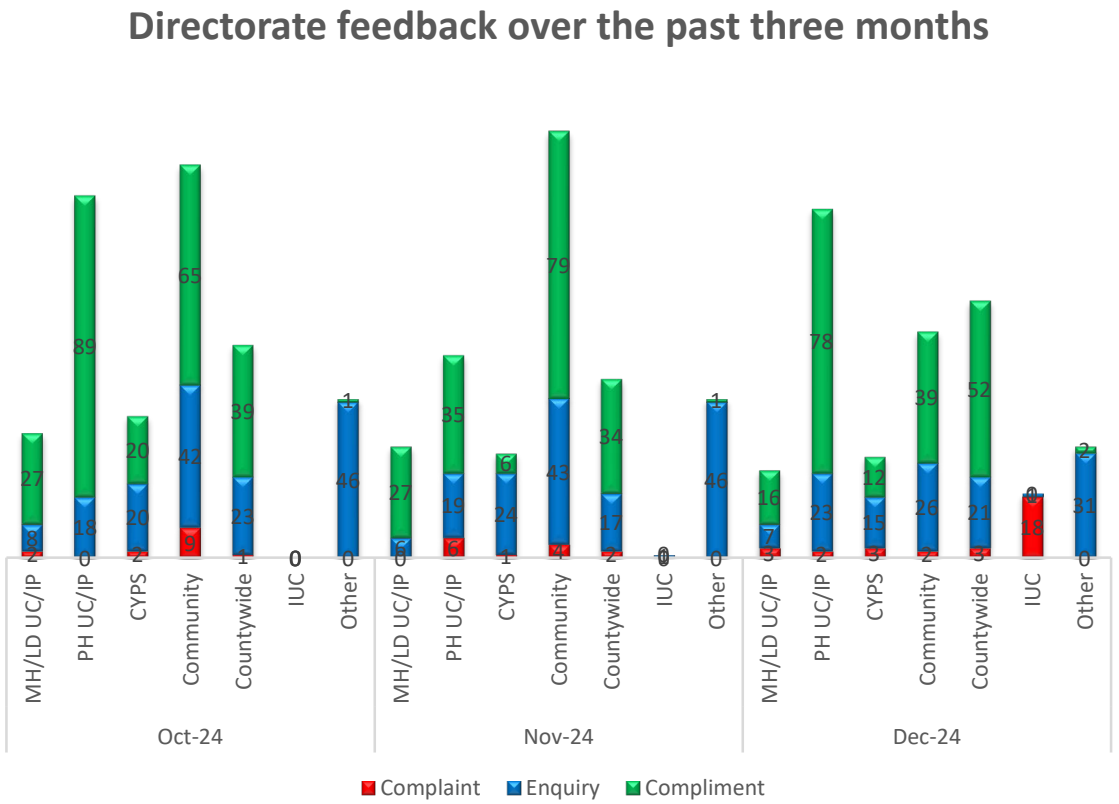
. **Key Highlights:**.

- 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	3	Early resolution:	**3**	7	16
		Closer look:	**0**		
PH urgent care and inpatient	2	Early resolution:	**2**	22	78
		Closer look:	**0**		
CYPS	3	Early resolution:	**3**	15	12
		Closer look:	**0**		
PH/MH/LD Community	3	Early resolution:	**2**	26	39
		Closer look:	**0**		
Countywide	3	Early resolution:	**3**	21	52
		Closer look:	**0**		
IUCS	19	Early resolution:	**18**	1	0
		Closer look:	**0**		
Other	0	Early resolution:	**0**	31	2
		Closer look:	**0**		
Totals	33	Early resolution:	**33**	122	199
		Closer look:	**0**		



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

Examples of complaints [as reported] for each directorate:

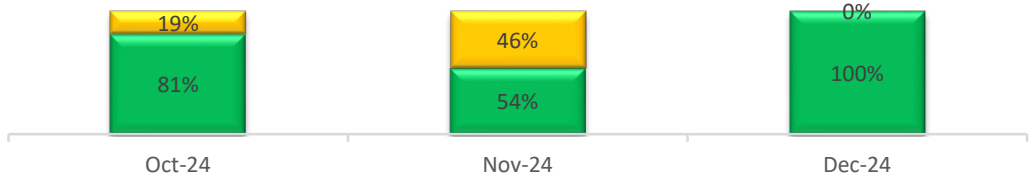
- **MH UC/IP: Mother of patient unhappy with the discharge from Wotton Lawn.**
- **PH UC/IP: Daughter of late patient unhappy with LPA arrangements during admission at North Cotswold Hospital.**
- **CYPS: Parents of patient unhappy of CAMHS communication in relation to sibling which led to a referral to the MASH team.**
- **Community: Patient unhappy with lack of support from the Recovery and Crisis teams.**
- **IUCS: Patient unhappy with advice given by 111.**

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	1	1
PH urgent care, inpatient	0	0	0	0	0	0
CYPS	0	0	1	0	0	1
PH/MH/LD Community	0	3	2	0	1	6
Countywide	0	1	1	0	0	2
IUC	0	0	0	1	0	1
Other	0	0	0	0	0	0
Totals	**0**	**4**	**4**	**1**	**2**	**11**

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

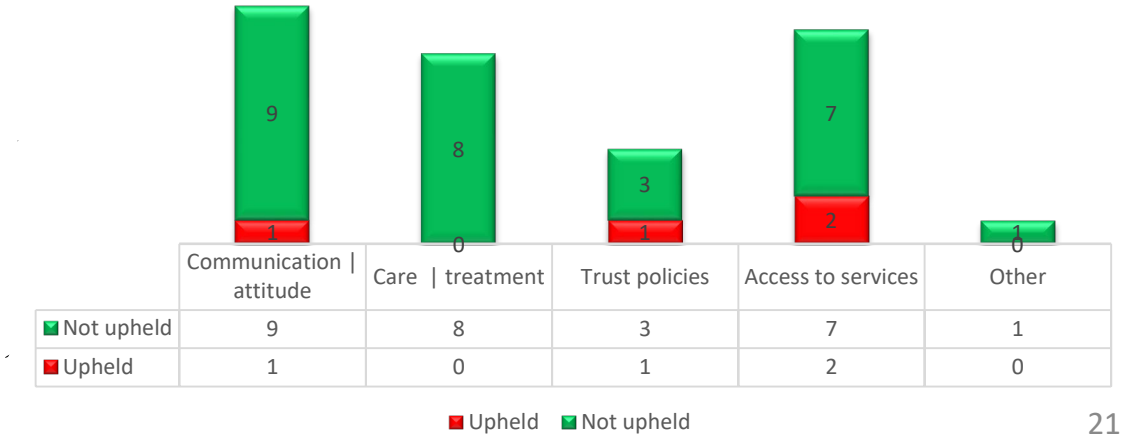


	Oct-24	Nov-24	Dec-24
7-12 months	0%	0%	0%
4-6 months	19%	46%	0%
1-3 months	81%	54%	100%

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
Community	Nurse was unaware they could refer to lymphoedema directly and asked GP to do it, which caused delay. **Access to services**
Community	Photos not all in line with guideline and policy. Some were of poor quality for gaining advice from specialists within remote assessments. Photos not uploaded to patient record after joint visit by bank & agency staff when new wounds were identified. **Trust policies**
Countywide	Dentist to communicate preference for limiting adults in surgery ahead of sessions, so that nurse is aware not to offer this option and confusion/discontent is avoided. **Communication**
Community	Assessment cancelled with less than 24hrs notice and significant delay in new appointment. **Access to services**

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



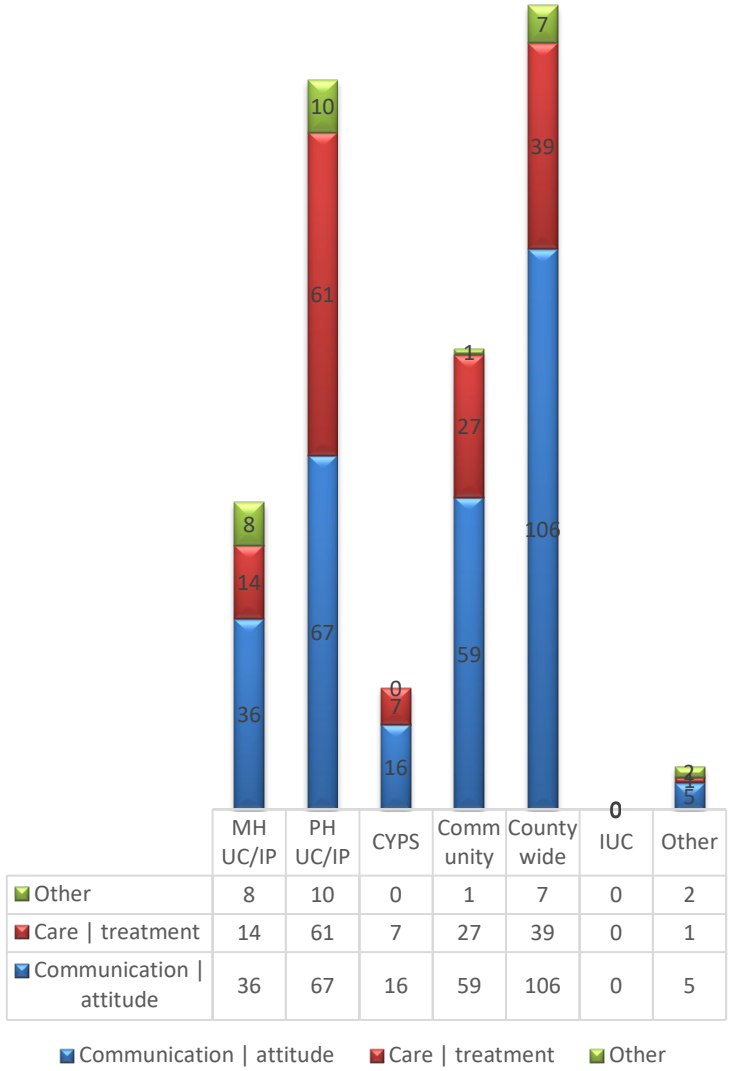
	Communication | attitude	Care | treatment	Trust policies	Access to services	Other
Not upheld	9	8	3	7	1
Upheld	1	0	1	2	0

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

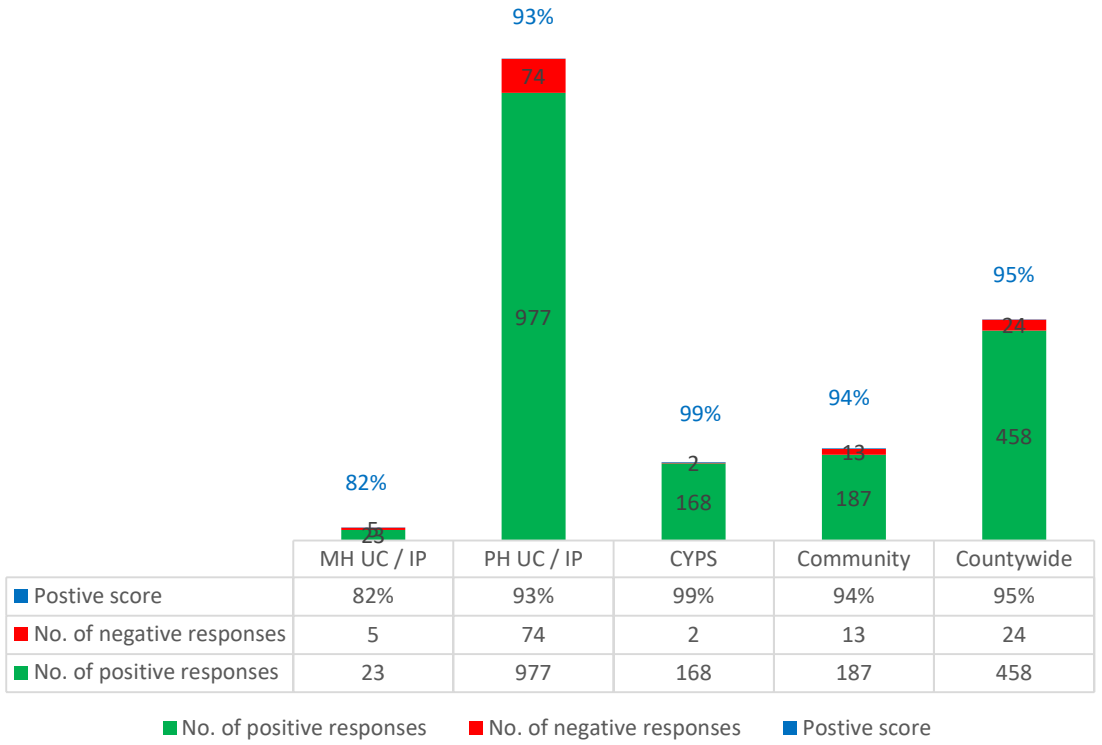
The table below is a sample of compliments received this month, and the chart opposite shows all COMPLIMENTS received this month by theme and directorate.

The 199 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
02/12/2024	16670	ICT Cotswold South 2 DN	"Thank you for your dedication and compassion."
05/12/2024	16797	Ciren Hosp-Windrush Ward	all the staff and the physiotherapist and the doctor who have been very helpful and kind to me during my stay in the Windrush ward. this I am very grateful for and the people on the drinks trolley
17/12/2024	16976	Reablement Cotswolds	"Very grateful for the work the home first team had done and that everyone who visited had been wonderful"
02/12/2024	16685	ICT Cotswold South OT	"Thank you for all your advice, kindness, professionalism and help, it is very much appreciated. "
13/12/2024	16940	Sexual Assault Referral SARC	Client told counsellor during one of her sessions that Crisis Worker was really wonderful and gave her really helpful information. She also said it was the first time that she had felt safe, talking to me, since the incident occurred.
20/12/2024	17022	MSK Physio	Message to say staff member: 'Went above and beyond to assist a patient who was left stranded by hospital transport, sharing her lunch as the patient is diabetic and had been waiting a long time. Making a difference through kindness'.
10/12/2024	16835	CYPS/PH-Health Visiting	Thank you for your support. We are grateful that you are here with us whenever needed.
18/12/2024	17003	Cardiac Rehabilitation Service	Patient expressed his thanks & gratitude for care given to him during his cardiac rehabilitation period
11/12/2024	16892	Homeless Healthcare Team	Patient is moving to a mainstream surgery. She said she was very sorry to leave and was very thankful for the amount of support she has received from us as she is housed and has gone through rehab. “



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



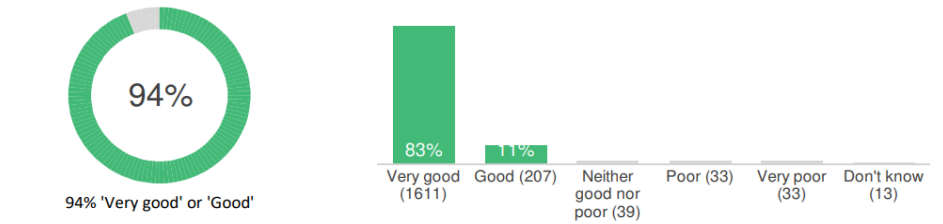
	MH UC / IP	PH UC / IP	CYPS	Community	Countywide
Postive score	82%	93%	99%	94%	95%
No. of negative responses	5	74	2	13	24
No. of positive responses	23	977	168	187	458

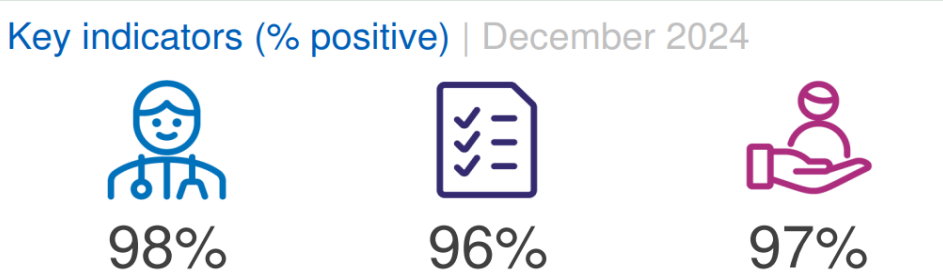
No. of positive responses No. of negative responses Postive score

Highlights for this month:

- The overall positive experience rating is 94% which is line with recent 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 92% for MIIU (79 responses). There were no responses from inpatients.
- Evaluation of 'You Said, We Did' Boards pilot to be evaluated in Q4.
- Service users made 12 requests for contact/action through the FFT.
- FFT set up to support new IUC service – not yet live. 111 and remote CAS Patient Experience Questionnaire (PEQs) managed by IC24.

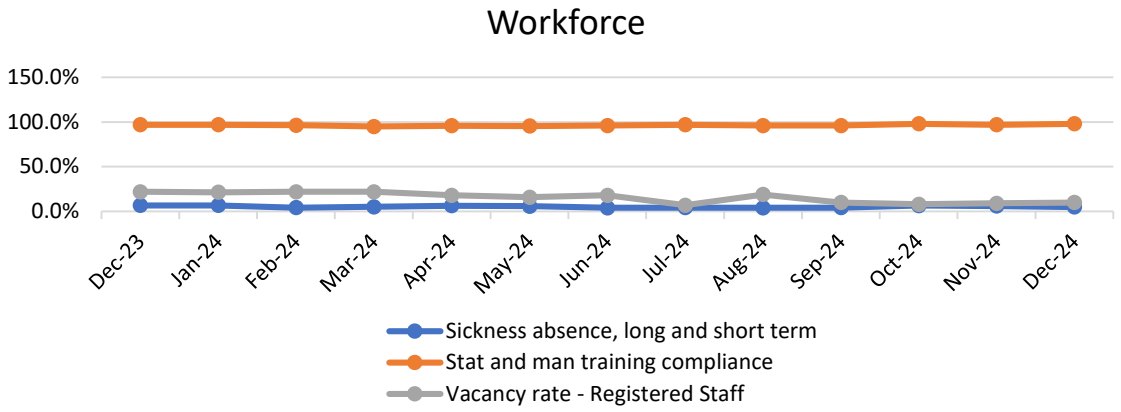
Patient feedback





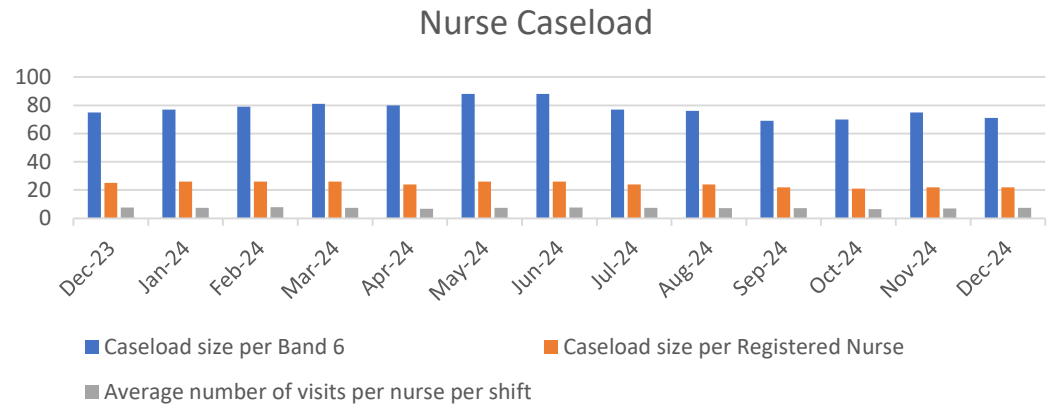
Carer feedback

ICT Community Nursing Workforce - December 2024

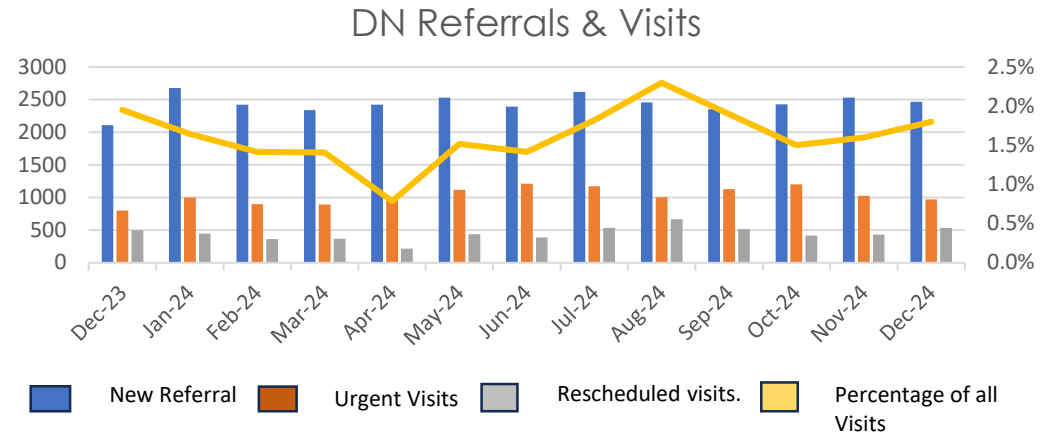


Newly qualified nurses have supported the reduction in vacancy rates from 22% to 9% however, on boarding and supporting these new recruits can take between a year and eighteen months which impacts on capacity especially for complex patients

We finish 2024 with a 0.2 WTE increase in specialist practice qualified nurses within the ICTs.
ICT localities continue to support 5 SPQ places for development each year.

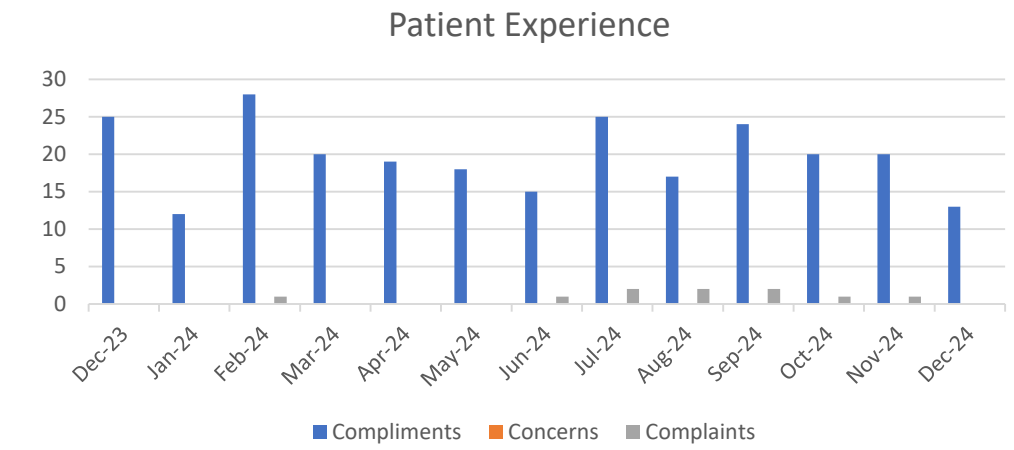


Caseload size has fluctuated throughout the year, there is a small increase of one from last December.

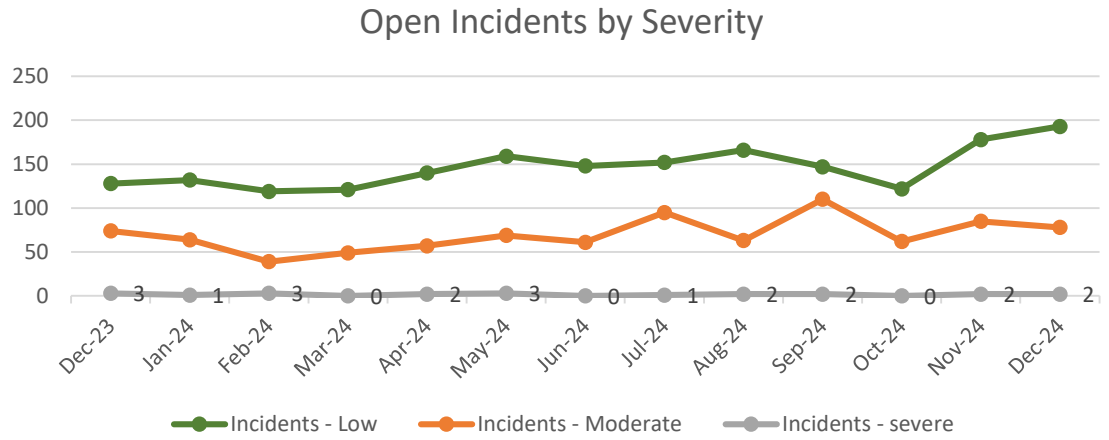


A slight increase in new referrals and rescheduled visits is noted in the last 2 months of 2024. the data shows a steady increase over the year in referrals into the community nursing teams

ICT Community Nursing – December 2024

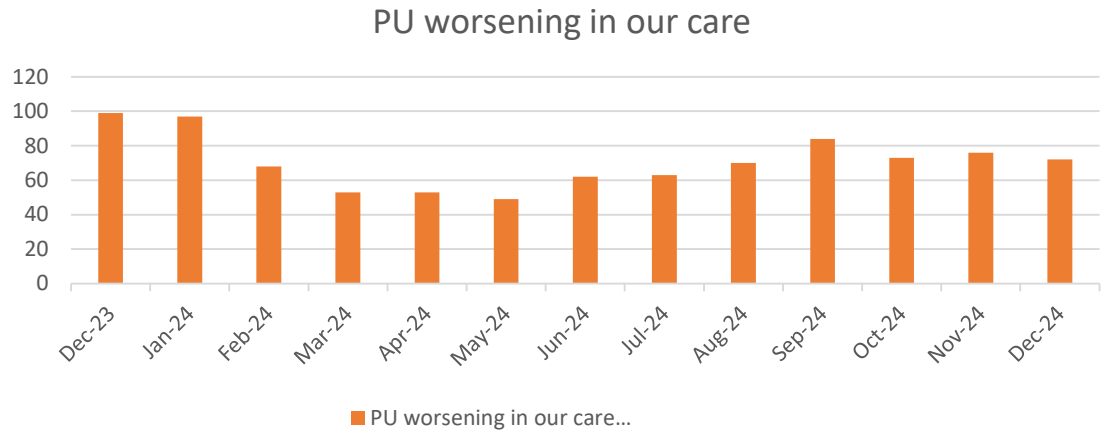


Compliments have reduced this month with no complaints or concerns raised.



An increase in open incidents correlates with the sickness rates that teams have been managing. Support from bank professional lead has been put in place to review and support this and the teams.

A proposed new slide to identify which localities are reporting has been suggested to Quality Committee to enable organisational awareness and support of hotspots as they occur.



A QI project proposal to understand the cat 1 & 2 incidence more fully has been proposed, to be led by TVN colleagues supported by DN Clinical nurse leads with the intention to commence in 2025..

Quality Dashboard

Quality Improvement Hub Support along the Improvement Lifecycle

NHS Gloucestershire Health and Care 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
- = Culture of Care
- = Optimising staffing ADHD/ASD team band
- =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

- = Improve giving and recording of snacks for CoHo patients
- = Transition from CAMHS to adult MH services
- = CYPS collaborative information library
- = (s) Local and national AAC pathways for children who may benefit from AAC
- +TTO (Tablets To Take Out) from inpatient settings in physical health units
- ↑(s) Guidance on treatment of hyponatraemia and hypernatremia in the community

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
- = Improving the number of patients receiving their depots in primary care
- = People Promise - Learning from Leavers
- = Paper Care Certificate Workbooks
- = Clinical System Team Model
- ↑ Improving access for mothers from ethnic minority into perinatal service
- ↑ Wrong site dental extractions
- ↑(s) Sexual health triage capacity and improving patient access
- ↑ Team nursing on Abbey Ward, WLH
- ↑ The Vale Stroke Unit
- ↑ Getting feedback from patients about MHA assessment

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
- ↑ IPS Project
- =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
- = 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
- ↑ Developing a process for Observed Practice within AHPs
- ↑ Staff retention - itchy feet

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
- ↑ Developing a FCP Occupational therapist in Primary Care
- ↑ CYPS Public Health Liaison Nursing
- ↑ Improving Working Environment in Stroud Recovery Team

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

- 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.

Directorate	No of Projects (QI and CI)
Countywide	7
MH Hospitals and UC	8
PH Hospitals and UC	4
Adult MH/PH/LD Community	10
CYPs	17
Corporate	7
Total: 53	

Training data November 2024:
34 Silver – 0.7% workforce
706 Bronze (current trained taken from Care to Learn) - 14.8% workforce
1017 Pocket QI, total trained overtime – 21% workforce

Appendix One
Quality Dashboard Development

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

Summarised timescales for development of the dashboard, current ownership of slides and any proposed developments agreed through Quality Committee.

Slide	Description	Ambitions for slide	Timescale (by end)	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.	Feb 25	Paul Gray
4 to 11	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 use SPC charts in order to track themes and trends., we have commenced by adding these to slide 11.	Mar 25	Nicola Mills
12 to 14	Closed Culture	To remain, with input to reflect organisational culture of care work programme.	Mar 25	James Wright
15	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. Ambition to add in run charts.	Nov 25	Nicola Hazle
16-17	Guardians of Safe Working	To remain as quarterly	N/A	Amjad Upall
18 - 22	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.	Nov 25	Kate Bowden
	Long Length of stay MH and CoHo	Removed, as captured in the integrated report under Board Domain.	Complete	Jane Stewart
23-24	District Nursing Data	Remove – plan to revise ICT metrics.	Jan 25	Jane Stewart
25	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.	Feb 25	Tanya Stacey

Appendix Two

Learning From Deaths Report Quarter Two

Quarter Two Learning From Deaths

- During Q2 2024-25, 116 Gloucestershire Health and Care NHS Foundation Trust (GHC) patients died:

GHC patient deaths reported during Q2 2024-25			
July	August	September	**Total**
40	42	34	**116**

- During Q2 2024-25 15 care record reviews and 3 investigations were completed.

Number of comprehensive investigations and care record reviews completed during Q2 2024-25 for deaths occurring in:							
	Q4 2022/23	Q2 2023/24	Q3 2023-/4	Q4 2023/24	Q1 2024/25	Q2 2024/25	Total
Comprehensive investigations	0	1	2	0	0	3	**6**
Care record reviews	1	1	1	8	3	15	**27**
Total	**1**	**2**	**3**	**8**	**3**	**18**	**33**

- The numbers above do not include open investigations and care record reviews.

- 0, representing 0.0% of the patient deaths reviewed during Q2 2024-25, were judged more likely than not to have been due to problems in the care provided to the patient.
- During Q2 2024-25, October's Mental Health Mortality Review Group was held as an Away Day and the group reconvened in December 2024.

Quarter Two Learning From Incidents

- A total of 44 incidents were raised in Q2 2024/25 (excluding those for Falls or Skin Integrity).
- All incidents had confirmed grading as No or Low Harm:
- 27 were related to Medication incidents.
- 5 were related Discharge planning/failure

Quarter Two Specific End of Life Learning

- **Learning for the Trust in Q2:**
- Reminders shared about the importance of planning ahead and checking to ensure that EOL meds / equipment / drug charts etc are in place and correct

- **Learning for system partners in Q2:**

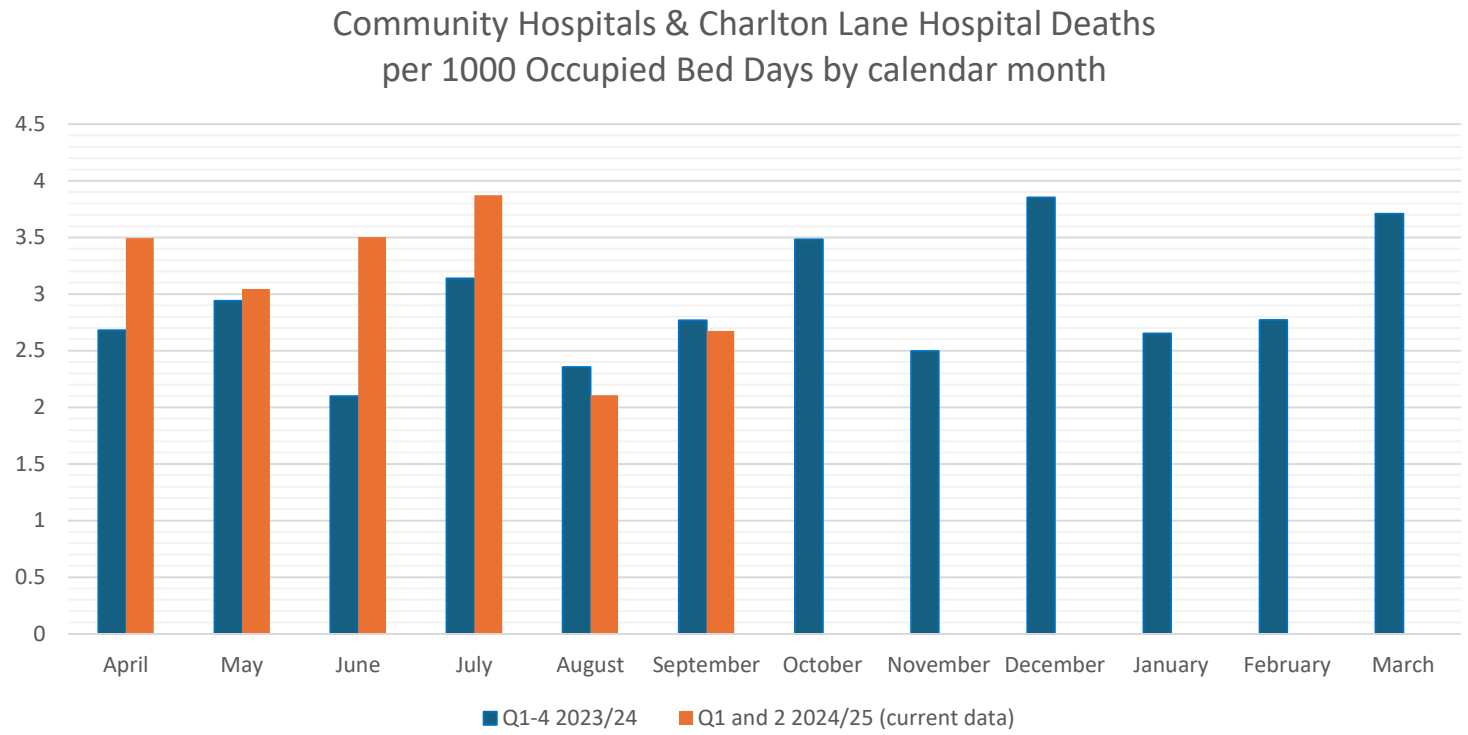
- Request for colleagues at GHFT when discharging a patient on syringe driver to include WFI in TTOs to prevent delay.

- Patient discharged from an acute hospital out of county arrived home in ambulance with no clothes on, this has been fed back to the EOL Lead at the trust concerned.

- Care Home support and education given regarding storage of medications.

Community Hospitals and CLH Inpatient Death Rate per Month

- During Q2 2024-5 there were 53 deaths in Community Hhospitals' (CH) and Charlton Lane Hospital (CLH) combined. Death rates in the chart below are given per 1000 occupied bed days. Comparison with rates observed in Q1-4 2023-24 are also shown, wherein there were 257 inpatient deaths in total for the whole financial year.



The death rate for Q1&2 2024-25 is slightly higher than the 2023-24 dataset.

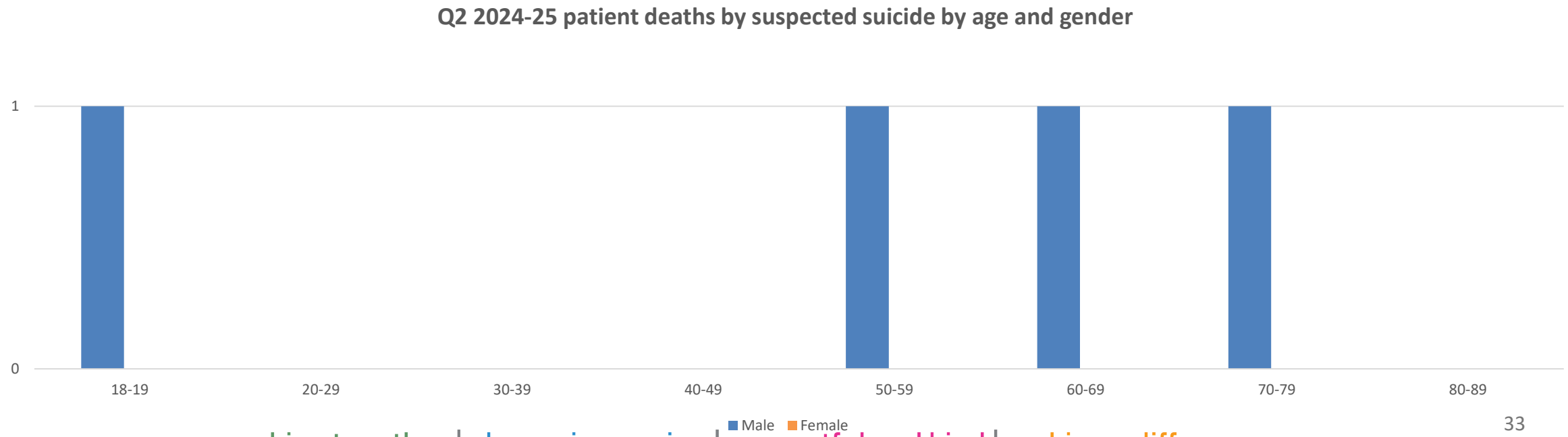
Mental Health Patients

Patient Confirmed/Suspected Suicides

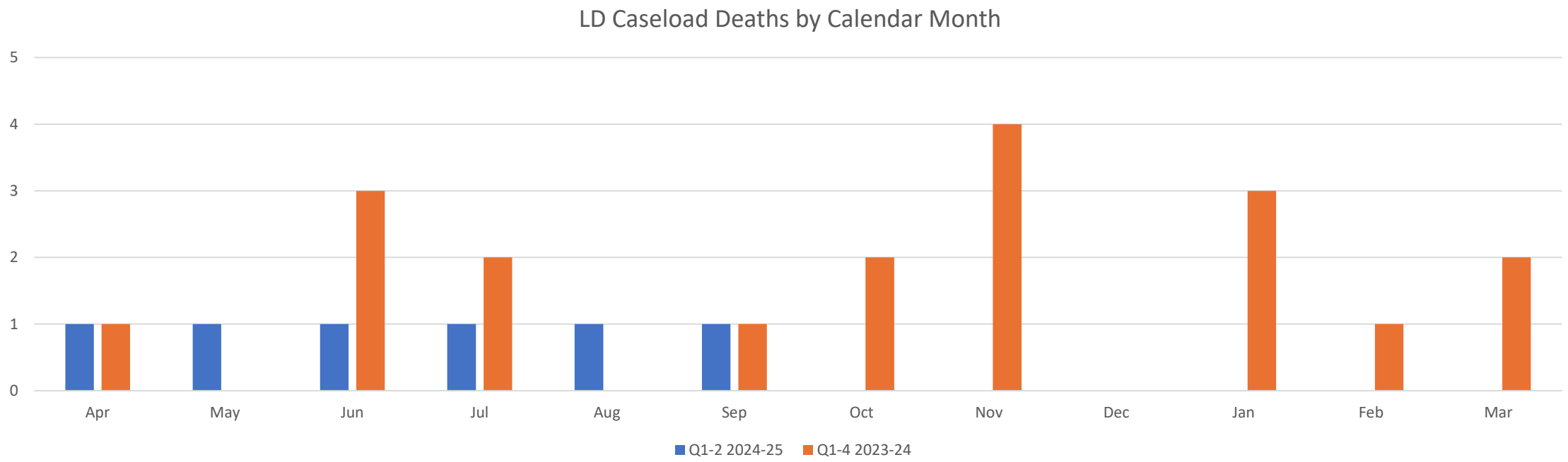
Age & Gender

(Excluding those with a primary diagnosis of dementia and those on the MHICT caseload)

During Q2 2024-25, there were 4 patient deaths by suspected suicide. All of these patients were open to community mental health team and were male.
Distribution by age group and gender is shown below.



Learning Disability Patients Deaths per Month



- During Q1&2 2024-25, there were 3 deaths of patients open to trust Learning Disability (LD) caseloads. Deaths per month are shown above with comparison to Q1-4 2023-24 figures, wherein there were 19 LD caseload deaths in total.
- All deaths have been referred to LeDeR for review.

Medical Examiner KPIs

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2021/22 YTD
Number of deaths generating MCCD resolved with the input of the ME service													
Number	64			52									
Number of times a MCCD is rejected by Registrar and reason this occurs	0			0									
Number of referrals to the Coronial Service													
Number	2 patients were investigated for Inquest without autopsy due to unnatural events. 4 x Form 100As issued re part 2 of the cause of death on the MCCD.			2 patients referred to HMC, one due to trauma related death, the other for postmortem as cause of death was unclear.									
Complaints made by bereaved relatives due to perceived delays to completion and release of MCCD (end to end timescales examined)	0			0									

REPORT TO: **TRUST BOARD PUBLIC SESSION – 23 January 2025**

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

AUTHOR: Chris Woon, Deputy Director of Business Intelligence

SUBJECT: **PERFORMANCE DASHBOARD DEC 2024-25 MONTH 9**

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 December (Month 9 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

Trust Board is asked to:

- **NOTE** the Performance Dashboard Report for December 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 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 but is reviewed at BIMG for each period*). 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. As an interim introduction, the Integrated Urgent Care Service KPIs are presented on its own domain section before it will be progressed into the ICS Agreed Domain.

- **Nationally measured domain** (under threshold)
  There were 4 indicators in exception this month. Specific focus was given in BIMG over the last few periods to understand the performance position, underlying issues and improvement planning on N03 Inpatient Follow-up within 72hrs and N11/ N12 Adolescent Eating Disorders referral to treatment.

- **Specialised & directly commissioned domain** (under threshold)
  2 health visiting indicators (S02 & S09) and 2 school nursing indicators (S14 & S18) were slightly behind their thresholds for the period.

- **ICS Agreed domain** (under threshold & outside of statistical control rules)
  There was 1 social care indicator (L19) in exception for the period.

- **Integrated Urgent Care Service**
  9 Integrated Urgent Care Service indicators are presented in exception for the period and are presented on page 8. KPI15 is still in development, alongside work to improve clinical system recording and system configuration to address data quality issues.

- **Board focus domain** (under threshold & outside of statistical control rules)
  5 indicators were in exception for the period;
  - 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) and B20 MH Older Adult Inpatients - Percentage of discharges within LOS threshold (70 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)

- **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 pg13) include the following indicators that were within normal variation but under threshold:

  - L08 Eating Disorders wait time for adult interventions within 16 weeks
  - B18 – MH Acute Inpatient discharges with a Length of Stay (LoS) of less than 26 days

The following two indicators are positively compliant this month having not been within threshold for a considerable period of time:

- L07 Eating Disorders wait time for adult assessments within 4 weeks has not been compliant at all in 2023/24 or 2024/25 until now.
- L12 Perinatal routine assessments within 2 weeks has been challenged with its threshold attainment since the beginning of the 2024/25 financial year.

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 issued been discussed before?

BIMG on 16 January 2025

Appendices:	AI-11.1/0125 Performance Dashboard

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

NHS
Gloucestershire Health and Care
NHS Foundation Trust

Snapshot Month
December

Quality & Performance Dashboard Report & BI Update

Aligned for the period to the end December 2024 (month 9)

In line with the Quality & Performance Indicator Portfolio and the Trust's Performance Management Framework; this report presents performance indicators across four domains including **Nationally measured**, **Specialised & Direct Commissioning**, **ICS Agreed** and **Board Focus** domain. The (fifth) **Operational** domain is only presented to Resources Committee (not Board) however is always reviewed within the monthly Business Intelligence Management Group (BIMG). In way of an introduction, the new **Integrated Urgent Care Service** KPIs are persented in its own section for this period only. These will be positioned within the ICS Agreed domain going forward.

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. Examples over the last quarter include Perinatal, Eating Disorders, Occupational Therapy, CYPS & Adult SaLT and CYPS Physio. An operationally led Patient Records Working Group is reporting into BIMG.

Quality & Performance Dashboard Summary

An Executive level observation of operational performance and quality assurance is provided within the Executive statement (on page 2), which has been ratified by the Trust's *Chief Operating Officer* and *Director of Nursing, Therapies & Quality (NQT)*.

The Dashboard itself (on pages 3-11) provides a high level view of Performance Indicators in exception across the organisation for the period. Indicators within this report are underperforming against their threshold or are showing special cause variation (as defined by Statistical Process Control SPC rules) and therefore warrant escalation and wider oversight. To note, confirmed data quality or administrative issues that are being imminently resolved will inform any escalation decision unless there has been consecutive, unresolved issues across periods. A full list of all indicators (in exception or otherwise) are available to all staff within the dynamic, online server version of this Tableau report. All services are using this tool, alongside their operational reporting portfolios to monitor wider performance.

Where performance is not achieving the desired results, operational service leads are prioritising appropriately to address issues. Additionally, where appropriate and in response to significant, ongoing and wide-reaching performance issues a single performance improvement plan is held at Directorate level to outline the risks, mitigation and actions. Areas of note are presented at the end of the report on 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, methodology or data quality updates, or offer context to wider indicators that may be in exception.

Business Intelligence Summary Update

A new high level proposal mapping out the delivery phases of for Trust-wide, Integrated report across the next 4 financial years was presented to Resources Committee in December 2024. Stakeholder collaboration continues through Quarter 4 to firm up the milestones within this plan.

A new Tableau navigation menu will be published in Quarter 4, alongside Tableau user video tutorials. Considerable BI development capacity continues to be directed to support the Integrated Urgent Care Service (IUCS) and indicators in exception are highlighted for the first time this month as mentioned above.

Executive Statement

Sarah Branton, Chief Operating Officer (COO) & Nicola Hazle, Director of Nursing, Therapies and Quality

Presented this month is a shorter Executive Summary. This indicates a move from a narrative-heavy report to one that provides greater focus, analysis and triangulation.

Key areas therefore to draw the Board's attention to are as follows:

- N07 – No children under 18 admitted to adult in-patient wards. A young person on the cusp of their 18th birthday was admitted. At the point of admission, clear goals of admission were in place with attention to quality and safety measures. An incident was raised and reported to the Care Quality Commission

- N12 Adolescent Eating Disorders – Urgent referral to NICE treatment start within week 1. In the latest national data (MHSDS) for August to October 2024, GHC achieved 100%, which is higher than the England average of 81%.

- L07 – Eating Disorders – Wait time for adult assessments will be 4 weeks – Performance is now within threshold at 100% for December, having not been compliant at all in 2023/24 or 2024/25.

- L19- Ensure that reviews of new short or long term packages take place within 8 weeks of commencement. Performance has been variable and not achieving target for a protracted period of time. A service improvement plan has been requested for presentation at the Business Intelligence Management Group in February 2025.

- Integrated Urgent Care Service. Launched in November 2024, this is the first time performance data has been included in this report. As an organisation we continue to work through a number of data quality issues inherent with commencing a new and complex service. The service is working to understand whether the data quality issues are technical, inputting practice, training, or indicative of further development required in configuration of services for onward referral. The IUCS Digital Board is continuing to systematically work through these in order to move to business as usual as quickly as possible.

- Relevant to this report, Recovery/ Service Improvement plans in place include:
  - N11-Adolescent Eating Disorders- Routine referral to NICE treatment start within 4 weeks
  - N12 Adolescent Eating Disorders – Urgent referral to NICE treatment start within week 1
  - o L08 – Eating Disorders -Wait time for adult psychological interventions will be 16 weeks

- Recovery/ Service Improvement plans in place and now under review with Chief Operating Officer oversight:
  - B19-MH PICU Inpatients – Percentage of discharges within LOS threshold (61days)
  - B20-MH Older Adult Inpatients -Percentage of discharges within LOS threshold (70days)
  - B18-MH Acute Inpatients – Percentage of discharges within LOS threshold (26days)

- Not included in this report but for Board awareness:

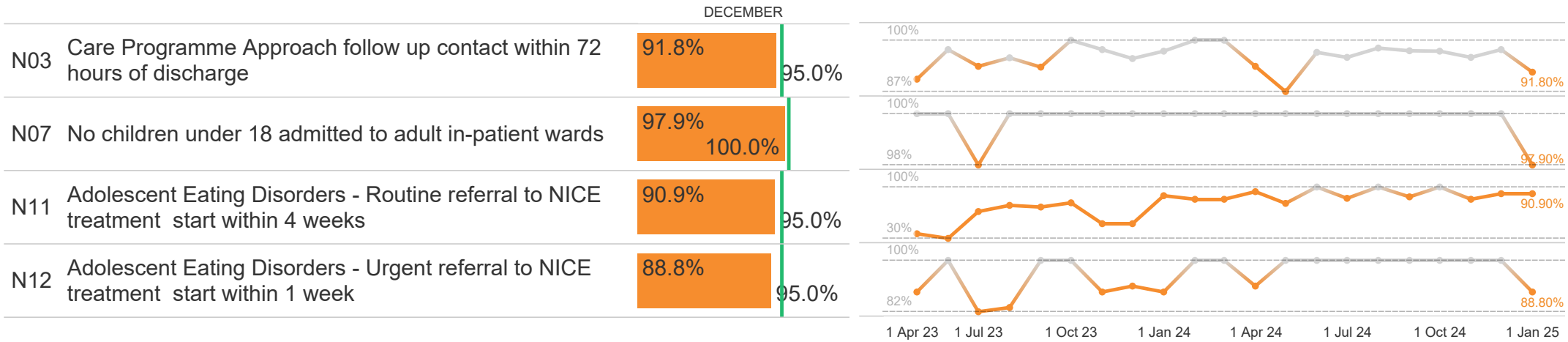
In partnership with Gloucestershire County Council, we are reviewing our areas of delegated responsibility to understand performance and the future direction of provision. This includes Occupational Therapy within community services (performance measure O11 – ICT Occupational Therapy Services - % routine referrals treated within 18 weeks) and Mental Health Social Work.

National Contract Domain

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 with the exception of N07 which was last in exception in June 2024.*

N03 - Care Programme Approach follow up contact within 72 hours of discharge
December is at 91.8% compliance, with 4 out of 49 discharges not having a follow-up within 72 hours of discharge (November was 97.2%).

N07 - No children under 18 admitted to adult in-patient wards
Performance in December is at 97.9% (November was 100%) compared to a 100% threshold, with 1 under 18 admission out of 49 admissions to adult inpatient wards.

The last time an under 18 was admitted to an adult inpatient ward was in June 2023.

N11 - Adolescent Eating Disorders - Routine referral to NICE treatment start within 4 weeks
December performance is reported at 90.9% against a performance threshold of 95.0%. There was 1 patient not treated within 4 weeks in December out of 11. Statistical process control is not used for this KPI as performance is too variable.

At the end of December there were 44 routine adolescent patients with an assessment completed that were waiting for treatment to commence. A decrease from November at 48. A recovery plan is in place for the eating disorders service.

In the latest national data (MHSDS) for August to October 2024, GHC achieved 73%, which is slighty lower than the England average of 77%.

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

Narrative continued on next page...

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N12 - Adolescent Eating Disorders - Urgent referral to NICE treatment start within 1 week
December performance is reported at 88.8% against a performance threshold of 95.0%. There was 1 patient not treated within 1 week in December out of 9. Statistical process control is not used for this KPI as performance is too variable.

In the latest national data (MHSDS) for August to October 2024, GHC achieved 100%, which is higher than the England average of 81%.

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).

Specialised Commissioning Domain

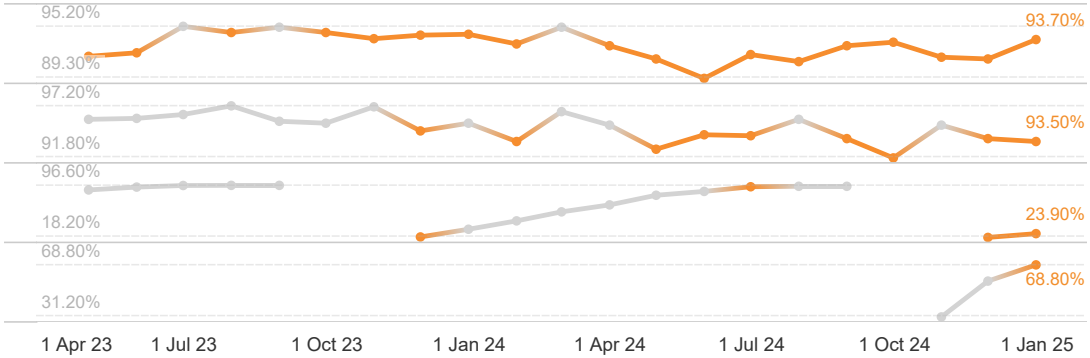
Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Non Compliant

Specialised Commissioning Domain

		DECEMBER
S02	% of live births that receive a New Birth Visit within 7- 14 days by a Health Visitor	93.7% 95.0%
S03	% of children who received a 6-8 weeks review	93.5% 95.0%
S14	Percentage of children in Year 6 with height and weight recorded	23.9% 25.0%
S18	Flu coverage for all children in school years R to year 11	68.8% 70.0%



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

S02 - % of live births that receive a New Birth Visit within 7- 14 days by a Health Visitor
Performance in December is 93.7% (November was 91.5%) compared to a threshold of 95.0% with 30 out of 483 babies not seen within 14 days. Performance is within normal variation.

S03 - % of children who received a 6-8 weeks review
Performance in December is 93.5% (November was 93.6%) compared to a threshold of 95.0% with 33 out of 510 infants not seen within 8 weeks. Performance is within normal variation.

S14 - Percentage of children in Year 6 with height and weight recorded
Performance in December is 23.9% (November was 18.2%) compared to a threshold of 25.0% with 5,193 children out of a projected cohort of 6,832 yet to be screened. SPC rules do not apply to this KPI.

There may be some slippage in the early months of the measurement programme, but the team are confident that they have scheduled in all schools and will achieve the final threshold at the end of the academic year.

S18 - Flu coverage for all children in school years R to year 11
Performance in December was 68.9% compared to a cumulative threshold of 70.0%, with 28,519 out of 91,679 pupils not having been vaccinated. SPC limits do not apply as this is a cumulative KPI.

Whilst not achieving the 70% target set internally, the service has achieved the National target (65%), and also achieved a 0.9% increase in its overall uptake for the 24/25 season compared to 23/24. This has been achieved through the service embracing a new way of working and continually striving to ensure we maximise uptake and protect the young people of Gloucestershire.

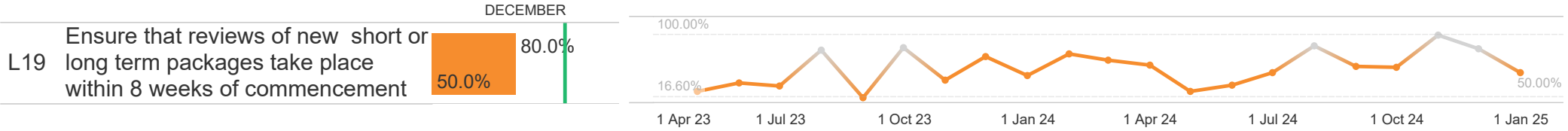
ICS Agreed Domain

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Non Compliant

ICS Agreed Domain



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

L19 - Ensure that reviews of new short or long term packages take place within 8 weeks of commencement
December performance is reported at 50.0% against an 80% performance threshold. SPC is not applied to this indicator due to the small number of cases. At the December data freeze date, there were 6 cases out of 12 reported as not meeting the threshold.

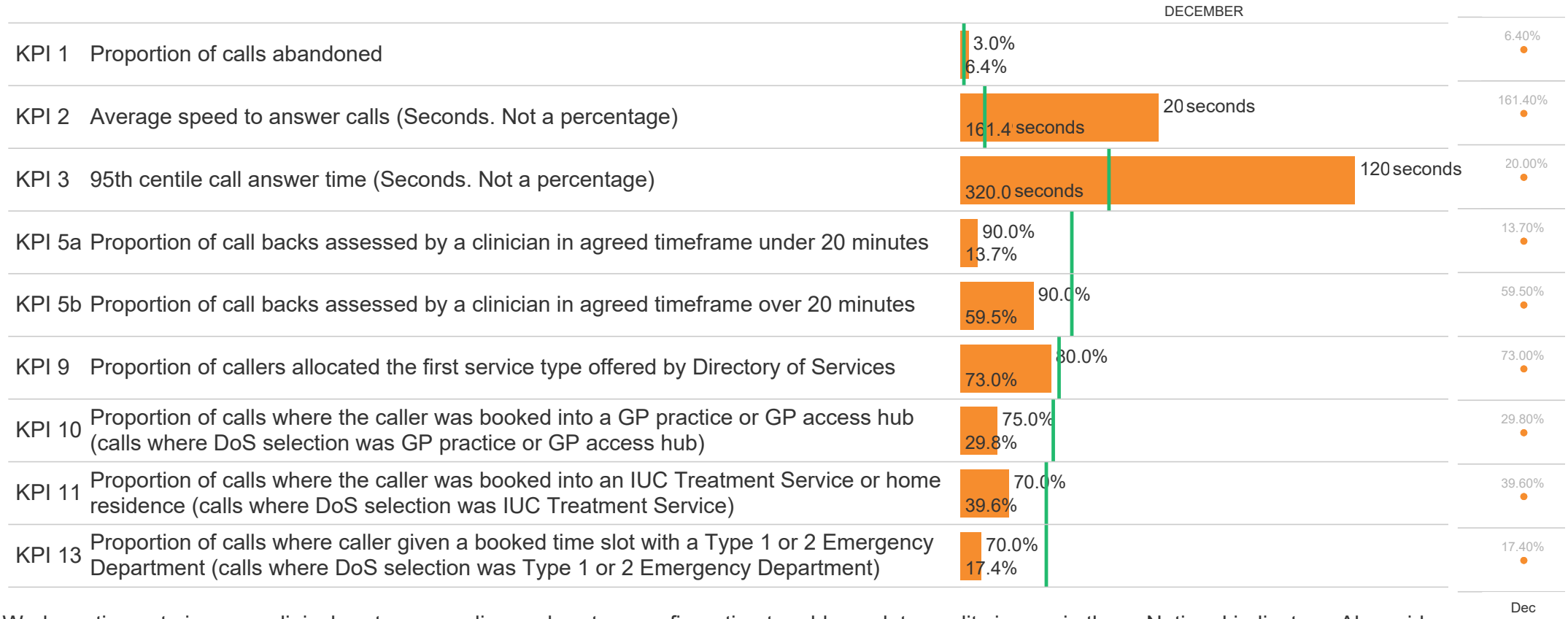
A correction to the clinical system has now updated the position to 5 cases out of 11 and performance is reported at 54.5%.

Integrated Urgent Care Services (IUCS) Summary

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Integrated Urgent Care



Work continues to improve clinical system recording and system configuration to address data quality issues in these National indicators. Alongside understanding technical processes, this continues to be a key factor in validating and confirming a fully accurate performance position for the period. With that considered, the latest *reported* position for the first full period is presented above. They are collated and shown separately on this occasion however the intention it to move them into the established domains as soon as possible. Consideration is being made for further internal monitoring measures to be presented within the Board or Operational Domain within the portfolio.

This is the first full reported position within the performance dashboard and therefore descriptions for all indicators are provided below for context. Exceptions are only shown above.

KPI 1 Proportion of calls abandoned *(% of NHS 111 calls abandoned)*
Majority of the abandoned calls driving non-compliance occurred across holiday period, particularly on weekends. 14.4% on Sat 21st & Sun 22nd Dec, 16.5% on Sat 28th & Sun 29th Dec. November was compliant at 2.5%. Early weeks of January indicating improved performance however still within non-compliance.

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KPI 2 Average speed to answer NHS 111 calls *(in seconds - does not include abandoned calls)*
As with KPI 1, non compliance also largely driven by holiday period, again particularly on weekends. 399 seconds average time on Sat 21st & Sun 22nd Dec.536 seconds on Sat 28th & Sun 29th Dec. Average being skewed by a number of calls taking over 30 minutes to answer. Check was carried out with IC24 on some longer to answer calls which revealed these were genuine long wait calls in the system. November performance was better but still non-compliant at 48.9 seconds. Early weeks of January indicating improved performance however still within non-compliance.

KPI 3 95th centile call answer time *(95th percentile NHS 111 call answer time - target for only 5% of calls or fewer to take longer than 120 seconds to answer)*
As KPI 2. Decrease in performance since November when the 95th centile was 210 seconds compared with December 320 seconds.

KPI 4 Proportion of calls assessed by a clinician or clinical advisor *(% of triaged system calls which are assessed by a clinician or clinical advisor)*

KPI 5a Proportion of call backs assessed by a clinician in agreed timeframe under 20 minutes *(% of callers who needed a call back in under 20 minutes who were called back in under 20 minutes (online and telephone))*
This assesses NHS 111 call-receiving organisation/CAS. Best performance in December only at 22.6% for the weekdays of week commencing 16th Dec. Disparity between weekends and weekdays as with previous KPI's, lowest performance was 4.7% on Sat 21st & Sun 22nd Dec and on Sat 28th & Sun 29th Dec. Improvement from November which had a compliance of 7.5%. Early indications in January showing improvement but still far from compliance.

KPI 5b Proportion of call backs assessed by a clinician in agreed timeframe over 20 minutes *(% of callers who needed a call back in an agreed timeframe over 20 minutes (different timeframes for each call depending on severity) who were called back within the agreed timeframe)*
This assesses NHS 111 call-receiving organisation/ CAS. Much better performance compared with KPI 5a, still not compliant on any weekends or weekdays across December however much closer. Best performance in December in week commencing 2nd Dec, for both the weekdays and weekend days, at 61% and 63% respectively. No signification variation in performance on weekend vs weekday for this KPI. Slight improvement since November which had compliance of 51.6%. Early indications in January showing improvement but still non-compliant.

KPI 6 Proportion of callers recommended self-care at the end of clinical input *(% of system callers who were triaged by a clinician and were subsequently recommended self care)*

KPI 7 Proportion of calls initially given a category 3 or 4 ambulance disposition that receive remote clinical intervention *(% of system callers with a cat 3 or 4 ambulance disposition who receive remote clinical intervention (validation)*

KPI 8 Proportion of calls initially given an ETC disposition that receive remote clinical intervention *(% of system callers with ETC (emergency treatment centre) disposition who receive remote clinical intervention (ETC definition can include ED or MIIU but not severe enough for ambulance)*

KPI 9 Proportion of callers allocated the first service type offered by Directory of Services *(% of system callers where DoS is opened who are allocated the first service type which the DoS recommends*
Very close to compliance, averaging around 70-75% every week. No significant variation between weekend and weekday performance. Steady since November which was also 73%. Early indications in January remain steady.

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KPI 10 Proportion of calls where the caller was boked into a GP practice of GP access hub (calls where DoS selection was GP practice or GP access hub) *(% of system callers where DoS selection is GP who were then booked for a GP)*
Far from compliance, best performance for Dec only at 35% for week commencing 2nd Dec. No significant variation between weekends and weekdays. Slight decline from November, from 34% to 29.8%. Early indications in January remain steady.

KPI 11 Proportion of calls where the caller was booked into an IUC Treatment Service or home residence (calls where DoS selection was IUC Treatment Service) *(% of system callers where DoS selection is IUC Treatment Service who were then booked for IUC Treatment Service (at service or at home))*
Quite far from compliance. Best performing week was the holiday weeks of week commencing 16th Dec and 23rd Dec. Some disparity between weekends and weekdays, weekdays of Dec averaging approx. 45%, weekdays approx. 35%, but evening out across more recent weeks. Improvement from November, from 22.3% to 39.6%. Early indications in January showing improvement but still non-compliant.

KPI 12 Proportion of calls where the caller was booked into a UTC *(% of system callers where DoS selection is UTC who were then booked for UTC)*
Not relevant for our system

KPI 13 Proportion of calls where caller given a booked time slot with a Type 1 or 2 Emergency Department (calls where DoS selection was Type 1 or 2 Emergency Department) *(% of system callers where DoS selection is Type 1 or 2 ED who were then booked Type 1 or 2 ED)*
Far from compliance, best performance for Dec only at around 20% across the holiday weeks. No significant variation between weekdays and weekends. Steady since November, from 18% to 17.4%. Early indications in January remain steady.

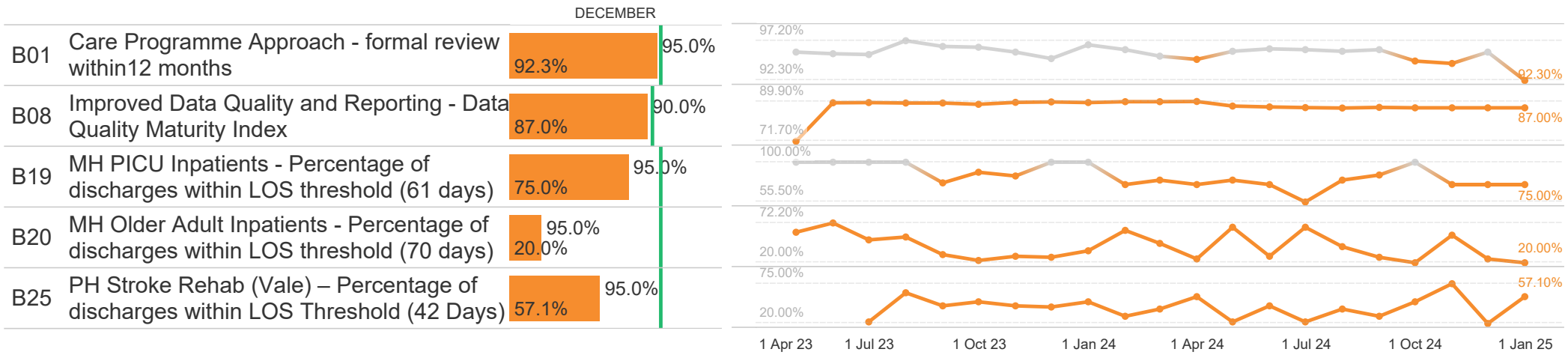
KPI 14 Proportion of calls where the caller was booked into a Same Day Emergency Care (SDEC) service *(% of system callers where DoS selection is SDEC who were then booked SDEC)*
Never recommended

KPI 15 Proportion of HCP calls that receive clinical consultation within 20 minutes *(% of callers into NHS 111 who needed a call back in under 20 minutes who were called back in under 20 minutes (online and telephone))*
Same as KPI 3a but with 95% target instead of nationally defined 90% target, and also with a financial incentive which 3a does not have.

Board Focus Domain

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 and the previous period.*

B01 - Care Programme Approach - formal review within12 months
December performance is reported at 92.3% against a performance threshold of 95.0%. There were 65 patients reviewed after 12 months in December. Performance is a low outlier and outside of normal variation.

Most of the patients that were reviewed after 12 months are within the Recovery North teams. There are operational pressures, with staff sickness and vacancies. The December vacancy rates for Tewkesbury recovery team and North Cotswold recovery team were 27.7% and 30%, respectively.

Patients are being seen regularly and their care reviewed within appointments. Staff are being encouraged to use my care plan and do 6-month reviews. Since the snapshot was taken, the December performance has increased slightly and is currently at 92.6%.

B08 - Improved Data Quality and Reporting - Data Quality Maturity Index
The latest performance is 87.0% against a performance threshold of 90%. Performance is within normal variation. This indicator is an amalgamation of Data quality performance across national data sets:

- *APC: Admitted patient care data set 99.5% (previous month 99.6%)*
- *CSDS: Community services data set 88.6 % (previous month 88.7%)*
- *ECDS: Emergency care data set 74.7% (previous month 74.3%)*
- *IAPT: Talking Therapies data set 99.8% (previous month no change*
- *MHSDS: Mental Health services data set 87.2% (previous month 88.4%)*

The main impact on performance is with ECDS and CSDS due to the challenges in configuration and data capture in SystmOne.

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The newly established and operationally led Patient Record Quality Governance Forum are monitoring updates and action plans and this group reports into BIMG.

B19 - MH PICU Inpatients - Percentage of discharges within LOS threshold (61 days)
Of the 12 patients whose PICU ward stay ended in December, 3 exceeded the 61 day threshold - a performance of 75% against a 95% target. (November was 75%). The average LOS for PICU was 34.7 days (Nov was 97.1 days). For the patients who exceeded 61 days the average length of stay was 116.3 days (Oct was 81.7). 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)
Of the 15 patients whose Older Adult ward stay ended in December, 12 exceeded the 70 day threshold - a performance of 20% against a 95% target. (November was 25%) The average LOS for a Older Adult wards was 142.9 days (Nov was 171.8 days). For the patients who exceeded 70 days the average length of stay was 170 days. (Nov was 218.2 days). The maximum continuous LOS on an Older Adult Ward was 332 days (Nov was 378days). Statistical process control is not used for this KPI as performance is too variable.

BI currently have an enquiry open with the national team around the calculation of ward stay length of stays within the national dashboards.

B25 - PH Stroke Rehab (Vale) – Percentage of discharges within LOS Threshold (42 Days)
In December the average LOS for a stroke rehab patient was 56.7 days, compared to the threshold of 42 days, (November was 52 days). Of the 7 stroke rehab patients discharged from a community hospital stay, 3 exceeded the length of stay threshold of 42 days. Statistical process control is not used for this KPI as performance is too variable. For the 3 patients who exceeded 42 days the average length of stay was 88.3 days. (November was 62) these were all due to a delay in either an onward package of care or an available place in a care home.

6.8% 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 (16.4%). On average this equates to 3.6 days nCTR for all patients and 7.7 days nCTR for each P1 patient. If patients were able to be discharged when they were clinically ready the average LOS would be 48.7 days, performance would remain at 57.1%.

Quality & Performance highlights to note

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

- **L07 - Eating Disorders - Wait time for adult assessments will be 4 weeks**

Performance is now within threshold at 100% for December, having not been compliant at all in 2023/24 or 2024/25. It has been improving through the year from a low of 30% in February 2024.

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

December performance is reported at 92.3% against a 95.0% performance threshold. There was 1 patient not receiving intervention within 16 weeks in December out of 28. The performance is within normal variation.

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) and is on the Risk Management Group agenda for the period.

- **L12 - Perinatal: Routine referral to assessment within 2 weeks**

Performance is compliant again at 61% in Decemberfor the second month, against a 50% threshold. It has not been compliant since April 2024. It was 69% in November 2024.

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

Of the 33 patients whose Adult Acute ward stay ended in December, 19 exceeded the 26 day threshold - a performance of 43.7% against a 95% target. (November was 28.5%) The average LOS for Adult Acute wards was 58.1 days (November was 74.1 days). For the patients who exceeded 26 days the average length of stay was 92.3 days. (Oct was 97.1). The maximum continuous LOS on an Adult Acute Ward was 473 days. Performance is within expected variation.

REPORT TO: **TRUST BOARD PUBLIC SESSION – 23 January 2025**

PRESENTED BY: Douglas Blair, Chief Executive

AUTHOR: Douglas Blair, Chief Executive

SUBJECT: **LEADERSHIP AND CULTURE PROGRAMME**

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

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

The purpose of this report is to:
To update the Board on progress with the establishment of an organisation wide Leadership and Culture Programme and seek approval for a short-term Board Assurance Committee.

Recommendations and decisions required
The Trust Board is asked to:

- **Note** the update provided
- **Approve** the terms of reference for the Leadership and Culture Board Assurance Committee

Executive summary
This paper is to provide the Board with a high-level update on the establishment of a Trust Leadership and Culture Programme that is in its scoping and discovery phases. The paper sets out the proposed approach, emerging workstreams and governance for the programme. The focus of this work is the bringing together of 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.

Risks associated with meeting the Trust's values

There are two strategic risks currently on the Board Assurance Framework that are linked to this programme of work. At last review (quarter 2), both risks were scored at 16.

- **Risk 4: 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).

- **Risk 9: 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.

Corporate Considerations	
Quality Implications	A culture of civility can create a safer and more supportive environment for both patients and staff, leading to improved quality of care, as referenced in evidence and bet practise.
Resource Implications	Dedicated resources for Programme Manager and OD input identified. Workstream leads and stakeholders will be required to commit time to participate and lead on improvement initiatives.
Equality Implications	GHC is committed to addressing the key themes highlighted in recent reports, such as "Too Hot to Handle? “, “Ten years on: The Snowy White Peaks of the NHS” and the Darzi Report.

Where has this issue been discussed before?

- Executive Roundtable 7 January 2025
- Executive Plus 14 January 2025

Appendices:	**Appendix 1** Draft Terms of Reference Leadership and Culture (L&C) Assurance Committee

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

LEADERSHIP AND CULTURE PROGRAMME UPDATE REPORT

1.0 INTRODUCTION

The Trust is establishing an enhanced Leadership and Culture Programme to bring together 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 paper sets out the proposed approach, emerging workstreams and governance for the programme. These proposals have been discussed with the Trust's senior leadership team and will be further co-produced with colleagues during the discovery phase.

2.0 PROGRAMME APPROACH

It is proposed that the programme will comprise a number of key workstreams that are currently in the development and scoping phase. These will incorporate some existing areas of work that are underway in GHC such as the NHS England Culture of Care programme - a national programme that is supporting all Mental Health trust providers to:

- re-set the purpose of inpatient care as therapeutic and safe as experienced by the person
- co-produce the standards for safe therapeutic inpatient care which is trauma-informed, autism-informed and equality-focused
- deliver a programme of support which includes a focus on leadership and considers 'ward to board' requirements to generate cultural change alongside broader workforce development and learning networks
- co-produce inpatient roles that enable and sustain therapeutic inpatient care, building on good practice where it exists, and reducing administrative burden

Other emerging workstream themes include Trust Values and Behaviours, leadership and strengthening our work on Equality, Diversity and Inclusion and Freedom to Speak up.

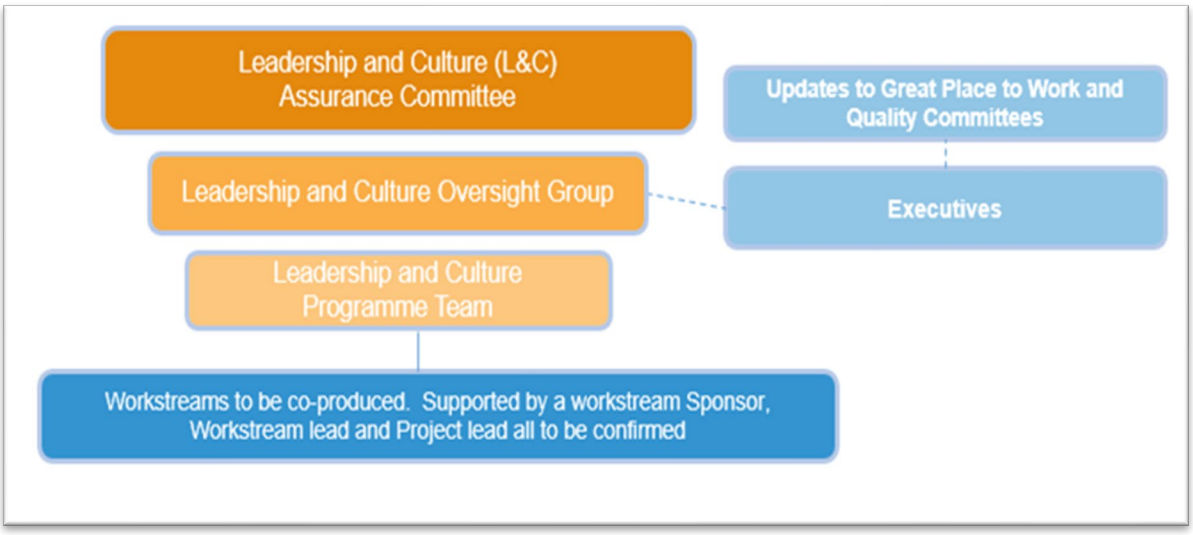
The Programme will include Executive sponsorship for workstreams and provide opportunity for colleagues to take up roles as workstream leads and stakeholders.

A core principle and approach to the programme will be one of co-production and design of the workstreams alongside promoting diversity of representation from across the trust including those who use our services and their carers.

Whilst it is important to recognise this as a GHC programme of work, we will work with, and draw on, the experiences of our system partners and national best practice approaches to improving leadership and culture.

3.0 GOVERNANCE

The proposed governance arrangements for the programme are set out below.



Given the importance and wide-ranging nature of this long-term improvement programme, it is proposed that its establishment is subject of scrutiny and assurance from a dedicated Board Committee. The terms of reference for a proposed short life Leadership and Culture Assurance Committee are set out in **Appendix 1** for approval.

4.0 NEXT STEPS

The Leadership and Culture programme is at its scoping and discovery phases at present with some allocated resources from the Trust Improvement and Partnerships and Human Resources and Organisational Development directorates to support coordination and subject matter expertise identified. There will also be a range of training, coaching and support developed to support workstreams. An outline timeline and deliverables for the next 4 months has been developed and is set out below.

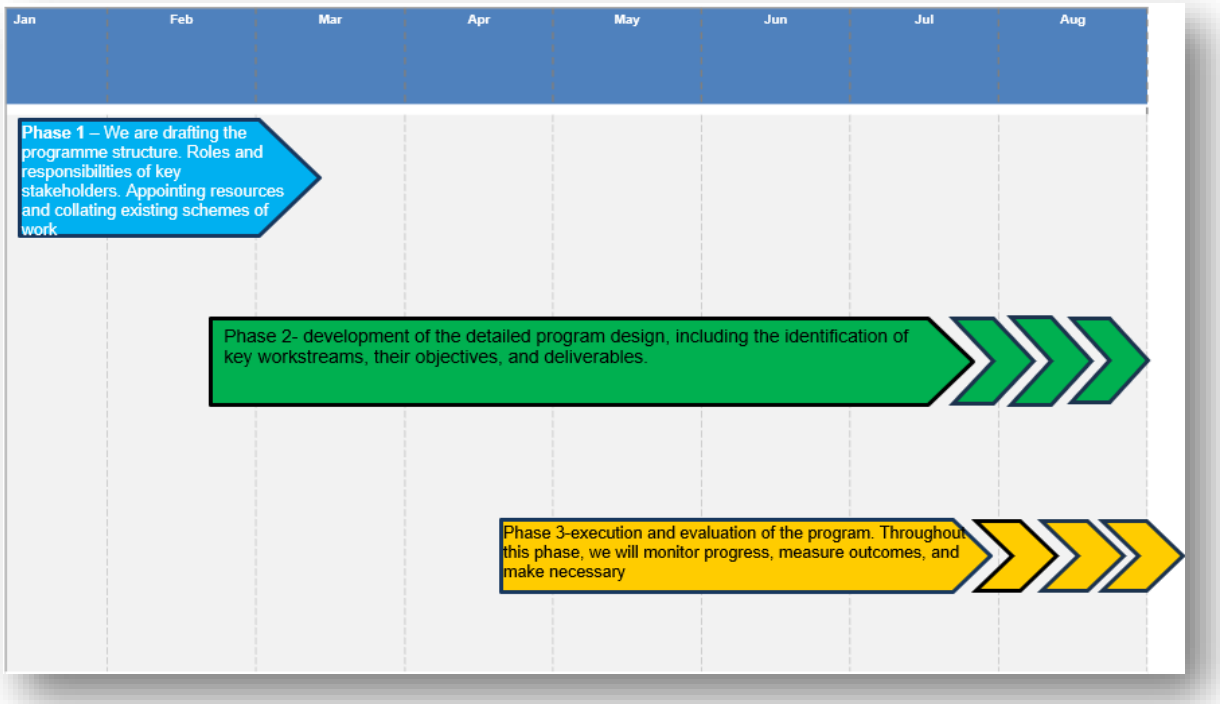
Outline Timelines & Deliverables

Deliverables	Timeline
Programme Manager identified	13 January 2025
Board Governance & outline programme governance confirmed	23 January 2025
Executive Sponsors confirmed	w/c 27 January 2025
Outline Communications & Expressions of Interest for roles within the programme	w/c 3 February 2025
'Workstream Sponsor' and 'Project Lead' confirmed	28 February 2025

Deliverables	Timeline
First Programme Oversight Group	TBC
First Board Assurance Committee	March 2025
Broader Communications on detailed Programme	End of March 205
Updates to Great Place to Work and Quality Committee	April 2025

The programme phases set out below will have an element of overlap as development of the workstream details are co-produced and improvement initiatives begin. It is recognised that this is a multi- year programme that will require ongoing evaluation of measurable outcomes, and the role of the Oversight group will be key in assurance of programme deliverables.

Programme Phases Q1 & Q2 2025



5.0 CONCLUSION

Trust Board is asked to:

1. **NOTE** the progress being made on the establishment of a dedicated Leadership and Culture programme.

2. **APPROVE** the establishment and Terms of Reference for a short life Assurance Committee.

APPENDIX 1

DRAFT TERMS OF REFERENCE

Leadership and Culture (L&C) Assurance Committee

1.0	**Purpose**
1.1	The purpose of the Leadership and Culture Assurance Committee is to receive and provide assurance to the Trust Board on the overarching delivery of the Leadership and Culture programme, ensuring that the programme is comprehensive, delivered on time and informing cultural change. The Committee will be established for an initial period of 12 months from March 2025 with possible extension following which oversight will revert to the appropriate Board governance committees.
2.0	**Membership**
2.1	<u>Membership</u> 1. Graham Russell (Chair) 2. Sumita Hutchison (NED/GPTW Chair) 3. Rosi Shepherd (NED/Quality Committee Chair) 4. Cathia Jenainati (Associate NED) 5. Douglas Blair (CEO/Executive Lead) 6. Neil Savage (Director of HR&OD) <u>In Attendance</u> • Michelle Hurley-Tyers, Deputy Director of HR&OD and Programme SRO (TBC) • TBC - Programme Manager <u>In Attendance (at Request of Committee)</u> • Workstream Leads
2.2	Other Officers or Directors of the Trust may attend at the discretion of the Chair.
3.0	**Quorum**
3.1	**Three** members, at least two of whom should be Associate/Non-Executive Director and one should be an Executive Director. Where a member is unable to attend a meeting of the Committee, that member may, with the agreement of the Committee Chair, nominate a deputy who will count towards the quorum.
4.0	**Reporting Arrangements**
4.1	The Committee will update each routine Board meeting on its activity, highlighting decisions made, issues being progressed and issues requiring further consideration or decision by the Board.

4.2	The Committee will highlight any key issues or concerns to other Board Governance Committees which require consideration by one or more of these Committees.
5.0	**Powers**
5.1	The Trust's Standing Orders, Standing Financial Instructions, Scheme of Reservation and Scheme of Delegation shall apply to the Committee.
6.0	**Responsibilities**
6.1	The Committee will receive regular progress assurance reports from the Leadership and Culture Programme Board which is leading on the development and delivery of the overarching project plan. The Committee will provide an oversight and assurance function to the Trust Board on the delivery of the programme.
7.0	**Frequency and Review of Meetings**
7.1	Committee meetings will be held bi-monthly, commencing in March 2025. The Chair may agree further meetings if necessary. Virtual meetings, at the discretion of the Committee Chair, may take place using appropriate electronic methods.
7.2	These Terms of Reference will be reviewed annually, with any change recommended to the Trust Board.
8.0	**Administration**
8.1	The Trust Secretary will ensure appropriate support is provided to the Committee.

Version	Date Approved	Approved by
Version 1		

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NHS Foundation Trust

AGENDA ITEM: 13/0125

REPORT TO: **TRUST BOARD PUBLIC SESSION – 23 January 2025**

PRESENTED BY: Rosanna James, Director of Improvement and Partnerships

AUTHOR: Julie Mackie, Head of Partnerships

SUBJECT: **LIVED EXPERIENCE WORKFORCE FRAMEWORK PROGRESS REPORT**

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

This report is provided for:

Decision ☐ Endorsement ☐ Assurance ☐ Information ☒

The purpose of this report is to:

- Update on development of the GHC Lived Experience Workforce Strategic Framework.
- Update regarding activities to establish a suitable leadership and support infra-structure, including plans for identified financial needs and increased resources.

Recommendations and decisions required:

1. **NOTE** the GHC executive team have accepted scoping outcomes that indicated a framework alone would be insufficient to support and expand GHC's lived experience workforce and endorsed further work on identified barriers.

2. **ACKNOWLEDGE** the progress to create a professional leadership role for Peer Support Workers (PSW) and Lived Experience Practitioners (LXP) within the Psychological Services in the Nursing Quality and Therapies Directorate (NTQ). This will establish a centralised 'hub' providing leadership and professional support to existing service level operational and supervision structures and support growth ambitions.

3. **ACKNOWLEDGE** the progress to date in developing the framework conceptual model that is being co-created by the task group and is based on current examples of best practice.

4. **NOTE** the GHC scoping activities did not include the lived experience workforce employed by VCSE partners that GHC commission or work in collaboration as part of existing service delivery models. Further work is being undertaken in this area and Rosanna James (Improvement & Partnership Director) is leading

strategic partnership discussions alongside Gloucestershire VCS Alliance about interest and potential opportunities with a workshop planned in January 2025.

5. **ACKNOWLEDGE** that the framework is the first stage to fill a gap in recording, information and resources for colleagues, managers and teams.

Executive summary

A request was made by the Working Together Advisory Committee and at Trust Board, to scope and progress the development of a strategic framework that sets out GHC's ambition to enhance and increase Lived Experience Practitioner (LXP) and Peer Support Worker (PSW) roles across the organisation as a way of improving service delivery and outcomes.
Recommendations based on robust research activities, reflected several barriers to expansion faced by lived experience colleagues, service managers and teams, and indicated that the development of a strategic framework alone would be insufficient to grow the PSW workforce and to realise the potential benefits to service delivery and patients. A paper was presented to the executive team in November 2024 to clarify GHC's strategic direction and recognise the need for additional leadership, training, and resources.

The executive team endorsed the findings, agreed in principle to identify additional finance, and approved next steps that are now in progress, including:

- A new leadership structure and appropriate training resource
- Inclusion of lived experience workforce in GHC's Workforce Strategy 2025 refresh
- A task group to further explore a blended model, including GHC employed (paid and voluntary) and through partnerships with VCSE.
- A task group to co-create the Lived Experience Workforce Framework to emphasise an ambition for lived experience workforce across the Trust – not just mental health services

The Lived Experience Workforce Framework conceptual model in **Appendix 1** and proposed leadership structure aims to ignite a culture shift and expand the number of PSW's/LEP's operating within GHC services. Additional improvements are anticipated through consistent recruitment practice including more accurate recording and monitoring of the lived experience workforce. Further work is required to identify measures for assurance and to quantify our ambition to grow the lived experience workforce.

Risks associated with meeting the Trust's values

N/A

Corporate considerations	
Quality Implications	LXP/PSW Policy, professional competencies, and governance structure consideration and development required.
Resource Implications	LXP/PSW leadership and support structures for Exec review in Jan 2025
Equality Implications	Not all services may be suitable for LXP/PSW roles.

Where has this issue been discussed before?
• GHC Exec Group – July 2024 – scoping paper outcomes. • Quality Assurance Group – October 2024 • Exec Team meeting – November 2024 • Quality Committee – January 2025

Appendices:	1. Draft PSW framework 2. HEE PSW Competency framework

Report authorised by:	Title:
Rosanna James	Director of improvement and Partnership

LIVED EXPERIENCE WORKFORCE STRATEGIC FRAMEWORK PROGRESS REPORT

1.0 INTRODUCTION AND BACKGROUND

GHC's lived experience workforce to date has developed organically and, in an ad-hoc way, through the vision of a minority of service leads predominantly in mental health services. In line with the NHS Long Term Plan, GHC has an ambition to enhance and increase LXP and PSW roles across the organisation, not just in mental health services but to be trailblazers for physical health, children's, learning disabilities and neurodiversity services.

A task and finish group chaired by the Head of Partnerships, with group members being drawn from Operational, HR and Quality directorates and from lived experience workforce met to scope the work, including:

- Background review of current establishment, relevant literature and benchmarking against other trusts.
- Conducted and analysed information from surveys and focus groups sessions, with current LXP colleagues, managers and clinical team leaders, patients/ service users; and 1:1 conversations conducted with senior managers

What emerged was a realisation that a framework alone would be insufficient to support existing employee's or expand the workforce. Expanding our lived experience workforce will require transforming our organisational culture and require additional resource to develop leadership support and infrastructure (recruitment, training, career development, etc). Whilst our research focused on GHC employed workforce, further work to understand and support a blended lived experience workforce approach with VCSE partners is progressing.

2.0 DEFINITION OF TERMS AND LIVED EXPERIENCE ROLES WITHIN GHC

It is important to note that peer support styled terms are used in a different context, either as paid or voluntary roles, and carry different responsibilities to those found in NHS roles. Similarly, we recognise that people with lived experience are employed in various roles across GHC (e.g. corporate, clinical, administrative and voluntary work roles etc...), some of which may be roles that are aimed at directly supporting an individual's pathway into employment. We also involve and include people who use our services, such as members of the youth and adult experts by experience programmes, communities and groups in a variety of consultation and co-production activities. These roles are not the focus of attention.

For clarity, in GHC, we follow national naming convention for **lived experience workforce** and use the terms **Lived Experience Practitioner (LXP**) and **Peer Support Worker** (**PSW**) in job titles to refer to a distinct role that aligns to the HEE competency Framework (Appendices 2). Core competencies of PSW's &

LXP's includes training and skills to formally and intentionally share lived experiences directly with patients as part of a service delivery model. The focus of the role is in building a relationship based on mutuality and reciprocity. The work involves a skilled interaction that enables and empowers a process of learning together using common experiences to support new perspectives, develop skills and strengths. It is the lived experience workforce (highlighted yellow in the table below) that we are intending to develop a leadership support and infrastructure and build a strategic framework.

TABLE 1: GHC Lived Experience roles and terms

Role	Description	Current Management arrangements in GHC	GHC Employment status
Peer Support Worker (this includes those with job title variants)	PSWs draw directly on their own lived experiences of mental or physical illness, using a recovery, holistic and strengths-based approach, to offer emotional and practical support to people going through similar kinds of experiences.	Operationally funded, managed, & supervised by the team in which they are based	Band 3 and 4
Lived Experience Practitioner	Offer Peer Support as part of their role, but also use their lived experience to train and inform staff and other organisations.		Band 4
Lead Peer Support Worker	Use their lived experience to provide educational course to others to help them self-manage their condition and/or recovery. N.B previously also a GHC wide lead role provided training, supervision, guidance and support to PSWs, teams and Managers is no longer a funded.	Managed by the Health and Wellbeing College	Band 5
Peer Facilitator or Self-Management Facilitator		Lead provides supervision in Health and Wellbeing College	Band 4
Experts by Experience	People who have lived experience of any of our services and use this to provide a perspective or expertise to improve care quality, service development, Quality Improvement (QI) projects, staff training, recruitment, etc.	Partnerships Team	Voluntary – with honorarium payment and expenses
Volunteers	Unpaid posts that use lived experience as part of defined role descriptions to support service users / service delivery.	Volunteer Co-ordinator & service	Volunteer posts

3.0 BARRIERS AND ISSUES IDENTIFIED

Several barriers to GHC expanding our LXP workforce were identified through scoping activity. Key issues include:

- There is no professional leadership or central support structure for our LXP/PSW's or service managers. For reference, the Northeast London Collaborative leadership structure includes NHS agenda for change band 1x 8a + 1x7 LXP/PSW's; previously GHC trialled a band 5 lead role that was considered valuable but an insufficient resource.
- There is inconsistent understanding and mixed views on lived experience roles across GHC services requiring a culture change amongst many leaders and service teams if we are to expand the number of LXP/PSW's.
- There is no guidance for managers and teams about how to develop and integrate lived experience roles into service designs and workforce models.
- There is an inconsistent approach to recruitment, job descriptions, and role titles, impacting data quality and benchmark reporting.
- A sustainable training strategy for LXP/PSW's is required as nationally funded provision we previously used is no longer available.
- There is evidence that these issues are having a negative impact on LXP/PSW staff retention. Reason for leaving and turnover rates for LXP/PSW 's within GHC requires further understanding.
- There is evidence that commissioning and service specifications are increasingly recognising the value added and benefits of roles specifically utilising lived experience. GHC can learn from other NHS Trusts and make the most of the value added from this workforce to drive improvement in outcomes for service users.

4.0 NEXT STEPS AND PROGRESS UPDATE

In November 2024, the executive team endorsed the summary report findings that a framework alone would be insufficient, agreeing in principle to approve and explore additional finance and resource needs for a leadership role and support infra-structure required (including training resource).

Action	Lead
Establish a T&F group to explore direct and in-direct resource needs, options, and costs (leadership role, supervision, training, etc) re request for additional funds. Draft proposal by Jan 2025 to Execs.	Julie Mackie, Ruth Thomas, LE-P and manager, NHS-E rep.
Support and set-up a lived experience support group/network (completed & operating)	Liz Curtis, Pippa Mileham & Katie Stonall
Establish a task and finish group to co-design the lived experience workforce framework & tools (including VCS partners). Draft framework completed for April 2025.	Julie Mackie, LXP's & PSW and subject experts.
Align strategic aims and ambitions for PSWs to the wider GHC strategic workforce planning workstream to ensure cohesion with wider workforce needs and resource limits. Completed by April 2025.	Rosanna James, Neil Savage and Julie Mackie

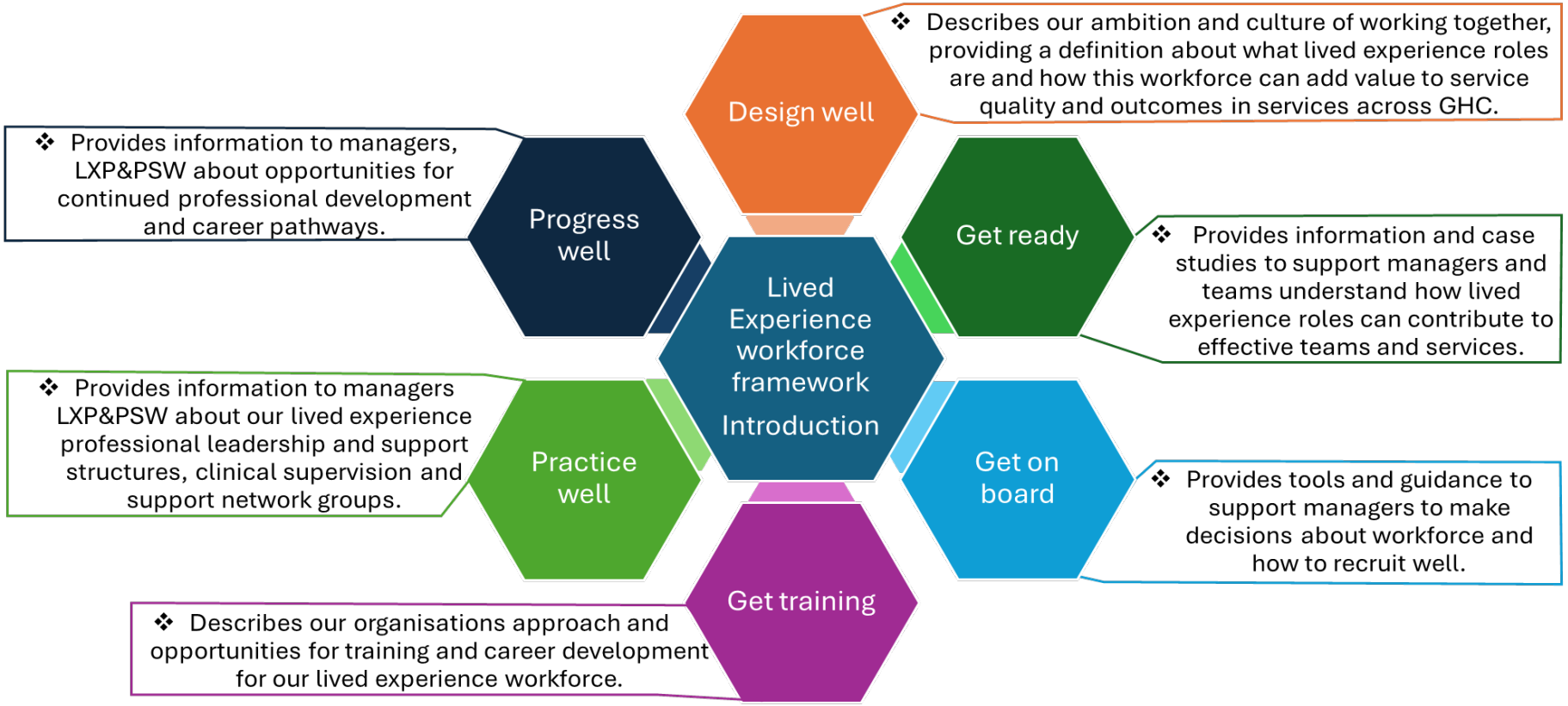
Progress Update:

- Identified a professional leadership structure for LXP/PSW 's within GHC's Psychological Services.
- A task group is developing a job description and job matching activity for an appropriate leadership role.
- A service has been identified to test out a pre-selection drop-in Q&A recruitment approach for a current vacancy.
- A conversation workshop is planned for 22nd January involving VCSE organisation leads. This will include presentations from current LXP/PSW and our partners the Nelson Trust to stimulate conversation about barriers, challenges, and opportunities for partnership working.

APPENDIX 1: DRAFT PSW FRAMEWORK

The purpose of the framework is to be a functional resource that provides clarity, information, guidance, and tools for service managers, line managers, service teams, and lived experience workforce members to develop and integrate lived experience roles in GHC's workforce and across services. The framework conceptual model and proposed strategic goals are outlined below.

Proposed GHC LE-P strategic framework conceptual model:



N.B. Informed by current best practice framework models.

Strategic goals (1-3 years):

- To develop professional leadership structure to support the current lived experience workforce, expand the number of LXP/PSW roles in GHC services and directorates including those not previously considered, and connect with VCSE partners.
- To expand the number of LXP/PSW through a blended workforce model featuring as part of GHC's Strategic Workforce Plan to ensure resource for support, training, and career progression.
- To consolidate information and guidance about LXP/PSW's employment, integration and support systems into a single accessible document.
- To consolidate information and guidance about different ways to involve lived experience in service delivery models including working with VCSE partners and community groups, and GHC's voluntary and expert by experience programmes.
- To embed a culture within GHC that understands and recognises the value added and benefits of a lived experience workforce to quality service delivery.

The Strategic Framework content will include:

1. Clear statement of GHC ambition and goals to develop and expand our lived experience practitioner workforce, including an initial priority to improve current leadership structures.

2. Definition and description of lived experience roles using colleagues' stories to promote understanding, identify benefits & to support role development across the Trust.

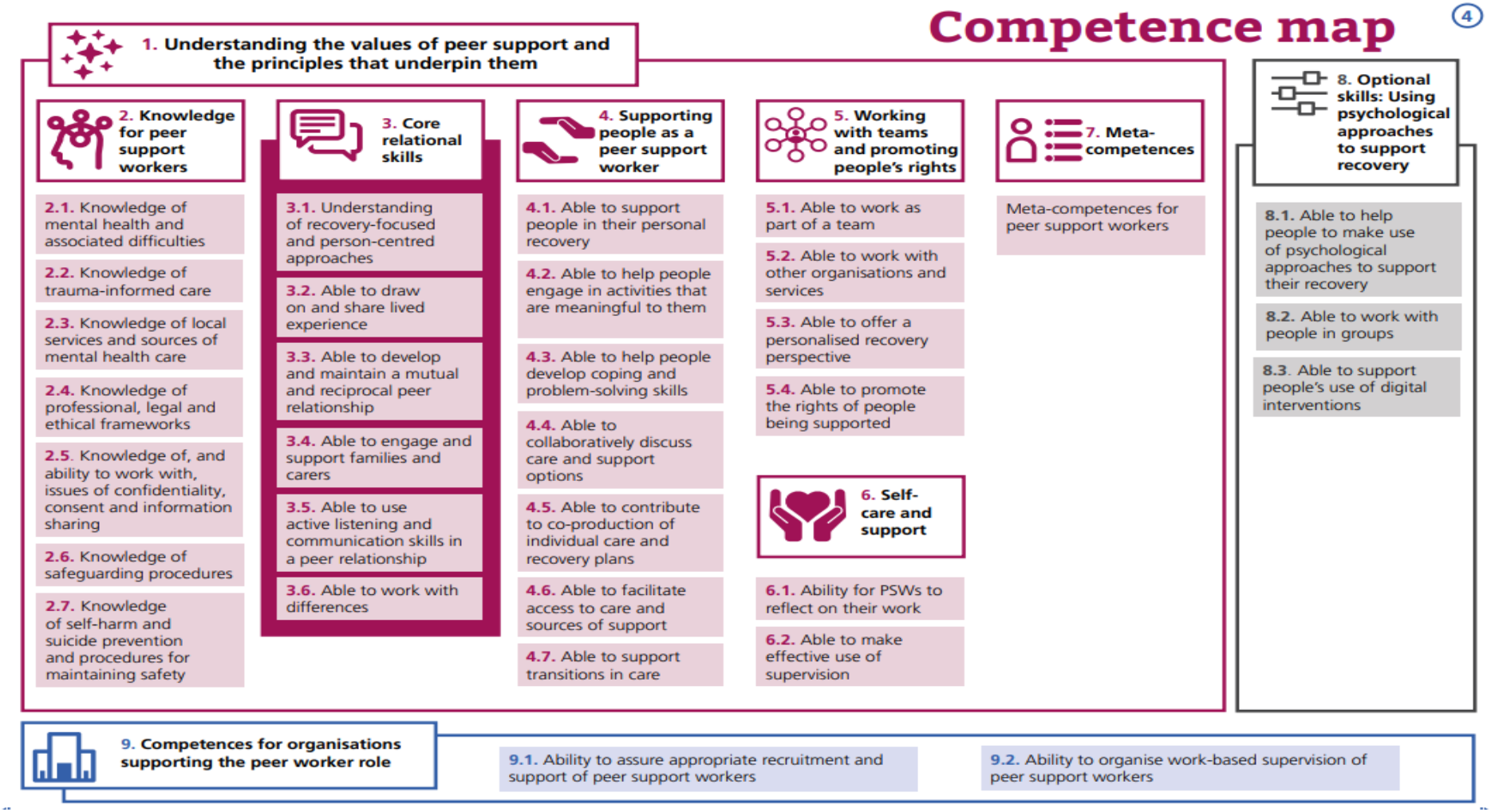
3. Statement of our Trust position to use Lived Experience (LE) prefix and to only employ people with LE in these clinical roles, e.g. Lived Experience Peer Support Workers (LE-PSW) or Lived Experience Practitioner (LE-P).

4. Define what we are doing to address our priority to ensure we have the right support structures in place to support and develop our current workforce, including lived experience professional leadership, support structures, training opportunities, etc.

5. Provide access to resources, information, guidance, and tools to support managers and teams to consider, develop, and integrate lived experience roles in service workforce and delivery models across GHC.

APPENDIX 2: PEER SUPPORT WORKER COMPETENCY FRAMEWORK

[The Competence Framework for MH PSWs - Part 1 - Supporting document.pdf]



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AGENDA ITEM: 14/0125

REPORT TO: **TRUST BOARD PUBLIC SESSION – 23 January 2025**

PRESENTED BY: Rosanna James, Director of Improvement and Partnerships

AUTHOR: James Powell, Head of Sustainability

SUBJECT: **2023-24 CARBON FOOTPRINT REPORT AND GREEN PLAN DELIVERY**

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 on the 23/24 carbon footprint metrics and the progress made on delivering the Gloucestershire Health and Care's (GHC) Green Plan, which was approved in January 2022.

The Green Plan is GHC's 3-year Sustainability Strategy aimed at meeting national NHS net zero requirements and supporting sustainability efforts across the Trust, the Integrated Care Board (ICB) and the wider system.

Recommendations and decisions required

The Trust Board is asked to **ACKNOWLEDGE** the positive progress in delivering the Green Plan and reducing our Carbon Footprint in line with NHS net zero targets.

Executive summary

This paper provides an update on the Trust's total carbon footprint for the 23/24 financial year. Our Carbon Footprint Data is completed in arrears as we require 12 months of data for completion. The data is then verified by NHS England in Q1/Q2 of the next financial year via ERIC. This data concludes our efforts for Year 2 of our 3 Year Green Plan. The paper also provides an update on progress against the Trust Green Plan, which will be refreshed in the 25/26 financial year.

Our total carbon footprint (combined direct carbon footprint and carbon footprint plus) **increased by 0.03%** compared to the previous year (2022-23). However, we've achieved **a 21% reduction** compared to our 2019-20 baseline. This rise can be attributed to increased waste, pharmacy, and electricity emission factors.

In 23/24, our direct emissions **decreased by 2%** compared to the previous year and showed a **32% reduction** from our 19/20 baseline. Our Green Plan set a target to reduce our **direct carbon footprint by 25% by 25/26** (against a 19/20 baseline). We have therefore exceeded this goal by achieving a 32% reduction in the current financial year. The risk of not achieving our overall Green Plan Target is therefore minimal, but we will not know until our 24/25 carbon footprint is released in Q2 of the 25/26 financial year.

Risks associated with meeting the Trust's values

The Goals and Targets set out in this 3-year Green Plan have been fully achieved and therefore presents no risk to meeting the Trusts values.

Corporate Considerations	
Quality Implications	N/A
Resource Implications	N/A
Equality Implications	N/A

Where has this issue been discussed before?

The 2023/24 report was approved by the Resource Committee on the 22nd October 2024.

Appendices:	Appendix 1 Green Plan Linked Goals Green Dashboard

Report authorised by: Rosanna James	**Title:** Director of Improvement and Partnerships

Acronyms used within this report	
GHC	Gloucestershire Health and Care NHS Foundation Trust
GHFT	Gloucestershire Hospitals NHS Foundation Trust
ICB	Integrated Care Board

2023/24 CARBON FOOTPRINT REPORT AND GREEN PLAN DELIVERY

1.0 INTRODUCTION

This report provides an overview of our total, direct and carbon footprint plus for the 23/24 financial year. The Trust's direct carbon footprint includes emissions within the organisations direct control, such as those from building energy, waste, water, business travel, fleet, inhalers, and anaesthetic gases. The Trust's carbon footprint plus includes the carbon footprint of the organisations indirect emissions which include supply chain, staff commuting, and patient and visitor travel. Combined, these make up GHC's total carbon footprint.

2.0 TOTAL CARBON FOOTPRINT

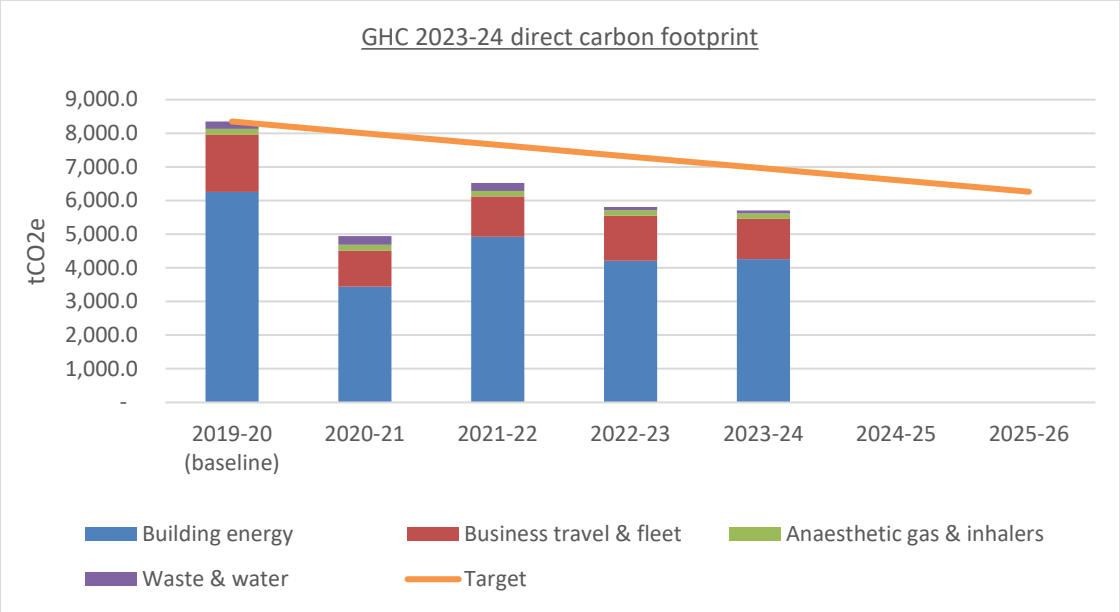
In 23/24, our total carbon footprint was estimated to be 22,838 tCO_2e, the equivalent of a person flying a return journey from London to Hong Kong 6,525 times. Our direct carbon footprint accounted for 25% of these emissions, with the remaining 75% attributed to our carbon footprint plus.

The primary contributors to our 23/24 total carbon footprint are:

- Supply chain: 48% of our total emissions
- Building energy:19% of our total emissions
- Commissioned health and care services:13% of our total emissions
- Staff commuting: 10% of our total emissions

3.0 23/24 DIRECT CARBON FOOTPRINT

In 23/24, our direct emissions were estimated to be 5,707 tCO_2e, or 25% of our total carbon footprint. This represents a 2% reduction compared to the previous year (2022-23) and a 32% reduction compared to our baseline year, surpassing our Green Plan Goal of a 25% reduction in direct emissions by 25/26.



The leading sources of our direct carbon footprint are:

- Building energy (fossil fuels): 48%
- Building energy (electricity): 27%
- Business travel: 17%

Key Headlines

Building Energy

- **Gas and Electricity**: overall consumption increased by 1% compared to the 22/23 financial year but emissions remain down 32% compared to our 19/20 baseline.
- **Electricity:** Emissions increased by 12% and electricity consumption increased by 6% compared to the 22/23 financial year
- **Gas:** emissions increased by 2% compared to the previous financial year
- This Increase in building energy emissions partially reflects the rise in national grid carbon intensity for 23/24, with electricity emission factor increased from 0.26155 kgCO2e in 2022 to 0.27486 kgCO2e in 2023.
- **Oil:** 50% reduction in emissions compared to the 22/23 financial year and 74% since our 19/20 baseline year. This is due to the closure of the Lydney and Dilke Hospitals.

Waste

- Emissions from waste decreased by 55% in 23/24 compared to 22/23 and 79% since our 19/20 baseline.
- This reduction reflects a 30% decrease in infectious waste disposal, coupled with an increase in the amount of general domestic waste and recycling.

Business Travel and Fleet

- Business Travel emissions decreased by 12% compared to the 22/23 financial year and 33% since our 19/20 baseline – surpassing our Green Plan target of a 25% reduction in business travel emissions.

4.0 23/24 CARBON FOOTPRINT PLUS

In 23/24, our carbon footprint plus was estimated to be 17,131 tCO_2e, or 75% of our total carbon footprint. This represents a 21% reduction compared to our baseline year and a 0.03% increase in the previous financial year. Whilst we are reporting an increase, we cannot accurately compare from the previous financial year due to a change in methodology in calculating our supply chain emissions factors. We now use the UK Government SIC code for emissions factors for supply chain emissions as recommended by NHS England.

Our Green Plan does not contain a total carbon footprint reduction target as our Carbon Footprint Plus calculations are based on spend (£) rather than the carbon value of items. This is a national challenge and NHS England is working on providing accurate carbon footprint plus data, though no release date has been announced.

The leading sources of emissions from our carbon footprint plus are:

- Supply Chain – 69%
- Commissioned Health and Social Care Services – 17%
- Staff Commuting – 14%
- Patient and Visitor Travel – 6%

Key Headlines

Supply Chain

- Pharmacy is the leading source of supply chain emissions, accounting for 22% of the supply chain total emissions
- Non-sterile gloves purchased decreased by 36% in 23/24 compared to the previous financial year, this is due to a reduction in demand and central stock since post-pandemic.

Staff Travel

- 4% increase in staff commuting compared to the 2022/23 financial year

Patient and Visitor Travel

- 2.3% decrease in patient and visitor travel emissions compared to the 2022/23 financial year

For Staff Travel /Patient Travel, the current methodology relies on the Health Outcomes for Travel Tool (HOTT) based on predictions for the year 2023-24. To ensure accuracy, future estimates for staff commuting will be based on staff surveys, whereas patient/visitor travel will be based on actual patient numbers.

5.0 GREEN PLAN DELIVERY

The GHC Green Plan outlines key areas of focus to achieve the Trust's sustainability targets and carbon reduction goals by NHS England. Each deliverable is aligned to a goal, including measurable impact on the Trust's carbon footprint.

Progress on the Green Plan implementation remains positive, with a detailed overview provided in **Appendix 1** of this paper.

6.0 ALIGNMENT WITH THE ONE GLOUCESTERSHIRE ICS GREEN PLAN

The ICB has collaborated with the Sustainability Teams at GHC and GHFT to align individual Trusts Green Plans with the objectives of the One Gloucestershire's ICS Green Plan, ensuring consistency with national NHS net zero targets.

7.0 2024/25 CARBON FOOTPRINT

The 24/25 financial year is our current Green Plan's final data collection period. By Q2 of the 25/26 financial year, our carbon footprint for the current financial year will be complete, and our final emissions reductions will be realised.

Our Green Plan aim was to achieve a 25% reduction in our direct emissions by 25/26, against a 19/20 baseline. We have already exceeded this target, having achieved a 32% reduction in our direct emissions for the 23/24 financial year (against a 19/20 baseline). With this 7% lead and additional carbon reduction benefits from the FoD hospital included in the 24/25 carbon footprint, the risk of us not meeting our Green Plan Target is low.

8.0 GREEN PLAN REFRESH

The Trust's Green Plan is due for a refresh in the 25/26 financial year. This will include the development of a new direct carbon footprint reduction target, and associated objectives and celebrating the successes over the past 3 years. Updated Green Plan Guidance from NHS England is yet to be released, but we have been assured that no major changes will take place.

We have held development sessions with key groups, including Fleet, Estates and the Board to support this and are currently in the scoping phase of delivery, with the aim to get the Green Plan Refreshed and approved by the Board in Q1 of the 25/26 financial year.

APPENDIX 1 - Green Plan linked Goals Dashboard

Net Zero

					Baseline		Green Plan Target		Annual Progress against baseline					
Green Plan Theme	**Green Plan Goal**	**Target Type**	**Carbon Footprint category**	**Metric**	**Year**	**Value**	**Target**	**Goal Date (end of FY)**	**20/21**	**21/22**	**22/23**	**23/24**	**RAG**	**Mitigations / Comments**
Net Zero	Decarbonise our estate by reducing emissions from building energy use.	NHS Mandatory	NHS Carbon Footprint	% reduction in emissions	19/20	6256 tco2e	**25%**	24/25	-82%	-21%	-36%	-34%		Target already exceeded – focus on sustaining and further reduction through heat decarbonisation.
	inclusion of low, ultra-low or zero emission vehicles in fleet.	NHS Mandatory	NHS Carbon Footprint	% of overall fleet	19/20	0% (98 vehicles)	**10%**	24/25	1% (1/93 vehicles)	18% (18/104 vehicles)	22% (24/106 vehicles)	22% (24/106 vehicles)		Target reached but 99% of the vehicles are hybrid and therefore we haven't reduced our carbon footprint from Trust Fleet - still accounts for 4% of direct emissions. Travel strategy due in 25/26 to reduce carbon footprint of fleet.
	Reduce Trust business mileage.	NHS Mandatory	NHS Carbon Footprint	% reduction	19/20	1422 tco2e	**20%**	24/25	-39%	-34%	-24%	-33%		Exceeded target but percentage reductions are decreasing annually.
	Develop and construct our first net zero community hospital in the Forest of Dean by 2024/25.	NHS Mandatory	NHS Carbon Footprint	new builds to meet Net Zero Carbon Hospital Standards	19/20			23/24						Formal NHS standard released in 23/24 financial year – clarifying if the FoD meets this standard.

					Baseline		Green Plan Target		Annual Progress against baseline					
Green Plan Theme	**Green Plan Goal**	**Target Type**	**Carbon Footprint category**	**Metric**	**Year**	**Value**	**Target**	**Goal Date (end of FY)**	**20/21**	**21/22**	**22/23**	**23/24**	**RAG**	**Mitigations / Comments**
	To increase our resilience against climate-related severe weather events.	ICS	NHS Carbon Footprint	County wide Climate Change Adaptation Plan in place				25/26						Benefits realisation of FoD required during the 25/26 financial year
	To develop sustainability and net zero principles into all new, existing, and decommissioning projects.	NHS Mandatory	NHS Carbon Footprint	Development of a Net Zero Building design standard				22/23						we have missed the target due to external delays in NHS England producing the Net Zero building standard - no penalties associated with us missing this target.

Equity and Procurement

					Baseline		Green Plan Target		Annual Progress against baseline					
Green Plan Theme	**Green Plan Goal**	**Target Type**	**Carbon Footprint category**	**Metric**	**Year**	**Value**	**Target**	**Goal Date (FY)**	**20/21**	**21/22**	**22/23**	**23/24**	**RAG**	**Mitigation/ Comments**
Equity and Procurement	Increase waste recycling rate.	NHS Recommended	NHS Carbon Footprint Plus	% increase in recycling rate	20/21	TBC	**50%**	24/25	TBC	TBC	TBC	TBC		new waste contract in place with clearer KPIs - will have data in 2025.
	Embed a 10% sustainability and social value into the weightings criteria of all procurement contracts.	NHS Mandatory	NHS Carbon Footprint Plus	Compliance to NHS England Social Value.										Completed 23/24 FY - mandated via NHS England.
	increase procurement spend with local businesses spend where financially viable.	NHS Recommended	NHS Carbon Footprint Plus	% increase in spend with local businesses	22/23	TBC	**TBC**	24/25	TBC	TBC	TBC	TBC		Local definition TBC – we are now using a Gloucestershire-based contractor for Heat Decarbonisation works.
	to reduce the use of single-use plastics used within the organisation where financially feasible.	NHS Mandatory	NHS Carbon Footprint Plus	% reduction	18/19		**10%**		NA	NA	-25%			No data is available for financial years 20/21 and 21/22, data was available for 22/23 and indicates that we are exceeding our 10% target.

Sustainable Models of Care

					Baseline		Green Plan Target		Annual Progress against baseline					
Green Plan Theme	**Green Plan Goal**	**Target Type**	**Carbon Footprint category**	**Metric**	**Year**	**Value**	**Target**	**Goal Date (FY)**	**20/21**	**21/22**	**22/23**	**23/24**	**RAG**	**Mitigation / Comments**
Sustainable Models of Care	Reduce Meter Dose Inhalers.	NHS Mandatory	NHS Carbon Footprint Plus	% reduction in Meter Dose inhalers	19/20	7 tco2e	**25%**	25/26	-14%	-29%	-31%	-31%		Exceeded target set in Green Plan.
	Reduce the use of pharmaceuticals and harmful medical gases.	NHS Mandatory	NHS Carbon Footprint	% reduction in co2e of anaesthetic gases	19/20	162 tco2e	**No target set**	25/26						Data is currently unavailable but anaesthetic gases only account for 1% of our total carbon footprint therefore limited scope for change/low carbon impact.
	Empower people across the organisation to make sustainable and nutritious food choices.	NHS Recommended	NHS Carbon Footprint Plus	% reduction in emissions from low carbon menu choices	19/20	22kgco2e	**No target set**	25/26		-27%				27% reduction in carbon emissions from menu choices and a 22% reduction in carbon emissions by portion.
	Increase the amount of sustainable and active travel facilities across the Trust to contribute towards improved air quality, health and wellbeing.	NHS Mandatory	NHS Carbon Footprint	Number of cycle spaces and number of EV charging points	19/20	TBC	**No target set**	23/24						New EV charging points at: FoD, ILC and Weavers Croft. New active travel facilities: FoD.
	Reduction in food waste.	NHS Recommended	NHS Carbon	% reduction in food waste	20/21	TBC	**60%**	25/26						Digital meal ordering system will significantly assist in this

					Baseline		Green Plan Target		Annual Progress against baseline					
Green Plan Theme	**Green Plan Goal**	**Target Type**	**Carbon Footprint category**	**Metric**	**Year**	**Value**	**Target**	**Goal Date (FY)**	**20/21**	**21/22**	**22/23**	**23/24**	**RAG**	**Mitigation / Comments**
			Footprint Plus											reduction when it goes live in 24/25.
	Increased impacts of digitally enabled care through a reduction in face-to-face appointments.	NHS Mandatory	NHS Carbon Footprint Plus	% reduction in face-to-face appointments	**19/20**	**TBC**	**25%**	**25/26**						NHS mandatory target - need to establish baseline value and progress.
	Understand opportunities that biodiversity and, greenspace offer in order to promote a more sustainable model of care.	NHS Mandatory	NHS Carbon Footprint Plus	Development of Greenspace and Biodiversity Strategy	**19/20**			**23/24**						FoD – added Greenspace. Strategy to be completed in the next Green Plan – no penalty for not completing during this Green Plan.

Workforce and System Leadership

					Baseline		Green Plan Target		Annual progress against baseline					
Green Plan Theme	**Green Plan Goal**	**Target Type**	**Carbon Footprint category**	**Metric**	**Year**	**Value**	**Target reduction**	**Goal Date (FY)**	**20/21**	**21/22**	**22/23**	**23/24**	**RAG**	**Comments**
Workforce and Systems Leadership	Improve the awareness of the Sustainability agenda across the organisation.	NHS Recommended	NHS Carbon Footprint Plus	Development of sustainability behaviour change campaign	20/21			23/24						Embedded into QI and working with teams across the organisation such as IPC and podiatry.
	Embed sustainability into Trust transformational, learning & development and quality improvement programmes of work.	NHS Recommended	NHS Carbon Footprint Plus	Sustainability Embedded into stated services	20/21			23/24						Embedded in QI, further work to embed in Transformation and L&D

GLOUCESTERSHIRE HEALTH AND CARE NHS FOUNDATION TRUST
COUNCIL OF GOVERNORS MEETING

Wednesday 13 November 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
	Sarah Nicholson	Cath Fern	Tussie Myerson
	Chas Townley	Alicia Wynn	Jenny Hincks
	Laura Bailey	Martin Pittaway	Michelle Kirk
	Marcia Gallagher	Sarah Waller	

IN ATTENDANCE: Steve Alvis, Non-Executive Director
Sandra Betney, Director of Finance/Deputy Chief Executive (Item 7)
Sarah Branton, Chief Operating Officer
Anna Hilditch, Assistant Trust Secretary
Cathia Jenainati, Associate Non-Executive Director
Kate Nelmes, Head of Communications
Lavinia Rowsell, Director of Corporate Governance / Trust Secretary
Lisa Proctor, AD of Contracts and Planning
Nicola de Iongh, Non-Executive Director/Deputy Chair

1. WELCOMES AND APOLOGIES

1.1 Apologies had been received from the following Governors: Amy Aitken, Paul Winterbottom, and Rebecca Halifax. Apologies had also been received from Douglas Blair (Chief Executive), Non-Executive Directors Bilal Lala, Sumita Hutchison, Jason Makepeace, and Jan Marriott, and Associate Non-Executive Director, Vicci Livingstone-Thompson.

1.2 Following the Governor elections in September, Graham Russell said that the Trust was very pleased to welcome its newly appointed Governors:

- Sarah Waller (Public Governor: Greater England & Wales)
- Marcia Gallagher (Public Governor: Forest of Dean)
- Michelle Kirk (Staff Governor: Health & Social Care Professionals)
- Amy Aitken (Staff Governor: Management & Administration)
- Martin Pittaway (Staff Governor: Management & Administration)

1.3 The Council noted that Neil Hubbard (Public Governor: Cheltenham) and Ismail Surty (Public Governor: Gloucester) had tendered their resignations. The Council joined Graham Russell in sending best wishes to both colleagues.

2. DECLARATIONS OF INTEREST

2.1 There were no new declarations of interest.

3. MINUTES OF THE PREVIOUS MEETINGS

3.1 The minutes from the previous Council meeting held on 18th September, and the extraordinary meeting on 24th October were received and 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 further consideration of NED remuneration would be taking place at the Nominations and Remuneration Committee meeting in January. Any recommendations in relation to Chair and NED remuneration would be presented back to the full Council of Governors for approval.

4.3 Steve Lydon referred back to the discussions that had taken place at the last meeting around the publication of the Darzi review and asked whether it was possible to have a regular standing item on Council agendas going forward by way of an update. It was agreed that this was an important area, and updates would continue to be provided via the Chair and Chief Executive reports.

5. CHAIR'S REPORT

5.1 Graham Russell informed the Governors that this had been an interesting period with many announcements at a national level about what needs to be done to improve the health and care sector. Graham said that he wished to highlight four key areas to the Council.

5.2 Firstly, Graham said 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 the Trust was in an excellent position to make a real gear change and a real difference. Graham Russell said that he hoped GHC could play an important role in designing the services, rather than just providing them.

5.3 Graham's second reflection related to the need to ensure that we make the very best use of our community hospitals. Graham had recently visited all of the Trust's community hospitals and said that these were 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 these spaces and this will be an important focus for the Trust as we continue to develop our offer to local communities. Michelle Kirk agreed but said it was important to be mindful of the exclusion criteria for community services. Marcia Gallagher said that the availability of clinics within the community hospitals came down the availability of Acute Trust staff to run them, noting endoscopy as an example. Sandra Betney said that she was the Chair of the Diagnostic Programme Board in Gloucestershire and advised that a system plan was currently in development for the provision of diagnostic services in Gloucestershire, including endoscopy. This plan also included a workforce strategy.

5.4 Graham Russell said that we should never underestimate the power of partnership. Collaborative working with others helps us to provide better services than if we were working on our own. 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. Graham Russell stressed the importance of working with the voluntary sector and he noted that a working lunch had been scheduled with colleagues from the Gloucester VCS in December to discuss how we can work better together. It was suggested that a copy of a presentation received at the Trust Board in September could be shared with all Governors. This related to a presentation on CAMHS and the progress the services had made in managing increased demand and waiting list challenges. There were some excellent examples of how working with non-NHS partners and the voluntary sector had helped in developing new and strengthened pathways to support patients and their families. **ACTION**

5.5 Graham's final reflection related to the importance of culture. Culture is how we operate; how we interrelate; how we work together; how we provide services; and how we behave. A tolerant and inclusive culture does take time to create but is easily lost and we should be mindful of that. More diverse organisations are better performing organisations and better able to serve all communities in Gloucestershire. A programme of work had commenced focussing on Leadership & Culture, and a further update would be presented to the Council later in the meeting.

6. CHIEF EXECUTIVE'S REPORT

6.1 The Council welcomed Sandra Betney, Deputy CEO to the meeting who provided a verbal update on key matters to the Governors, including the launch of the Integrated Urgent Care Service (IUCS), the introduction of the new Mental Health Bill, and an update on new Executive Board appointments.

6.2 On 19th November the Trust would be launching a new Integrated Urgent Care Service in collaboration with IC24. This marks a big step for our Trust, providing out of hours primary care and NHS111 services. 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.

6.3 Sandra Betney informed the Council that the IUCS was a great opportunity, but it was important to acknowledge that it could be a bumpy start and a huge amount of work had taken place to assess the potential risks and to mitigate against these. Risk areas included clinical coverage, IT systems, staffing/workforce, patient safety and clinical governance. It was important that the Trust was able to offer a responsive service as well as ensuring a smooth transition from the existing provider. Steve Lydon asked whether a customer walk through of the new service had been carried out in advance of go live. Sandra Betney said that this had taken place, with a mass call in, full pathway testing and walk throughs. She said that this had led to some changes and had helped identify key areas for monitoring. Steve Lydon said that people presented at Emergency Departments due to failures elsewhere in the pathway. He said that he fully supported the IUCS and welcomed the assurance provided around service testing and the identification of key risks and performance measures for monitoring.

6.4 The Council noted that on 6th November the new Mental Health Bill was introduced in Parliament by the government to reform the Mental Health Act 1983 (MHA). Full implementation of the 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. Sandra Betney advised that the Bill would have major implications for GHC in terms of how we work and the need for additional resources. The Trust's Mental Health Legislation Scrutiny Committee would lead on the oversight of this work.

6.5 The Council of Governors noted that two new Executive Directors had now joined the Trust. Sarah Branton (Chief Operating Officer) and Rosanna James (Director of Improvement and Partnership) had both commenced in post on 4th November 2024.

7. TRUST STRATEGY & BUSINESS PLANNING

Trust Strategy Refresh

7.1 Sandra Betney presented the Governors with the proposals for taking forward the Trust Strategy refresh. The Trust's overarching strategy "Our Strategy for the Future 2021 – 2026: Better Care Together" was approved in 2021. Governors received a reminder of the four key strategic aims identified in the strategy, alongside the supporting strategies in place such as Quality, People, Digital and Estates.

7.2 A 3-year review was planned of the strategic context, changes in the operating environment, and alignment to annual Business Planning to support monitoring against the strategic aims. The development of a new service delivery framework had also been proposed to cover 3-year high level transformation priorities. The Council was informed however, that the Strategy refresh which had been planned for Summer 2024 had not been pursued due to significant board member transition and it was felt imperative to engage the full board in future strategy development.

7.3 Sandra Betney advised that the main headings of the strategy still hold true, and there was no need for radical immediate change at a high level. System working means increasingly we are making a contribution to a wider strategic ambition, rather than setting our own unique path, and there was a need to develop more strategic thinking in relation to specific areas of service delivery, rather than add similar high-level thinking. The Council noted that this had been considered at a recent Board seminar and the Board's preference was for a 'Strategic Delivery Framework' reset against national plans and linked to system strategy. This would be 5 years in scope and would be 'Modular' in style, giving the ability to develop more detailed strategy in relation to specific areas within the same broad framework. Sandra Betney said that work would now be progressed to shape this, with completion of the new framework scheduled for September 2025. It was noted that it was the Governor's role to work alongside the Board to set strategic direction, so engagement with Governors would be built into the timeline.

7.4 Graham Russell thanked Sandra for providing this update, noting that he welcomed the proposal to develop a more dynamic strategy.

Integrated Business Planning & Budget Setting Update

7.5 Lisa Proctor, Associate Director of Contracts and Planning was in attendance to provide an update to the Council on progress with the 2025/26 integrated business planning and budget setting process.

7.6 The business planning process creates alignment with the Trust Strategy and creates a process aligning objectives and budgets, including cost improvement across the organisation. It creates a framework to allow and encourage prioritisation in the context of scarce resources and encourages links between support services and operational objectives.

7.7 The Council noted the "bubble" diagram in relation to the 2024/25 objectives, which grouped agreed objectives into the 4 key strategic aim categories of Better Health, sustainability, high quality care and great place to work. There were 363 milestones identified in the 2024/25 round of planning, and it was encouraging to note that at the end of quarter 2, 70% of these have now been completed, and 29% were underway and on target for achievement by year end.

7.8 Some of the improvements to the business planning process introduced this year were highlighted, and included the embedding of multi-year objectives, the use of a new resource allocation tool, and the continued strengthening of quality assurance processes to ensure business plans are consistent across the Trust.

7.9 The timeline for the 2025/26 business planning process was presented for information, with final Board sign off scheduled for the end of March 2025.

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 in May and a paper was presented to the Council in September highlighting the key themes arising and looking at what might be put in place to achieve these.

8.2 Anna Hilditch provided an update on the proposals and some of the specific actions that would be carried out over the coming months to progress this. A Membership refresh was currently underway, working closely with the Trust's Communications Team to update membership leaflets, website, and other materials. Members of the Membership & Engagement Committee would receive a draft of the new materials for comment.

8.3 It was agreed that it would be helpful to share the previous paper that was received at the September meeting with all Governors, noting that a number of new Governors had joined the Council since then. **ACTION**

9. WORKING TOGETHER ADVISORY COMMITTEE (WTAC) REVIEW

9.1 The Council welcomed Julie Mackie, Head of Partnerships who was in attendance to give a presentation on the Trust's Working Together Plan and the proposals to review the Working Together Advisory Committee.

9.2 Julie Mackie said that the Trust's Working Together Plan had a clear vision, goal, aims and approach. One of its key aims was to include everyone by making it easy for all people and communities to have their say, get feedback and be involved in ways that suit them. The WTAC has increased our awareness of coproduction activity, progress of our objectives, and helped drive forward change that may not have been prioritised. However, some barriers and limitations had been identified over time and these were highlighted in the presentation.

9.3 Some change ideas were presented, to include the renaming and re-design of the WTAC, ensuring that co-production was seen as a Trust wide agenda, working more closely with VSCE, developing mechanisms for feedback and measuring the benefits of co-production. It was also proposed that the Trust look at innovative ways to better engage our governors and members, ensuring they play a more active role as representatives of the communities represented.

9.4 Julie Mackie informed the Council that a workshop had taken place in October to start to explore the future direction and focus for the WTAC, and a further workshop was planned for December with a wide range of stakeholders and partner organisations invited to participate to share thinking. It was noted that a number of Governors attended the WTAC, either in a Governor capacity or representing the organisations they are appointed from. It was agreed that the invitation to attend this December workshop would be opened up to all Governors and further details would be shared with colleagues following the meeting. **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 Following discussion at the last Council meeting, the dashboard had been changed slightly to include the metric for staff turnover rather than vacancy rate. However, Governors agreed that it was important to continue to monitor vacancies and asked if this could be reinstated. Assurance was given to the Governors that the full range of workforce performance metrics were presented to and scrutinised regularly at the Great Place to Work Committee. It was noted that the Performance Report was received and considered at the last committee meeting in November and this provided strong workforce KPI scores and demonstrated positive benchmarking when compared to other similar organisations.

10.3 Bob Lloyd-Smith noted the reference in the Chief Operating Officer report to the Sexual Assault referral Centre (SARC) service and seeking accreditation for the service. He said that he would welcome further information about this. It was suggested that this could be picked up as a future service presentation for Governors and this would be considered further. **ACTION**

10.4 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.

12.2 It was noted that the two new Public Governor vacancies would be included in the next round of elections, due to commence early December 2024.

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 There was no other business.

15. DATE OF NEXT MEETING

15.1 The next meeting would take place on Wednesday 22nd January 2025 at 9.30 – 1.00pm. This would be a joint Governor and NED development session, taking place at Churchdown Community Centre. The next scheduled Council of Governors meeting would take place on Wednesday 19th March.

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.
13 Nov 2024	5.4	CAMHS presentation as received at September Trust Board to be shared with all Governors as an example of good partnership working and collaboration	**Complete**. Emailed round – 20/12/24
	8.3	Ways of Working paper as presented at the September meeting to be shared with all Governors, noting that a number of new Governors had joined the Council since that time	**Complete**. Emailed round – 20/12/24
	9.4	The invitation to attend the WTAC December workshop would be opened up to all Governors and further details would be shared with colleagues following the meeting	**Complete.**
	10.3	A future service presentation for Governors on the Sexual Assault referral Centre (SARC) service to be considered.	**Ongoing**. Added to future presentation schedule.

ASSURANCE REPORT TO BOARD

REPORT TO:	**TRUST PUBLIC BOARD – 23 JANUARY 2025**
COMMITTEE:	**CHARITABLE FUNDS COMMITTEE – 18 DECEMBER 2024**
AUTHOR:	Trust Secretariat
PRESENTED BY:	Nicola de Iongh, 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

No issues reported.

ADVISE: Advise of areas of ongoing monitoring or development

The Committee received the 2nd Hardship Funds Cohort Closure and Future Approach Report, and advised that if the future cohort is close to £25k, this would be taken back to the Committee to discuss a potential further increase.

The Committee discussed maximising income streams of the overall charitable funds, including short term investment opportunities.

The Committee agreed that the Annual Committee Effectiveness Review would be postponed until the following year, due to changes to the Committee membership.

ASSURE: Inform the Board where positive assurance has been achieved

Nothing to highlight.

APPROVALS: Decisions and Approvals made by the Committee

The Committee **approved** the bid for the 17th Big Health Day for £6k. It was noted the total funds required were £20k; £6k would be provided by GCC and the ICB. £2k would be provided by Barnwood Trust. Written confirmation for these funds would be sought ahead of submission of the amount.

The Committee **agreed** to retain the initial cap of £500 for the future Hardship Fund and to increase the total funds available to £25k.

The Committee **endorsed** the relaunch of Microhive; a social enterprise which collects donations directly from staff salaries.

The Committee **approved** making the Charitable Funds Co-Ordinator role a permanent position and acknowledged the considerable progress made already. The Committee **approved** the updates to the Charitable Funds policy.

CELEBRATE: Share any practice innovation or action that the committee considers to be outstanding
Nothing to report.

ITEMS RECEIVED: The following items were received and discussed at the meeting
The Committee **received** an update on the League of Friends for information purposes.

ASSURANCE REPORT TO BOARD

REPORT TO:	**Trust Public Board – 23 JANUARY 2025**
COMMITTEE:	**RESOURCES COMMITTEE – 19 DECEMBER 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

Nothing to report.

ADVISE: Advise of areas of ongoing monitoring or development

The Committee received the Finance Report and was informed that at the end of month 8, cash was £40.642m. This was mainly due to NHS debtors and discussions had been held about improving processes.

A verbal update was provided on the System Finance Position and Deficit Risk Share Update as of month 8, and it was agreed the Trust Board should receive a written submission at its next meeting in January.

ASSURE: Inform the Board where positive assurance has been achieved

The Committee received the Performance Report for month 8 and the indicators in exception were received and discussed.

The Committee received the Future for GHC Integrated Board Reporting Report, which presented the first outline of a multi-year timeline for achieving a greater integration between the Trust's assurance mechanisms, and discussed recommendations for the pre-phase of the plan.

An excellent update on the National Cost Collection Information (NCCI) was shared with the Committee.

The Committee received the Emergency Preparedness Resilience and Response (EPRR) Core Standards, Winter Preparedness and Risk Annual Report, and it was reported the Trust had been rated as substantially compliant against the Core Standards Assurance for the 2024 period.

APPROVALS: Decisions and Approvals made by the Committee

The Committee **actioned** the additional recommendation (within the Finance Report), requiring the Committee to approve the accuracy and robustness of the capital forecast submitted, which included the charge against capital allocations, the impact of IFRS 16, and the total CDEL charge.

The Committee received the ICS Data Strategy and the plan for further development was endorsed prior to being presented to the ICS Systems Resources Committee, and subsequently the Integrated Care Board (ICB).

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

The health inequalities data shared in granular detail within the NCCI presentation was acknowledged, and the committee recognised the benefit of this information to some of the ongoing strategic discussions within the ICS on integrated neighborhood teams.

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

A report on Integrated Business Planning and Budget Setting Process 2025-26 was received and the Committee **noted** that the outputs would be received by the Trust Board in March 2025, for approval.

The Service Development Report was received and **noted**.

The Cyber Security Assurance Report was received and it was agreed that further work would be carried out around cyber assurance processes between the Resources Committee, the Audit and Assurance Committee and the Trust Board.

ASSURANCE REPORT TO BOARD

REPORT TO:	**TRUST PUBLIC BOARD – 23 JANUARY 2025**
COMMITTEE:	**QUALITY COMMITTEE – 9 JANUARY 2025**
AUTHOR:	Trust Secretariat
PRESENTED BY:	Steve Alvis, Vice 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

The Committee received the Quality Dashboard Report. In regard to safeguarding assurance it was confirmed that data related to referral practice is now being shared by the Local Authority. Ongoing work would continue, and this will align with the improvement plan for the Adult Safeguarding Audit .

The Committee remain closely sighted on the trend related to Rapid Tranquilisation and would receive a further briefing at the next Quality Committee meeting. This would include further information on data and benchmarking.

The Committee received the Guardian of Safe Working Report (within the Quality Dashboard), which highlighted breaches relating to the residents' rest periods, with assurance that there would be implementation of changes to the consultant on call rota.

ASSURE: Inform the Board where positive assurance has been achieved

The Committee received a Deep Dive in to Community Nursing by Nancy Farr, Professional Head of Community Nursing and Hannah Williams, Deputy Director of Nursing. There was a range of evidence and information to assure the safety, clinical effectiveness and experience of the community district nursing services. The Committee **noted** that national benchmarking data demonstrates a lower rate of registered nurses compared to other areas. Recruitment difficulties were **noted**.

The Committee was assured of the work progressing relating to the oversight of pressure ulcers and **noted** that the ongoing reporting of pressure ulcers linked to the wider integrated performance reporting developments. The Committee was asked to **support** the quality improvement work which was taking place within community nursing, which included the trialing of the new wound app, and to recognise the opportunities of Advanced Nurse

Practitioner roles in district nursing teams, particularly in the context of recruitment and retention pressures. The Committee **noted** that wider system discussions in relation to the role of community nursing and in understanding the management of pressure ulcers were beneficial.

The Committee received the Research and Development Annual Report and **noted** the work which had been achieved and also the limited resources available. The Committee was informed that further opportunities would be looked in to.

APPROVALS: Decisions and Approvals made by the Committee

Nothing to report.

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

Nothing to report.

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

A verbal update on Integrated Urgent Care (IUC) Mobilisation was provided and it was noted a full report would be received at the next Quality Committee meeting in March.

The Learning Disability Mortality Review (LeDeR) Annual Report was received and **noted**.

The Committee received the Future For GHC Integrated Board Reporting, which provided an update on integrated Board reporting. It was **noted** that this had previously been received by the Resources Committee in December.

The Peer Support Worker Strategic Framework Progress Report was received and the progress made was **noted**. The Committee discussed the focus on the leadership element and noted the impact was still to be developed.

The Quality Assurance Group (QAG) Summary Reports for November and December were **noted** and the Committee reflected positively on the new format being used. The Committee was informed of one item to alert. In December, QAG discussed the neurodiversity caseload in the CYPS directorate, prompted by the waiting list size. This is sighted by the system with discussions with stakeholders to inform a review. It was **noted** that a historic medical model approach was contributing to the level of diagnostic demand and potential over-diagnosis of autism and ADHD conditions.

ASSURANCE REPORT TO BOARD

REPORT TO:	**Trust Public Board – 23 January 2023**
COMMITTEE:	**MENTAL HEALTH LEGISLATION SCRUTINY COMMITTEE (MHLS) 15 JANUARY 2025**
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

Nothing to report.

ADVISE: Advise of areas of ongoing monitoring or development

The Committee received an update from the Mental Health Act Forum. It was reported that Managers had raised concerns about physical activity at Wotton Lawn Hospital, noting the potential that part of the gym may potentially be utilised temporarily as part of the S136 Maxwell suite development. It was **noted** that this was being discussed further with the Executive Team and was under consideration.

The Committee was informed that Mental Health Act managers' training profiles were being reviewed in line with their new 'worker' status.

The Committee received an update on CQC Mental Health Act Monitoring Visits and **noted** that the majority of visits were now overdue due to CQC changes. Regular discussions with CQC colleagues continued.

The Committee received the Approved MH Professional (AMHP) Update Report and was informed that an ethnicity task and finish group was being established to review and improve the ethnicity reporting and identifying the number of reported 'unknowns.' It was **noted** that the majority of unknown ethnicity related to section 2, rather than section 3 patients.

The Committee **agreed** that national and regional benchmarking would be included on the Committee work plan going forward, in line with the Committees Terms of Reference.

ASSURE: Inform the Board where positive assurance has been achieved

The Mental Capacity Act (MCA) Practice, Deprivation of Liberty Safeguards (DoLS) Applications and Liberty Protection Safeguard (LPS) Update Report was received by the

Committee and assurance was provided that the new DoLS leaflet was in place and this was legally compliant. An easy read version was being developed.

The Committee was informed that the Mental Health Act task and finish group was being reinstated to explore the implications of the new MHA.

APPROVALS: Decisions and Approvals made by the Committee

The Committee ratified the changes made to the Receipt, Scrutiny and Rectification of Mental Health Act Documents policy, and **noted** that the changes included moving from joint medical recommendation to a singular medical recommendation in order to reduce the possibility of invalid section.

The Committee **reviewed** and **approved** the changes to the MHLS Committee Terms of Reference. These would be presented to the Trust Board in March for sign off, alongside those of the other Board governance committees.

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

The Committee was informed of the significant improvement in Mental Capacity Act (MCA) compliance following the development of new forms which had been adopted; **noting** that compliance had increased from 27% in June, to 71%.

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

The Mental Health Legislation Operational Group update was received by the Committee.

It was **noted** no issues had arisen from Mental Health Act Manger (MHAM) Reviews.

No new legal updates were reported.

The Annual Review of the MHLS Committee was received and the positive outcome was **noted.**

ASSURANCE REPORT TO BOARD

REPORT TO:	**TRUST PUBLIC BOARD – 23 JANUARY 2025**
COMMITTEE:	**GREAT PLACE TO WORK COMMITTEE (GPTW) 16 JANUARY 2025**
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 was informed via the Learning and Development Strategic Framework update that no confirmation had yet been received nationally for the Continuing Professional Development (CPD) funds for Nursing and AHP colleagues. This was included on the Trust Risk Register under risk 405. It was **noted** monies were received for 2024/25, but there was no guarantee of any further funding, and this could have a significant impact on clinical training and development. A new corporate risk was being prepared.

ADVISE: Advise of areas of ongoing monitoring or development

A new standing item was added to the Committee agenda 'National Workforce Policy Update' to ensure the Committee would be fully sited on areas which may have a future impact the Trust. The following was highlighted during the meeting:

1. Neonatal Care – new legal entitlements for parents from April 2025
2. National Sexual Safety programme – a Trust group is progressing this locally
3. Nursing and Midwifery Role Profiles – these were expected to be published in Spring
4. New Workforce Solution – the national and local replacement process has begun for ESR
5. Summary of national Managers Regulation consultation
6. The 2024 English Devolution White Paper – with potential impact on employment

ASSURE: Inform the Board where positive assurance has been achieved

A Staff Story on retention was shared with the Committee, which provided assurance of the processes enabling retention of a valuable clinical member of staff to continue working within the Trust.

The Committee received the Recruitment and Retention Strategic Framework update and **noted** that good progress was being made against the strategic objectives; however, in

order to become an even greater place to work, there were further areas for the Committee to focus on, including the exit process for staff.

The Learning & Development Strategic Framework Update was received by the Committee, which provided good assurance about activities which were making a difference. It was however flagged that digital skills had more ground to cover. This was also reflected in the ICS Digital Workforce Strategy shared in the meeting.

The Committee received the Performance Report – Workforce KPIs, which provided assurance that activities were going in the right direction and that the Trust benchmarked well on most KPIs. It was recognised that a further update was required on triangulation and integrated reporting. Chris Woon, Deputy Director of Business Intelligence would be invited to a future meeting to provide an update.

APPROVALS: Decisions and Approvals made by the Committee

No approvals were made.

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

The Committee received the People Promise Update, and **noted** the positive feedback received from regional directors and the national team, with further opportunity to make improvements. The Committee congratulated Jade Ajetunmobi on the work achieved.

A presentation was received on the Apprenticeships and T-Levels, and the Committee was impressed with the approach to this. The Committee **noted** that there were still some obstacles and challenges, and that strategic workforce planning was critical to further success in these areas. It was also **noted** that the apprenticeship salary did not appear to be sustainable to live on, which impacted the number of candidate applications. An ICS review was being carried out to address this.

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

The Committee Effectiveness and Terms of Reference Review 2024/25 was received, and it was **agreed** this would be discussed in more detail prior to the next meeting.