[2]GETHER NHS FOUNDATION TRUST

BOARD MEETING

THURSDAY 26 JULY 2018 AT 10.00AM
TRUST HQ, RIKENEL

AGENDA

10.00	1	**Apologies**	
	2	**Declaration of Members Interests**	
10.05	3	**Minutes of the Previous Board Meeting held on 31 May 2018**	**PAPER A**
	4	**Action Points and Matters Arising**	
	5	**Questions from the Public**	
IMPROVING QUALITY			
10.10	6	**Patient Story Presentation**	**VERBAL**
10.40	7	**Performance Dashboard Report – May 2018**	**PAPER B**
10.45	8	**Service Experience Report – Quarter 4**	**PAPER C**
10.55	9	**Non-Executive Director Audit of Complaints Annual Report**	**PAPER D**
11.05	10	**Guardian of Safe Working Report**	**PAPER E**
BREAK – 11.15AM			
IMPROVING ENGAGEMENT			
11.25	11	**Chief Executive's Report**	**PAPER F**
IMPROVING SUSTAINABILITY			
11.40	12	**Summary Financial Report**	**PAPER G**
11.50	13	**Operational Plan Feedback from NHSi**	**PAPER H**
12.00	14	**Board Committee Summaries** • Audit Committee – 25 May • Development Committee – 19 June and Annual Report • Delivery Committee – 23 May, 27 June, 25 July (v) • Governance Committee – 29 June • Charitable Funds Committee – 11 July • Mental Health Legislation Scrutiny Committee – 11 July	**PAPER I1** **PAPER I2** **PAPER I3** **PAPER I4** **PAPER I5** **PAPER I6**
INFORMATION SHARING (TO NOTE ONLY)			
12.15	15 16 17	**Chair's Activity Report** **Council of Governor Minutes – May 2018** **Use of the Trust Seal – Quarter 1**	**PAPER J** **PAPER K** **PAPER L**
12.20	18	**Any Other Business**	
12.25	19	**Date of Next Meeting** Wednesday 26 September 2018 at Trust HQ, Rikenel	

PUBLIC QUESTIONS PROTOCOL

Written questions for the Board Meeting

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

A question under this protocol may be asked in writing to the Trust Secretary by 10am, 4 clear working days before the date of the Board meeting.

A written answer will be provided to a written question and will also be read out at the meeting by the Chair or other Trust Board member to whom it was addressed.

If the questioner is unable to attend the meeting in person, the question and response will still be read out and a formal written response will be sent following the meeting.

A record of all questions asked, and the Trust's response, will be included in the minutes from the Board meeting for public record.

Oral Questions without Notice

A member of the public who has put a written question may, with the consent of the Chair, ask an additional oral question on the same subject.

Public Board meetings also have time allocated at the start of each agenda for the receipt of oral questions from members of the public present, without notice having been given.

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

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

Exclusions

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

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

For further information, please contact the Trust Secretary/Assistant Trust Secretary on 01452 894165. Public questions can be submitted for Trust Board meetings by emailing: anna.hilditch@nhs.net

[2]GETHER NHS FOUNDATION TRUST

BOARD MEETING
THE KINDLE CENTRE, HEREFORD
31 MAY 2018

PRESENT

Ingrid Barker, Joint Trust Chair
Marie Crofts, Director of Quality
Marcia Gallagher, Non-Executive Director
Andrew Lee, Director of Finance
Jane Melton, Director of Engagement and Integration
Colin Merker, Acting Chief Executive
Nikki Richardson, Non-Executive Director
Paul Roberts, Joint Chief Executive
Neil Savage, Director of Organisational Development
Duncan Sutherland, Non-Executive Director
Jonathan Vickers, Non-Executive Director

IN ATTENDANCE

Jane Ellis, Healthwatch Herefordshire
Jan Furniaux, Service Director, Gloucestershire Localities (Item 7)
Anna Hilditch, 2g Assistant Trust Secretary
Kate Nelmes, 2g Head of Communications
Mark Scheepers, 2g Clinical Director
William Thomas, Liaison
Mark Walker, 2g Head of Research (Shadowing Director of E&I)

1. WELCOMES, APOLOGIES AND INTRODUCTIONS

1.1 Apologies were received from John Campbell, Dr Amjad Uppal, Maria Bond and Dominique Thompson.

1.2 The Board welcomed Paul Roberts to his first public Board meeting as Joint Chief Executive.

2. DECLARATIONS OF INTERESTS

2.1 The Director of E&I advised that she was now a member of the West of England Clinical Research Network's Executive Committee, as a provider Trust representative.

2.2 The Board noted that Ingrid Barker was the Joint Chair, and Paul Roberts the Joint Chief Executive of both 2gether and Gloucestershire Care Services.

3. MINUTES OF THE PREVIOUS MEETING HELD ON 28 MARCH 2018

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

4. MATTERS ARISING AND ACTION POINTS

4.1 The Board reviewed the action points, noting that these were now complete or progressing to plan. There were no matters arising from the previous meeting.

5. QUESTIONS FROM THE PUBLIC

5.1 The Board had not received any questions in advance of the meeting and there were no public questions raised at this point on the agenda.

6. PATIENT EXPERIENCE PRESENTATION

6.1 Jo Denney introduced this item by informing the Board that the Trust's commitment to working in partnership with carers has been recognised with the award of a second gold star under the national Triangle of Care scheme. The scheme is run by the Carers Trust, and brings carers, service users and professionals closer together to jointly promote the recovery of people with mental health conditions. Two stars is the highest level that a Trust such as 2gether can attain. Jo Denney said that she was delighted that this work had been recognised with a second gold star; however, membership of the scheme was about much more than accreditation and she said that she hoped that it demonstrated to people who use services, families and communities, that 2gether hold carers, and the role that they play, in the highest regard and are committed to ensuring their involvement. Carers not only need our full support; they are also experts in their own right who should be fully included in the delivery of health and social care wherever possible.

6.2 The Board welcomed Kaye, who cared for her husband who suffered with dementia. Kaye provided the Board with a brief history of her husband's diagnosis. She said that it was important for people to own and recognise that they were a carer. It was not a choice that people made and was a position that people could often find difficult. Kaye informed the Board that she had been lucky that 2gether and the staff that she had encountered had met all of her needs as a carer and she highlighted some areas of excellent individual practice. Kaye said that from the first appointment with the Memory Clinic, through diagnosis, medication and support, she had been fully involved and supported from day one. Kaye said that some of the visits/clinic sessions had taken place jointly with 2gether and an Alzheimer's Society Nurse which had been very helpful in terms of joint working.

6.3 However, Kaye informed the Board that not all people had experienced the same high level of engagement and communication from 2gether, and she provided some very helpful suggestions to help health professionals improve engagement with carers. Some of these suggestions included:

- If you say you are going to call or arrive at a certain time for a visit – please don't be late.
- If a carer calls and leaves a message for you to call back – please call back
- On visits, take the time to accept a drink and speak to the patient and carer like "people"
- Make a note of the key discussion points from the appointment which can be agreed by all parties
- Be flexible with location for visits – carers may feel guilty talking about a loved one in front of them
- Communicate opportunities to attend support groups – carers often accept more advice on looking after their loved ones from other carers, rather than professionals

6.4 The Director of Quality thanked Kaye for attending and speaking so openly and clearly about her experience of 2gether's services and her treatment as her husband's primary carer. She said that she was very pleased that Kaye had had such a positive interaction with 2gether but acknowledged that the Trust needed to do more to ensure that everyone received this level of service. The Director of E&I said that there were people who did not feel as supported as Kaye and the Trust did need to do more. A lot of work was underway, including the production of a series of films to share with carers.

6.5 The Deputy Chief Executive asked Kaye about the main reasons why she felt that other people's experiences had not been as positive. Kaye said that in the majority of cases it related to the member of staff. She had heard of incidences where someone had attended

a home visit to cover a period of absence and had informed the carer to "ask your own dementia nurse" which she said had caused frustration. The nurse was there in the home and could have assisted. The Deputy Chief Executive advised that Herefordshire Dementia Services had been rated as "requiring improvement" at the last CQC inspection in 2015. He said that since that time the management of the Community Dementia Service had changed completely, with more compassionate leadership in place and he was confident that this situation would now be much improved. Dr Mark Scheepers made reference to the Learning from Excellence process. He said that this was a pilot at the minute but it encouraged people to be more compassionate by taking the learning from what the Trust did right, rather than things that had gone wrong.

6.6 Ingrid Barker thanked Kaye for attending the meeting and for speaking about her experiences. Thanks were also expressed to Jo Denney for the successful achievement of Triangle of Care.

6.7 Kaye thanked the Board for the opportunity to speak and informed the Board that being a carer…."Your connection is with the heart, not with the mind".

7. PERFORMANCE DASHBOARD AND IAPT UPDATE

Performance Dashboard

7.1 The Board received the performance dashboard outturn report which set out the performance of the Trust's Clinical Services for the full 2017/18 contract period, against our NHSI, Department of Health, Herefordshire and Gloucestershire CCG Contractual and CQUIN key performance indicators.

7.2 The Board noted that of the 139 reportable performance measures, 123 were compliant and 16 were non-compliant. Of the remaining 40 indicators, 9 were for baseline information to inform future reporting, 7 have had either no activity or insufficient activity recorded against them during the year to support reliable performance reporting and 24 were not yet available, of which 20 were new Gloucestershire CCG Contractual measures. Work was underway with services to ensure data capture and reporting processes which will enable performance against these indicators to be reported during 2018/19.

7.3 The Board noted the dashboard outturn report for 2017/18 and the assurance that this provided. Work continued on those non-compliant indicators; however, the Board agreed that this was a very positive picture of performance overall and congratulated staff on achieving this position.

Improving Access to Psychological Therapies (IAPT) Update

7.4 The Board received a summary report covering 2017/18 performance against the IAPT service improvement plan objectives and the forward plan targets for delivery in 2018/19. Jan Furniaux, Service Director for Gloucestershire Localities was in attendance to present this report.

7.5 Whilst significant improvements have been achieved there have been real challenges in maintaining our performance with access rates in line with our plan trajectories and the achievement of national waiting time standards on a consistent basis throughout the year due to lower than planned staffing capacity levels in our services in both localities. The Trust has agreed 2018/19 contracts with Gloucestershire and Herefordshire CCGs and both

include additional investment for IAPT services with plan trajectories to achieve 19% access rate by Q4 in 2018/19.

7.6 The successful implementation of the service improvement plans for 18/19 requires a significant increase in IAPT workforce and this remains an ongoing challenge for the service going forward to recruit to the plan staffing establishment. The achievement of our plans in this year will bring our IAPT service performance into line with the national trajectory set out in the NHSE Mental Health Five Year Forward View (FYFV) for achieving a 25% access target by 2021.

7.7 The 2018/19 plan includes the delivery of digital IAPT services which have recently been introduced into the care pathway in both our Gloucestershire and Herefordshire localities providing both low and high intensity interventions. The introduction of digital services improves patient choice in service provision on offer and will significantly contribute towards meeting access targets and waiting standards. Jan Furniaux advised that it was still very early in the implementation of digital solutions to see whether the desired outcomes would be achieved; however, she said that the concept was tested and proven and Trust practitioners had been very impressed with the tools available.

7.8 The 2019/20 and 2020/21 plans are less detailed and subject to review during 2018/19 (particularly in relation to the digital options which may deliver more or less than the 3% planned in 2018/19). It is anticipated that a significant proportion of the IAPT Access growth to 2021 will come from developing shared care pathways with long term condition services.

7.9 A range of initiatives are being developed to support our IAPT workforce recruitment and retention as part of the service development plan aimed at increasing our workforce and improving retention on a sustainable basis to provide the required staffing capacity levels to meet the targets and standards over the next three years. Given the challenges in terms of recruitment, assumptions on the impact that digital tools may have on capacity and particularly our access target the proposed plan presents a Medium to High Risk for the Trust in its delivery.

7.10 Service Development Improvement Plans are being produced for both counties which will set out detailed modelling, action and contingency plans to mitigate the risks further. These plans will be fully drafted by the end of May 2018.

7.11 Jonathan Vickers said that he felt assured by the high level of process and scrutiny around IAPT performance. However, he referred to the IST team's initial review of 2gether IAPT services and their recommendation around low staff productivity. Jan Furniaux advised that the Trust expected staff to engage in approximately 18 hours of face to face activity per week. This had been thoroughly reviewed and new reporting tools were in place to ensure that this could be more accurately measured. There had been significant improvements made in this area.

7.12 The Board noted that the Trust had a modelling tool to review staffing levels, acknowledging that this was a key risk in achieving IAPT targets. Assurance was received that robust monitoring was carried out to ensure that an up to date and accurate picture of staffing levels was in place.

7.13 The Board thanked Jan Furniaux for attending and presenting this very helpful report. Continued Board level monitoring of IAPT performance would take place at the Delivery Committee.

8. QUALITY REPORT 2017/18

8.1 The Board received the Quality Report for 2017/18, noting that this had also been received and approved at the Audit Committee on 25 May.

8.2 This final draft of the Annual Quality Report summarised the progress made in achieving targets, objectives and initiatives identified, and had been collated following an extensive review of all associated information received from a variety of sources throughout the year. The Board acknowledged the huge amount of work carried out to produce the Quality Report and noted that input had been received from internal and external stakeholders throughout the year in both Gloucestershire and Herefordshire, and their formal feedback would be published as part of the final report

8.3 The Board noted the requirement that External Assurance on the Quality Report must provide a limited assurance report on the content of Quality Reports produced by Foundation Trusts. KPMG, the Trust's External Auditors, had reviewed the draft report for consistency and tested a number of mandated and local indicators. They had issued a clean unqualified audit opinion.

8.4 In terms of the 2017/18 indicators that were not achieved at year-end, the Board noted that the use of Prone restraint had not reduced during the year. The Director of Quality said that the overall figure had gone up slightly in 2017/18 but advised that the Trust now used more supine restraint and an effective training programme was in place for staff in restraint. She said that she was confident that there would be a reduction in this figure next year.

8.5 It was noted that the number of reported suicides in Herefordshire appeared to have increased whilst the caseload had remained static. The Board noted that there had been an increase in the national trend but work was taking place both in Gloucestershire and Herefordshire to review the Suicide Prevention Strategies in liaison with local health partners and the local authority.

8.6 A dip in performance in the Trust's Friends and Family Test was highlighted. The Director of E&I said that this would be investigated further but she suggested that the increased number of responses to the test could have had an impact on these figures. It was pleasing to see an increase in engagement with the survey.

8.7 The Board agreed that overall, the Quality Report demonstrated a huge amount of positive and excellent work that was taking place within the Trust. The Board had received good assurance throughout the year on progress with the targets and the work that was in place to monitor and improve those non-compliant indicators. This would continue in 2018/19.

9. LEARNING DISABILITIES MORTALITY REVIEW

9.1 Dr Mark Scheepers, Clinical Director informed the Board that Learning from Deaths (LfD) is required from all Trusts. Deaths, whether these were natural or unnatural, expected or unexpected and whether there were problems with care all have to be reported nationally. For people with Learning Disabilities (LD), there is a requirement to participate in a national programme.

9.2 The Learning Disabilities Mortality Review (LeDeR) programme was established to support local areas to review the deaths of people with learning disabilities, identify learning from those deaths, and take forward the learning into service improvement initiatives. It is being implemented at the time of considerable spotlight on the deaths of patients in the NHS, and

the introduction of the national Learning from Deaths framework in England in 2017. The programme is led by the University of Bristol and commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England.

9.3 The programme has developed a review process for the deaths of people with learning disabilities. All deaths receive an initial review; those where there are any areas of concern in relation to the care of the person who has died, or if it is felt that further learning could be gained, receive a full multi-agency review of the death. Deaths subject to the current priority review themes (aged 18-24 years or from a Black or minority ethnic background) receive multiagency review and expert panel scrutiny. At the completion of the review, an action planning process identifies any service improvements that may be indicated.

9.4 The national LeDeR Annual Report for 2017 was published on 4th May 2018 and a summary of the national findings included:

- By the end of November 2017, all but two of the 39 LeDeR Steering Groups were operational.
- The most significant challenge to programme delivery has been the timeliness with which mortality reviews have been completed, largely driven by four key factors: a) large numbers of deaths being notified before full capacity was in place locally to review them b) the low proportion of people trained in LeDeR methodology who have gone on to complete a mortality review c) trained reviewers having sufficient time away from their other duties to be able to complete a mortality review and d) the process not being formally mandated.
- From 1st July 2016 to 30th November 2017, 1,311 deaths were notified to the LeDeR programme. By 30 November 2017, 103 reviews had been completed and approved by the LeDeR quality assurance process. As of 2nd May 2018 – 2349 notifications had been received. 200 reviews have been completed and approved by the QA process.
- The most commonly reported learning and recommendations were made in relation to the need for:
  a) Inter-agency collaboration and communication
  b) Awareness of the needs of people with learning disabilities
  c) The understanding and application of the Mental Capacity Act (MCA).

9.5 Mark Scheepers informed the Board that 2gether had a number of trained reviewers; however, carrying out the mortality reviews was extremely time consuming. The Board agreed that there was a need to ensure that the necessary capacity was in place to be able to achieve the objectives of the programme. However, the importance of the LeDeR programme was recognised and the Board thanked Dr Mark Scheepers for attending the meeting to present this important report.

10. LEARNING FROM DEATHS – QUARTER 4

10.1 In accordance with national guidance and legislation, the Trust currently reports all incidents and near misses, irrespective of the outcome, which affect one or more persons, related to service users, staff, students, contractors or visitors to Trust premises; or involve equipment, buildings or property. This arrangement is set out in the Trust policy on reporting and managing incidents. In March 2017, the National Quality Board published its National Guidance on Learning from Deaths: a Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care. This guidance sets out mandatory standards for organisations in the collecting of data, review and investigation, and publication of information relating to the deaths of patients under their care.

10.2 This report included data for the period January to March 2018 (Q4 2017/18). During this period there were 795 patient deaths recorded, of which 264 (33.2%) received a table-top review only, 54 (6.8%) were closed after a case record review and 26 (3.3%) were notified as Serious Incidents. Of the 795 patient deaths notified, 451 remained open (43.2%) and require a Mortality Review. 415 of those (92%) await a table-top review and 34 (7.5%) require additional discussion at MoReC (a Care Record Review).

10.3 The Board noted that concerns about the growing number of overdue table-top reviews had been raised at the Gloucestershire Mortality Steering Group, led by Gloucestershire CCG. These deaths largely occur within the Community Dementia Nursing teams, predominantly the ACI Monitoring caseload. The additional administration support previously sourced to address this did not come to fruition. The Gloucestershire Mortality Steering Group has suggested that whilst the focus nationally remains on hospital inpatients (and specifically on Eating Disorders and Psychosis within Mental Health) that it would be reasonable for 2gether to ring-fence the ACI-Monitoring caseload deaths as data collection only. Data could be revisited if the national focus should move towards dementia care at a later date.

10.4 The Board recognised that this work was still at a developmental stage and that processes in primary care in particular were less developed to date. A multi-provider mortality work-stream continues to be developed by the Strategic Transformation Partnership and is led by the CCGs in both counties to enable cross-provider information sharing to ensure the most appropriate health care provider reviews a death, and that there are clear opportunities to pass concerns between organisations.

10.6 The Board noted the contents of the Learning from Deaths Report for Quarter 4 of 2017/18/

11. NON-EXECUTIVE DIRECTOR AUDIT OF COMPLAINTS

11.1 The Board received the Non-Executive Director Audit of Complaints that was conducted by Nikki Richardson. This audit covered three complaints that had been closed between 1 January and 31 March 2018 (Quarter 4 2017/18).

11.2 Nikki Richardson said that she had been involved in reviewing the NED Audit of Complaints process a few years ago and she was therefore very pleased to see that these changes had all now been implemented.

11.3 The Board noted that the 3 complaints that had been reviewed during the quarter had all had good input from the Complaints Team and Nikki Richardson advised that the quality of the final response letter to complainants had significantly improved since her last audit which was excellent. However, more work was needed in relation to the investigation process which in some cases was unnecessarily lengthy and complicated.

11.4 The Board welcomed this report, noting that familiar themes had been picked up. Good triangulation between the Board Committees could be demonstrated. The Director of E&I advised that the report and its findings would be shared with the Service Experience Team for learning and action where required, acknowledging that there was more that could be done.

11.5 The Board noted the content of this report and the assurances provided. Ingrid Barker informed the Board that she had asked colleagues at GCS to start to develop a similar process of NED oversight of complaints as this was seen as a valuable piece of assurance for the Board.

12. COMPLAINTS ANNUAL REPORT 2017/18

12.1 The Director of E&I provided the Board with full assurance that 100% of complainants were contacted within 3 days or less to acknowledge and further clarify their concerns. Significant assurance was provided that the Trust had made considerable effort to listen to, understand, and resolve complaints over the past year. The themes of complaints received during 2017/18 had been reviewed and comparisons made with information from previous years. Data had been recorded and analysed in an effort to understand and ensure that complaints and concerns from individuals were responded to promptly and effectively. Methods of disseminating learning across the Trust continue to be refined and developed.

12.2 The Board noted that the number of complaints received during 2017/18 was lower than the previous year. The Director of E&I reported that although the numbers of formal complaints had reduced, there was significant assurance that individuals were increasingly prepared to share their concerns. This was evidenced by the increased number of concerns resolved without the formality of the NHS complaints process.

12.3 The Board noted that a number of practice developments were planned for the coming year.

12.4 Focus on embedding robust processes for taking forward the learning from complaints would continue in 2018/19, and the Governance Committee would take the lead on monitoring this work. The Director of Finance added that the Trust's Internal Auditors would be carrying out an audit during 2018/19 on learning from incidents and complaints, which would give further assurance around this.

12.5 The Board was happy to approve the content of this annual report and expressed its thanks to the Service Experience Team.

13. CQC INSPECTION UPDATE

13.1 The Board was informed that the CQC would be publishing the results of their inspection of 2gether's services, on Friday 1 June. Communication with staff, partners and internal & external stakeholders would take place as soon as the final report was received and made publically available.

14. CHIEF EXECUTIVE'S REPORT

14.1 The Chief Executive presented his report to the Board which provided an update on key national communications and a summary of progress against local developments and initiatives. The key headings included:

- Progress on the strategic intent to merge with Gloucestershire Care Services NHS Trust (GCS)
- Carter Mental Health Community Services Work
- "One Gloucestershire" Integrated Care System
- Herefordshire and Worcestershire STP – Integrated Care System Development Programme
- Integrated Care Alliance Board (ICAB)
- BSc in Mental Health Nursing, University of Gloucestershire

14.2 The Board also noted the extensive engagement activities that had taken place during the past month, and the importance of these activities in order to inform strategic thinking, raise awareness of mental health, build relationships and influence the strategic thinking of

others. The report offered the Board significant assurance that the Executive Team was undertaking wide engagement.

15. ANNUAL MEMBERSHIP REPORT 2017/18

15.1 The Board received and noted the Annual Membership Report which provided a brief update on information for members, Governor Engagement Events and information about membership for the 2017/18 financial year.

15.2 Membership at the end of the year stood at 7805, an increase of 362 members (5%) over the year. 320 of those new members were in public constituencies. A Membership Advisory Group had met 3 times during the year, and a further 4 meetings were planned this year. The Group comprises Governors and members, and has reviewed the Trust's membership form and explored ideas for a new membership pack, as well as new methods of engaging with existing and prospective members. A survey, conducted in April 2017, had helped to inform the membership programme.

15.3 Work has also been done to cleanse the membership database, and to amend processes in order to comply with new data protection rules taking effect at the end of May 2018. One impact of these changes will mean that staff members who leave the organisation will no longer be automatically transferred to a public constituency, but must submit a membership form instead. This is likely to impact on membership figures.

15.4 The Board noted the key performance indicators for 2018/19 which included increasing membership in those constituencies and groups which were currently under-represented. The Communications Team would also review the Membership Strategy as the merger with GCS progressed.

16. SUMMARY FINANCIAL REPORT

16.1 The Board received the summary Finance Report that provided information up to the end of April 2018. The month 1 position was a surplus of £111k which was £42k above the planned surplus. The month 1 forecast outturn was an £834k surplus in line with the Trust's control total. The Trust had an Oversight Framework segment of 2 as at 18th April 2018. The Trust has finalised 2018/19 contracts with Gloucestershire CCG, Herefordshire CCG, and NHS England and budgets for 2018/19 were approved by the Board in March.

16.2 The Director of Finance highlighted the Trust's current cash position of £9.8m which was showing as "amber". He advised that the Trust had not yet received the agreed STF funding but this was expected during June.

16.3 An action was agreed at the last Board meeting for the development of an easy read communication around the Trust's year-end financial position that could be shared with staff, Governors and stakeholders. The Board asked that this be progressed, alongside a message of thanks to Trust staff for their efforts in helping the Trust achieve its financial year-end targets.

ACTION: Director of Finance to develop easy read communication around the Trust's year-end financial position that could be shared with staff, Governors and stakeholders

17. RESEARCH UPDATE

17.1 This report provided an update of the development, delivery and governance of research activity during Phase 1 of the implementation of the Trust's research strategy 2016 - 2020. The Director of E&I formally introduced Mark Walker, the Trust's new Head of Research and Development to the Board.

17.2 Significant assurance was offered that the Trust was meeting the objectives set in the Trust's Research and Development Strategy 2016 - 2020. The Trust had more than doubled its staffing capacity for research in the last 18 months.

17.3 There was significant assurance that the team leading the Trust's Research function has a sound grasp of the funding issues concerning the different income streams involved in research and is well supported by the dedicated Finance staff to assess the financial implications of each new research project that is proposed. The Trust is well placed to manage the expanded research portfolio and assess the financial implications of future developments.

17.4 The Director of E&I advised that the co-development of the Phase 2 Strategy Implementation Plan would be led by the new Head of Research and Development and reviewed by the Development Committee on behalf of the Board. Closer integration and merger with Gloucestershire Care Services NHS Trust will bring further and progressive opportunities for developing research for practice. Conversations have commenced to understand the opportunities and to co-develop ideas for future collaboration. It was noted that the Sustainability and Transformation Partnerships represented a further opportunity for research and new knowledge about the delivery of care to inform future pathways. Development activity with the Trust's strategic partners would continue to realise the benefits of research activity for and with service users, carers and staff.

17.5 The Board recognised the amount of work taking place to increase the Trust's research portfolio and thanked all those involved for their efforts over the past year.

18. PROVIDER LICENCE DECLARATIONS

18.1 The Board is required to make a number of self-certifications each year regarding compliance with the terms of the Trust's provider licence and the systems and processes for ensuring such compliance. This report set out those declarations, along with the evidence to support the declaration of compliance. The Board noted that this report had been presented to the May Council of Governors meeting in order that the Board might take the views of Governors into account when making these declarations. Governors noted the report and no concerns were raised in respect of systems and processes for compliance with licence conditions. However, Governors noted that the Council of Governors had previously considered undertaking a skills appraisal in order to identify training requirements for Governors. While this had not come to fruition, Governors felt it would be a valuable exercise to inform the merger transition work in relation to the Council.

18.2 It is a requirement of the governance condition of the Trust's licence that the Trust signs off a Corporate Governance Statement. The Corporate Governance Statement requires the Trust Board to confirm:

- Compliance with the governance condition at the date of the statement; and
- Forward compliance with the governance condition for the current financial year, specifying (i) and risks to compliance and (ii) any actions proposed to manage such risks

The governance condition of the licence concerns the Trust's internal systems and processes. Hence, the references to risks within the corporate governance statement relate to risks to those systems and processes, rather than wider risks to the Trust or the achievement of the Trust's objectives.

18.3 The Board agreed to make a declaration 'Confirmed' in respect of compliance at the time of the declaration, and in respect of forward compliance for the current year, and in the interests of transparency to include the risk to forward compliance and mitigation of compliance in respect of each element of the Corporate Governance Statement.

18.4 The Trust was also required to self-certify regarding the provision of necessary training to Governors, pursuant to Section 151(5) of the Health and Social Care Act 2012. The Board noted the training and development opportunities provided to Governors, which included induction, service presentations, access to external training and attendance at external events, as well as the outputs from the Trust's joint Board/Governor engagement work undertaken during the year and intended to support Governors to undertake their role. The Board therefore made a declaration of 'Confirmed' in respect of the provision of Governor training.

18.5 Foundation Trusts are also required to make an annual self-certification regarding their systems for compliance with provider licence conditions (General Condition G6). The self-certification relates to systems and processes in place in the financial year just ended, and to systems and processes in place for the current financial year. The Board agreed a declaration of 'Confirmed' in respect of this declaration, and to publish the self-certification within one month as required by NHS Improvement. The Board noted that a further declaration regarding Commissioner Requested Services was not applicable to 2gether.

19. MENTAL HEALTH LEGISLATION SCRUTINY COMMITTEE – ANNUAL REPORT 17/18

19.1 The Board received an annual report setting out the activities of the Mental Health Legislation Scrutiny Committee during 2017/18.

19.2 The report set out areas of activity undertaken by the Committee during the year, and provided an assessment of assurance in respect of each activity, along with supporting evidence. The Committee's report offered a significant level of assurance overall, with the majority of requirements listed as significant or full assurance with one area considered to be limited;

- Procedures are in place and operating satisfactorily to inform detained patients and their nearest relatives about applicable provisions of the MHA and of their rights: The limited assurance rating related to an ability to maintain a consistent level of compliance with the giving and re-giving of rights especially in patients on Community Treatment Orders.

19.3 Full assurance was noted for training compliance, however, the Delivery Committee would be asked to monitor compliance with Breakaway Training. The report also provided significant assurance on the controls in place for ensuring that the Trust monitored and sustained compliance with the Mental Health Act, Mental Capacity Act, Human Rights Act (and their associated codes of practice) and where necessary took action to address non-conformities.

19.4 The Deputy Chief Executive said that the MHLS Committee was an assurance arena that many other Trusts didn't have, and it was key in the monitoring of compliance with the MH Act. The Committee was making a real difference and was operating effectively, with the formation of a MH Operational Group which reported back to the Committee.

19.5 The Board noted the Mental Health Legislation Scrutiny Committee's annual report and the assurances provided, and approved the Committee's priorities for 2018/19.

20. BOARD COMMITTEE REPORTS – CHARITABLE FUNDS COMMITTEE

20.1 Duncan Sutherland presented the summary report from the Charitable Funds Committee meeting held on 27 March.

20.2 The Committee received a revised Charitable Funds Strategy which included the potential use of a professional fundraiser. The Committee approved the proposal to procure a professional fundraiser, noting that there was no obligation to appoint if no suitable candidate came forward. If a fundraiser was appointed that person would report directly to the Director of Finance. This appointment would be discussed with procurement and a brief report would be provided to members setting out expectations and clear parameters of the role.

20.3 The Committee also reviewed its Terms of reference. No major changes were proposed, however the title of the Terms of reference had been amended to reflect the fact that the Committee formally reported to the Board of Trustees, rather than the Foundation Trust Board. It was also agreed that the Terms of Reference would come back to the Committee for review following any appointment of a Professional Fundraiser.

21. BOARD COMMITTEE REPORTS - AUDIT COMMITTEE

21.1 Marcia Gallagher presented the summary report from the Audit Committee meeting held on 4 April. This report and the assurances provided were noted.

21.2 Marcia Gallagher provided a verbal report from the Audit Committee meeting held on 25 May. The Committee had received the Annual Accounts, Annual Report, Quality Report and associated certificates for 2017/18. The External Auditors had issued a clean, unqualified audit opinion on the Trust's accounts. The Committee expressed their thanks to the Director of Finance and his team for preparing the accounts and for ensuring their timely submission.

21.3 A full written summary report from this meeting would be presented at the next Board meeting.

22. BOARD COMMITTEE REPORTS – DEVELOPMENT COMMITTEE

22.1 Jonathan Vickers presented the summary report from the Development Committee meeting held on 18 April. This report and the assurances provided were noted.

23. BOARD COMMITTEE REPORTS – DELIVERY COMMITTEE

23.1 The Board received the summary reports from the Delivery Committee meetings held on 29 March and 25 April. These reports and the assurances provided were noted.

23.2 Jonathan Vickers provided a verbal update from the Delivery Committee meeting held on 23 May, and a full written summary from this Committee would be presented to the Board at its next meeting.

24. BOARD COMMITTEE REPORTS – GOVERNANCE COMMITTEE

24.1 Nikki Richardson presented the summary report from the Governance Committee meeting that had taken place on 27 April. This report and the assurances provided were noted.

25. INFORMATION SHARING REPORTS

25.1 The Board received and noted the following reports for information:

- Chair's Report
- Council of Governors Minutes – March 2018
- Use of the Trust Seal – Quarter 4 2017/18

25.2 The Board noted the full assurance regarding engagement activities provided by the Chair's report. It was noted that more work would be carried out to look at increasing NED and Chair activity by way of raising profiles during the merger process.

26. ANY OTHER BUSINESS

26.1 The Board noted the proposal to move away from holding closed session Board meetings every month, with Board meetings to be held every other month. This would free up time for further Board development activities. A query was raised as to how the Board would receive assurance on finance and performance issues if a formal meeting was not held and associated reports received. The receipt of such reports at the Executive Committee and the Delivery Committee had been considered by way of offering this assurance; however, it was agreed that the Trust Secretary would be asked to prepare a brief report setting out how the Board could take assurance on financial matters in the absence of a formal Board meeting.

ACTION: Report to be prepared setting out how the Board could take assurance on financial matters in the absence of a formal Board meeting each month

27. DATE OF THE NEXT MEETING

27.1 The next Board meeting would take place on Thursday 26 July 2018 at Trust HQ, Rikenel, Gloucester

Signed: ……. **Date: ……**
Ingrid Barker, Chair

BOARD MEETING
ACTION POINTS

Date of Mtg	Item ref	Action	Lead	Date due	Status/Progress
31 May 2018	16.3	Director of Finance to develop easy read communication around the Trust's year-end financial position that could be shared with staff, Governors and stakeholders	Andrew Lee	July	**Complete** Briefing produced and presented at June Team Talk session to staff
	26.1	Report to be prepared setting out how the Board could take assurance on financial matters in the absence of a formal Board meeting each month	John McIlveen	July	**Verbal Update at the meeting in July**

Agenda item 7 **PAPER B**

Report to:	Trust Board Meeting – 26 July 2018
Author:	Chris Woon, Head of Information Management and Clinical Systems
Presented by:	John Campbell, Director of Service Delivery
SUBJECT:	**Performance Dashboard Report for the period to the end of May 2018 (month 2)**

This Report is provided for:			
Decision	Endorsement	**Assurance**	**To Note**

EXECUTIVE SUMMARY:

Overview

This month's report sets out the performance of the Trust's Clinical Services for the period to the end of May 2018 (month 2) of the 2018/19 contract period, against our NHSI, Department of Health, Herefordshire and Gloucestershire CCG Contractual and CQUIN key performance indicators.

Of the 202 performance indicators, 90 are reportable in May with 80 being compliant and 10 non-compliant at the end of the reporting period.

Where performance is not compliant, Service Directors are taking the lead to address issues with a particular focus continuing to be on IAPT service measures.

Work is ongoing in accordance with our agreed Service Delivery Improvement Plans to address the underlying issues affecting this performance.

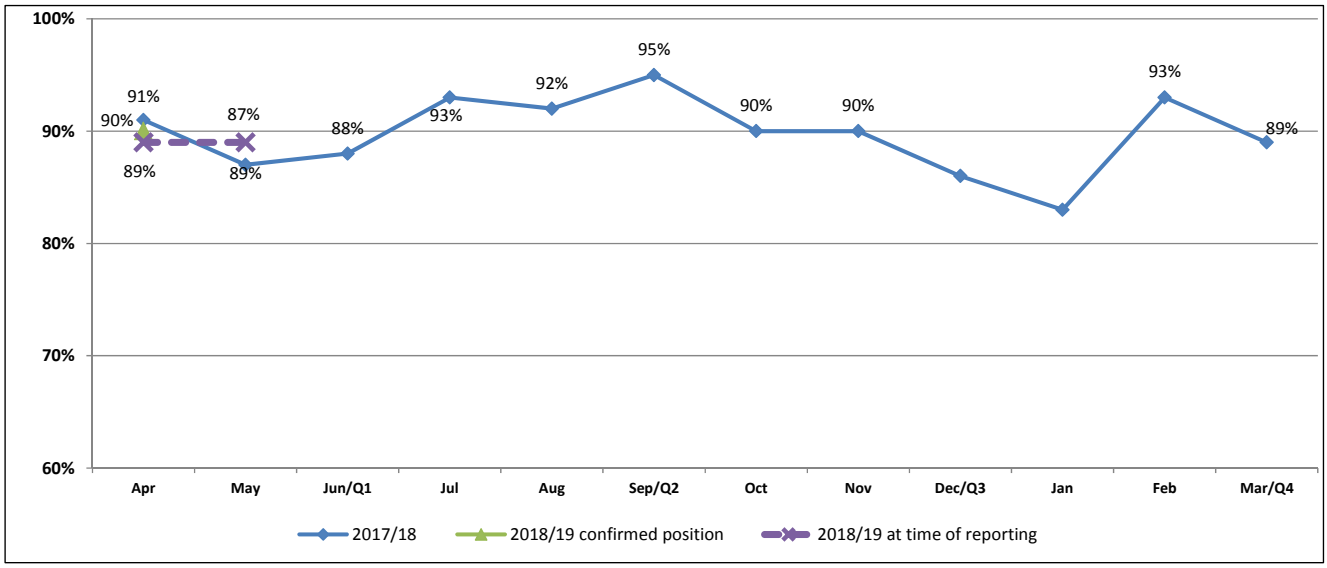
A red flag '  ' continues to be placed next to indicators where further analysis and work is required or ongoing to fully scope potential data quality or performance issues.

New indicators have been identified with dark blue in the indicator number column.

The following table summarises our performance position as at the end of May 2018 for each of the KPIs within each of the reporting categories.

Indicators Reported in Month and Levels of Compliance							
Indicator Type	Total Measures	Reported in Month	Compliant	Non Compliant	% non-compliance	Not Yet Required or N/A	NYA
NHSi Requirements	14	13	10	3	23	1	0
Never Events	17	17	17	0	0	0	0
Department of Health	10	8	7	1	13	2	0
Gloucestershire CCG Contract	97	23	19	4	17	68	6
Social Care	15	13	13	0	0	2	0
Herefordshire CCG Contract	24	16	14	2	13	8	0
CQUINS	25	0	0	0	0	25	0
Overall	202	90	80	10	11	106	6

The following graph shows our percentage compliance by month and the previous year's compliance for comparison. A "2018/19 confirmed position" line has been added to show the position of our performance reported a month in arrears to enable late data entry and late data validation to be taken into account.



The confirmed position for April 2018 has increased to 90%. This is due to the following non-compliant indicator being removed from the contract by Gloucestershire Commissioners:

- MAS Post Diagnostic Support: Time from referral to assessment – 4 weeks

Summary Exception Reporting

The following 10 key performance thresholds were not met for the Trust for May 2018:

NHS Improvement Requirements

- 1.02 – Number of C Diff cases - avoidable
- 1.08 – New psychosis (EI) cases treated within 2 weeks of referral
- 1.10 – IAPT: Waiting times: Referral to treatment within 18 weeks

Department of Health Requirements

- 2.21 – No children under 18 admitted to an adult in-patient ward

Gloucestershire CCG Contract Measures

- 3.63 – Adolescent Eating Disorders: Routine referral to NICE treatment within 4 weeks
- 3.64 – Adolescent Eating Disorders: Routine referral to Non-NICE treatment within 4 weeks
- 3.65 – Adolescent Eating Disorders: Urgent referral to NICE treatment within 1 week
- 3.67 – Adult Eating Disorders: Wait time for assessments will be 4 weeks

Herefordshire CCG Contract Measures

- 5.08 – IAPT: Recovery rate
- 5.09a – IAPT maintain 15% of patients entering the service against prevalence

RECOMMENDATIONS

The Board is asked to:

- Note the Performance Dashboard Report for May 2018.
- Accept the report as a significant level of assurance that our contract and regulatory performance measures are being met or that appropriate action plans are in place to address areas requiring improvement.
- Be assured that there is ongoing work to review all of the indicators not meeting the required performance threshold. This includes a review of the measurement and data quality processes as well as clinical delivery and clinical practice issues.

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

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

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

Reviewed by:		
John Campbell	Date	June 2018

Where in the Trust has this been discussed before?		
Delivery Committee	Date	June 2018

What consultation has there been?		
Not applicable.	Date	

Explanation of acronyms used:	
	AKI Acute kidney injury ASCOF Adult Social Care Outcomes Framework CAMHS Child and Adolescent Mental health Services C-Diff Clostridium difficile CLDT Community Learning Disability Teams CPA Care Programme Approach CQUIN Commissioning for Quality and Innovation CRHT Crisis Home Treatment CSM Community Services Manager CYPS Children and Young People's Services DNA Did not Attend ED Emergency Department EI Early Intervention EWS Early warning score HoNoS Health of the Nation Outcome Scale IAPT Improving Access to Psychological Therapies IST Intensive Support Team (National IAPT Team) KPI Key Performance Indicator LD Learning Disabilities MHL Mental Health Liaison MRSA Methicillin-resistant Staphylococcus aureus MUST Malnutrition Universal Screening Tool NHSI NHS Improvement NICE National Institute for Health and Care Excellence SI Serious Incident SUS Secondary Uses Service VTE Venous thromboembolism YOS Youth Offender's Service

1. CONTEXT

This report sets out the performance Dashboard for the Trust for the period to the end of May 2018, month two of the 2018/19 contract period.

1.1 The following sections of the report include:

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

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

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

2.1 The following tables outline the performance in each of the performance categories within the Dashboard as at the end of May 2018. Where indicators have not been met during the reporting period, an explanation is provided relating to the non-achievement of the Performance Threshold and the action being taken to rectify the position.

2.2 Performance indicators include all relevant Trust activity allocated between Gloucestershire and Herefordshire based on locality of the service.

2.3 Where stated, 'Cumulative Compliance' refers to compliance recorded from the start of this contractual year April 2018 to the current reporting month, as a whole.

	=	**Target not met**
	=	**Target met**
NYA	=	**Not yet available**
NYR	=	**Not yet required**
N/A	=	**Not applicable: No data to report or baseline data to inform 2018/19**

DASHBOARD CATEGORY - NHSI REQUIREMENTS

NHS Improvement Requirements				
	In month Compliance			Cumulative Compliance
	Mar	Apr	May	
Total Measures	14	14	14	14
	1	1	3	1
	12	12	10	12
NYA	0	0	0	0
NYR	0	0	0	0
N/A	1	1	1	1

Performance Thresholds not being achieved in Month

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

1.02: Number of C Diff cases – avoidable

One patient on Willow Ward, Charlton Lane tested positive for C diff in May. A review meeting is planned for the end of June, after which it will be confirmed whether the case is avoidable or unavoidable. For transparency the case is assumed to be avoidable until confirmed otherwise.

1.08: New psychosis (EI) cases treated within 2 weeks of referral

There were 2 cases in May that did not meet the performance threshold. Although we were able to offer both of these young people an appointment within 2 weeks, they chose to wait beyond this due to educational study and examinations.

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

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

Cumulative Performance Thresholds Not being Met

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

As above

Changes to Previously Reported Figures

None

Early Warnings / Notes

1.02: Number of C Diff cases – avoidable

Although we are showing this indicator as non-compliant for May due to 1 case. The performance threshold for the whole financial year is less than 3 cases; therefore we have shown the cumulative total as compliant.

NHS Improvement Requirements

ID	Performance Measure (PM)		2017/18 Outturn	April-2018	May-2018	June-2018	(Apr-May) Cumulative Compliance	Forecast 18/19 Outturn
1								
1.01	Number of MRSA Bacteraemias	PM	0	0	0	0	0	0
		Gloucestershire	0	0	0		0	
		Herefordshire	0	0	0		0	
		Combined Actual	0	0	0		0	
1.02	Number of C Diff cases (day of admission plus 2 days = 72hrs) - avoidable	PM	0	0	0	0	<3	0
		Gloucestershire	0	0	1		1	
		Herefordshire	0	0	0		0	
		Combined Actual	0	0	1		1	
1.03	Care Programme Approach follow up contact within 7 days of discharge	PM	95%	95%	95%	95%	95%	95%
		Gloucestershire	99%	98%	100%		99%	
		Herefordshire	99%	100%	100%		100%	
		Combined Actual	99%	99%	100%		99%	
1.04	Care Programme Approach - formal review within12 months	PM	95%	95%	95%	95%	95%	95%
		Gloucestershire	98%	97%	97%		97%	
		Herefordshire	98%	96%	97%		97%	
		Combined Actual	98%	97%	97%		97%	
1.05	Nationally reported - Delayed Discharges (Including Non Health)	PM	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%
		Gloucestershire	3.2%	2.7%	0.8%		1.7%	
		Herefordshire	2.4%	0.0%	2.1%		1.1%	
		Combined Actual	3.0%	2.0%	1.1%		1.5%	
1.05b	- Delayed Discharges - Outliers	PM						
		Gloucestershire	10.1%	7.4%	6.7%		7.0%	
		Herefordshire	12.5%	0.0%	1.8%		0.9%	
		Combined Actual	10.7%	5.6%	5.5%		5.6%	
1.06	Admissions to Adult inpatient services had access to Crisis Resolution Home Treatment Teams	PM	95%	95%	95%	95%	95%	95%
		Gloucestershire	99%	100%	97%		98%	
		Herefordshire	100%	100%	100%		100%	
		Combined Actual	99%	100%	98%		99%	
1.07	New psychosis (EI) cases as per contract	PM	72	6	12	18	12	72
		Gloucestershire	80	9	12		12	
		PM	24	2	4	6	4	24
		Herefordshire	31	3	6		6	
		PM	96	8	16	24	16	96
		Combined Actual	111	12	18		18	
1.08	New psychosis (EI) cases treated within 2 weeks of referral	PM	50%	53%	53%	53%	53%	53%
		Gloucestershire	71%	89%	33%		75%	
		Herefordshire	68%	67%	67%		67%	
		Combined Actual	70%	83%	50%		72%	

NHS Improvement Requirements

ID	Performance Measure (PM)		2017/18 Outturn	April-2018	May-2018	June-2018	(Apr-May) Cumulative Compliance	Forecast 18/19 Outturn
1.09	IAPT - Waiting times: Referral to Treatment within 6 weeks (based on discharges)	PM	75%	75%	75%	75%	75%	75%
		Gloucestershire	69%	87%	92%		90%	
		Herefordshire	59%	82%	83%		82%	
		Combined Actual	67%	86%	90%		88%	
1.10	IAPT - Waiting times: Referral to Treatment within 18 weeks (based on discharges)	PM	95%	95%	95%	95%	95%	95%
		Gloucestershire	88%	94%	97%		95%	
		Herefordshire	75%	85%	84%		85%	
		Combined Actual	85%	92%	94%		93%	
1.11	**MENTAL HEALTH SERVICES DATA SET PART 1 DATA COMPLETENESS: OVERALL**	PM	97%	97%	97%	97%	97%	97%
		Gloucestershire	99.9%	99.9%	99.9%		99.9%	
		Herefordshire	99.9%	99.9%	99.9%		99.9%	
		Combined Actual	99.9%	99.9%	99.9%		99.9%	
1.11a	Mental Health Services Data Set Part 1 Data completeness: DOB	PM	97%	97%	97%	97%	97%	97%
		Gloucestershire	100.0%	100.0%	100.0%		100.0%	
		Herefordshire	100.0%	100.0%	100.0%		100.0%	
		Combined Actual	100.0%	100.0%	100.0%		100.0%	
1.11b	Mental Health Services Data Set Part 1 Data completeness: Gender	PM	97%	97%	97%	97%	97%	97%
		Gloucestershire	99.9%	99.9%	99.9%		99.9%	
		Herefordshire	99.9%	99.9%	99.9%		99.9%	
		Combined Actual	99.9%	99.9%	99.9%		99.9%	
1.11c	Mental Health Services Data Set Part 1 Data completeness: NHS Number	PM	97%	97%	97%	97%	97%	97%
		Gloucestershire	99.9%	100.0%	100.0%		100.0%	
		Herefordshire	99.9%	100.0%	100.0%		100.0%	
		Combined Actual	99.9%	100.0%	100.0%		100.0%	
1.11d	Mental Health Services Data Set Part 1 Data completeness: Organisation code of commissioner	PM	97%	97%	97%	97%	97%	97%
		Gloucestershire	100.0%	100.0%	100.0%		100.0%	
		Herefordshire	100.0%	100.0%	100.0%		100.0%	
		Combined Actual	100.0%	100.0%	100.0%		100.0%	
1.11e	Mental Health Services Data Set Part 1 Data completeness: Postcode	PM	97%	97%	97%	97%	97%	97%
		Gloucestershire	99.8%	99.8%	99.8%		99.8%	
		Herefordshire	99.9%	99.9%	99.8%		99.9%	
		Combined Actual	99.8%	99.8%	99.8%		99.8%	
1.11f	Mental Health Services Data Set Part 1 Data completeness: GP Practice	PM	97%	97%	97%	97%	97%	97%
		Gloucestershire	99.6%	99.6%	99.6%		99.6%	
		Herefordshire	99.7%	99.9%	99.8%		99.8%	
		Combined Actual	99.7%	99.7%	99.7%		99.7%	

NHS Improvement Requirements

ID	Performance Measure (PM)		2017/18 Outturn	April-2018	May-2018	June-2018	(Apr-May) Cumulative Compliance	Forecast 18/19 Outturn
1.12	**MENTAL HEALTH SERVICES DATA SET PART 2 DATA COMPLETENESS : OVERALL**	PM	50%	50%	50%	50%	50%	50%
		Gloucestershire	94.7%	95.1%	95.5%		95.3%	
		Herefordshire	90.9%	88.7%	88.7%		88.7%	
		Combined Actual	94.1%	94.1%	94.5%		94.3%	
1.12a	Mental Health Services Data Set Part 2 Data completeness: CPA Employment status last 12 months	PM	50%	50%	50%	50%	50%	50%
		Gloucestershire	89.4%	90.0%	90.6%		90.3%	
		Herefordshire	86.4%	82.8%	82.7%		82.7%	
		Combined Actual	88.9%	88.9%	89.4%		89.1%	
1.12b	Mental Health Services Data Set Part 2 Data completeness: CPA Accommodation Status in last 12 months	PM	50%	50%	50%	50%	50%	50%
		Gloucestershire	96.6%	97.2%	97.4%		97.3%	
		Herefordshire	87.1%	83.6%	84.0%		83.8%	
		Combined Actual	94.9%	95.0%	95.3%		95.2%	
1.12c	Mental Health Services Data Set Part 2 Data completeness: CPA HoNOS assessment in last 12 months	PM	50%	50%	50%	50%	50%	50%
		Gloucestershire	98.2%	98.3%	98.5%		98.4%	
		Herefordshire	99.2%	99.6%	99.6%		99.6%	
		Combined Actual	98.4%	98.5%	98.7%		98.6%	
1.13	Learning Disability Services: 6 indicators: identification of people with a LD, provision of information, support to family carers, training for staff, representation of people with LD; audit of practice and publication of findings	PM	6	6	6	6	6	6
		Gloucestershire	6	6	6		6	
		Herefordshire	6	6	6		6	
		Combined Actual	6	6	6		6	

DASHBOARD CATEGORY – DEPARTMENT OF HEALTH PERFORMANCE

DoH Performance				
	In month Compliance			Cumulative Compliance
	Mar	Apr	May	
Total Measures	27	27	27	27
	1	1	1	1
	24	24	24	24
NYA	0	0	0	0
NYR	1	2	2	2
N/A	1	0	0	0

Performance Thresholds not being achieved in Month

2.21: No children under 18 admitted to adult inpatient wards
There was 1 admission to an under 18 adult ward in Herefordshire in May.

A 17 year old known to CYPS with co-morbid Eating Disorders and history of a previous inpatient admission was admitted due to suicidal intent to Mortimer Ward, Stonebow.

CYPS staff were engaged and a search was carried out nationally for an appropriate bed. The patient was transferred 11 days after admission.

Cumulative Performance Thresholds Not being Met

2.21: No children under 18 admitted to adult inpatient wards
To date there have been 2 admissions of under 18s to adult wards in Herefordshire.

Changes to Previously Reported Figures

None

Early Warnings

None

Note in relation to year end compliance predictions (forecast outturn)

2.21: No children under 18 admitted to adult inpatient wards

Unfortunately the annual performance threshold is zero and it has not been met therefore the performance for the year will be none compliant. Historic performance indicates that without changes in the tier 4 services arrangements - outside of the remit of ^{2}gether - we will not be able to meet this indicator.

DOH Never Events

ID	Performance Measure (PM)		2017/18 Outturn	April-2018	May-2018	June-2018	(Apr-May) Cumulative Compliance	Forecast 18/19 Outturn
2								
2.01	Wrongly prepared high risk injectable medications	PM	0	0	0	0	0	0
		Actual	0	0	0		0	
2.02	Maladministration of potassium containing solutions	PM	0	0	0	0	0	0
		Actual	0	0	0		0	
2.03	Wrong route administration of oral/enteral treatment	PM	0	0	0	0	0	0
		Actual	0	0	0		0	
2.04	Intravenous administration of epidural medication	PM	0	0	0	0	0	0
		Actual	0	0	0		0	
2.05	Maladministration of insulin	PM	0	0	0	0	0	0
		Actual	0	0	0		0	
2.06	Overdose of midazolam during conscious sedation	PM	0	0	0	0	0	0
		Actual	0	0	0		0	
2.07	Opioid overdose in opioid naive patient	PM	0	0	0	0	0	0
		Actual	0	0	0		0	
2.08	Inappropriate administration of daily oral methotrexate	PM	0	0	0	0	0	0
		Actual	0	0	0		0	
2.09	Suicide using non collapsible rails	PM	0	0	0	0	0	0
		Actual	0	0	0		0	
2.10	Falls from unrestricted windows	PM	0	0	0	0	0	0
		Actual	0	0	0		0	
2.11	Entrapment in bedrails	PM	0	0	0	0	0	0
		Actual	0	0	0		0	
2.12	Misplaced naso - or oro-gastric tubes	PM	0	0	0	0	0	0
		Actual	0	0	0		0	
2.13	Wrong gas administered	PM	0	0	0	0	0	0
		Actual	0	0	0		0	
2.14	Failure to monitor and respond to oxygen saturation - conscious sedation	PM	0	0	0	0	0	0
		Actual	0	0	0		0	
2.15	Air embolism	PM	0	0	0	0	0	0
		Actual	0	0	0		0	
2.16	Severe scalding from water for washing/bathing	PM	0	0	0	0	0	0
		Actual	0	0	0		0	
2.17	Mis-identification of patients	PM	0	0	0	0	0	0
		Actual	0	0	0		0	

DOH Requirements

ID	Performance Measure (PM)		2017/18 Outturn	April-2018	May-2018	June-2018	(Apr-May) Cumulative Compliance	Forecast 18/19 Outturn
2.18	Mixed Sex Accommodation - Sleeping Accommodation Breaches	PM	0	0	0	0	0	0
		Gloucestershire	0	0	0		0	
		Herefordshire	0	0	0		0	
		Combined	0	0	0		0	
2.19	Mixed Sex Accommodation - Bathrooms	Gloucestershire	Yes	Yes	Yes		Yes	
		Herefordshire	Yes	Yes	Yes		Yes	
		Combined	Yes	Yes	Yes		Yes	
2.20	Mixed Sex Accommodation - Women Only Day areas	Gloucestershire	Yes	Yes	Yes		Yes	
		Herefordshire	Yes	Yes	Yes		Yes	
		Combined	Yes	Yes	Yes		Yes	
2.21	No children under 18 admitted to adult in-patient wards	PM	0	0	0	0	0	0
		Gloucestershire	6	0	0		0	
		Herefordshire	5	1	1		2	
		Combined	11	1	1		2	
2.22	Failure to publish Declaration of Compliance or Non Compliance pursuant to Clause 4.26 (Same Sex accommodation)	Gloucestershire	Yes	Yes	Yes		Yes	
		Herefordshire	Yes	Yes	Yes		Yes	
		Combined	Yes	Yes	Yes		Yes	
2.23	Publishing a Declaration of Non Compliance pursuant to Clause 4.26 (Same Sex accommodation)	Gloucestershire	Yes	Yes	Yes		Yes	
		Herefordshire	Yes	Yes	Yes		Yes	

DOH Requirements

ID	Performance Measure (PM)		2017/18 Outturn	April-2018	May-2018	June-2018	(Apr-May) Cumulative Compliance	Forecast 18/19 Outturn
2.24	Serious Incident Reporting (SI)	Glos	33	3	3		6	
		Hereford	18	1	1		2	
2.25	All SIs reported within 2 working days of identification	PM	100%	100%	100%	100%	100%	100%
		Gloucestershire	100%	100%	100%		100%	
		Herefordshire	100%	100%	100%		100%	
2.26	Interim report for all SIs received within 5 working days of identification (unless extension granted by CCG)	PM	100%	100%	100%	100%	100%	100%
		Gloucestershire	100%	100%	100%		100%	
		Herefordshire	100%	100%	100%		100%	
2.27	SI Report Levels 1 & 2 to CCG within 60 working days	PM	100%	100%	100%	100%	100%	100%
		Gloucestershire	100%	NYR	NYR		NYR	
		Herefordshire	100%	NYR	NYR		NYR	
2.28	SI Report Level 3 - Independent investigations - 6 months from investigation commissioned date	PM	100%	100%	100%	100%	100%	100%
		Gloucestershire	N/A	NYR	NYR		NYR	
		Herefordshire	N/A	NYR	NYR		NYR	
2.29	SI Final Reports outstanding but not due	Gloucestershire	5	3	3		6	
		Herefordshire	2	1	1		2	

DASHBOARD CATEGORY – GLOUCESTERSHIRE CCG CONTRACTUAL REQUIREMENTS

Gloucestershire Contract				
	In month Compliance			Cumulative Compliance
	Mar	Apr	May	
Total Measures	76	76	98	98
🔴	9	4	4	5
🟢	29	18	19	18
NYA	26	6	6	6
NYR	7	66	66	66
N/A	5	3	2	2

Performance Thresholds not being achieved in Month

3.63: Adolescent Eating Disorders: Routine referral to NICE treatment within 4 weeks

3.64: Adolescent Eating Disorders: Routine referral to Non-NICE treatment within 4 weeks

3.65: Adolescent Eating Disorders: Urgent referral to NICE treatment within 1 week

In response to current performance, a responsive implementation plan has been developed to improve wait times. This plan outlines the timeframe for staff recruitment which will, when initiated, start to ease waiting times as patients are assessed and treated. Priority is being given to CYP to ensure they are assessed and treated in line with national expectation. No child currently requiring emergency treatment waits more than a week from assessment to treatment in line with national KPI's. There are currently 26 urgent CYP referrals awaiting assessment. These assessments will not meet the national KPI but will be completed by end of August 2018. By this time additional staff will have been appointed so that the assessment to treatment for urgent cases can occur within 4 weeks. Performance and progress will continue to be monitored closely.

3.67: Adult Eating Disorders: Wait time for assessments will be 4 weeks

Work is ongoing to remodel the Adult pathway and understand the increase in demand on the service.

Cumulative Performance Thresholds Not being Met

3.18: IAPT access rate: Access to psychological therapies for adults should be improved

Services in Gloucestershire have a stepped target across the 2018/19 financial year:

Month	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Access Target	1.25%	1.29%	1.33%	1.40%	1.42%	1.46%	1.50%	1.54%	1.56%	1.58%	1.58%	1.58%
Access Target year	15.00%	15.50%	16.00%	16.80%	17.00%	17.50%	18.00%	18.50%	18.75%	19.00%	19.00%	19.00%

May's performance is ahead of current plan at 1.31% (15.72% pa), but we are reporting this indicator as cumulatively non-compliant as we are not yet at 19%

3.63: Adolescent Eating Disorders: Routine referral to NICE treatment within 4 weeks
3.64: Adolescent Eating Disorders: Routine referral to Non-NICE treatment within 4 weeks
3.65: Adolescent Eating Disorders: Urgent referral to NICE treatment within 1 week
As above

3.67: Adult Eating Disorders: Wait time for assessments will be 4 weeks
As above

Changes to Previously Reported Figure

MAS Post Diagnostic Support: Time from referral to assessment – 4 weeks
Previously reported as non-compliant, this indicator has been discussed with Gloucestershire Commissioners and removed from Schedule 4 of the contract.

Early Warnings/Notes
None
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Note in relation to year end compliance predictions (forecast outturn)

3.18 IAPT Access rate:
The performance threshold for 2018/19 has increased from 15% to 19% and although we are compliant for the required access rate in April and May, it too early in the period to determine whether we will be able to meet 19% by the end of the financial year.

3.26 & 3.27 CYPS: Referral to treatment within 8 & 10 weeks
We were below the performance threshold for 2017/18 and although works is ongoing and issues being addressed it is too early in the period to determine whether we will be compliant by the end of the financial year.

3.63 – 3.65: Adolescent Eating Disorders Waiting Times
See note on page 16

3.67: Adult Eating Disorders: Wait time for assessments will be 4 weeks
Work is ongoing to remodel the pathway and understand the increase in demand on the service. It is too early in the financial year to determine whether we will be compliant by the end of the financial year.

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Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2017/18 outturn	April-2018	May-2018	June-2018	(Apr-May) Cumulative Compliance	Forecast 18/19 Outturn
	B. NATIONAL QUALITY REQUIREMENTS							
3.01	Zero tolerance MRSA	PM	0	0	0	0	0	0
		Unavoidable	0	0	0		0	
3.02	Minimise rates of Clostridium difficile	PM	0	0	0	0	0	0
		Unavoidable	0	0	0		0	
3.03	Duty of candour	PM	Report	Report	Report	Report	Report	Report
		Actual	Compliant	Compliant	Compliant		Compliant	
3.04	Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS,	PM	99%	99%	99%	99%	99%	99%
		Actual	100%	100%	100%		100%	
3.05	Completion of Mental Health Services Data Set ethnicity coding for all detained and informal Service Users	PM	90%	90%	90%	90%	90%	90%
		Actual	99%	98%	100%		99%	
3.06	Completion of IAPT Minimum Data Set outcome data for all appropriate Service Users	PM	90%	90%	90%	90%	90%	90%
		Actual	99%	99%	100%		99%	
	C. Local Quality Requirements							
	Domain 1: Preventing People dying prematurely							
3.07	Increased focus on suicide prevention and reduction in the number of reported suicides in the community and inpatient units	PM	Report				Annual	Report
		Actual	28				NYR	
3.08	To reduce the numbers of detained patients absconding from inpatient units where leave has not been granted	PM	< 144			< 36	<36	< 144
		Actual	122				NYR	
3.09	Compliance with NICE Technology appraisals within 90 days of their publication and ability to demonstrate compliance through completion of implementation plans and costing templates.	PM	Report				Annual	Annual
		Actual	N/A				NYR	
	Domain 2: Enhancing the quality of life of people with long-term conditions							
3.10	2G bed occupancy for Gloucestershire CCG patients	PM	> 91%	> 91%	> 91%	> 91%	> 91%	> 91%
		Actual	93%	96%	97%		96%	
3.11	Care Programme Approach: 95% of CPAs should have a record of the mental health worker who is responsible for their care	PM	95%	95%	95%	95%	95%	95%
		Actual	100%	100%	100%		100%	
3.12	CPA Review - 95% of those on CPA to be reviewed within 1 month (Review within 13 months)	PM	95%	95%	95%	95%	95%	95%
		Actual	99%	99%	99%		99%	
3.13	Assessment of risk: % of those 2g service users on CPA to have a documented risk assessment	PM	95%			95%	95%	95%
		Actual	99%				NYR	
3.14	Assessment of risk: All 2g service users (excluding those on CPA) to have a documented risk assessment	PM	85%			85%	85%	85%
		Actual	97%				NYR	

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2017/18 outturn	April-2018	May-2018	June-2018	(Apr-May) Cumulative Compliance	Forecast 18/19 Outturn
3.15	People within the memory assessment service with a working diagnosis of dementia to have a care plan within 4 weeks of diagnosis	PM	85%	85%	85%	85%	85%	85%
		Actual	93%	83%	90%		87%	
3.16	AKI (previous CQUIN 1516) 95% of pts to have EWS score within 12 hours	PM	95%			95%	95%	95%
		Actual	98%				NYR	
	Domain 3: Helping people to recover from episodes of ill-health or following injury							
3.17	IAPT recovery rate: Access to psychological therapies for adults should be improved	PM	50%	50%	50%	50%	50%	50%
		Actual	51%	52%	55%		54%	
3.18	IAPT access rate: Access to psychological therapies for adults should be improved	PM	15.00%	1.25%	1.30%	1.34%	19.00%	19.00%
		Actual	13.32%	1.28%	1.31%		15.72%	
3.19	IAPT reliable improvement rate: Access to psychological therapies for adults should be improved	PM	50%	50%	50%	50%	50%	50%
		Actual	70%	66%	70%		68%	
3.20	Care Programme Approach (CPA): The percentage of people with learning disabilities in inpatient care on CPA who were followed up within 7 days of discharge	PM	95%	95%	95%	95%	95%	95%
		Actual	100%	NA	NA		NA	
3.21	To send :Inpatient and day case discharge summaries electronically, within 24 hours to GP	PM	Report				Annual	Report
		Actual	93%				NYR	
	Domain 4: Ensuring that people have a positive experience of care							
3.22	To demonstrate improvements in staff experience following any national and local surveys	PM	Report				Annual	Annual
		Actual	Compliant				NYR	
3.23	Number of children in crisis urgently referred that receive support within 24 hours of referral by CYPS	PM	95%			95%	95%	95%
		Actual	100%				NYR	
3.24	Children and young people who enter a treatment programme to have a care coordinator - (Level 3 Services) (CYPS)	PM	98%	98%	98%	98%	98%	98%
		Actual	99%	98%	98%		98%	
3.25	95% accepted referrals receiving initial appointment within 4 weeks (excludes YOS, substance misuse, inpatient and crisis/home treatment and complex engagement) (CYPS)	PM	95%			95%	95%	95%
		Actual	98%				NYR	
3.26	Level 2 and 3 – Referral to treatment within 8 weeks , excludes LD, YOS, inpatient and crisis/home treatment) (CYPS)	PM	80%			80%	80%	80%
		Actual	78%				NYR	
3.27	Level 2 and 3 – Referral to treatment within 10 weeks (excludes LD, YOS, inpatient and crisis/home treatment) (CYPS)	PM	95%			95%	95%	95%
		Actual	86%				NYR	

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2017/18 outturn	April-2018	May-2018	June-2018	(Apr-May) Cumulative Compliance	Forecast 18/19 Outturn
3.28	Adults of working age - 100% of MDT assessments to have been completed within 4 weeks (or in the case of a comprehensive assessment commenced within 4 weeks)	PM	85%	85%	85%	85%	85%	85%
		Actual	90%	86%	88%		87%	
	Vocational Services (Individual Placement and Support)							
3.29	100% of Service Users in vocational services will be supported to formulate their vocational goals through individual plans (IPS)	PM	98%			98%	98%	98%
		Actual	100%				NYR	
3.30	The number of people on the caseload during the year finding paid employment or self-employment (measured as a percentage against accepted referrals into the (IPS) Excluding those in employment at time of referral - Annual	PM	50%				50%	50%
		Actual	NYA				NYR	
3.31	The number of people retaining employment at 3/6/9/12+ months (measured as a percentage of individuals placed into employment retaining employment) (IPS)	PM	50%				50%	50%
		Actual	NYA				NYR	
3.32	The number of people supported to retain employment at 3/6/9/12+ months	PM	50%				50%	50%
		Actual	NYA				NYR	
3.33	Fidelity to the IPS model	PM	90%				90%	90%
		Actual	100%				NYR	
	General Quality Requirements							
3.34	GP practices will have an individual annual (MH) ICT service meeting to review delivery and identify priorities for future.	PM	Annual				Annual	Annual
		Actual	NYA				NYR	
3.35	Care plan audit to show : All dependent Children and YP <18 living with adults know to Recovery, MAHRS, Eating Disorder and Assertive Outreach Services. Recorded evidence in care plans of impact of the mental health disorder on those under 18s plus steps put in place to support.(Think family)	PM	Qtr 3			TBC	TBC	Report
		Actual	75%				NYR	
3.36	Transition- Joint discharge/CPA review meeting within 4 weeks of adult MH services accepting :working diagnosis to be agreed, adult MH care coordinator allocated and care cluster and risk levels agreed as well as CYPS discharge date.	PM	100%			100%	100%	100%
		Actual	0%				NYR	
3.37	Number and % of crisis assessments undertaken by the MHARS team on CYP age 16-25 within agreed timescales of 4 hours	PM	90%	90%	90%	90%	90%	90%
		Actual	NYR	NYA	NYA		NYA	
3.38	MHARS Wait time to Assessment: Triage wait time 1 hour	PM		TBC	TBC	TBC	TBC	TBC
		Actual		NYA	NYA		NYA	
3.39	MHARS Wait time to Assessment: Full Assessment 4 hours	PM	90%	TBC	TBC	TBC	TBC	TBC
		Actual	NYR	NYA	NYA		NYA	

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2017/18 outturn	April-2018	May-2018	June-2018	(Apr-May) Cumulative Compliance	Forecast 18/19 Outturn
	New KPIs for 2017/18							
3.40	LD: To deliver specialist support to people with learning disabilities in accordance with specifically developed pathways	PM	95%			25%	95%	95%
		Actual	100%				NYR	
3.41	LD: To demonstrate a reduction in an individual's health inequalities thanks to the clinical intervention provided by 2gether learning disability services.	PM	Report			TBC	TBC	TBC
		Actual	Compliant				NYR	
3.42	LD: People with learning disabilities and their families report high levels of satisfaction with specialist learning disability services	PM	75%			75%	75%	75%
		Actual	Compliant				NYR	
3.43	LD: To ensure all published clinical pathways accessed by people with learning disabilities are available in easy read versions	PM	95%			95%	95%	95%
		Actual	100%				NYR	
3.44	LD: The CLDT, IHOT & LDISS will take a proactive and supportive role in ensuring the % uptake of Annual Health Checks for people with learning disabilities on their caseload is high	PM	75%				75%	75%
		Actual	80%				NYR	
3.45	Of those supported by 2g to access AHC 100% are then further supported with their Health Action Plans & screening	PM					100%	75%
		Actual					NYR	
3.46	IAPT DNA rate	PM	<16%	<16%	<16%	<16%	<16%	<16%
		Actual	13%	14%	13%		13%	
3.47	IAPT Equity of Access for Service Users: aged 65 and over on the caseload					TBC	TBC	TBC
		Actual					NYR	
3.48	IAPT Equity of Access for Service Users: Numbers of BAME on the caseload					TBC	TBC	TBC
		Actual					NYR	
3.49	IAPT Clinical productivity by Groups and 1:1 sessions for: Hi Intensity					> 18 per week	> 18 per week	> 18 per week
		Actual					NYR	
3.50	IAPT Clinical productivity by Groups and 1:1 sessions for: Lo Intensity					> 18 per week	> 18 per week	> 18 per week
		Actual					NYR	
3.51	IAPT treatment outcomes: Women in the Perinatal period showing reliable improvement in outcomes between pre and post treatment	PM	50%	50%	50%	50%	50%	85%
		Actual	75%	68%	76%		72%	
3.52	% of CYP entering partnership in CYPS have pre and post treatment outcomes and measures recorded					50%	50%	50%
		Actual					NYR	

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2017/18 outturn	April-2018	May-2018	June-2018	(Apr-May) Cumulative Compliance	Forecast 18/19 Outturn
3.53	Patients with Dementia have weight assessments on admission	PM				85%	85%	85%
		Actual					NYR	
3.54	Patients with Dementia have weight assessments at weekly intervals	PM				85%	85%	85%
		Actual					NYR	
3.55	Patients with Dementia have weight assessments near discharge	PM				85%	85%	85%
		Actual					NYR	
3.56	Patients with Dementia have delirium screening on admission	PM				85%	85%	85%
		Actual					NYR	
3.57	Patients with Dementia have delirium screening at weekly intervals	PM				85%	85%	85%
		Actual					NYR	
3.58	Patients with Dementia have delirium screening near discharge	PM				85%	85%	85%
		Actual					NYR	
3.59	CPI: Referral to Assessment within 4 weeks	PM	85%	85%	85%	85%	85%	85%
		Actual	91%	91%	91%		91%	
3.60	CPI: Assessment to Treatment within 16 weeks	PM	85%	85%	85%	85%	85%	85%
		Actual	99%	100%	94%		96%	
3.61	Comprehensive audit in relation to timeliness and quality of discharge communication (non-medical)						Report	
		Actual					NYR	
3.62	Daily submission of information to inform the daily escalation level	PM		Report	Report	Report	Report	Report
		Actual		NYA	NYA		NYA	
3.63	Adolescent Eating Disorders - Routine referral to NICE treatment start within 4 weeks	PM	95%	95%	95%	95%	95%	95%
		Actual	29%	0%	33%		21%	
3.64	Adolescent Eating Disorders - Routine referral to non-NICE treatment start within 4 weeks	PM	95%	95%	95%	95%	95%	95%
		Actual	9%	N/A	0%		0%	
3.65	Adolescent Eating Disorders - Urgent referral to NICE treatment start within 1 week	PM	95%	95%	95%	95%	95%	95%
		Actual	64%	25%	50%		33%	
3.66	Adolescent Eating Disorders - Urgent referral to non-NICE treatment start within 1 week	PM	95%	95%	95%	95%	95%	95%
		Actual	N/A	N/A	N/A		N/A	
3.67	Eating Disorders - Wait time for adult assessments will be 4 weeks	PM	95%	95%	95%	95%	95%	95%
		Actual	36%	61%	68%		64%	
3.68	Eating Disorders - Wait time for adult psychological interventions will be 16 weeks	PM		95%	95%	95%	95%	95%
		Actual		NYA	NYA		NYA	

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2017/18 outturn	April-2018	May-2018	June-2018	(Apr-May) Cumulative Compliance	Forecast 18/19 Outturn
3.69	LD Health facilitation - awareness and support for all stakeholders including reasonable adjustments support to reduce health inequalities						Annual	
		Actual					NYR	
3.70	LD: Patients on the LD challenging behaviour pathway have a single positive behaviour support plan (containing primary, secondary and reactive interventions) completed within 30 days of allocation to clinician	PM				25%	95%	95%
		Actual					NYR	
3.71	LD: Active involvement in Care and Treatment Reviews & Blue Light protocol meetings to prevent admission and actively support and plan for integration/discharge in the community: 100% completion of the CTR Provider Checklist prior to CTR meetings	PM				100%	100%	100%
		Actual					NYR	
3.72	LD: Active involvement in Care and Treatment Reviews & Blue Light protocol meetings to prevent admission and actively support and plan for integration/discharge in the community: 75% CTRs being completed within 10 days of admission to Berkeley House	PM				75%	75%	75%
		Actual					NYR	
3.73	CYP report being satisfied or more than satisfied with Service Experience: 95% of CYP asked to complete Service Questionnaire	PM				95%	95%	95%
		Actual					NYR	
3.74	CYP report being satisfied or more than satisfied with Service Experience: Satisfaction rate of 75%	PM				75%	75%	75%
		Actual					NYR	
3.75	CYP report being satisfied or more than satisfied with Transition to Adult Services: 95% of CYP asked to complete Service Questionnaire	PM				95%	95%	95%
		Actual					NYR	
3.76	CYP report being satisfied or more than satisfied with Transition to Adult Services: Satisfaction rate of 75%	PM				75%	75%	75%
		Actual					NYR	
3.77	CYPS Youth Support Mental Health Workers: Practioner feedback demonstrating access to MH consultation and support : 95% of CYP asked to complete Questionnaire	PM				95%	95%	95%
		Actual					NYR	
3.78	CYPS Youth Support Mental Health Workers: Practioner feedback demonstrating access to MH consultation and support : Satisfaction rate of 75%	PM				75%	75%	75%
		Actual					NYR	
3.79	YP Substance Misuse: Referral to be offered appointment within 5 working days	PM		95%	95%	95%	95%	95%
		Actual		NYA	NYA		NYA	

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2017/18 outturn	April-2018	May-2018	June-2018	(Apr-May) Cumulative Compliance	Forecast 18/19 Outturn
3.80	Perinatal: Urgent Referral to Assessment within 4 - 6 hours - During working hours (unless otherwise negotiated with referrer or patient) in conjunction with Crisis Team	PM				95%	95%	95%
		Actual					NYR	
3.81	Perinatal: Out of hours emergencies assessed by MHARS to be discussed with the Specialist Perinatal Service the next working day	PM					95%	95%
		Actual					NYR	
3.82	Perinatal: Urgent referrals with High risk indicators (following telephone screening) will be seen with 48 working hours	PM				95%	95%	95%
		Actual					NYR	
3.83	Perinatal: Preconception advice - Referral to assessment within 6 weeks	PM				50%	50%	95%
		Actual					NYR	
3.84	Perinatal: Preconception advice - Referral to assessment within 8 weeks	PM				95%	95%	95%
		Actual					NYR	
3.85	Perinatal: Routine referral to assessment within 2 weeks	PM				50%	50%	95%
		Actual					NYR	
3.86	Perinatal: Routine referral to assessment within 6 weeks	PM				95%	95%	95%
		Actual					NYR	
3.87	Perinatal: Number of women asked if they have a carer	PM	80%			80%	80%	80%
		Actual	82%				NYR	
3.88	Perinatal: Number of women with a carer offered carer's assessment	PM	90%			90%	90%	90%
		Actual	90%				NYR	
3.89	Perinatal: Women and families views inform the development of the service via a service user forum	PM					Report	Annual
		Actual					NYR	
3.90	Perinatal: all perinatal care plans to be reviewed within 3 months	PM				95%	95%	95%
		Actual					NYR	
3.91	Perinatal: Reduction in number of episodes of Crisis	PM					Report	Report
		Actual					NYR	
3.92	Perinatal: Number of women screened and signposted	PM					Report	Report
		Actual					NYR	
3.93	GARAS: Accepted referrals receive an initial assessment appointment within 6 weeks	PM				95%	95%	95%
		Actual					NYR	
3.94	GARAS: Pre and Post outcome measures: Number reported to have decreased symptoms of distress	PM				95%	95%	95%
		Actual					NYR	
3.95	GARAS: Pre and Post outcome measures: Number reported to have improved quality of life	PM				95%	95%	95%
		Actual					NYR	
3.96	GARAS: Pre and Post outcome measures: Number reported to have improved functional ability	PM				95%	95%	95%
		Actual					NYR	
3.97	GARAS: Pre and Post outcome measures: Number reported to have improved mental health	PM				95%	95%	95%
		Actual					NYR	

Schedule 4 Specific Measures that are reported Nationally

Performance Thresholds not being achieved in Month

NHS Improvement

1.02: Number of C Diff cases – avoidable
One patient on Willow Ward, Charlton Lane tested positive for C diff in May. A review meeting is planned for the end of June, after which it will be confirmed whether the case is avoidable or unavoidable. For transparency the case is assumed to be avoidable until confirmed otherwise.

1.08: New psychosis (EI) cases treated within 2 weeks of referral
There were 2 cases in May that did not meet the performance threshold. Although we were able to offer both of these young people an appointment within 2 weeks, they chose to wait beyond this due to educational study and examinations.

Changes to Previously Reported Figures

None

Early Warnings / Notes

1.02: Number of C Diff cases – avoidable
Although we are showing this indicator as non-compliant for May due to 1 case. The performance threshold for the whole financial year is less than 3 cases; therefore we have shown the cumulative total as compliant.

Note in relation to year end compliance predictions (forecast outturn)

2.21: No children under 18 admitted to adult inpatient wards
Although there were no admissions in Gloucestershire in April or May we are anticipating that there will be some during 2018/19.

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

ID	Performance Measure (PM)		2017/18 Outturn	April-2018	May-2018	June-2018	(Apr-May) Cumulative Compliance	Forecast 18/19 Outturn
NHSI 1.01	Number of MRSA Bacteraemias avoidable	PM	0	0	0	0	0	0
		Actual	0	0	0		0	
NHSI 1.02	Number of C Diff cases (day of admission plus 2 days = 72hrs) - avoidable	PM	0	0	0	0	<3	0
		Actual	0	0	1		1	
NHSI 1.03	Care Programme Approach follow up contact within 7 days of discharge	PM	95%	95%	95%	95%	95%	95%
		Actual	99%	98%	100%		99%	
NHSI 1.05	Delayed Discharges (Including Non Health)	PM	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%
		Actual	3.2%	2.7%	0.8%		1.7%	
NHSI 1.06	Admissions to Adult inpatient services had access to Crisis Resolution Home Treatment Teams	PM	95%	95%	95%	95%	95%	95%
		Actual	99%	100%	97%		98%	
NHSI 1.08	New psychosis (EI) cases treated within 2 weeks of referral	PM	50%	53%	53%	53%	53%	53%
		Actual	71%	89%	33%		75%	
NHSI 1.09	IAPT - Waiting times: Referral to Treatment within 6 weeks (based on discharges)	PM	75%	75%	75%	75%	75%	75%
		Actual	69%	87%	92%		90%	
NHSI 1.10	IAPT - Waiting times: Referral to Treatment within 18 weeks (based on discharges)	PM	95%	95%	95%	95%	95%	95%
		Actual	88%	94%	97%		95%	
DoH 2.18	Mixed Sex Accommodation Breach	PM	0	0	0	0	0	0
		Actual	0	0	0		0	
DoH 2.21	No children under 18 admitted to adult in-patient wards	PM	0	0	0	0	0	0
		Actual	6	0	0		0	
DoH 2.25	All SIs reported within 2 working days of identification	PM	100%	100%	100%	100%	100%	100%
		Actual	100%	100%	100%		100%	
DoH 2.26	Interim report for all SIs received within 5 working days of identification (unless extension granted by CCG)	PM	100%	100%	100%	0%	100%	100%
		Actual	100%	100%	100%		100%	
DoH 2.27	SI Report Levels 1 & 2 to CCG within 60 working days	PM	100%	100%	100%	0%	100%	100%
		Actual	100%	NYR	NYR		NYR	

DASHBOARD CATEGORY – GLOUCESTERSHIRE SOCIAL CARE

Gloucestershire Social Care				
	In month Compliance			Cumulative Compliance
	Mar	Apr	May	
Total Measures	15	15	15	15
	0	0	0	0
	13	13	13	13
NYA	0	0	0	0
NYR	0	0	0	0
N/A	2	2	2	2

Performance Thresholds not being achieved in Month
None

Cumulative Performance Thresholds Not being Met
None

Changes to Previously Reported Figures
None

Early Warnings/Notes
None

Gloucestershire Social Care

ID	Performance Measure		2017/18 outturn	April-2018	May-2018	June-2018	(Apr-May) Cumulative Compliance	Forecast 18/19 Outturn
4.01	The percentage of people who have a Cluster recorded on their record	PM	95%	95%	95%	95%	95%	95%
		Actual	98%	99%	99%		99%	
4.02	Percentage of people getting long term services, in a residential or community care reviewed/re-assessed in last year	PM	95%	95%	95%	95%	95%	95%
		Actual	97%	95%	97%		97%	
4.03	Ensure that reviews of new packages take place within 12 weeks of commencement	PM	80%	80%	80%	80%	80%	80%
		Actual	74%	100%	100%		100%	
4.04	Current placements aged 18-64 to residential and nursing care homes per 100,000 population	PM	13	13	13	13	13	13
		Actual	9.44	9.61	9.10		9.61	
4.05	Current placements aged 65+ to residential and nursing care homes per 100,000 population	PM	22	22	22	22	22	22
		Actual	16.54	17.90	18.67		17.90	
4.06	% of WA & OP service users on caseload asked if they have a carer	PM	80%	80%	80%	80%	80%	80%
			88%	88%	88%		88%	
4.07	% of WA & OP service users on the caseload who have a carer, who have been offered a carer's assessment	PM	90%	90%	90%	90%	90%	90%
		Actual	91%	91%	91%		91%	
4.08a	% of WA & OP service users/carers on caseload who accepted a carers assessment	PM	TBC	TBC	TBC	TBC	TBC	TBC
		Actual	43%	41%	41%		41%	
4.08b	Number of WA & OP service users/carers on caseload who accepted a carers assessment	PM	TBC	TBC	TBC	TBC	TBC	TBC
		Actual	521	511	541		541	
4.09	% of eligible service users with Personal budgets	PM	80%	80%	80%	80%	80%	80%
		Actual	95%	95%	97%		97%	

Gloucestershire Social Care

ID	Performance Measure		2017/18 outturn	April-2018	May-2018	June-2018	(Apr-May) Cumulative Compliance	Forecast 18/19 Outturn
4.10	% of eligible service users with Personal Budget receiving Direct Payments (ASCOF 1C pt2)	PM	15%	15%	15%	15%	15%	15%
		Actual	19%	17%	17%		17%	
4.11	Adults subject to CPA in contact with secondary mental health services in settled accommodation (ASCOF 1H)	PM	80%	80%	80%	80%	80%	80%
		Actual	87%	83%	87%		87%	
4.12	Adults not subject to CPA in contact with secondary mental health service in settled accommodation	PM	90%	90%	90%	90%	90%	90%
		Actual	96%	96%	96%		96%	
4.13	Adults subject to CPA receiving secondary mental health service in employment (ASCOF 1F)	PM	13%	13%	13%	13%	13%	13%
		Actual	18%	17%	17%		17%	
4.14	Adults not subject to CPA receiving secondary mental health service in employment	PM	20%	20%	20%	20%	20%	20%
		Actual	21%	22%	23%		23%	

DASHBOARD CATEGORY – HEREFORDSHIRE CCG CONTRACTUAL REQUIREMENTS

Herefordshire Contract				
	In month Compliance			Cumulative Compliance
	Mar	Apr	May	
Total Measures	22	22	23	23
	2	3	2	3
	12	12	14	13
NYA	0	0	0	0
NYR	0	1	1	1
N/A	8	8	7	7

Performance Thresholds not being achieved in Month

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

5.09a IAPT achieve 15% of patients entering the service against prevalence
This service is subject to an agreed Service Development Improvement Plan which is under specific monthly review by the Delivery Committee. Trajectory plans and an associated investment envelope has been agreed with Herefordshire CCG in order to meet the 19% access target by quarter 4 2018/19. A service improvement development plan is being produced.

This indicator is now reported as a monthly percentage performance against the required access rate threshold of 19%.

5.09b is in the same format as previous reports and shows the cumulative number accessing the service.

Cumulative Performance Thresholds Not being

5.08: IAPT: Recovery rate
As above

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

5.15: CYP Eating Disorders: Routine referral to NICE treatment within 4 weeks
There were 2 cases in April and both started treatment outside of the required 4 weeks.

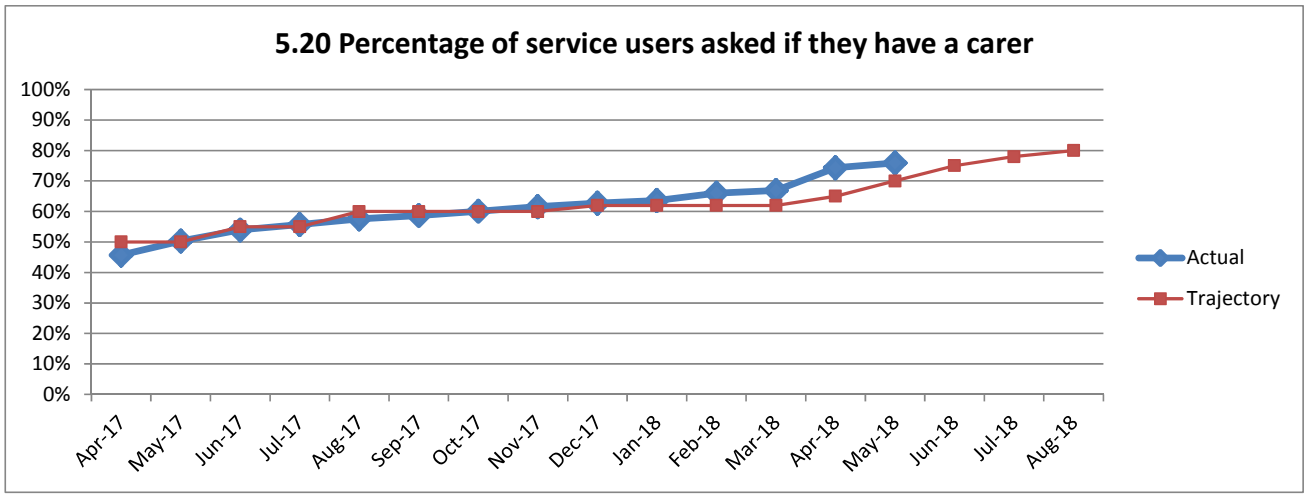
One case was due to the initial appointment, which was within 4 weeks, being cancelled by the family. The second case was as a result of unprecedented caseload activity and the need to manage deteriorating presentations in existing cases.

Changes to Previously Reported Figures

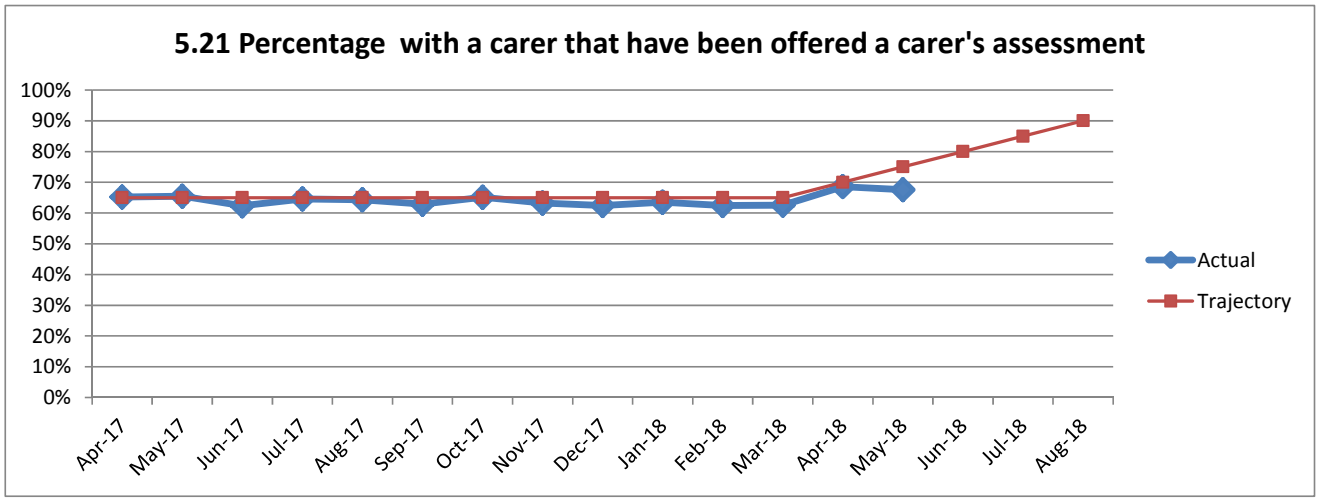
None

Early Warnings / Notes

5.20: Percentage of service users asked if they have a carer
The following chart monitors progress against a trajectory to reach 80% by August 2018.



5.21: Percentage with a carer that have been offered a carer's assessment
The following chart monitors progress against a trajectory to reach 90% by August 2018.



Note in relation to year end compliance predictions (forecast outturn)

5.09a: IAPT roll-out (access rate) – IAPT maintain 15% of patient entering the service against prevalence:
See earlier note on Page 30.

5.15: CYP Eating Disorders: Treatment waiting time for patient referrals within 4 weeks:
Discussions with Commissioners around whether the service has resources to meet this target need to be resolved before year end forecast can be confirmed.

5.17: CYP Eating Disorders: Treatment waiting time for patient referrals within 1 week:
Discussions with Commissioners around whether the service has resources to meet this target need to be resolved before year end forecast can be confirmed.

Herefordshire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2017/18 Outturn	April-2018	May-2018	June-2018	(Apr-May) Cumulative Compliance	Forecast 18/19 Outturn
5.01	Duty of Candour	Plan	Report	Report	Report	Report	Report	Report
		Actual	Compliant	Compliant	Compliant		Compliant	
5.02	Completion of a valid NHS number field in metal health and acute commissioning data sets submitted via SUS.	Plan	99%	99%	99%	99%	99%	99%
		Actual	100%	100%	100%		100%	
5.03	Completion of Mental Health Services Data Set ethnicity coding for all service users	Plan	90%	90%	90%	90%	90%	90%
		Actual	100%	100%	97%		99%	
5.04	Completion of IAPT Minimum Data Set outcome data for all appropriate service users	Plan	90%	90%	90%	90%	90%	90%
		Actual	100%	100%	100%		100%	
5.05	Zero tolerance MRSA	Plan	0	0	0	0	0	0
		Unavoidable	0	0	0		0	
5.06	Minimise rates of Clostridium difficile	Plan	0	0	0	0	0	0
		Unavoidable	0	0	0		0	
5.07	VTE risk assessment: all inpatient service users to undergo risk assessment for VTE	Plan	95%	95%	95%	95%	95%	95%
		Actual	98%	98%	100%		99%	
5.08	IAPT Recovery Rate: The number of people who are below the caseness threshold at treatment end	Plan	50%	50%	50%	50%	50%	50%
		Actual	49%	49%	42%		46%	
5.09a	IAPT Roll-out (Access Rate) - IAPT maintain 15% of patient entering the service against prevalence	Plan		1.25%	1.30%	1.34%	19.00%	19.00%
				1.18%	1.14%		13.68%	
5.09b	IAPT Roll-out (Access Rate) - Number accessing service	Plan	2,178	182	370	565	370	2758
		Actual	1,977	171	219		219	

Herefordshire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2017/18 Outturn	April-2018	May-2018	June-2018	(Apr-May) Cumulative Compliance	Forecast 18/19 Outturn
5.10a	Dementia Service - number of new patients aged 65 years and over receiving an assessment	Plan	540	45	45	45	90	540
		Actual	667	65	74		139	
5.10b	Dementia Service - total number of new patients receiving an assessment	Plan						
		Actual	711	68	78		146	
5.11	Patients are to be discharged from local rehab within 2 years of admission (Oak House). Based on patients on ward at end of month.	Plan	80%	80%	80%	80%	80%	80%
		Actual	100%	100%	100%		100%	
5.12	All admitted patients aged 65 years of age and over must have a completed MUST assessment	Plan	95%	95%	95%	95%	95%	95%
		Actual	100%	100%	100%		100%	
5.13	Any attendances at ED with mental health needs should have rapid access to mental health assessment within 2 hours of the MHL team being notified.	Plan	80%	80%	80%	80%	80%	80%
		Actual	89%	95%	88%		90%	
5.14	Attendances at ED, wards and clinics for self-harm receive a mental health assessment (Mental Health Liaison Service)	Plan	85%	85%	85%	85%	85%	85%
		Actual	96%	97%	93%		95%	
5.15	CYP Eating Disorders: Treatment waiting time for routine referrals within 4 weeks - NICE treatments	Plan	95%	95%	95%	95%	95%	95%
		Actual	96%	0%	100%		33%	
5.16	CYP Eating Disorders: Treatment waiting time for routine referrals within 4 weeks - non-NICE treatments	Plan	95%	95%	95%	95%	95%	95%
		Actual	N/A	N/A	N/A		N/A	
5.17	CYP Eating Disorders: Treatment waiting time for urgent referrals within 1 week - NICE treatments	Plan	95%	95%	95%	95%	95%	95%
		Actual	80%	N/A	100%		100%	
5.18	CYP Eating Disorders: Treatment waiting time for urgent referrals within 1 week - non-NICE treatments	Plan	95%	95%	95%	95%	95%	95%
		Actual	N/A	N/A	N/A		N/A	
5.19	CYP Access: Number and percentage of CYP entering treatment	Plan				30%	30%	30%
		Actual					NYR	

Herefordshire Carers Information

ID	Performance Measure		2017/18 Outturn	April-2018	May-2018	June-2018	(Apr-May) Cumulative Compliance	Forecast 18/19 Outturn
5.20	Working Age and Older People service users on the caseload asked if they have a carer. (Only includes people referred since 1st March 2016, when the new Carers Form went live on RiO).	Plan						
		Actual	67%	74%	76%		76%	○
5.21	Working Age and Older People service users on the caseload who have a carer who have been offered a carer's assessment. (Includes people referred since 1st March 2016, when the new Carers Form went live on RiO).	Plan						
		Actual	63%	69%	68%		68%	○
5.22	Working Age and Older People service users/carers who have accepted a carers assessment. (Only includes people referred since 1st March 2016, when the new Carers Form went live on RiO).	Plan						
		Actual	28%	28%	26%		26%	○

Schedule 4 Specific Measures that are reported Nationally

Performance Thresholds not being achieved in Month

NHS Improvement

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

Department of Health

2.21: No children under 18 admitted to adult inpatient wards
There was 1 admission to an under 18 adult ward in Herefordshire in May.

A 17 year old known to CYPS with co-morbid Eating Disorders and history of a previous inpatient admission was admitted due to suicidal intent to Mortimer Ward, Stonebow.

CYPS staff were engaged and a search was carried out nationally for an appropriate bed. The patient was transferred 11 days after admission.

Note in relation to year end compliance predictions (forecast outturn)

2.21: No children under 18 admitted to adult inpatient wards
See earlier note on Page 12.

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

ID	Performance Measure (PM)		2017/18 Outturn	April-2018	May-2018	June-2018	(Apr-May) Cumulative Compliance	Forecast 18/19 Outturn
NHSI 1.01	Number of MRSA Bacteraemias avoidable	PM	0	0	0	0	0	0
		Actual	0	0	0		0	
NHSI 1.02	Number of C Diff cases (day of admission plus 2 days = 72hrs) - avoidable	PM	0	0	0	0	<3	0
		Actual	0	0	0		0	
NHSI 1.03	Care Programme Approach follow up contact within 7 days of discharge	PM	95%	95%	95%	95%	95%	95%
		Actual	99%	100%	100%		100%	
NHSI 1.04	Care Programme Approach - formal review within12 months	PM	95%	95%	95%	95%	95%	95%
		Actual	98%	96%	97%		97%	
NHSI 1.05	Delayed Discharges (Including Non Health)	PM	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%
		Actual	2.4%	0.0%	2.1%		1.1%	
NHSI 1.08	New psychosis (EI) cases treated within 2 weeks of referral	PM	50%	53%	53%	53%	53%	53%
		Actual	68%	67%	67%		67%	
NHSI 1.09	IAPT - Waiting times: Referral to Treatment within 6 weeks (based on discharges)	PM	75%	75%	75%	75%	75%	75%
		Actual	59%	82%	83%		82%	
NHSI 1.10	IAPT - Waiting times: Referral to Treatment within 18 weeks (based on discharges)	PM	95%	95%	95%	95%	95%	95%
		Actual	75%	85%	84%		85%	
DoH 2.18	Mixed Sex Accommodation Breach	PM	0	0	0	0	0	0
		Actual	0	0	0		0	
DoH 2.21	No children under 18 admitted to adult in-patient wards	PM	0	0	0	0	0	0
		Actual	5	1	1		2	

DASHBOARD CATEGORY – GLOUCESTERSHIRE CQUINS

Gloucestershire CQUINS				
	In month Compliance			Cumulative Compliance
	Mar	Apr	May	
Total Measures	12	12	12	12
	1	0	0	0
	11	0	0	0
NYA	0	0	0	0
NYR	0	12	12	12
N/A	0	0	0	0

Performance Thresholds not being achieved in Month
None

Cumulative Performance Thresholds Not being Met
None

Changes to Previously Reported Figures
None

Early Warnings
None

Gloucestershire CQUINS

ID	Performance Measure (PM)		2017/18 Outturn	April-2018	May-2018	June-2018	(Apr-May) Cumulative Compliance	Forecast 18/19 Outturn
	CQUIN 1							
7.01a	Improvement of health and wellbeing of NHS Staff	PM	Qtr 4			Report	Report	Report
		Actual	Compliant				NYR	
7.01b	Healthy food for NHS staff, visitors and patients	PM	Qtr 4			Report	Report	Report
		Actual	Compliant				NYR	
7.01c	Improving the update of flu vaccinations for frontline clinical staff	PM	Qtr 4			Report	Report	Report
		Actual	Compliant				NYR	
	CQUIN 2							
7.02a	Improving Physical healthcare to reduce premature mortality in people with SMI: Cardio Metabolic Assessment and treatment for Patients with psychoses	PM	Qtr 4			Report	Report	Report
		Actual	Compliant				NYR	
7.02b	Improving Physical healthcare to reduce premature mortality in people with SMI: Collaboration with primary care clinicians	PM	Qtr 4			Report	Report	Report
		Actual	Compliant				NYR	
	CQUIN 3							
7.03	Improving services for people with mental health needs who present to A&E	PM	Qtr 4			Report	Report	Report
		Actual	Compliant				NYR	
	CQUIN 4							
7.04	Transition from Young People's Service to Adult Mental Health Services	PM	Qtr 4			Report	Report	Report
		Actual	Compliant				NYR	
	CQUIN 5							
7.05a	Preventing ill health by risky behaviours - alcohol and tobacco: Tobacco screening	PM	Qtr 4			Report	Report	Report
		Actual	Compliant				NYR	
7.05b	Preventing ill health by risky behaviours - alcohol and tobacco: Tobacco brief advice	PM	Qtr 4			Report	Report	Report
		Actual	Compliant				NYR	
7.05c	Preventing ill health by risky behaviours - alcohol and tobacco: Tobacco referral and medication	PM	Qtr 4			Report	Report	Report
		Actual	Compliant				NYR	
7.05d	Preventing ill health by risky behaviours - alcohol and tobacco: Alcohol screening	PM	Qtr 4			Report	Report	Report
		Actual	Compliant				NYR	
7.05e	Preventing ill health by risky behaviours - alcohol and tobacco: Alcohol brief advice or referral	PM	Qtr 4			Report	Report	Report
		Actual	Compliant				NYR	

DASHBOARD CATEGORY – LOW SECURE CQUINS

Low Secure CQUINS				
	In month Compliance			Cumulative Compliance
	Mar	Apr	May	
Total Measures	1	1	1	1
	0	0	0	0
	1	0	0	0
NYA	0	0	0	0
NYR	0	1	1	1
N/A	0	0	0	0

Performance Thresholds not being achieved in Month
None

Cumulative Performance Thresholds Not being Met
None

Changes to Previously Reported Figures
None

Early Warnings
None

Low Secure CQUINS

ID	Performance Measure (PM)		2017/18 Outturn	April-2018	May-2018	June-2018	(Apr-May) Cumulative Compliance	Forecast 18/19 Outturn
	CQUIN 1							
8.01	Reducing the length of stay in specialised MH services	PM	Qtr 4			Report	Report	Report
		Actual	Compliant				NYR	

DASHBOARD CATEGORY – HEREFORDSHIRE CQUINS

Herefordshire CQUINS				
	In month Compliance			Cumulative Compliance
	Mar	Apr	May	
Total Measures	12	12	12	12
	0	0	0	0
	12	0	0	0
NYA	0	0	0	0
NYR	0	12	12	12
N/A	0	0	0	0

Performance Thresholds not being achieved in Month
None

Cumulative Performance Thresholds Not being Met
None

Changes to Previously Reported Figures
None

Early Warnings
None

Herefordshire CQUINS

ID	Performance Measure (PM)		2017/18 Outturn	April-2018	May-2018	June-2018	(Apr-May) Cumulative Compliance	Forecast 18/19 Outturn
7								
	CQUIN 1							
9.01a	Improvement of health and wellbeing of NHS Staff	PM	Qtr 4			Report	Report	Report
		Actual	Compliant				NYR	
9.01b	Healthy food for NHS Staff, Visitors and Patients	PM	Qtr 4			Report	Report	Report
		Actual	Compliant				NYR	
9.01c	Improving the uptake of Flu vaccinations for Front Line Clinical Staff	PM	Qtr 4			Report	Report	Report
		Actual	Compliant				NYR	
	CQUIN 2							
9.02a	Improving Physical healthcare to reduce premature mortality in people with SMI: Cardio Metabolic Assessment and treatment for Patients with psychoses	PM	Qtr 4			Report	Report	Report
		Actual	Compliant				NYR	
9.02b	Improving Physical healthcare to reduce premature mortality in people with SMI: Collaborating with primary care clinicians	PM	Qtr 4			Report	Report	Report
		Actual	Compliant				NYR	
	CQUIN 3							
9.03	Improving services for people with mental health needs who present to A&E	PM	Qtr 4			Report	Report	Report
		Actual	Compliant				NYR	
	CQUIN 4							
9.04	Transition from Young People's Service to Adult Mental Health Services	PM	Qtr 4			Report	Report	Report
		Actual	Compliant				NYR	
	CQUIN 5							
9.05a	Tobacco screening	PM	Qtr 4			Report	Report	Report
		Actual	Compliant				NYR	
9.05b	Tobacco brief advice	PM	Qtr 4			Report	Report	Report
		Actual	Compliant				NYR	
9.05c	Tobacco referral and medication offer	PM	Qtr 4			Report	Report	Report
		Actual	Compliant				NYR	
9.05d	Alcohol screening	PM	Qtr 4			Report	Report	Report
		Actual	Compliant				NYR	
9.05e	Alcohol brief advice or referral	PM	Qtr 4			Report	Report	Report
		Actual	Compliant				NYR	

Agenda Item: 8 **Enclosure: Paper C**

Report to: [2]gether NHS Foundation Trust Board – 26 July 2018
Author: Angie Fletcher, Service Experience Clinical Manager
Presented by: Jane Melton, Director of Engagement and Integration

Subject: **Service Experience Report Quarter 4 2017/18**

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

EXECUTIVE SUMMARY

(1) Introduction

This Service Experience Report provides a high level overview of feedback received from service users and carers in Quarter 4 2017/18. The key purpose of this paper is to offer assurance that the trust listens to people's experiences and takes action as a result of the important learning gathered.

(2) Assurance

Assurance is provided to the Governance Committee that service experience information has been reviewed, scrutinised for themes, and considered for both service-specific and general learning across the organisation.

Significant assurance that the organisation has listened to, heard and understood service user and carer experience of [2]gether's services.
This assurance is offered from a triangulation of information gathered across all domains of feedback including complaints, concerns, comments and compliments. Survey information has also been integrated into the process of analysis to understand service experience.

Significant assurance that service users generally value the service being offered and would recommend it to others.
During Quarter 4, 84% of people who completed the Friends and Family Test said that they would recommend [2]gether's services. This score is relatively consistent with the previous quarter scores recorded for the previous year. Response rates have continued to increase this quarter meaning that more feedback was received and this may have an impact on the overall FFT score. 2gether benchmarks slightly below other local organisations for FFT scores in the last year. Further work to refine the process of gathering FFT scores continues and feedback is provided to each team.

Limited assurance that people are participating in the local survey of quality in sufficient numbers. The new **How did we do?** survey was launched during Quarter 1 of this year. Whilst feedback given by respondents has generally been positive, response rates remain lower than hoped for. However, an increase in the number of responses received has been seen in Quarter 4.The SED are working with operational colleagues to raise awareness of the importance of obtaining feedback about our services. The SED are also actively exploring additional ways in which they can support clinical services to obtain increased service experience feedback.

Significant assurance that services are consistently reporting details of compliments they have received.
Compliments continue to be reported to the Service Experience Department. Numbers have increased again during Quarter 4 and work continues to increase reporting by colleagues throughout the Trust.

Full Assurance that complaints have been acknowledged in required timescale
During Quarter 4 100% of complaints received were acknowledged within 3 days.

Significant assurance that all people who complain have their complaint dealt with by the initially agreed timescale.
75% of complaints were closed within timescales agreed with the complainant. This is an increase from previous Quarters (67%). The SED are working hard with Trust colleagues to ensure that future complaints are closed in a timely way.

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

(3) Recommended learning and improvement
The Trust continues to seek feedback about service experience from multiple sources on a continuous basis.
This quarter concerns and complaint themes continue to focus on communication issues by our services with service users and/or their carers. Colleagues across the Trust are working hard to develop practice in this area – the continued implementation of the Triangle of Care being an example of this.

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

- We must explain the reasons why we make decisions.
- We must include everyone involved when planning care.

An update on complaints referred for external review following investigation by our Trust is included within this report.

RECOMMENDATIONS

The Trust Board is asked to:

- Note the contents of this report

Corporate Considerations	
Quality Implications	Patient and carer experience is a key component of the delivery of best quality of care. The report outlines what is known about experience of ^{2}gether's services in Q4 2017/18 and makes key recommendations for actions to enhance quality.
Resource Implications	The Service Experience Report offers assurance to the Trust that resources are being used to support best service experience.
Equalities Implications	The Service Experience Report offers assurance that the Trust is attending to its responsibilities regarding equalities for service users and carers.
Risk Implications	Feedback on service experience offers an insight into how services are received. The information provides a mechanism for identifying performance, reputational and clinical risks. This paper offers limited assurance on 1 aspect covered by the report. The SED are working with operational and clinical colleagues in order to identify and mitigate any risks associated with this. The SED closely monitor performance indicators relating to areas of limited assurance and regularly review the mitigating actions accordingly.

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

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

Reviewed by:		
Jane Melton, Director of Engagement and Integration	Date	July 18th 2018

Where in the Trust has this been discussed before?		
Governance Committee	Date	June 2018

What consultation has there been?		
Lauren Edwards, Deputy Director of Engagement		June 2018

Explanation of acronyms used:	
NHS	National Health Service
PALS	Patient Advice and Liaison Service
CYPS	Children and Young People Service
SED	Service Experience Department
HR	Human Resources

CEO	Chief Executive Officer
BME	Black and Minority Ethnic Groups
IAPT	Improving access to psychological therapies
PHSO	Parliamentary and Health Service Ombudsman
CQC	Care Quality Commission
CHI ESQ	Children's Experience of Service Questionnaire
CAMHS	Child and Adolescent Mental Health Service
MHA	Mental Health Act
MCA	Mental Capacity Act
CCG	Clinical Commissioning Group
Q2	Quarter 2 (previous quarter 2017/18)
FFT	Friends and Family Test (survey)

2gether
Making life better

2gether
NHS Foundation Trust

Service Experience Report

Quarter 4

1st January 2018 to 31st March 2018

"In the three months I have been here I have found the nurses to be lovely, nice people."

Stonebow, Herefordshire

"I have been here for about two weeks and all of the nursing staff are amazing."

Wotton Lawn, Gloucestershire

Contents

Key

NHS	National Health Service
PALS	Patient Advice and Liaison Service
CYPS	Children and Young People Service
SED	Service Experience Department
HR	Human Resources
CEO	Chief Executive Officer
BME	Black and Minority Ethnic Groups
IAPT	Improving access to psychological therapies
PHSO	Parliamentary and Health Service Ombudsman
CQC	Care Quality Commission
CHI ESQ	Children's Experience of Service Questionnaire
CAMHS	Child and Adolescent Mental Health Service
MHA	Mental Health Act
MCA	Mental Capacity Act
CCG	Clinical Commissioning Group
Q3	Quarter 3 (previous quarter 2017/18)
FFT	Friends and Family Test (survey)

Service Experience Report

1st January 2018 to 31st March 2018

Complaints 	**15** complaints were made this quarter. This is the same as last time. We want people to tell us about any worries about their care. This helps us to make things better.	↔
Concerns 	**48** concerns were raised through PALS. This is the more than last time (Q3=44).	↑
Compliments 	**712** people told us they were pleased with our service. This is more than last time (Q3=454). We want teams to tell us about every compliment they get.	↑
FFT 	**84%** of people said they would recommend our service to their family or friends. This nearly the same as last time (Q3=85%).	↔
Quality Survey 	Gloucestershire: **85** people told us what they thought. This is lots more than last time (Q3=29) Herefordshire: **21** people told us what they thought. This is less than last time (Q3=43) More people are telling us what they think about their care. We want more people to tell us what they think.	↑ (number of replies)
We must listen 	We must explain the reasons why we make decisions. We must include everyone involved when planning care.	

Key

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

Section 1 – Introduction

1.1 Overview of the paper

1.1.1 This paper provides an overview of people's reported experience of ²gether NHS Foundation Trust's services between **1st January 2018 and 31st March 2018**. It provides examples of the learning that has been achieved through service experience reporting, and an update on activity to enhance service experience.

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

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

- A synthesis of service experience reported to ²gether NHS Trust
- Patient Advice and Liaison Service (PALS)
- Meetings with stakeholders
- ²gether quality surveys
- National Friends and Family Test (FFT) responses

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

1.2 Strategic Context

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

1.2.2 ²gether NHS Trust's Service User Charter, Carer Charter and Staff Charter outline the commitment to delivering our values and this is supported by active implementation of ²gether's Service Experience Strategy (2013) (see below). The Service Experience Strategy will be reviewed and updated during 2018/19 in collaboration with our stakeholders.

A shared goal to listen to, respond to, and improve service experience; through a continuous cycle of learning from experience we will provide the best quality service experience and care:

Our vision for best Service Expereince:
As we serve patients and their carers, we will go beyond what people expect of us to ensure that we earn their trust, confidence, and foster hope for the future.

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

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

Section 2 – Emerging Themes about Service Experience

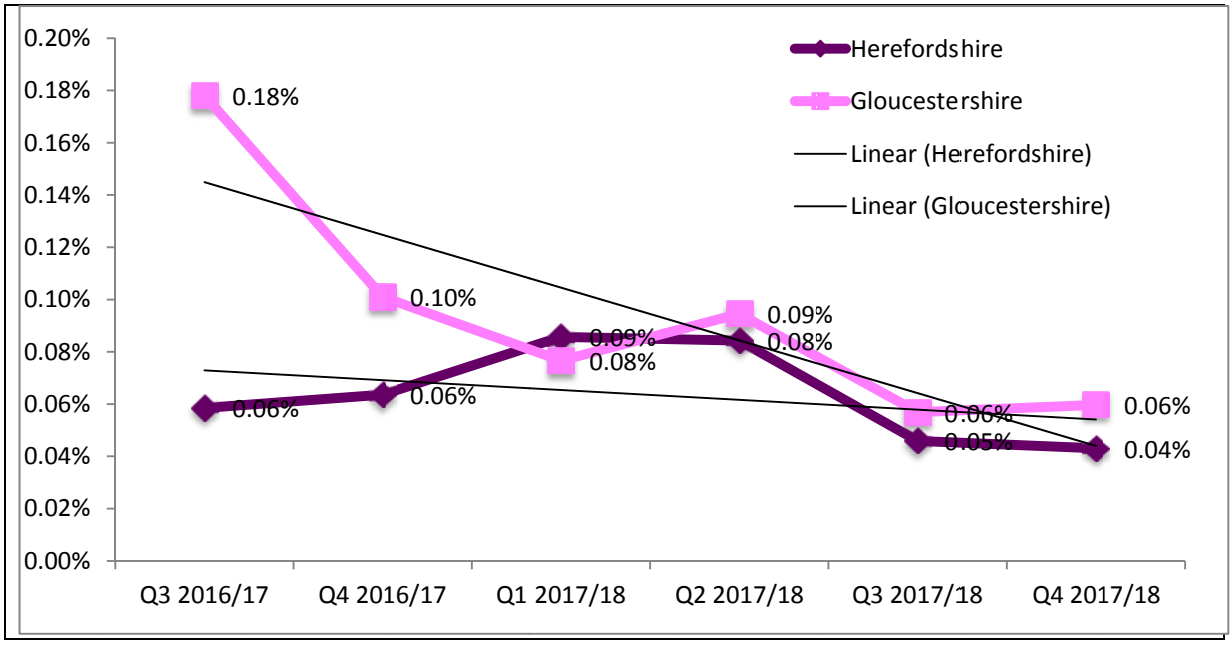
2.1 Complaints

2.1.1 Formal complaints to NHS service providers are highly governed and responses must follow specific procedures (for more information, please see the Trust's Policy and Procedure on Handling and Resolving Complaints and Concerns). We value feedback from those in contact with our services as this enables us to make services even more responsive and supportive. We encourage people to let us know if they are concerned so that we can resolve issues at the earliest possible opportunity.

Table 1: Number of complaints received this quarter

County	Number (numerical direction)		Interpretation	Assurance
Gloucestershire	13	⟷	The number of complaints reported in Gloucestershire is consistent with the previous quarter (Q3 n=13)	Significant
Herefordshire	2	⟷	The number of complaints reported in Herefordshire is consistent with the previous quarter (Q3 n=2).	Significant
Total	15	⟷	The total number of complaints received is the same as the previous quarter (Q3 n=15)	Significant

Figure 1: Graph showing proportion of complaints to number of individual service contacts



2.1.2 The proportion of complaints to contacts has fluctuated minimally over time, remaining low and relatively consistent over the past year.

2.1.3 Table 2 summarises our responsiveness. This quarter has seen an improvement in the percentage of complaints closed within the initially agreed

timescale. This follows a decrease during Quarter 3 (the only decrease this year).

2.1.4 Three complaints were not closed within agreed timescales. The delays were due to the additional time required to complete robust investigations due to the complexity of the issues raised. Two of these 3 complaints were further delayed by the locality review and approval process; an important step in the quality assurance process. For each delay, complainants were contacted in order to provide explanation, an apology, and regular updates on the progress of their complaint response.

2.1.5 The SED monitor delayed response rates carefully, working closely with operational colleagues to ensure that the complaints policy is adhered to in relation to all aspects of complaint handling.

Table 2: Responsiveness

Target	% Number	Direction compared with Q3	Interpretation	Assurance
Acknowledged with three days	100%	⟷	**All** complaints were acknowledged within target timeframes (Q3=100%)	**Full**
Response received within agreed timescales	75%	↑	This is higher than last quarter (Q3=67%). Three letters of response were not received by the complainant by the date agreed.	**Significant**
Concerns escalated to complaint	9%	↑	Of 46 concerns closed (Q3= 41 closed), 4 were escalated to a formal complaint; this is more than last quarter (Q3=2%)	**Significant**

2.1.6 In Quarter 4 a low number of complaints required additional action following the provision of a final response to the complainant. This could suggest that the complaint investigation process continues to be robust and that complaint response letters generally explain and answer the queries raised by complainants without the need for further clarification (Table 3).

Table 3: Satisfaction with complaint process

Measure	Number (numerical direction)		Interpretation	Assurance
Reopened complaints	3	↑	This figure is similar to the previous quarter (Q3 n=2)	**Significant**
Local Resolution Meetings	1	⟷	This figure is the same as the previous quarter (Q3 n=1).	**Significant**
Referrals to external review bodies	1	⟷	One complaint was referred for external review to the Local Government Ombudsman (Q3 n=1). See Table 13 for more detail.	**Significant**

2.1.7 Analysis of data is undertaken by the Service Experience Department in order to identify any patterns or themes. Analysis of complaint themes from

complaints closed during Quarter 4 is shown by the status of complaint outcome (Table 4) and by staff group involved (Table 5).

Table 4: Outcome of complaints closed this quarter

Outcome	No.	%
Not upheld *No element of the complaint was upheld*	1	8%
Partially upheld *Some elements of the whole complaint were upheld*	7	58%
Upheld *All elements of the whole complaint were upheld*	3	25%
Withdrawn *Complaint was withdrawn*	1	8%

Following feedback from complainants and Experts by Experience, the Trust no longer uses the terms upheld/partially upheld/not upheld within response letters. However, these categories are required to be recorded for national reporting purposes.

In total, 12 complaints were closed this quarter. This is less than Quarter 3 (n=20).

83% of the complaints closed this quarter had at least some or all issues of complaint upheld. This differs from Quarter 3 (75% upheld/ partially upheld).

**Individual issues within each formal complaint are either upheld or not upheld. Partially upheld is not used for individual issues, the term is used to classify the overarching complaint where some but not all of the issues were found to have been upheld. Percentages rounded to nearest whole number*

Table 5: Breakdown of closed complaint issues by staff group for Quarter 4

Outcome	Total No.*	Upheld	Not upheld	Withdrawn
Medical	12	8	2	2
Nursing	34	18	16	0

The number of complaint issues involving different disciplines and staff groups is recorded for *NHS Digital*. The SED have continued to refine Datix inputting in order to capture all disciplines identified within complaints.

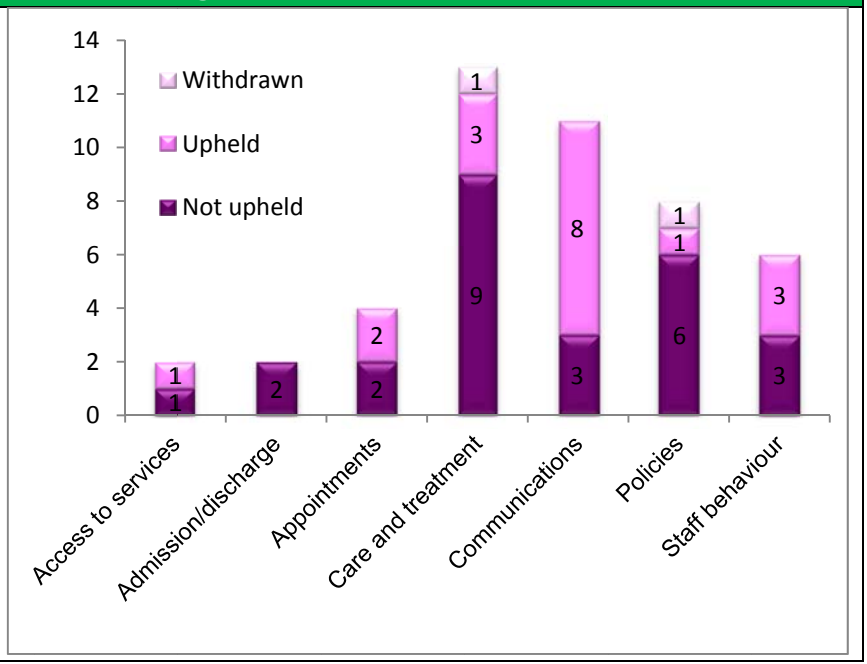
Quarter 4 figures show Nursing as the main staff group identified within complaints. This has decreased from the previous quarter (Q3 n=59) and is likely to be reflective of the decreased number of issues contained within individual complaints closed in Quarter 4. Nursing represents the largest staff group in the Trust and has the greatest number of individual contacts with service users and carers.

Work is ongoing to ensure that professional leads are aware of any themes relating to professional groups.

**The numbers represented in these data relate to a breakdown of individual complaint issues following investigation*

2.1.8 Table 6 provides an overview of the issue of complaint in the context of the investigation outcome (upheld or not upheld). Analysis shows that the main theme emerging from Q4 issues of complaint relates to aspects of communication.

Table 6: Overarching closed complaint themes

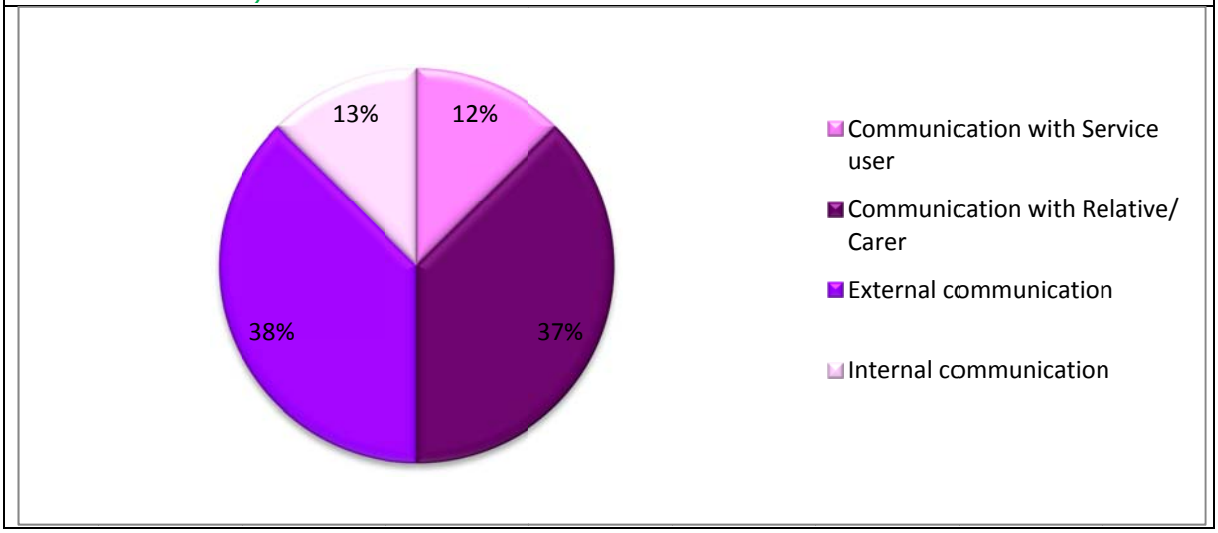
Theme	Chart showing number of issues raised and their outcome
Access to services *Access to treatment/drugs*	
Admission/discharge *Poor planning*	
Appointments *Waiting for/at an appointment*	
Care and treatment *e.g. observation, support*	
Communication *Internal and external*	
Policies *e.g. not followed*	
Staff behaviour *Values and attitude*	

2.1.9 Further analysis of upheld issues relating to communication is shown in Figure 2.

Figure 2: Review of identified complaint themes

Breakdown of upheld complaint issues

The Trust takes all issues within individual complaints very seriously. The themes reflected below demonstrate the outcomes of complaint issues that have been investigated and upheld. The main upheld complaint theme relates to ***communication,*** shown in relation to those the issue detail below.



2.1.10 *Communication* with service users and relatives continues to dominate complaint thematic data. Colleagues across the Trust are working to develop and improve practice in this area. Recent sessions held at both our Trusts Senior Leadership Forum and Leadership Forum have focused on complaint themes and learning from complaint outcomes in order to improve our services to ensure communication is clear and inclusive to all involved.

Individual examples of actions taken by Trust colleagues linked to the thematic data are listed in Table 8.

Table 8: Examples of complaints closed and action taken

Example	You said	We did	Assurance
Care and treatment	My daughter's Care Co-ordinator was absent from work and no-one stepped in to offer my daughter support	We apologised and explained that our team has a system of support available to service users should their Care Co-ordinator be unavailable – we agreed that this could have been explained more clearly to you.	Significant
Access to services	My sister experienced a deterioration in her mental health and it took far too long for her to be taken into hospital	Our investigation found that the MHA Assessment had been delayed, with no rationale or explanation given. We apologised and have reminded colleagues of the importance of clearly documenting and sharing the decision-making process with those involved.	Significant
Communication	I requested a change in psychiatrist and received a rude letter from the team manager refusing my request	We apologised to you for the tone of the letter and ensured that your Care Co-ordinator took time to fully explain to you the rationale for the terms used and what they meant.	Significant

2.2 Concerns

2.2.1 The Trust endeavours to be responsive to feedback and to resolve concerns with people at the point at which they are raised. This has resulted in complaint numbers being maintained at a lower level and a corresponding increase in the number of PALS contacts. **DatixWeb**, a service experience recording and reporting system, has continued to be used for this quarter. Trends have been analysed and are reflected in Table 9.

Table 9: Number of concerns received this quarter

County	Number (numerical direction)		Interpretation	Assurance
Gloucestershire	37	↔	The number of concerns raised in Gloucestershire is the same as the last quarter (Q3 n=37)	Significant
Herefordshire	9	↑	More concerns have been raised in Herefordshire compared to the last quarter (Q3 n=2)	Significant
Corporate	2	↓	There are fewer concerns about corporate services compared to last quarter (Q3 n=4)	Significant
Total	48	↔	The number of concerns raised is similar to last quarter (Q3 n=44)	Significant

2.2.2 The number of concerns raised remains relatively consistent with previous quarters. There were 94 other contacts with the Service Experience Department (Q3 n=61) covering a range of topics: people asking advice about

our services and requesting contact from the clinical team, requesting information relating to accessing healthcare records and enquiries about our processes. This provides assurance that more people are contacting the SED with issues or queries even though the number of concerns and complaints received remains low.

2.2.3 Table 10 outlines the themes of concerns raised this quarter. The main theme identified is "Communication" and this is consistent with the main theme of our formal complaints. Examples of concerns and actions taken during Quarter 4 are shown in Table 12.

Table 10: Overarching concern themes this quarter

**The numbers represented in this data relate to a breakdown of individual issues and do not equal the number of concerns*

Theme	No.*	Chart showing percentages
Access to treatment *Treatment or medication*	2	
Admission/discharge *Community or inpatient*	2	
Appointments *e.g. cancelled, staff DNA*	3	
Commissioning *e.g. lack of services*	1	
Communication *Internal and external*	18	
Facilities *e.g. temperature*	1	
Care and Support *e.g. observation, support*	4	
Prescribing *e.g. failure to prescribe*	1	
Privacy/wellbeing *e.g. noise*	5	
Policies *e.g. Health Records, MHA*	7	
Staff attitude *Behaviour and actions*	10	
Other *e.g.*	3	

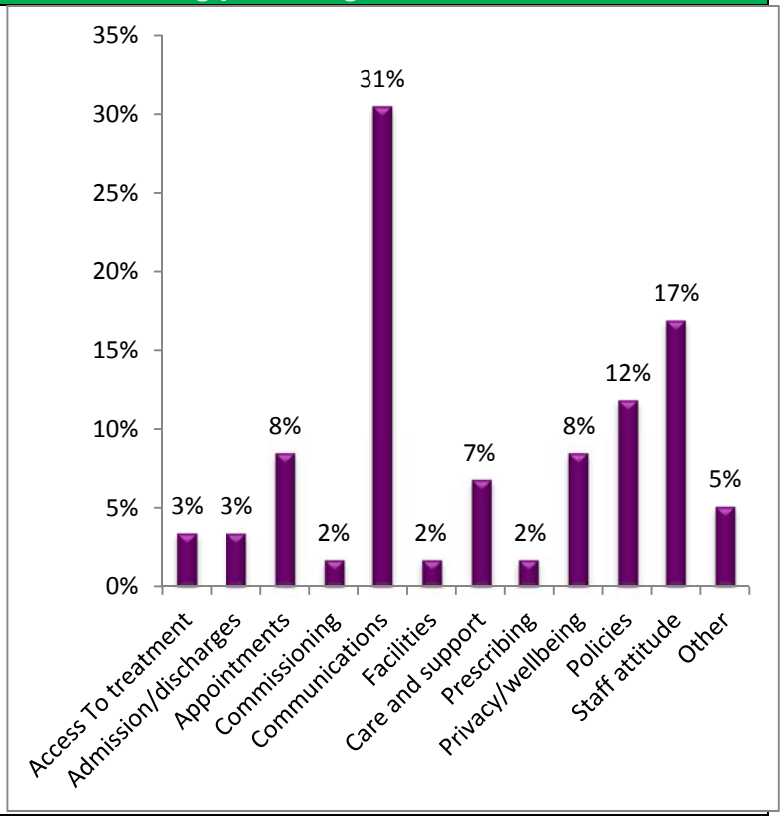


Table 11: Breakdown of concerns by staff group for this quarter

Outcome	No	%	
Admin	4	8%	As outlined in Table 5, nursing represents the largest staff group in the Trust and has the greatest number of contacts with service users and carers. Work is ongoing to ensure that professional leads are made aware of any themes relating to their staffing group.
HCA	1	2%	
Medical	3	6%	
Nursing	28	57%	
Psychological Wellbeing Practitioner	4	8%	
Social Worker	2	4%	
No staff identified	7	14%	

Table 12 Examples of concerns and action taken:

Example	You said	We did	Assurance
Access to services / commissioning	My son will soon be 18 and I have been told that the nearest ADHD service is in Bristol, which has a two year waiting list	We explained that our Trust is not currently commissioned to deliver ADHD services for adults and gave advice about how to escalate your concerns further.	Significant
Communication	A member of staff has written a letter to our relative's GP which I believe to be completely inaccurate	The team manager contacted you to offer an explanation of services and apologised for any incorrect information.	Significant
Lack of support	During an inpatient stay my relative was involved in an incident where severe injuries were sustained. No-one from the Trust has been in contact with me since	We apologised for the lack of contact and explained that a Serious Incident (SI) review was being conducted and that you would be included in this process. The SI team has since been in touch with you regarding this.	Significant
Complaint Management	I want to make a complaint but I am worried my Health Record will be changed when people find out	We offered reassurance that complaint information is kept separately from healthcare records. We suggested that you could request a copy of your records so you could be sure.	Significant

2.2.4 PALS Visits

2.2.4.1 Patient Advice and Liaison Service (PALS) visits are undertaken in clinical services to ensure that people's concerns are raised and resolved as soon as possible. Visits to Wotton Lawn Hospital, Gloucestershire, and Stonebow Unit, Herefordshire, were undertaken during Quarter Charlton Lane visits are planned to commence from Quarter 1 2018/19.

2.2.4.2 During each visit the SED PALS Officers visited the designated ward and spoke with service users and families. The majority of feedback given has been positive and any issues raised were reported directly to the ward for timely resolution wherever possible. A summary report of each visit is sent by the PALS Officers to the Ward Manager, Modern Matron, Deputy Director of Nursing, and Locality Governance Lead. SED have successfully recruited a PALS volunteer to support ongoing PALS visits throughout the Trust.

2.2.4.3 PALS provided the following types of support and assistance during visits undertaken during Quarter 4:

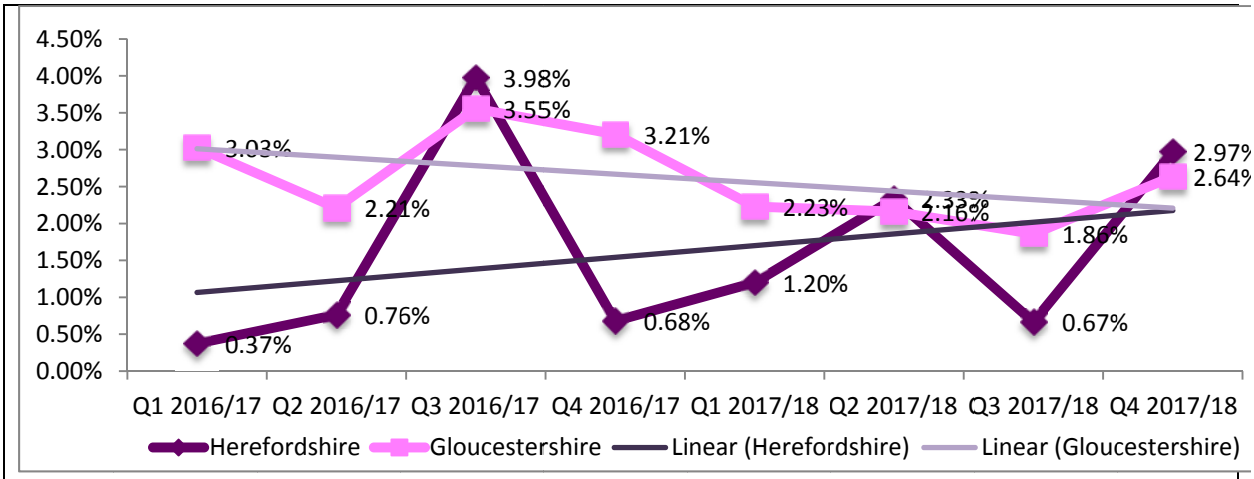
- Assisting service users to resolve queries relating to the ward environment.
- Providing support about how to give feedback about Trust services.

- Receiving compliments about the ward and staff from both service users and members of their families.
- Listening to service users' and carers' experiences of our wards.
- Responding to concerns and queries by liaison with staff and ward managers

2.3 Compliments

2.3.1 The SED continues to encourage the reporting of compliments received by Trust services. **712** compliments were received this quarter. This is a **57%** increase compared to Quarter 3 (n=454). A dedicated email address is set up to simplify the process for colleagues to report compliments that they have received: 2gnft.compliments@nhs.net. Figure 3 shows the percentage of compliments to contacts as reported during Quarter 4.

Figure 3: Graph showing proportion of compliments to number of individual contacts with services:



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

Examples of compliments received during Quarter 4:

You have been amazing and a great inspiration. *IAPT, Herefordshire*

Service users said they cannot believe how much abuse the staff take and never react. They also take on so much. *Abbey Ward, Wotton Lawn*

He is the first person to do anything about my complaint and it's finally getting somewhere. *Service Experience Department*

The staff and care are brilliant – even when they don't know they are being observed, staff are caring and patient; dad is the happiest he's been for a while. *Cantilupe Ward, Stonebow*

The staff are amazing. I feel that if you have good management, you have good staff and this is the case there. *Berkeley House, Gloucestershire*

2.4 – Complaints referred for external review following investigation by our Trust

2.4.1 Current open referrals for external review:

Table 13: current open referrals for external review

Reviewing organisation	Date of first contact from reviewing organisation	Date official investigation confirmed	Date official investigation completed	Current status of referral
PHSO	01/12/2016	07/08/2017	N/A	Investigation ongoing
PHSO	25/01/2017	07/08/2017	N/A	Investigation ongoing
LGO	23/01/2018	N/A	N/A	Awaiting further information

PHSO - Parliamentary and Health Service Ombudsman, LGO - Local Government Ombudsman

2.4.2 Referrals made for external review of complaint this quarter

The Local Government Ombudsman informed us that one complainant had contacted them to request a review of their complaint and the LGO asked for a copy of the final response letter. We are awaiting contact from the LGO with a decision on whether they will take this on for further review.

2.4.3 Completed external complaint investigations

PHSO: PHSO informed us of a decision to decline to further review a referred complaint as it was outside of their timescales

CQC: CQC have informed us that they have closed a case following completion of Trust actions to their satisfaction.

2.5 Surveys

2.5.1 'How did we do?' Survey

2.5.1.1 The Trust continues to implement the Trust's **How did we do?** survey. This survey combines the "Friends and Family Test" and "Quality Survey" and is used for all Trust services apart from IAPT and CYPS/CAMHS, where alternative service experience feedback systems are in place.

2.5.1.2 Survey results are reported internally, locally to our Commissioners, and nationally to NHS Benchmarking. It is important that colleagues encourage and support people who use our services to make their views and experiences known so we can learn from feedback and make improvements where needed.

2.5.1.3 The two elements of the **How did we do?** survey are reported separately below as Friends and Family Test and Quality Survey responses.

2.5.2 Friends and Family Test (FFT) Service User/ Carer feedback

2.5.2.1 Service users are asked "*How likely are you to recommend our service to your friends and family if they needed similar care or treatment?*". Our Trust has played a key role in the development of an Easy Read version of the FFT. Roll out of this version ensures that everybody is supported to provide feedback.

2.5.2.2 Table 14 details the number of responses received each month. The FFT score is the percentage of people who stated that they would be 'extremely likely' or 'likely' to recommend our services. The FFT questionnaire is available in all Trust services and combined figures for a Trust-wide score are given in Table 14.

Table 14: Returns and responses to Friends and Family Test in Q4

	Number of responses	FFT Score (%)
January 2018	257 (222 positive)	86%
February 2018	276 (220 positive)	80%
March 2018	417 (357 positive)	86%
Total	**950** (799 positive) **(Quarter 3 = 864)**	**84%** **(Quarter 3 = 85%)**

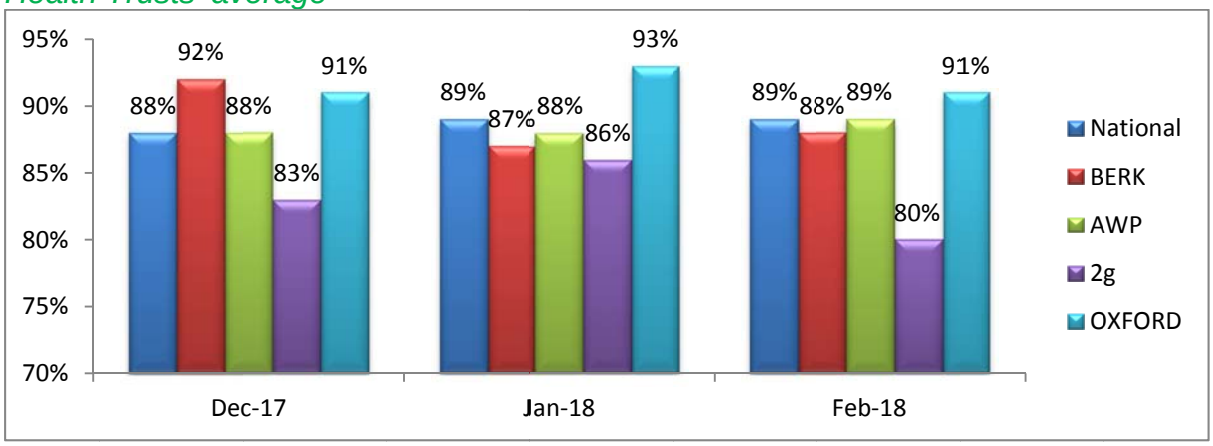
2.5.2.3 Some difficulties have arisen when sending text messages to people due to mobile telephone numbers not always being recorded in the appropriate way on RiO. SED and locality colleagues have taken steps to raise awareness of how to record mobile telephone numbers within RiO. The response rate to the text messages that were sent successfully has been encouraging, with a response rate of 30% (Q3 = 9%).

2.5.2.4 Quarter 4 FFT response rates have continued to increase each quarter throughout 2017/18. Along with the addition of CYPS FFT response data to the Trust total, the launch of the FFT text message survey has increased the amount of responses received. When analysing responses it is encouraging to see that a high percentage of the responses received by text message are from people who have had contact from our inpatient services. This has historically been an area where survey feedback has been difficult to obtain.

2.5.2.5 The FFT score for this quarter is similar to the previous quarter, remaining relatively consistent throughout 2017/18. Response rates have increased in Quarter 4 meaning that more feedback was received and this may have had an impact on the FFT score. The Trust continues to maintain a high percentage of people who would recommend our services.

2.5.2.6 Figure 4 shows the FFT Scores for December 2017, January and February 2018 (the most recent data available) compared to other Mental Health Trusts in our region, and the average of Mental Health Trusts in England. Our Trust consistently receives a high percentage of recommendation in line with other Mental Health Trusts in the region but shows a small dip in recent data in comparison with others. (*March 2018 data are not yet available*)

Figure 4: Friends and Family Test Scores – comparison between the 2gether Trust, other Mental Health Trusts in the NHS England South Central region, and the Mental Health Trusts' average



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

Friends and Family Test Comments

Comments are fed-back to services in order that they can be shared with team members and for appropriate actions to be taken as a result of the valuable learning.

What was good about the visit?

She listened. She was wonderful.
Let's Talk, Gloucester

Every member of staff have been exceptional & nothing is too much for them to help us with
Community Dementia Team North, Gloucestershire

V professional. V cheerful. Exceptional all round.
Jenny Lind, Stonebow

Very friendly team, explained what would happen. *IHOT*

The whole team at 2gether are exceptional professional people. I wouldn't be here today without the support and trust of this fine people

I was seen at home within 24 hours of seeing my GP, put on medication immediately and had weekly visits to check how I was doing. The support and care has been fantastic, I couldn't have asked for more *Perinatal Team*

A great level of care and dedication to patients was given by the whole hospital team.
Mulberry Ward CLH

All the staff are very friendly and helpful listen you very carefully
Recovery Team North

What would have made the visit better?

Service is rubbish. No message left on phone calls after you cancelled my appointment. I will be very reluctant to ring again. *Let's Talk, Gloucester*

Lots of waiting, negligible results. 12+ months wasted and things are worse. *CYPS Gloucester and Forest*

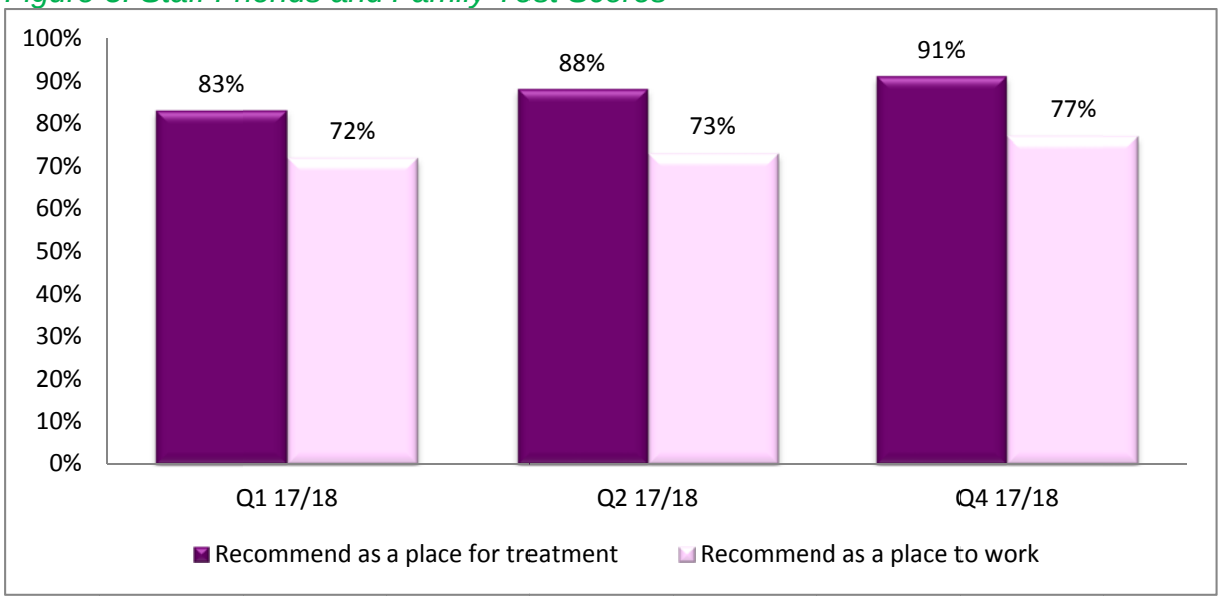
Decisions are made without taking anything the patient says into consideration. *Priory Ward WLH, Gloucestershire*

I felt like they did not want to listen and they put me in touch with the complete wrong service *Eating Disorders Team, Herefordshire*

2.5.3 Friends and Family Test (FFT) 2gether Staff feedback

Our staff are asked about their experience of working for our Trust during quarters 1, 2 and 4 each year. In Q3 the FFT is replaced by the annual Staff Survey.

Figure 5: Staff Friends and Family Test Scores



2.5.3.1 The results of the Staff FFT continue to reflect that of service user feedback. Feedback shows that the majority of staff respondents would recommend 2gether as an employer. The high percentage of staff who would recommend Trust Services to those close to them shows some correlation between staff experience and service user experience of care, with staff feedback being slightly more positive

2.5.4 How did we do?

2.5.4.1 The How Did We Do? survey (Quality Survey questions) provides people with an opportunity to comment on key aspects of the quality of their treatment. It was initially launched as a paper based survey in April 2017. From 1st November 2017 the survey was distributed via text message to people who were discharged from our community and inpatient services. The

text message asks the FFT questions and provides a link for people to complete additional Trust Quality survey questions.

2.5.4.2 Quality survey targets were reviewed and refreshed in line with the launch of the 'How did we do?' survey. Three out of the four targets set have been exceeded. This suggests that, of those people who responded to the survey, most are feeling supported to meet their needs and explore other activities. The one target that hasn't been fully achieved this quarter continues to receive the majority of positive responses. The increase in the target set for 2017/18 is demonstrative of our desire to consistently improve our services. Table 15 shows responses in relation to set targets for this quarter.

Table 15: How Did We Do? Quality survey questions and responses

Question	County	No. of responses	Target Met?
Were you involved as much as you wanted to be in agreeing the care you receive?	Gloucestershire	82 (70 positive)	**87%** TARGET 92%
	Herefordshire	21 (20 positive)	
Have you been given information about who to contact outside of office hours if you have a crisis?	Gloucestershire	84 (67 positive)	**84%** TARGET 74%
	Herefordshire	20 (20 positive)	
Have you had help and advice about taking part in activities that are important to you?	Gloucestershire	85 (72 positive)	**88%** TARGET 69%
	Herefordshire	19 (19 positive)	
Have you had help and advice to find support for physical health needs if you have needed it?	Gloucestershire	80 (69 positive)	**88%** TARGET 76%
	Herefordshire	15 (15 positive)	

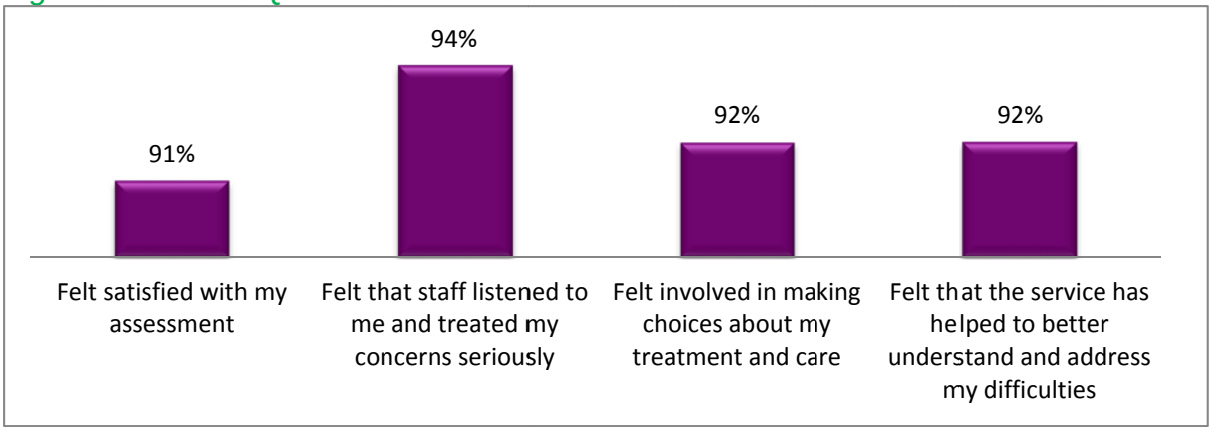
2.5.4.3 Although response rates for the survey have increased the level of response continues to be lower than we would like. The SED along with locality managers are working to raise awareness of the survey and encourage Service Users and Carers to give feedback in this way. Work is also underway to focus on these areas as part of the implementation of the action plan formulated following the findings of the CQC National Community Mental Health Survey for our Trust.

2.5.5 Improving Access to Psychological Therapies – Patient Experience Questionnaire (IAPT PEQ)

2.5.5.1 Our IAPT Let's Talk services use a nationally agreed survey to gain feedback and measure levels of satisfaction with the service. The national requirements for the IAPT PEQ have been reviewed by SED and IAPT service leads and two new IAPT questionnaires have been launched during Quarter 3 2017/18.

2.5.5.2 Feedback questionnaires are sent to people following the initial assessment and after discharge from the service. Quarter 4 feedback shows that people are largely satisfied with these elements of the Let's Talk service.

Figure 6: IAPT PEQ Satisfaction scores



2.5.5.3 The IAPT PEQ seeks comments from people about the service that they have received. A selection of comments is shared below:

Very good service, quick referral, good to know I will be receiving help.

I've found the service to be punctual and reassuring. I was unable to attend "group therapy" on my first referral, however, I've now been offered a "one on one" consultation which I'm hoping will help me out.

Very understanding and compassionate. Very clearly stated my options and timelines for receiving treatment.

I would have liked a more personalised service face to face rather than by phone. Therapist provided quality service, listening and providing good advice.

Professional and safe. I have been given some techniques to help cope. I have been listened to, taken seriously and responses have always been helpful. Thank you.

Very good though it does get tiring explaining how you feel so many times to so many people.

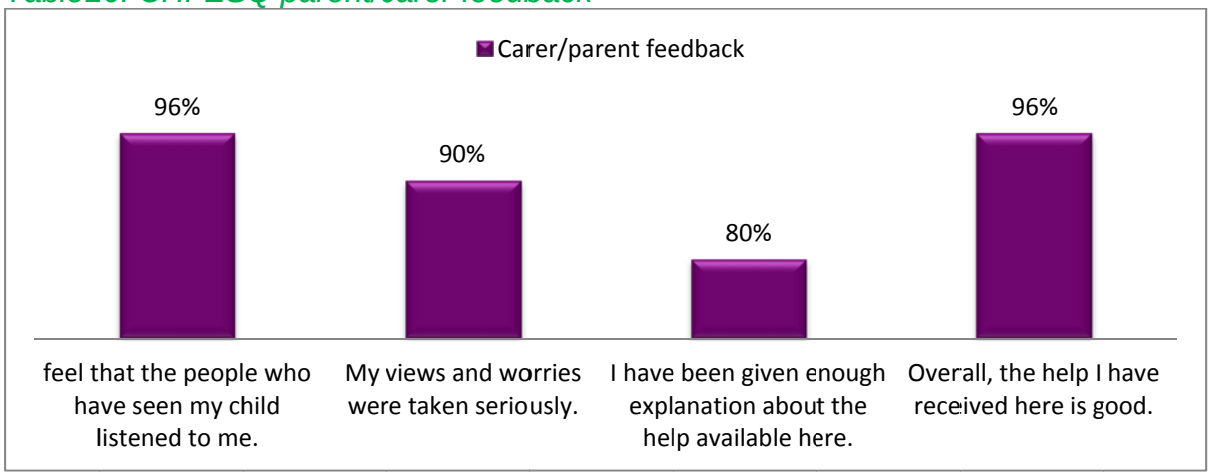
I had three different therapists but each brought something different to my experience. Each equally gave worthwhile advice so I am sure my experience and improving my situation was helped by this.

2.5.6 Children and Young People service (CYPS)

2.5.6.1 CYPS gather service feedback using the Experience of Service Questionnaire, known as CHI-ESQ. CHI-ESQ is a nationally designed survey to gain feedback from children, young people and their parents/carers. There are three versions of the CHI-ESQ survey used, these are identified by age and role type as follows: Age 9 -11 yrs, Age 12 -18 yrs and Carer & Parent. All the surveys ask questions based upon the same theme but are presented differently in age appropriate format.

2.5.6.2 Tables 16 and 17 reflect responses to questions asked to the differing groups of respondents during Quarter 4.

Table16: CHI-ESQ parent/carer feedback



Examples of some feedback given by Carers & Parents:

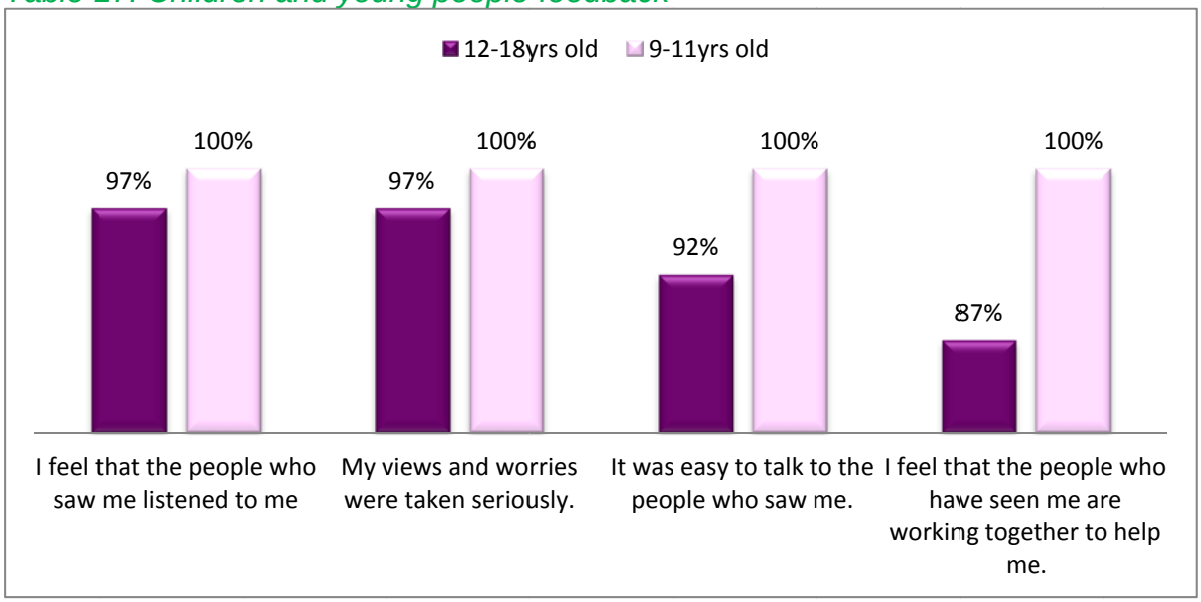
It was helpful to be able to be present at all appointments as I think the three person conversations hopefully helped my child to recover better.

To improve therapists and services more appropriate for my child's autistic needs and understanding.

Everyone understood how I was feeling. Even got a cup of tea!

It was a great service and I felt listened to and the strategies to help my child are useful.

Table 17: Children and young people feedback



Examples of some feedback given by children and young people:

I was surprised to feel comfortable here and the care I received was professional.

Liked how the people cared for me

That they understood me and most of the activities were fun

The appointment times/schedules. It was hard to have consistent appointments because of college.

Section 3 – Learning from Service Experience Feedback

Section 3.1 – learning themes emerging from individual complaints

The Service Experience Department, in partnership with Service Managers, routinely record, report and take actions based upon the valuable feedback from complaints, concerns, compliments and comments. Table 18 illustrates the lessons learnt from **individual** complaints and concerns. Reporting of local service experience activity on a monthly and quarterly basis at each locality governance meeting continues to be embedded. The SED is also attending these meetings regularly to discuss local themes, trends and learning.

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

Effective dissemination of learning across the organisation is vital to ensure ²gether's services are responsive to people's needs and that services continue to improve. Service Experience feedback has contributed to the *Learning ²gether from Incidents, Complaints and Claims* report issued within the Trust on 1st December 2017.

Table 18 illustrates points of learning from Service Experience feedback. Localities, in partnership with corporate services, are asked to develop action plans to ensure that the learning is incorporated into future practice.

Table 18: Points of learning from Service Experience feedback Q4 closed complaints– action plan to be sought from locality leads

Organisational Learning (action plan/assurance to be sought)
Care Co-ordinators should ensure that care planning meetings include contributions from all those involved in the service user's care as well as clearly explaining the care and support provided by each professional/agency.
When colleagues are answering telephone calls they should ascertain what or who calls are related to in order to ascertain who the best placed member of staff on duty is to take the call.
We should ensure that guidance for providing and writing reports is available to colleagues on the Governance section of the intranet.

Organisational Learning (action plan/assurance to be sought)
We must clearly communicate what services are provided by which organisations, and work closely other organisations to provide more joined up care for service users with complex mental and physical health problems.
Where indicated we must ensure that letters contain a clear rationale for a decision, and an acknowledgement if the service user has expressed that they do not agree with the decision.
Healthcare records should be reviewed as part of the referral decision-making process and consideration taken to joint triage and review cases involving multiple teams working with individuals

Section 3.3 – Assurance of learning and action from aggregated learning themes from Quarter 4

Effective dissemination of learning across the organisation is vital to ensure we are responsive to people's needs and that services continue to improve. Table 19 illustrates the assurance that services have provided around actions that have been completed as a result of previous aggregated lessons learnt.

Table 19: Points of learning from Service Experience feedback Q4 2017/18 – action plan has been completed

Organisational Learning	Assurance of actions	Date received
Team Managers must ensure that clinical team members are aware of and compliant with the following points when writing health care records: **RECORDING INFORMATION** – Information entered should be objective and recorded in a clear, accurate and timely fashion. **CLINICAL OPINION** –is important and should be included in the clinical record – however it must be clear that it is opinion and not fact. Sources of factual information should be referenced where known. **HISTORICAL**	**Gloucestershire Localities** Discussed with CSMs at Delivery & Governance Committee on the 10th May. CSMs to take locality forums for discussion and cascading to clinicians.	**April/May 2018**
	Countywide Locality: The learning highlighted went out on a trust-wide communication on 11th December 2017 following the outcome from the Ombudsman. . At the time this was placed on the in-patient agendas, cascaded to all managers to take back to their teams. Community teams have communicated in the monthly team business meetings as well as in 1:1 supervision sessions with staff and email where appropriate.	
	Herefordshire Localities:. This learning has been disseminated to staff via a range of routes: • Via Team Talk and from there to clinicians via MDTM • Staff reading Bytesize. • Team managers disseminating the SED reports from Hereford Governance via MDTM. • Team managers are now required to hold a file containing learning from complaints and Serious Incidents. As new learning is added,	

Organisational Learning	Assurance of actions	Date received
INFORMATION– it is important to describe this accurately and not summarise, as this may change the significance and accuracy of the original event. **DIFFERENCE OF OPINION** - Where a service user disagrees with the accuracy of information in the clinical records this must be reviewed with the service user to ensure the information is correct. Action should be taken to amend any inaccuracies identified.	staff will be required to sign a confirmation that they have read the learning. This will be audited and monitored via Hereford Delivery Committee. • Learning will also be disseminated via Hereford Delivery Committee. Clinical alerts are disseminated to all clinical staff and a hard copy will be retained in the lessons learned from complaints/SI's folder.	
	CYPS and CAMHS Localities: This has been discussed in the SED report at Governance committee and taken to the Delivery committee for dissemination through team managers to discuss with staff in team meetings and copies of the SED report are made available to staff. Staff are also signposted to learning through the Governance in Brief document which is shared bi-monthly. Staff receive Bytesize and Team Talk, staff have also been informed of learning through the mandatory read and alert circulated Trust-wide	
Each time a care plan is updated, staff must encourage Service Users to sign copies to indicate agreement, demonstrate the principles of coproduction and evidence Service User involvement. Scanned copies of the signed document must be uploaded to healthcare records. Where Service Users decline to sign/receive copies of the care plan this must be clearly documented within the health care record.	**Gloucestershire Localities:** CSMs to take to Forums reminding clinical staff to involve service users in the development of care plans and evidence this as outlined.	
	Countywide Locality: Learning added to the in-patient managers agenda across all in-patient sites, cascaded to all managers to take back to their teams via team meetings. Community teams have communicated in the monthly team business meetings as well as in 1:1 supervision sessions with staff and email where appropriate.	**April/May 2018**
	Herefordshire Localities: All clinical staff have been made aware of the importance of collaborative care planning and that a signed copy of the agreed care plan should be provided to the service user. RiO and the Cluster Care plans support this. All clinical staff will be reminded to document all declined care plans.	
	CYPS and CAMHS Localities: Staff have been using the new CYPS/CAMHS Care Plan with young people. Reminders about the procedure around this are discussed at Team meetings. Guidance was shared with CYPS/CAMHS in Governance in Brief which is emailed to the CYPS and CAMHS teams	
Involvement of the Service Experience Department at an early stage when staff receive concerns or	**Gloucestershire Localities:** CSMs were reminded to involve the Service Experience Dept when they receive concerns or complaints at the Delivery & Governance Committee on the 10th May and to	**April/May 2018**

Organisational Learning	Assurance of actions	Date received
complaints should be considered for advice and support for all involved and assistance to resolve issues in a timely way.	advise their respective Team Leaders accordingly through forums.	
	Countywide Locality: Learning added to the in-patient managers agenda across all in-patient sites, cascaded to all managers to take back to their teams via team meetings. Community teams have communicated in the monthly team business meetings as well as in 1:1 supervision sessions with staff and email where appropriate.	
	Herefordshire Localities: All Hereford Team/Ward Managers are aware of the role of the SED, and their responsibility with regards timely management of complaints. They will try and resolve the complaint informally where appropriate.	
	CYPS and CAMHS Localities: Service Managers are advised of concerns received by staff and inform the Service Experience Team by email and then advise staff to liaise with the Service Experience Team for advice and support regarding concerns received.	
The Trust Complaint handling policy and procedure must be followed. All complaint investigations must be reviewed and a checklist signed by the appropriate Service Director or appointed senior member of staff. This is to review the thoroughness of the investigation and the appropriateness of the learning and action identified.	**Gloucestershire Localities:** CSMs to be reminded that all completed investigations must be sent to the Service Director or designated deputy for sign off before it is sent back to the Service Experience Dept. This has also been raised at the Delivery & Governance Committee on the 10th May.	
	Countywide Locality: Learning added to the in-patient managers agenda across all in-patient sites, cascaded to all managers to take back to their teams via team meetings. Community teams have communicated in the monthly team business meetings as well as in 1:1 supervision sessions with staff and email where appropriate.	**April/May 2018**
	Herefordshire Localities: All Team/Ward managers are aware of this process. The assurance is that when allocated to an investigator, the assurance checklist and an attachment-Top 10 tips for investigators- are attached, along with the investigation template. The Service Director checks all complaints received for quality assurance.	
	CYPS and CAMHS Localities: Complaint investigations are reviewed by the Service Director and other members of the senior leadership team where appropriate to review the thoroughness of the investigation. Following this process the checklist is then signed by the Service Director.	

Organisational Learning	Assurance of actions	Date received
All wards and teams should date stamp paper-based information received and have a system for recording and following up written correspondence where required.	**Gloucestershire Localities:** CSMs to raise at respective Forums to discuss with both clinical and admin colleagues reminding them of the need to date stamp paper-based information received and having a system for recording and following up written correspondence when required.	**April/May 2018**
	Countywide Locality: Learning added to the in-patient managers agenda across all in-patient sites, cascaded to all managers to take back to their teams via team meetings. Community teams have communicated in the monthly team business meetings as well as in 1:1 supervision sessions with staff and email where appropriate.	
	Herefordshire Localities: All community and inpatient administration staff are aware of the need to date stamp all paper correspondence received and upload to the clinical record, where appropriate. Administration processes are regularly reviewed to ensure optimum efficiency and management of Key Performance Indicators. The Trust also undertakes regular audit of: • Standards of record keeping Clinical records-both qualitative and quantitative.	
	CYPS and CAMHS Localities: CYPS and CAMHS admin teams all date stamp information received	

**** These individual points of learning have arisen from PHSO feedback in Q3. An apology has been made to the individual concerned. Several mechanisms were immediately employed to assure learning including dedicated focus on matters through the Trusts Leadership Forum and Team Manager briefing sessions with Executives and Locality Directors; Clinical Alert document on the Trust intranet with mandatory read requirement; feedback to and involvement of clinicians involved, updates to relevant Trust policies.***

Agenda Item 9 **PAPER D**

Report to: Trust Board – 26 July 2018
Author: Angie Fletcher, Service Experience Clinical Manager
Jane Melton, Director of Engagement and Integration
Presented by: Jane Melton, Director of Engagement and Integration

SUBJECT: **Non-Executive Audit of Complaints: Annual Report 2017-2018**

This Report is provided for:

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

EXECUTIVE SUMMARY

This report presents high level information and analysis of the Non-Executive Audit of complaints undertaken by four individual NEDs in 2017 / 18. Each NED reviewed three complaints closed within the particular quarter period. In total 12 complaints were reviewed by 4 NEDs.

(1) Assurance

Full assurance is provided by this report that the programme of NED audits has been undertaken and that results have been reported to the Board.

In 58% (7 of 12) the assurance level in relation to the approach to investigating the complaint was regarded as **Full or Significant.**

In 75% (9 of 12) the assurance level in relation to the style of the CEO letter and the Service Expereince Tem communication was regarded as **Full or Significant.**

In 50% (6 of 12) the assurance level in relation to learning from the feedback expressed in Trust response to the complainant was regarded as **Full or Significant**.

S**ignificant assurance** is reported on the progress being made to further develop investigation practice, respond to complainants with sensitivity and embed learning from complaints into practice.

(2) Improvement – practice developments

Limited assurance in some of the complaint cases reviewed in the 4 NED audits was evident. The Trust is aiming for at least significant assurance **in all cases** of complaint investigation and response in line with our values and the NHS Constitution.

Improvements planned are embedded in Sections 2 and 3 of the paper.

RECOMMENDATIONS

The Trust Board is asked to

- note the paper
- note that the Trust is responding to the common themes in the audit findings
- endorse the continued implementation of the quarterly NED audit of complaints.

Corporate Considerations	
Quality implications:	The NED audit process offers assurance that the Trust continues to enable continuous improvement to service quality by implementing learning from complaints and our effort to resolve concerns.
Resource implications:	The NED audit and the improvements to complaint resolution / management practice proposed are undertaken within available resources.
Equalities implications:	No individual is excluded from using the NHS Complaints process. NEDs are reviewing complaints from the audit to ensure equality and rigor of complaint investigation and response.
Risk implications:	Feedback from NED audits offers an insight into how our complaints response could be perceived and learnt from to guide practice development. Compliant information provides an important mechanism for identifying performance, reputational and clinical risks.

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

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

Reviewed by:		
Jane Melton, Director of Engagement and Integration	Date	9th July 2018

Where in the Trust has this been discussed before?		
Trust Governance Committee	Date	June 2018
NED audits, Q1,2,3 and 4 presented to Board		September 2017 November 2017 March 2018 May 2018

What consultation has there been?		
	Date	

Explanation of acronyms used:	NHS – National Health Service SED – Service Experience Department NED – Non Executive Director CEO – Chief Executive Officer

Annual Review of NED Audit of Complaints – 2017/18

1.0 Background

1.1 The Trust continues the good practice of commissioning quarterly 'snapshot' audits of standards for complaint handling and resolution in the Trust. The audit is undertaken by a Non-Executive Director (NED) of the Trust Board on a rotational basis.

1.2 The aim of the NED audit is to monitor whether the Trust is meeting its standards for best complaint management, resolution and learning in line with the NHS Constitution for England[2]. The standards emphasise the requirements for rigor of the complaint investigation, the openness, sensitivity and candour of communications, and the organisation's efficacy in and progress of learning from complaints.

1.3 In 2017/18 NED audits were undertaken each quarter. A random sample of 3 complaints closed within the quarterly timeframe was selected by the NED undertaking the audit. Each quarterly audit was undertaken by a different NED with a focus on a qualitative perception of the investigative approach, the management and tone of response from the Complaints Team and CEO letter in addition to the assurance of learning from feedback that is expressed to the complainant in the Trust's response.

2.0 Review of NED audits judgements and indicative future actions

2.1 Results and assurance levels

Table 1 indicates the level of assurance observed by the auditing Non-Executive Director over the 4 consecutive quarters during 2017/18. Assurance levels were indicated for three specific domains by each of the individual NED audits. These included 1) The investigative approach; 2) The Complaints Team / CEO Letter of response; 3) Learning from feedback expressed in the findings. Sections 2.2, 2.3 and 2.4 report on the audit results for these distinct but related areas and the action being taken to further develop practice.

Table 1: NED Audit outcome judgements against set standards for 2017/18

NED	Audit Q and Case	Assurance level: Investigative approach	Assurance level: Complaints Team / CEO letter	Assurance level: Learning from feedback expressed in Trust response	Assurance by quarter
DS	Q1 - 1	Limited	Limited	Limited	4 Limited
DS	Q1 - 2	Significant	Significant	Significant	5 Significant or Full
DS	Q1 – 3	Full	Full	Limited	
QQ	Q2 – 1	Full	Significant	Limited	3 Limited
QQ	Q2 – 2	Full	Full	Full	6 Significant or Full
QQ	Q2 – 3	Limited	Limited	Significant	
MB	Q3 – 1	Limited	Limited	Limited	5 Limited
MB	Q3 – 2	Full	Full	Limited	4 Full
MB	Q3 - 3	Full	Full	Limited	

NED	Audit Q and Case	Assurance level: Investigative approach	Assurance level: Complaints Team / CEO letter	Assurance level: Learning from feedback expressed in Trust response	Assurance by quarter
NR	Q4 – 1	Limited	Significant	Significant	2 Limited 7 Significant or Full
NR	Q4 – 2	Significant	Significant	Significant	
NR	Q4 - 3	Limited	Full	Significant	
Overall assurance		58% (7 of 12)	75% (9 of 12)	50% (6 of 12)	

2.2 Investigative approach

2.2.1 In **7 out of the 12 (58%)** cases reviewed the investigative approach to complaints was considered to be of expected quality to offer full or significant assurance.

2.2.2 Action:

- Review investigators training programme to ensure focus on examples of learning from complaint investigation excellence
- Continue SED coaching of investigators about excellence in investigation
- Review current processes and continue to work with locality colleagues to seek earlier resolution and more timely responses to formal complaints.
- Pilot of complaint investigation by clinical members of Service Experience Department to expedite complaint responses and complete robust investigations.

2.3 Complaints Team / CEO letter

2.3.1 In **9 out of the 12 cases (75%)** of cases reviewed the Complaint Team approach / CEO letter was considered to be of expected quality and sensitivity to offer full or significant assurance.

2.3.2 **Action:**

- Learning from examples regarded as providing ‘full’ assurance
- Collaborate with colleagues from Gloucestershire Care Services (GCS) to share and learn from best practice in complaints resolution locally.

2.4 Learning

2.4.1 In **6 out of the 12 cases (50%)** reviewed the assurance of learning from feedback expressed in Trust response was considered to be of expected quality to offer full or significant assurance.

2.4.2 **Action:**

- Leadership workshops with colleagues to build culture of learning from feedback through involvement from ward to Board.
- Emphasis on briefing of investigators about their role to suggest and establish points of learning from complaint excellence in investigation whether or not issues are upheld.
- Development of the system of disseminating and embedding learning points for routine consideration at Locality Boards and brought through into Quality and Clinical Risk Sub-committee reports from localities.

- Take part in the review and implementation of any recommendations received from scrutiny of the complaint resolution process.

3. FUTURE DEVELOPMENTS

3.1 A theme of limited assurance in some of the complaint cases reviewed emerged from this review of the NED Audits. Mitigating action has been taken to assure the Board of further developments in the processes of complaint resolution.

3.2 The following additional actions are being taken and will be monitored through weekly Complaints meetings with the Director of Engagement and Integration, through reports to Quality and Clinical Risk meetings, by assurances from future NED Audits and feedback in the Complaints Annual Report.

3.1.1 The SED are working together with operational colleagues to develop systems to disseminate and embed learning from complaints and service experience feedback and to provide assurance of actions.

3.1.2 Practice notes are being issued to share Trust wide learning via localities and more general communications to be disseminated and discussed at team meetings.

3.1.3 Locality colleagues have been asked to share quarterly Service Experience locality trend and theme reports via the Trust QCR Committee to demonstrate an analysis and review of locality activity and learning for improvement and learning from excellence.

3.1.4 Systems are being trialled, reviewed and enhanced to capture evidence of actions completed following learning from complaints. These will be monitored by SED and locality colleagues to provide assurance that learning is being actioned in relation to the recommendations made.

3.1.5 When learning actions are evidenced, a system of assurance monitoring and review will be activated. Audit actions will be reviewed to ensure that they are embedded in practice.

3.1.6 Monitoring of themes and trends will continue by SED and locality colleagues and will also include the identification of any learning in areas where actions have already been completed to quality check the embedding of the action and that the action met the required need and provide an opportunity to learn from good practice.

3.1.7 The Trust intranet section for the Service Experience Department is being reviewed to ensure that learning from feedback is stored for staff to easily access in the form of practice notices and locality reports.

3.1.8 Examples of learning from complaints will be presented to the Trust's Governance Committee by Locality Leads for assurance of learning.

4. CONCLUSION

4.1 The NED audit of complaints is a valuable and valued process for continued learning to deliver resolution for people who complain.

4.2 Further dedicated leadership action is required to ensure progress towards full assurance of best practice.

4.3 Systems to continuously, monitor and provide assurance that our Trust learns, responds and reviews practice following service experience feedback need to further develop.

Agenda item 10 **Enclosure Paper E**

Report to:	Trust Board, 26 July 2018
Author:	Dr Nader Abbasi, Consultant & Guardian of Safe Working Hours
Presented by:	Dr Amjad Uppal, Medical Director
SUBJECT:	**Guardian of Safe Working Hours Quarterly Report covering November, December 2017, January 2018**

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

This Report is provided for:

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

EXECUTIVE SUMMARY

All new Psychiatry Trainees, Foundation Trainees and GP Trainees rotating into a Psychiatry placement from 1st February 2017 and 2nd August 2017 are now on the new 2016 Terms and Conditions of Service although there are exceptions. There are currently 35 trainees working in the 2gether NHS Foundation Trust, 34 on the on the new Terms and Conditions of Service on different sites and 1 Advanced Trainee still on old contract.

The 'exception' reporting process, which is part of the new Juniors Doctors Contract enables them to raise and resolve issues with their working hours and training The trainees can raise exception reports for excessive hours worked, missed breaks, or missed educational opportunities and this system is well established in the Trust

The reports where possible have been resolved by the preferred option of time off in lieu (TOIL); those where TOIL will impact on colleagues' workload or educational opportunities have received payments.

Exception reports may also trigger work schedule reviews and if necessary fines can be imposed on the Trust by the Guardian of Safe Working. Exception reporting rates are variable between different sites.

The reporting process and junior doctors forum are being revised to improve acceptance. Guardians meet regularly nationally and locally, they also share a NHS network hosted forum to discuss progress.

The Quarterly Board report from the Guardian which summarises all exception reports, work schedule reviews and rota gaps, and provides assurance on compliance with safe working hours by both the employer and doctors in approved training programs, will be

considered by CQC, GMC, and NHS employers as key data during reviews.

In the initial phase of new contract implementation there were difficulties with both collection of data relating to junior doctors' hours and mechanisms for the departments to cope with the issues which arise due to new ways of working.

RECOMMENDATIONS

1) The Board is asked to note the content of this paper, in particular in regard to challenges within Hereford Junior doctors' rota.
2) The Board is asked to support the medical directorate in encouraging clinical directors, directorate managers, and educational supervisors to be aware of their responsibilities within the new contract, in particular that payment for additional hours worked should be the exception rather than the rule.

Corporate Considerations	
Quality implications	Implementing the new contract is a DoH requirement justified by a need to ensure consistent quality care and working conditions for junior doctors
Resource implications:	The cost of implementing this contract is being progressed through Execs. It is also important to make sure our rotas are compliant to avoid fines.
Equalities implications:	Nil
Risk implications:	Financial risk if the Trust breaches, a number of issues have been identified in the implementation phase which are identified in the report, together with the plans to resolve them.

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

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

Reviewed by:		
Dr Amjad Uppal	Date	20 July 2018

Where in the Trust has this been discussed before?		
Executive Committee	Date	9 July 2018

What consultation has there been?		
	Date	

Explanation of acronyms used:	CQC – Care Quality Commission DME – Director of Medical Education HEE – Health Education England

1. CONTEXT

1.1 The safety of patients is of paramount concern for the NHS, and significant staff fatigue is a hazard both to patients and to the staff themselves. The 2016 national contract for junior doctors encourages stronger safeguards to prevent doctors working excessive hours, during negotiations on the junior doctors' contract agreement was reached to the introduction of a "Guardian of Safe Working hours" in organisations that employ or host NHS trainee doctors to oversee the process of ensuring safe working hours for junior doctors. The Guardian role was introduced with the responsibility of ensuring doctors are properly paid for all their work and by making sure doctors are not working unsafe hours.

1.2 The role sits independently from the management structure, with a primary aim to represent and resolve issues related to working hours for the junior doctors employed by it. The guardian will ensure that issues of compliance with safe working hours are addressed, as they arise, with the doctor and /or employer, as appropriate; and will provide assurance to the trust board or equivalent body that doctors' working hours are safe.

1.3 The work of Guardian will be subject to external scrutiny of doctors' working hours by the Care Quality Commission (CQC) and by the continued scrutiny of the quality of training by Health Education England (HEE). These measures should ensure the safety of doctors and therefore of patients.

1.4 The system in the new junior doctors' contract for monitoring safe working practices are very new and will require Trust-wide cultural and administrative changes. Although at our Trust many individuals approached have been supportive this change will require time.

1.5 The Guardian's Quarterly Report, as required by the junior Doctor's contract, is intended to provide the Board with an evidence based report on the working hours and practices of Junior Doctors within the Trust, confirming safe working practices and highlighting areas of concern.

2. THE GUARDIAN OF SAFE WORKING HOURS REPORT

2.1 Exception Reporting

The Trust uses Allocate as the reporting system which appears to function reasonably for this purpose.

Since beginning of November 2017 till end of January 2018 exception reports have been generated and a break down has been provided in following tables.

2.2 The table below shows the number of trainee posts available and filled by Health Education, some have been filled by Trust from August 2017 to present.

Grade	**Trainees**	**Glos**	**Hereford**	**New Contract**	**Old Contract**
F1	5	4	1	5	0
F2	5	3	2	5	0
GP	7	5	2	7	0
CT	8	7	1	8	0
ST	10	9	1	9	1
Total	**35**	**28**	**7**	**34**	**1**

Exception reports by site	
Gloucester	6
Hereford	15
Total	21

Exception reports by grade						
Grade	F1	F2	GP	CT	ST	Total
	5	1	12	3	0	21

Exception reports, response time					
	Addressed within 48 hrs	Addressed within 7 days	Addressed in longer than 7 days	Addressed by Guardian	Still open
F1	3	0	0	0	2
F2	0	1	0	0	0
GP	5	2	5	0	0
CT	3	0	0	0	0
ST	0	0	0	0	0
Total	11	3	5	0	2

2.3 Out of 21 reports in this period, 19 have been related to hours, 1 related to service support and 1 in relation to educational opportunities. We had 19 resolutions and 2 are still open at the time pending a meeting and outcome.

Resolutions have included:

- 1/21 No further action
- 7/21 time in lieu agreed
- 11/21 overtime payment agreed
- 2/21 pending meeting with Educational Supervisor
- 7/21 required work schedule reviews in this period, which needs to be considered designing next rota.

2.4 It is also important to declare that there are 10 historical 'open' reports that are not from this period covered by the report. These are reports mainly from the trainees that have left the Trust before 'outcoming' and 'closing' the reports. It is also important to clarify that most of these were addressed and resolved but the system at present only allows the trainee to 'close' the 'open' exception report. We are in discussion with the software provider Allocate to find a way to solve this problem in future. We are also in the process of devising a system which will ensure that trainees achieve satisfactory resolution to enable them to 'close' the reports.

2.5 Work Schedule reviews

During this rota since November 2017 we have had no formal work schedule reviews although it has been recommended through some of the reports outcome. We need to be aware that all of the work schedule recommendations are within Hereford rota where there has been a long standing shortage of trainees.

2.6 Locum Booking and Vacancies

2.6.1 During this period 23 shifts have been covered by agency locum doctors for on-call shifts.

There was also a full time agency locum junior doctor working in Gloucester, and a junior doctor working in Hereford for a month and a half in this time period.

2.6.2 In this time period we have one junior doctor Foundation Year 2 level who could not work on calls at all and another Core Trainee level doctor who could not work nights.

2.7 Fines

2.7.1 At this stage no fines have as yet been levied, but as rotas go if no action taken by Trust to rectify junior doctors shortage in Hereford fines may need to be imposed in line with national guidance.

3. Challenges:

3.1 **Engagement:** Although there have been significant improvements in both engagement and response times, these still need further progress as we are breaching our target times. We have put a system in place when an HR staff member would contact trainee and their supervisor to remind them of response times in case they become overdue. This is unsatisfactory and against the Contract guidance.

3.2 **Software System:** The Trust uses a nationally procured system for medical staff rotas called Allocate Software System, which is the system now used for Exception reporting. The system went live last year just before our new trainees started in February 2017. Each junior doctor on new contract was provided with log in details and been registered on the system in order to enable them to submit an exception report if necessary. The educational supervisors have also been registered and set up on the system. All exception reports also are copied to the Guardian, the Director of Medical Education (DME) and the administrator.

There is no direct helpline on the system and it has been raised with the software company and hopefully will be resolved soon. There is no formal route of communication between the system administration, HR, Guardian and trainees. This has been raised and a meeting is being arranged.

3.3 **Junior doctor rota:** In order to make rotas compliant with the new contract and European Working Time Directive Regulations, it was necessary to apply some changes and junior doctors covering inpatients are now working waking nights. There were concerns regarding lack of emergency training opportunities for trainees and the Director of Medical Education has been working with the trainees to devise a solution. There is a risk of breach in Hereford due to trainee shortage (2.4 whole time equivalent) in case of sickness or annual leave.

3.4 **Workload:** The new contract does have workload implications for the Guardian, administrator, DME, Educational and Clinical supervisors when a trainee submits an exception report. The amount of time spentdepends on the number of exception reports submitted and it is too early to make a judgment about this currently.

3.5 **Administrative support for the Guardian role:** Currently the Guardian has been assisted by admin from HR and medical staffing and they have been very supportive in introducing the new system, answering queries from users and others.

3.6 **Junior Doctors Forum:** Our Junior Doctors Forum predates the introduction of the new contract and has been further strengthened by the Guardian and the DME. There have been already meetings on both sites with good attendance of trainees along other representatives. There are sessions on induction programmes for new trainees to familiarise them with new contract and Guardian's role.

4. Exception Reports and Fines

4.1 The whole point of exception reporting system is to allow employers to address issues and concerns as they arise, in real time, and to keep doctors' working hours, both rostered and actual, within safe working limits. If the system of work scheduling and exception reporting is working correctly, and anything than truly exceptional circumstances, the levying of a fine indicates that the system has failed or that someone - the supervisor, Guardian or the individual doctor concerned - has failed to discharge his or her responsibility appropriately.

4.2 Any levying of a fine should therefore be followed by an investigation in to why it was necessary and remedial action to ensure that it does not happen again. The most important thing to remember is that fines should rarely, if ever be applied at all.

4.3 There have been around 21 exception reports during this period with 2 still open and need addressing by trainees and supervisors. We have been able to encourage trainees and educational supervisors to attend to their reports on a timely manner through constant reminders. There has been a consistent reduction in number of exception reports on both sites due to training and amendment to rotas. There are still a number of exception reports raised from Hereford site which remain a concern and need further changes and alteration to rota.

4.4 The new contract contains safeguards to protect the safety of our junior doctors and patients and ensures doctors are accessing required education and training. In the event of a junior doctor submitting an exception report, the appropriate supervisor must meet with the trainee to review this and the action agreed to prevent it re-occurring. The priority must always be to give the doctor time back in lieu to ensure safety is not breached, therefore payment for additional hours worked should always be discussed and agreed with the appropriate budget holder and should be the exception rather than the rule.

5. Networking

5.1 The Guardian has attended national training and is a member of the regional forum of Safe Working Guardians as well as having email contact with a number of other Guardians in the region to share updates and experience. The Guardian also regularly attends joint Directors of Medical Education and Guardian Meetings. Intelligence from this network suggests that the level of exception reporting has been similar across Trusts within the region.

5.2 There is a national view that junior doctors are reluctant to report excess hours, for fear of damaging their relationship with their training supervisors - even possibly affecting their jobs in the future, hence the culture of no blame being of utmost importance. We have organised to include a presentation by Guardian in all Induction Programs of Trust to address this issue.

6. Next Steps

6.1 To increase engagement and support to Educational Supervisors as they familiarise themselves with the new system and make decisions. To ensure that all Consultants are aware of their contractual duties regarding the 2016 contract terms and conditions and are trained on the Allocate system to ensure that they respond to junior doctors in an appropriate and timely fashion.

6.2 To encourage wider junior doctor engagement in the Junior Doctors Forum and better consistency in the information provided through local Induction programmes, introducing the Guardian role, and the principles behind the Forum by attendance at each junior doctor induction/training events.

6.3 To organize training sessions as part of academic programme for both trainees and Educational Supervisors in order to improve understanding of new contract and exception reports to encourage reporting and also speed up the response to exception Reports ensuring they are dealt within the specified time.

6.4 To ensure effective communication with all relevant parties to maximise safe working and effective training. The Guardian, DME and HR have arranged monthly meetings to review all the new exception reports and explore ways to improve response times.

6.5 Communication strategy to encourage wider understanding of the impact of the new contract for all staff and attendance at relevant meetings.

6.6 Review and scrutinize of data collected through exception reports and junior doctors' forum to address difficulties within Hereford rota.

7. CONCLUSION

7.1 The roll out of the 2016 Safe Working Hours terms and conditions continues. Many juniors have embraced the system and are genuinely committed to Exception Reporting and maintaining a professional work-life balance, promoting safe working. Information gleaned from the exception reports

enables the DME to keep informed of the challenges and threats to the provision of quality Trainee placements at the Trust.

7.2 The Exception Reporting process allows Trainees to give the Guardian notice of working unsafe hours. However, it remains a concern that despite known understanding in the Trust and comments regarding the respond time it still remains a problem. The challenge increases in the area of Educational Supervisors and Trainees engagement and improving the response to their contractual duties although some improvement has noticed.

7.3 Overall, the Guardian role represents an opportunity for a cultural move towards a valued based approach to trainees as opposed to the blame culture often encountered in the past, however the challenge remains engagement with a workforce that are sceptical about the benefits of the new contract.

7.4 The lack of administrative support for the Guardian function, though planned to be resolved, is a hindrance to collating full data for the regular reports from the Guardian.

8. RECOMMENDATION

8.1 The Board is asked to read and note of this report from the Guardian of Safe Working.

8.2 The Board is asked to support the medical directorate in encouraging Clinical Directors, and Educational Supervisors to be aware of their responsibilities within the new contract, in particular that payment for additional hours worked should be the exception rather than the rule.

8.3 Hereford remains a challenge due to the long standing shortage of trainees in the region. This is being addressed with the relevant Schools and Health Education bodies.

Agenda item 11 **Enclosure Paper F**

Report to: 2gether NHS Foundation Trust Board – 26th July 2018
Author: Paul Roberts, Joint Chief Executive and Colin Merker, Deputy Chief Executive
Presented by: Paul Roberts, Joint Chief Executive and Colin Merker, Deputy Chief Executive

SUBJECT: **Chief Executive's Report**

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

This Report is provided for:
Decision Endorsement Assurance **To Note**

EXECUTIVE SUMMARY
This paper provides the Board with:

1. A summary of headline news against Quality, Sustainability and Engagement criteria
2. An overview of engagement by Board members

RECOMMENDATIONS

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

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

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

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

Reviewed by:		
Chief Executive	Date	*July 2018*

Where in the Trust has this been discussed before?		
	Date	

What consultation has there been?		
N/A	Date	

Explanation of acronyms used:	

1. Chief Executive Engagement

I remain committed to spending a significant proportion of my time visiting front-line services in both organisations and continue to be impressed and heartened by the professionalism and commitment of colleagues across the organisations and in the pride that they take in the delivery of, in many cases, outstanding services.

Services I have visited in recent weeks include:

Gloucestershire Care Services: Cirencester Community Hospital, the **I**ndependent Living Centre in Cheltenham, the Podiatry Centre, at St Paul's Medical Centre, in Cheltenham where some enthusiastic colleagues gave me an off-the-cuff lecture on podiatry and its importance to service users and how they work as part of some key multi-disciplinary teams such as diabetes; and as a springboard to visiting the GCS County-wide services (which include among other services: tissue viability, early supported discharge for stroke, muscular skeletal advanced practitioners, cardiac rehabilitation, community dental, sexual health, podiatry, speech and language therapy, adult physio therapy, integrated community equipment service) I had a really informative presentation from the Head of Countywide and members of the team about these services, the triumphs and challenges, which has set me up well to make more visits over the coming weeks.

[2]gether Services: an **"**Open Door" event in Charlton Lane; Wotton Lawn, the adult inpatient unit in Gloucester; Working Well Centre, in the Orchard Centre, in Gloucester, Herefordshire psychiatrists at their regular divisional meeting and the Stonebow Inpatient Unit. Having met the Gloucestershire psychiatrists at their regular medical staff committee meeting, it was good to have the opportunity to introduce myself to their Herefordshire counterparts. We had a useful discussion which focussed on the particular context of Herefordshire. The county, whilst large in square miles, is small in population: 190,000 compared with 620,000 in Gloucestershire. Historically, partly due to particularly severe NHS financial

pressures, it has not invested as much in mental health and learning disability services as in Gloucestershire – the team therefore is relatively small and has to be flexible. I was impressed by the passion for the County and the determination to ensure that Herefordshire plays a significant part in the development of our new integrated organisation.

2. Progress on the strategic intent to merge ^{2}gether NHS Foundation Trust with Gloucestershire Care Services NHS Trust (GCS)

The development of outstanding integrated mental and physical health services firmly rooted in local communities is the vision that lies behind the proposed merger of ^{2}gether NHS Foundation Trust and Gloucestershire Care Services NHS Trust. This vision is a major vehicle for delivering both the One Gloucestershire Programme. This vision will remain central the complex work required to ensure this merger happens over the coming months.

A range of initial engagement events have now been held with colleagues and wider stakeholders to start to develop an engagement process which will ensure that the people that we serve and those we work with are genuinely engaged in the co-production of outstanding services which meet the needs of our communities and tackle inequalities. The Strategic Intent Leadership Group, which is comprised of Non-Executive Directors from both Trusts, with myself and the Joint Chair is committed to keeping this as the bedrock to all our joint work.

We are beginning to consider how the vision and values of both organisations can be taken forward to inspire our new organisation to achieve our ambitions. This work will involve colleagues, Board and our stakeholders.

The practical processes required to take forward a merger are being taken actioned by the Programme Management Executive Group, monitored by the Strategic Intent Leadership Group, and to date we are on track for the Boards to consider the Strategic Outline Case, which must be submitted and approved by NHSI, by the end of September 2018. We would then expect to hear from NHSI in November 2018.

3. Carter Mental Health Community Services Work

As advised in my last report the Lord Carter report into the "Operational Productivity and Performance in English NHS Mental Health and Community Health Services: unwarranted variations" was published on 24th May 2018. Given ^{2}gether NHS Foundation Trust's input into the report as a "high performing" Mental Health Trust a breadth of comparator information has been made available to them which was discussed at a meeting of the Joint Executives of both Trusts who are now taking forward opportunities for learning and improving efficiencies. This type of joint work, which uses the joint expertise of both Trusts is just one example of how our planned joint work can improve the way we work.

4. Integrated Care Systems

4.1 One Gloucestershire Integrated care System

The proposal for establishing an integrated care system (ICS) in Gloucestershire was one of four approved by NHS Improvement and NHS England as this paper was being finalised. This means Gloucestershire will be one of only fourteen ICSs nationally. The paper approved at the NHSi and

NHSE Board meeting said: “These systems demonstrate strong leadership teams, capable of acting collectively, and with an appetite for taking responsibility for their own performance…. They have also set out ambitious plans for strengthening primary care, integrating services and collaborating between providers. Although they experience the operational and financial pressures that other systems do, our assessment is that they are more likely to improve performance against NHS Constitutional standards and financial sustainability by working together as a system”.

The ICS provides an additional impetus not only for the joint work being pursued through the STP programme but also for the intended merger between 2gether and Gloucestershire Care Services NHS Trust.

4.2 Herefordshire and Worcestershire Integrated Care System approach

Herefordshire and Worcestershire (H&W) Strategic Transformation Partnership (STP) did not apply to be considered as a national ICS, as the Midlands and East NHSE have adopted an approach of funding an ICS development programme across all of their STP’s during 2018/19. The principles of the ICS opportunity in Gloucestershire apply to H&W and so we are working with colleagues in this STP to develop options for change that will improve outcomes and support sustainability of the system. Whilst community services in Herefordshire sit within the Acute Services Trust, Wye Valley Trust (WVT), the philosophies and values of the Gloucestershire programme still set the direction of travel we need to be progressing in Herefordshire collectively with our system partners.

5. National issues

5.1 The NHS Funding Settlement

The government has announced a 3.4% real terms funding rise for the NHS over five years. This is a welcome investment, but there are many demands on this funding. It must pay for recovering current performance and financial gaps, pay rises for staff, keeping up with NHS cost and demand growth, and any early steps to either transform the service or enhance performance in areas like cancer and mental health. It is important not to lose this opportunity to reform NHS services and look to invest in the right services for patients.

We need to recognise how dependent the NHS is on wider public services, in particular public health and social care. Ensuring that these services are sustainably funded is crucial to the success of the health and care system over the next ten years.

A full briefing available on the NHS Providers website

5.2 NHS 70

By definition, the NHS has had an impact on everybody reading this – you are part of it, whether as a member of staff, a volunteer, a non-executive director or a governor. You and your family will have depended on it at some time in your life. For many of us the NHS is more than a job – it is a vocation. The values implicit in the NHS are inherently civilised – the NHS is a commitment to each other, an agreement to ensure that our health and wellbeing when we are at our most vulnerable is the responsibility of us all. I am delighted to have been able to join in local celebrations

of this milestone but also to see the NHS recognised across the country for the key role it plays in our society.

6. Engagement

Internal Board Engagement

01.05.18	The Deputy Chief Executive, Director of Service Delivery and Director of Finance & Commerce attended a Complex Care/Out of County Placement meeting
01.05.18	The Director of Service Delivery carried out a Board visit to the Memorial Centre in Cirencester
02.05.18	The Deputy Chief Executive and Director of Service Delivery attended a Herefordshire Future Structure meeting
02.05.18	The Director of Finance & Commerce carried out a Board visit to the Stroud Recovery Team
03.05.18	The Director of Organisational Development chaired Transformation (CIP) Project Board
04.05.08	The Deputy Chief Executive attended the Medical Scrutiny Committee meeting
08.05.18	Members of the Executive Team attended the Trust Council of Governors meeting
09.05.18	The Director of Quality attended a board visit at Stroud and Cotswolds CPI Team at Weavers Croft
10.05.18	The Director of Quality attended a team visit to CYPS team based at Evergreen House
14.05.18	Members of the Executive Team conducted Team Talk throughout the Trust
14.05.18	The Director of Organisational Development attended Corporate Induction
14.05.18	The Executive Team attended an Executive Development session
14.05.18	The Executive Team attended a Senior Leadership Group meeting
15.05.18	The Director of Engagement and Integration conducted a Board Visit with the Stroud Later Life CMHT
16.05.18	The Director of Engagement and Integration conducted a Board Visit with the CYPS Level 3 Team at Park House, Stroud

16.05.18 The Director of Engagement and Integration chaired the Trust's Research Overview Sub-Committee

16.05.18 The Director of Service Delivery took part in a Telephone conference regarding Herefordshire CAMHS

16.05.18 The Director of Finance & Commerce attended a Final Audit meeting.

16.05.18 The Director of Organisational Development attended the Strategic Intent Leadership Group

18.05.18 The Deputy Chief Executive and Director of Service Delivery attended an Alzheimer's Contract Meeting

18.05.18 The Director of Service Delivery conducted a Board visit to the Information Team

21.05.18 Members of the Executive Team attended an Executive Business meeting

21.05.18 The Director of Engagement and Integration and the Director of Organisational Development attended a Programme Management Executive Board for 2G and GCS

22.05.18 The Director of Organisational Development conducted a Patient Safety Visit at Oak House in Hereford

23.05.18 The Director of Service Delivery attended a Delivery Committee meeting

23.05.18 The Deputy Chief Executive, Director of Finance & Commerce and the Director of Organisational Development attended the Gloucester Care Services Annual Staff Awards event

24.05.18 The Director of Engagement and Integration and The Director of Quality attended a perinatal 'whose shoes' event held at Kingsholm Stadium

24.05.18 The Director of Organisational Development conducted a Board Visit to the West MH ICT Team at Pullman Court

25.05.18 The Director of Finance & Commerce attended the Final Accounts Audit Committee

25.05.18 The Director of Organisational Development hosted a Senior HR 2gether and GCS Teams Workshop Session

27.05.18 The Director of Quality attended the Smoking Cessation Project Board

29.05.18 The Deputy Chief Executive and Director of Organisational Development attended JNCC

29.05.18	The Director of Service Delivery attended a Capital Review Group meeting
30.05.18	The Deputy Chief Executive attended a GP Pilot and HEE S/W New models of Care Examples meeting
30.05.18	The Director of Finance & Commerce attended Temporary Staffing Demand Project Board
31.05.18	The Executive Team attended a Trust Board meeting
01.06.18	The Director of Service Delivery attended a Glos STP Mental Health Workforce Plan meeting
01.06.08	The Deputy Chief Executive attended the Medical Scrutiny Committee meeting
04.06.18	The Executive Team attended an Executive Business meeting
04.06.18	The Director of Organisational Development attended the Programme Management Executive Meeting
04.06.18	The Director of Finance & Commerce and the Director of Organisational Development attended a Programme Management Executive Workshop
05.06.18	Members of the Executive team participated in an Executive Team away day with colleagues from Gloucester Care Services
05.06.18	The Deputy Chief Executive attended an Engagement event held in Hereford
08.06.18	Members of the Executive Team attended Senior Leadership Networks meeting
08.06.18	The Medical Director led a Short Life Working Group with the LNC
11.06.18	Members of the Executive Team conducted Team Talk throughout the Trust
11.06.18	The Director of Organisational Development attended Corporate Induction
11.06.18	The Executive Team attended an Executive Development session
11.06.18	The Executive Team attended a Leadership Forum
14.06.18	The Director of Finance & Commerce chaired the People Committee meeting

15.06.18 The Director of Service Delivery participated in a conference call regarding Hereford CAMHS Relocation Progress

15.06.18 The Director of Engagement and Integration chaired the Trust's Quality and Clinical Risk Sub-Committee

15.06.18 The Director of Organisational Development attended a STP Workforce Steering Group

18.06.18 The Executive Team attended an Executive Business Committee meeting

18.06.18 The Director of Engagement and Integration and the Director of Organisational Development attended a Programme Management Executive Meeting with Gloucestershire Care Services

19.06.18 The Director of Engagement and Integration attended the Trust's Development Committee

19.06.18 The Deputy Chief Executive and Director of Service Delivery attended a Herefordshire Future Structure meeting

19.06.18 The Deputy Chief Executive and Director of Service Delivery attended a Herefordshire CAMHS meeting

19.06.18 The Deputy Chief Executive and Director of Service Delivery attended an AMPH Costings meeting

19.06.18 The Director of Engagement and Integration and the Director of Organisational Development hosted a Patient and Staff Survey Working Group meeting with Trust Governors

20.06.18 The Director of Service Delivery conducted patient Safety visits to Willow and Mulberry Wards

20.06.18 The Deputy Chief Executive and the Director of Organisational Development attended a Strategic Intent Leadership Group

20.06.18 The Medical Director attended the Herefordshire Division meeting along with the Joint Chair and Joint Chief Executive

21.06.18 The Executive Team attended a Joint - GCS/2G Business Executive Team Meeting

21.06.18 The Executive Team attended a 2G Business Executive Team Meeting

22.06.18 The Director of Service Delivery attended a meeting regarding Urgent Treatment Centres

25.06.18 The Director of Engagement and Integration, the Director of Finance & Commerce and the Director of Organisational Development attended Corporate Induction

25.06.18 The Executive Team attended an Executive Development session

25.06.18 The Director of Service Delivery attended a meeting regarding Action for Children

26.06.18 The Director of Finance & Commerce chaired the Transformation (CIP) Project Board

27.06.18 The Director of Service Delivery attended IAPT Leadership & Management Responsibilities meetings

27.06.18 The Director of Service Delivery attended Delivery Committee

27.06.18 The Director of Finance & Commerce attended the Temporary Staffing Demand Project Board

28.06.18 The Executive Team attended a Joint Board Seminar

29.06.18 The Director of Service Delivery conducted site visits to Hereford community services.

Board Stakeholder Engagement

01.05.18 The Deputy Chief Executive attended a Dementia Pilot monthly meeting with Gloucestershire Clinical Commissioning Group

01.05.18 The Director of Engagement and Integration attended the Operating Model Working Group at Herefordshire Council

02.05.18 The Deputy Chief Executive and Director of Service Delivery attended a Mental Health Delivery Plan meeting with Herefordshire CCG

02.05.18 The Medical Director held a relatives meeting following a serious incident involving a patient death

02.05.18 The Director of Organisational Development attended the STP Workforce Steering Group

03.05.18 The Director of Engagement and Integration met with a professional colleague from Gloucestershire University

03.05.18 The Deputy Chief Executive attended a STP Delivery Board meeting

03.05.18 The Deputy Chief Executive attended a Hereford and Worcester STP meeting at Malvern Community Hospital

04.05.18	The Deputy Chief Executive and Director of Service Delivery attended a Social Care meeting with Gloucestershire Clinical Commissioning Group
04.05.18	The Director of Engagement and Integration met with the CEO of Carers Gloucestershire
08.05.18	The Director of Engagement and Integration attended Gloucestershire's Health and Care Overview and Scrutiny Committee
08.05.18	The Deputy Chief Executive attended an Integrated Care Alliance Programme Board
08.05.18	The Deputy Chief Executive attended a Regulation 28 Meeting
08.05.18	The Director of Finance & Commerce attended the Resources Steering Group
08.05.18	The Director of Organisational Development attended the STP Social Partnership Forum
08.05.18	The Director of Organisational Development attended the Trade Union Meeting with GCS
09.05.18	The Deputy Chief Executive attended a Mental Health and Community Pre-Publication Cohort Day with NHS Improvement
10.05.18	The Director of Engagement and Integration met with the CEO of Cobalt
10.05.18	The Director of Service Delivery conducted a visit to Balcarras School with CYPS colleague
11.05.18	The Director of Service Delivery attended a #hello my name is - human connections and compassionate care event.
11.05.18	The Director of Quality hosted a "Hello My Name is" Nursing Event for 2gether Trust at The Bowden Hall
14.05.18	The Deputy Chief Executive attended a Cheltenham Integrated Locality Board meeting
14.05.18	The Director of Engagement and Integration attended the NHS 70 Parliamentary Awards at Pullman Place
14.05.18	The Director of Organisational Development attended a NHS Improvement Retention Programme meeting
15.05.18	The Deputy Chief Executive attended a STP Partnership Board meeting

15.05.18 The Director of Organisational Development attended a meeting with NHS Improvements

16.05.18 The Director of Service Delivery attended the Herefordshire HOSC meeting

16.05.18 The Deputy Chief Executive attended a Forest of Dean Integrated Locality Board meeting

17.05.18 The Deputy Chief Executive attended a STP CEO's Meeting and diagnostic workshop

17.05.18 The Director of Quality attended the Herefordshire CQRF

17.05.18 The Deputy Chief Executive attended a Networking Transformation Project Board Meeting

17.05.18 The Director of Service Delivery and Director of Finance & Commerce attended a Herefordshire Contract Management Board meeting

17.05.18 The Director of Service Delivery attended a Dementia STP/Strategy/Clinical Programme Board with Gloucestershire Clinical Commissioning Group

18.05.18 The Deputy Chief Executive attended a NHS Digital meeting with NHS England

22.05.18 The Director of Engagement and Integration attended the Gloucestershire Care Services Research and Innovation Forum

22.05.18 The Deputy Chief Executive attended a Gloucester City Place Based Pilot Board Meeting

22.05.18 The Director of Service Delivery attended the 10th Learning Disability Big Health Check Day

23.05.18 The Director of Service Delivery attended a HR Audit meeting with UK Assurance

23.05.18 The Director of Quality attended a Quality in Nursing event at Dowty's Sports and Social Club

24.05.18 The Deputy Chief Executive attending a Safeguarding meeting with Gloucestershire Clinical Commissioning Group

24.05.18 The Deputy Chief Executive and Director of Service Delivery attended a Dementia CPG Board

24.05.18 The Director of Organisational Development attended the STP Mental Health Workforce meeting

25.05.18	The Director of Engagement and Integration participated in a Gloucestershire Health and Care Overview and Scrutiny Committee Work Planning meeting
29.05.18	The Director of Engagement and Integration chaired the Gloucestershire Clinical Commissioning Group's Tackling Mental Health Stigma Group
29.05.18	The Director of Engagement and Integration and the Director of Finance and Commerce took part in a Stakeholder Merger Event in Gloucestershire
29.05.18	The Director of Organisational Development attended the Workforce and Organisational Development Action Group
30.05.18	The Director of Organisational Development attended the Gloucestershire LWAB meeting
01.06.18	The Deputy Chief Executive attended a Dementia Pilot Monthly Meeting
01.06.18	The Director of Quality met with Paul Keedwell, Executive Director of Nursing and Practice at Devon Partnership NHS Trust.
01.06.18	The Director of Organisational Development attended the Gloucestershire STP Mental Health Workforce Plan meeting
04.06.18	The Deputy Chief Executive attended an Action Learning Set-Integrated Care Strategy meeting and workshop
05.06.18	The Director of Quality attended an away day with Gloucester Care Services
05.06.18	The Director of Engagement and Integration attended a Health and Wellbeing Board Workshop with Herefordshire Council
05.06.18	The Director of Engagement and Integration took part in a Stakeholder Merger Event in Herefordshire
06.06.07	The Director of Service Delivery and the Director of Finance & Commerce attended a Gloucester Trust Contract Management meeting with Gloucestershire Clinical Commissioning Group
06.06.18	The Director of Service Delivery attended a Draft Plan Follow up meeting with colleagues from NHS Improvement
06.06.18	The Director of Quality and Director of Finance & Commerce attended a meeting with NHS Improvement
07.06.18	The Director of Quality attended Gloucestershire CQRG at Sanger House

07.06.18	The Deputy Chief Executive attended a STP Delivery Board
07.06.18	The Deputy Chief Executive attended a Herefordshire and Worcestershire STP Delivery Board
07.06.18	The Director of Service Delivery participated in a Community Dementia Dog Working Lunch
08.06.18	The Medical Director met with HM Senior Coroner in Herefordshire
09.06.18	The Director of Engagement and Integration was a key note speaker at FESTIVall Community Inclusion Event in Winchcombe
11.06.18	The Deputy Chief Executive attended a Forest of Dean Integrated Locality Board meeting.
12.06.18	The Deputy Chief Executive attended an Integrated Care Alliance Programme Board
12.06.18	The Deputy Chief Executive attended the Joining Up Your Information Project Board and Clinical Information Sharing Projects Group Meeting
12.06.18	The Director of service Delivery attended the A & E Delivery Board in Hereford
13.06.18	The Deputy Chief Executive attended a Gloucestershire County Council Corporate Peer Challenge: Partner Focus Group
13.06.18	The Deputy Chief Executive and the Director of Engagement and Integration attended a Forest of Dean Integrated Locality Board meeting
13.06.18	The Director of Organisational Development attended a NHS Improvement meeting on Retention programme
14.06.18	The Director of Engagement and Integration chaired a quarterly strategic meeting between 2gether and Swindon and Gloucestershire MIND
15.06.18	The Deputy Chief Executive attended an LDR Refresh day with Gloucestershire Clinical Commissioning Group
15.06.18	The Director of Engagement and Integration met with colleagues from Herefordshire Healthwatch
20.06.18	The Deputy Chief Executive attended a Forest of Dean Integrated Locality Board meeting
20.06.18	The Director of Service Delivery attended a meeting with PWC relating to Violence and Aggression internal audit

21.06.18 The Deputy Chief Executive attended a STP CEO's Meeting

22.06.18 The Deputy Chief Executive attended a Shared Control Action Learning Set and workshop in Malvern

25.06.18 The Director of Engagement and Integration presented at the Adults and Wellbeing Scrutiny Members Workshop in Herefordshire

26.06.18 The Deputy Chief Executive and Director of Service Delivery attended a Dementia CPG Board meeting

26.06.18 The Deputy Chief Executive attended the Gloucestershire Strategic Forum

26.06.18 The Deputy Chief Executive attended the Sustainability & Transformation Partnership Advisory Group meeting

26.06.18 The Director of Engagement and Integration attended the STP Clinical Reference Group in Worcestershire

27.06.18 The Director of Finance & Commerce attended the Resources Steering Group

27.06.18 The Director of Organisational Development attended the Gloucestershire LWAB

28.06.18 The Director of Service Delivery attended the LD Inpatient Service Development Project Board

28.06.18 The Deputy Chief Executive and Director of Finance & Commerce attended a CITS Partnership Board

29.06.18 The Deputy Chief Executive attended a Cheltenham Integrated locality Board Sub-Group meeting

National Engagement

03.05.18 The Director of Finance & Commerce attended the South and London Finance Directors meeting in London

14.05.18 The Medical Director attended the Caldicott Guardians National Annual Conference

15.05.18 The Director of Quality attended a Clinical Senate Review of Proposal for Mental Health in Camden & Islington

17.05.18 The Director of Engagement and Integration attended a Royal College of Occupational Therapists, Strategic Intentions Launch Event in London

17.05.18 The Director of Organisational Development chaired a South West HR Directors Network Meeting

18.05.18 The Director of Engagement and Integration attended an AHP Leaders Event with NHS England, Wellington House, London

21.05.18 The Director of Organisational Development participated in the West Midland HR Directors Network Teleconference

23.05.18 The Medical Director attended the NHSI Mental Health and Community Health Productivity and Efficiency Review in London

25.05.18 The Director of Quality attended the West Midland Director of Nursing CCG, Trust and provider meeting in Birmingham

06.06.18 The Director of Engagement and Integration attended an NHS England Development Event for STP/ICS Leads and Clinical Leads in London with Gloucestershire STP/ICS Clinical Chair and CEO

07.06.18 The Director of Engagement and Integration attended a Link Directors Network Forum for the West of England Academic Health Science Network at the University of the West of England, Bristol

12.06.18 The Director of Engagement and Integration attended a "Transformational Collaboration" Conference in Manchester with a Non-Executive colleague at Gloucestershire Care Services

12.06.18 The Medical Director attended the NHS England Responsible Office Network Forum

13.06.18 The Director of Service Delivery attended the annual NHS Confederation conference

14.06.18 The Director of Service Delivery attended the annual NHS Confederation conference

18.06.18 The Director of Engagement and Integration attended the Health and Social Care Board Workshop at the University of the West of England, Bristol

19.06.18 The Director of Engagement and Integration attended a Chief Allied Health Professions Officers Conference in London

19.06.18 The Director of Organisational Development chaired the South West HR Directors Network Teleconference

21.06.18 The Director of Organisational Development attended the NHS England South LWAB

22.06.18 The Director of Engagement and Integration attended the South West Public Participation Development Workshop in Chippenham

25.06.18 The Director of Organisational Development participated in the HRD Network Chairs teleconference

27.06.18 The Director of Engagement and Integration chaired an International Practice Development teleconference

29.06.18 The Director of Organisational Development attended the Enabling BME Leadership Masterclasses with NHS Improvement

Agenda item 12 **Enclosure No** **Paper G**

Report to: 2gether NHS Foundation Trust Board 26th July 2018
Author: Stephen Andrews, Deputy Director of Finance
Presented by: Andrew Lee, Director of Finance and Commerce

SUBJECT: **Summary Finance report for period ending 30th June 2018**

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

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

EXECUTIVE SUMMARY

- The month 3 position is a surplus of £263k which is in line with the planned surplus.
- The month 3 forecast outturn is an £834k surplus in line with the Trust's control total.
- The Trust has an Oversight Framework segment of 2 and a Finance and Use of Resources metric of 1, which is the best achievable.
- The 2018/19 contracts with Gloucestershire CCG, Herefordshire CCG, NHS England and Worcestershire Joint Commissioning Unit have been signed.
- The agency cost forecast is £4.17m, an increase of £0.021m on last year's expenditure level. This would be £1.036m above the Agency Control Total.
- The Trust has identified £691k of recurring savings up to June 2018 which is ahead of plan.
- The Trust has a year end cash projection of £16.2m which is £6.4m greater than the plan.

RECOMMENDATIONS

It is recommended that the Board:

- note the month 3 position

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

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

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

Reviewed by: Andrew Lee, Director of Finance and Commerce		
	Date	16th July 2018

Where in the Trust has this been discussed before?		
	Date	

What consultation has there been?		
	Date	

Explanation of acronyms used:	See footnotes

1. CONTEXT

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

2. EXECUTIVE SUMMARY

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

Indicator	**Measure**		**Comments**
NHS I Oversight	Single Oversight Framework Segment	2.0	as at April 2018
Use of Resources	Financial Risk rating	1.0	as at June 2018
Income	FOT vs FT Plan	101.7%	
Operating Expenditure	FOT vs FT Plan	101.8%	
Year end Cash position	£m	16.2	
PSPP	%age of invoices paid within 30 days	95.0%	90% paid in 10 days
Capital Income	Monthly vs FT Plan	201.4%	sale of Fieldview
Capital Expenditure	Monthly vs FT Plan	109.7%	£509k expenditure.

The parameters for the traffic light dashboard are as follows;

Indicator	RED 	AMBER 	GREEN 
NHS I FOT segment score	>3	2.5 - 3	<2.5
Use of Resources Score	>3	2.5 - 3	<2.5
INCOME FOT vs FT Plan	<99%	99% - <100%	=>100%
Expenditure FOT vs FT Plan	>101%	>100% - 101%	=<100%
CASH	<£8m	£8-£10m	>£10m
Public Sector Payment Policy - YTD	<=80%	>80% - <95%	>=95%
Capital Income - Monthly vs FT Plan	<90%	90% - 100%	>100%
Capital Spend - Monthly vs FT Plan	>115% or <85%	110% - 115% or 85% to 90%	>90% to <110%

- The financial position of the Trust at month 3 is a surplus of £263k which is in line with the plan (see appendices 1 & 8).
- Income is £549k over recovered against budget and operational expenditure is £526k over spent, and non-operational items are £23k over spent.

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

Trust Summary	Annual Budget £000	Budget to Date £000	Actuals to Date £000	Variance to Date £000	Year End Forecast £000	Year End Variance £000
Cheltenham & N Cots Locality	(5,175)	(1,294)	(1,252)	42	(5,114)	62
Stroud & S Cots Locality	(5,975)	(1,494)	(1,485)	9	(5,984)	(10)
Gloucester & Forest Locality	(4,415)	(1,104)	(1,057)	47	(4,394)	21
Social Care Management	(4,992)	(1,248)	(1,408)	(160)	(5,810)	(818)
Entry Level	(5,034)	(1,258)	(1,459)	(201)	(5,345)	(311)
Countywide	(31,357)	(7,861)	(7,836)	26	(31,441)	(84)
Children & Young People's Service	(6,113)	(1,528)	(1,616)	(88)	(6,093)	20
Herefordshire Services	(13,300)	(3,356)	(3,362)	(6)	(13,596)	(296)
Medical	(15,297)	(3,824)	(3,994)	(170)	(15,512)	(215)
Board	(1,422)	(356)	(445)	(89)	(1,998)	(575)
Internal Customer Services	(1,844)	(461)	(451)	10	(1,845)	(0)
Finance & Commerce	(6,419)	(1,600)	(1,536)	64	(6,465)	(45)
HR & Organisational Development	(3,445)	(861)	(744)	117	(3,271)	174
Quality & Performance	(3,142)	(786)	(749)	36	(3,212)	(70)
Engagement & Integration	(1,466)	(367)	(365)	2	(1,503)	(37)
Operations Directorate	(1,149)	(287)	(301)	(13)	(1,248)	(99)
Other (incl. provisional / savings / dep'r	(5,815)	(1,302)	(1,487)	(185)	(5,578)	237
Income	117,194	29,249	29,810	561	119,239	2,045
TOTAL	**834**	**262**	**263**	**1**	**834**	**0**

The key points are summarised below;

In month

- The Social Care Management over spend relates to Community Care and is offset by additional income
- The Entry directorate over spend relates to expenditure above budget on IAPT services
- The Medical over spend has been caused by agency expenditure - £164k in month 3 and £473k year-to-date
- Other expenditure is overspent due to increased depreciation costs
- Income is over recovered due to additional income for activity related Community Care work and additional development funds which weren't budgeted

Forecast

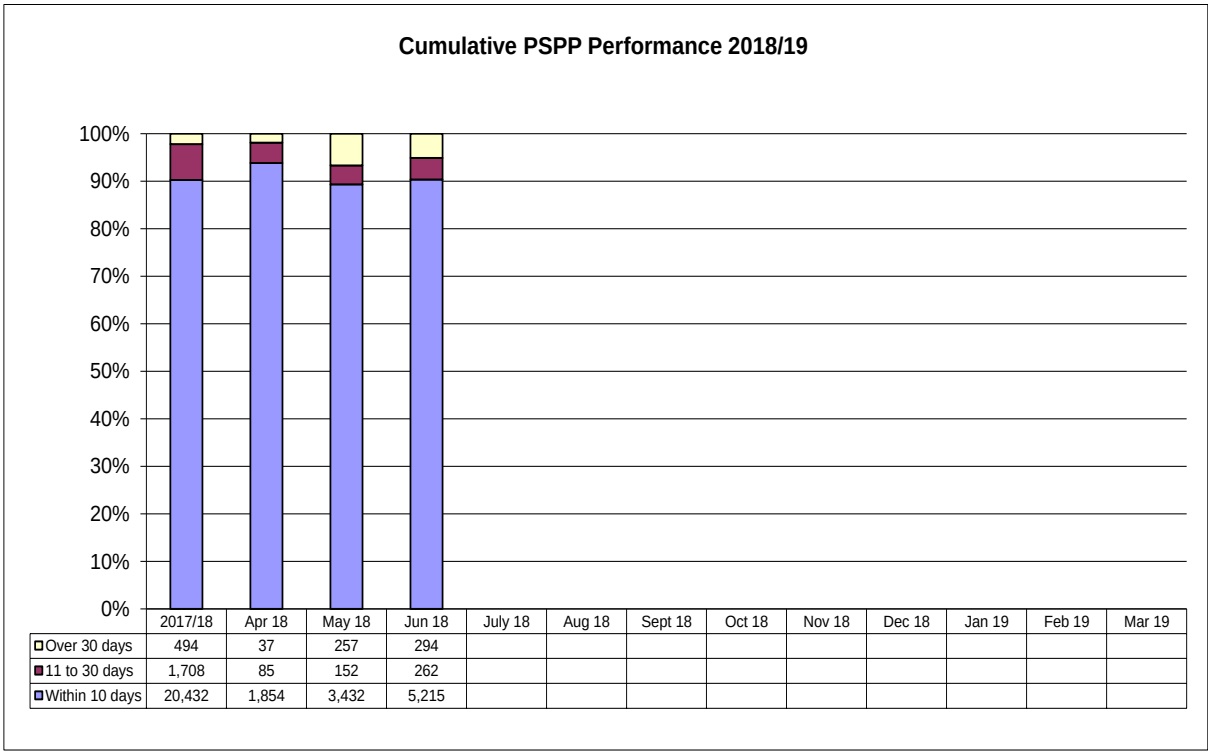
- The Social Care Management forecast over spend relates to Community Care and is offset by additional income
- The Entry directorate forecast over spend relates to expenditure above budget on IAPT services
- The Herefordshire services forecast over spend is expected due to specialling costs and cost pressures caused by difficulties in recruiting to the wards. The specialling costs are matched with additional income of £180k.
- The Medical forecast over spend is due to anticipated continuing usage of

agency during 2018/19

- The forecast over spend on Board is linked to expenditure on STP OD projects for which there is some budget in reserves.

PUBLIC SECTOR PAYMENT POLICY (PSPP)

The cumulative Public Sector Payment Policy (PSPP) performance for month 3 is 90% of invoices paid in 10 days and 95% paid in 30 days. The cumulative performance to date is depicted in the chart below and compared with last year's position:



	2017/18	Apr 18	May 18	Jun 18	July 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19
Over 30 days	494	37	257	294									
11 to 30 days	1,708	85	152	262									
Within 10 days	20,432	1,854	3,432	5,215									

	10 days		30 days	
	In month	**YTD**	**In month**	**YTD**
Number paid	1,800	5,215	1,897	5,477
Total Paid	1,931	5,771	1,931	5,771
%age performance	**93%**	**90%**	**98%**	**95%**
Value paid (£000)	5,620	16,185	5,861	16,694
Total value (£000)	5,920	17,366	5,920	17,366
%age performance	**95%**	**93%**	**99%**	**96%**

Agenda item **13** **PAPER H**

Report to: Trust Board – 26th July 2018
Author: Andrew Lee, Director of Finance & Commerce
Presented by: Andrew Lee, Director of Finance & Commerce

SUBJECT: **2018/19 OPERATIONAL PLAN FEEDBACK FROM NHSI**

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

EXECUTIVE SUMMARY

Our 2018/19 Operational Plan refresh was approved at our April Board and subsequently submitted in accordance with the NHSI requirements.

We then had a feedback meeting on 6th June with NHSI at Rikenel. This was a very positive meeting, and attending from 2gether were Neil Savage, Marie Crofts, John Campbell and myself. At the meeting NHSI confirmed that we would not be required to make a mandatory resubmission of our plan, but could resubmit if we wished to update anything but had to do so by 20th June at the latest. Following internal discussions we confirmed that we would not be resubmitting.

We then received formal written feedback from NHSI in a letter dated 7th June. NHSI requested that the feedback letter be shared with our Board, and it is attached to this cover sheet. I would also bring to your attention the following points with regard to the letter:-

(i) We continue to manage IAPT very closely and take all steps possible to support performance improvement. We secured additional recurrent funding from both CCG's for 2018/19 with regard to IAPT performance improvement, but recruitment remains difficult (particularly in Herefordshire), with IAPT performance continuing to receive significant focus at both Board and Delivery Committee meetings.

(ii) Although there remains real focus upon driving down agency costs, the need to temporarily recruit agency staff to drive IAPT performance improvement plus increased medical locum cover, means that at present we are not forecast to reduce our agency costs over our 2017/18 level which will result in an inability to deliver our agency spend ceiling target (although we remain on track to deliver our overall revenue control total).

(iii) We have confirmed to our NHSI relationship team that appropriate demand and capacity planning took place as part of agreeing our 2018/19 CCG contracts, and is hence built into our Operational Plan refresh.

RECOMMENDATIONS
The Board is asked to note the 2018/19 Operational Plan feedback letter from NHSI.

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

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

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

Reviewed by:		
	Date	

Where in the Trust has this been discussed before?		
	Date	

What consultation has there been?		

Explanation of acronyms used:	

NHS Improvement

7 June 2018

Sent via email to:
Ms Ingrid Barker
Chair
2gether NHS Foundation Trust
Ingrid.Barker@glos-care.nhs.uk

Ian Dalton
Chief Executive
NHS Improvement
Wellington House
133-155 Waterloo Road
London
SE1 8UG

Email:
enquiries@improvement.nhs.net
Tel: 0203 747 0000

www.improvement.nhs.uk/

Dear Ingrid

2018/19 Operational plan feedback

Thank you for the submission of your Board-approved operational plan for 2018/19. This letter follows NHS Improvement's review of that plan and highlights next steps.

It is critical that each trust meets the commitments in its annual plan to deliver safe, high-quality services and the agreed access standards for patients within the resources available. Our central commitment to delivering a strong provider landscape can only be achieved through your success and a robust set of plans, and wherever possible we will work to support you to deliver the ambitions set out in your plan.

To this end, as part of the assurance of your plan NHS Improvement has reviewed your submission and set out below some key elements of your plan that require further review and follow up action. Should your Trust wish to make any further amendments to the plan already submitted, NHS Improvement have put in place the facility for a further submission. The deadline for resubmission is 20 June and detail of the technical process for completing this will be sent to the Trust's key planning contacts shortly. The revised plan will then be used in national reporting from month 3 onwards and NHS Improvement will use your Board approved plan to monitor and assess your Trust's delivery during 18/19.

Activity, capacity and performance

Although there has been new additional investment into IAPT for 18/19 and both the Trust and its commissioners believe there is sufficient capacity and activity commissioned, we have concerns regarding the deliverability of the IAPT recovery plan and the trajectories shown in the plan due to known difficulties in recruitment. We expect the Trust to have assured itself that all practicable steps have been taken to support IAPT performance improvement and to track delivery closely throughout the year. We will review your Trust's IAPT recovery plan to determine next steps for oversight.

Agency

Agency expenditure is expected to remain within the agency ceiling in 2018/19, a c.24% reduction compared to 2017/18 outturn. Whilst the Trust took steps in late 2017/18 to reduce agency expenditure there will be a need for continued focus to deliver the position this year.

Next steps

Please confirm with your relationship management team by 18 June if you wish to make a further plan submission.

There are concerns nationally about whether providers have sufficient capacity to deliver the plans which have been submitted to date. We expect every Trust Board to ensure that appropriate demand and capacity planning has been undertaken by their organisation, the output of which provides assurance that sufficient capacity exists to deliver the plan submitted. We also expect that where bed closures are planned there are robust plans in place to offset the capacity reduction. Across the country we are aware that a lack of capacity in Mental Health services is resulting, on occasion, in patients in crisis being cared for in an inappropriate acute hospital setting. Increasing numbers of 12 hour breaches declared by A&E departments relate to Mental Health patients awaiting access to Mental Health inpatient beds or other Mental Health services. We expect the plans your organisation has submitted to reflect the capacity necessary to ensure that patients presenting at acute hospitals, requiring support from Mental Health services, (including access to inpatient care where necessary) do not experience significant delays in accessing appropriate care.

We would be grateful if by separate return you could send confirmation to your relationship management team that appropriate demand and capacity planning has been completed by your Trust, along with confirmation of the number of beds in place in your Trust as at 31 March 2018 and planned in each quarter thereafter through 2018/19.

We expect this letter to be shared with your Board and would ask that as part of the move towards greater transparency and closer system working you share it with your STP leadership.

If you wish to discuss the above or any related issues further, please contact Tim Beasley, Head of Regulation (tim.beasley@nhs.net) or your relationship management team.

Yours sincerely

Jennifer Howells
Regional Director
NHS Improvement and NHS England

cc Paul Roberts, Chief Executive Officer
Andrew Lee, Director of Finance
Spencer Prosser, Regional Director of Finance, NHS Improvement
Elizabeth O'Mahony, Chief Financial Officer, NHS Improvement
Tom Edgell, Interim Delivery and Improvement Director, NHS Improvement

2gether NHS Foundation Trust

PAPER I1

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Audit Committee

DATE OF COMMITTEE MEETING: 25 May 2018

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

INTERNAL AUDIT REPORTS

Annual Report and Head of Internal Audit Opinion
The Head of Internal Audit's opinion was that the work performed by the Trust was "generally satisfactory with some improvements required". The Governance, risk management and control in relation to business critical areas was generally satisfactory. However, there were some areas of weakness and/or non-compliance in the framework of governance, risk management and control which potentially put the achievement of objectives at risk. Some improvements were required in those areas to enhance the adequacy and/or effectiveness of the framework of governance, risk management and control. However, it was noted that the Trust had made good progress in strengthening its internal control environment during 2017/18 and there had been a positive direction of travel in terms of the number and severity of issues noted over the course of the IA reviews.

Internal Audit Annual Plan 2018/19
The internal audit plan is driven by the Trust's organisational objectives and priorities, and the risks that may prevent the Trust from meeting those objectives. The Audit Committee had received and provided comment on the draft plan at its April meeting and those changes and additions had been incorporated into the final plan. The Committee approved the Internal Audit Plan 2018/19.

Corporate Governance and Risk Management IA Report (Low Risk)
The governance structure of 2G and GCS's collaborative working arrangements were reviewed to determine if they were sufficient and fit for purpose. The report generated an overall low risk rating, and 2 low risk recommendations were identified. Actions were in place to address the 2 low risk recommendations that had been generated.

Procurement Procedures IA Report (Low Risk)
This report generated an overall low risk rating, with 1 medium risk recommendation identified. This related to the lack of defined roles and responsibilities for all stakeholders involved in the Procurement process. Actions were in place to strengthen procedures and the Committee received assurance that these actions had already been implemented.

FSS Core Financial Systems IA Report (Medium Risk)
This audit reviewed the design and operating effectiveness of key controls in place relating to the Core Financial Systems operating within NHS Gloucestershire Shared Services (GSS). The report generated an overall medium risk rating, with 2 medium risk and 1 low risk recommendations identified. The medium rated risks related to a significant lack of governance controls supporting the administration of VAT returns; and issues regarding the completeness and accuracy of authorised signatory lists. The Committee noted the actions in place to manage these risks.

POST BALANCE SHEET EVENTS REPORT

The Committee considered any events that had occurred since the start of April 2018 that would materially affect the accounts or going concern disclosure for 2017/18. The Committee approved the following proposed disclosure in the 2017/18 Accounts that "There are no events after the Balance Sheet Date that need reporting".

The Committee also considered and approved the going concern disclosures in the Statutory Accounts and the Letter of Representation.

FINAL ACCOUNTS AND CERTIFICATES

The Committee reviewed and approved the Statutory Accounts for the year ending 31st March 2018 on behalf of the Board.

The Committee expressed its thanks to Steve Andrews, Tanya Hartley and the Finance team for the work involved in completing these accounts. Thanks were also expressed to colleagues at KPMG for carrying out a very robust and thorough audit. 2gether had performed well and the huge efforts of all those involved in preparing the accounts and achieving the Trust's year-end financial position was recognised.

QUALITY REPORT

The Audit Committee approved the Quality Report 2017/18, taking account of the External Auditors review. The Quality Report would be included as part of the Trust Annual Report and would be submitted to NHSI by the end of May 2018.

This final draft of the Annual Quality Report summarised the progress made in achieving targets, objectives and initiatives identified, and had been collated following an extensive review of all associated information received from a variety of sources throughout the year. The Committee acknowledged the huge amount of work carried out to produce the Quality Report and noted that input had been received from internal and external stakeholders throughout the year in both Gloucestershire and Herefordshire, and their formal feedback would be published as part of the final report

The Committee noted the requirement that External Assurance on the Quality Report must provide a limited assurance report on the content of Quality Reports produced by Foundation Trusts. KPMG had reviewed the draft report for consistency and tested a number of mandated indicators - and had issued an unqualified audit opinion.

ANNUAL REPORT AND ACCOUNTS INCLUDING REMUNERATION REPORT

The Committee reviewed and approved the Annual Report 2017/18. The Trust's Annual Report was developed under guidance provided by the UK Government and NHS Improvement and the report had been reviewed by Trust Executives and by our auditor, KPMG.

The Committee agreed that the annual report demonstrated the huge efforts of staff to achieve targets and objectives, and significant assurance was received around the Trust's performance from the results of national surveys and reports.

ANNUAL EXTERNAL AUDIT REPORT – INCLUDING QUALITY REPORT AUDIT

The Committee received the Annual External Audit Report (ISA 260) from KPMG. The report summarised the audit findings and conclusions following the audit of the Trust's 2017/18 financial statements, annual report and quality report.

Financial Statements

The Committee noted that KPMG intended to issue an unqualified audit opinion on the accounts following the Audit Committee adopting them and receipt of the management representations letter.

KPMG had completed their audit of the financial statements and had read the content of the Annual Report (including the Remuneration Report) and reviewed the Annual Governance Statement (AGS). Their key findings were:

- There are no unadjusted audit differences.
- Minor presentational changes to the accounts have been agreed with Finance, mainly related to compliance with the Group Accounting Manual (GAM).
- In addition to routine requests, management representations over key management's assumptions in relation to the alternative site model are being requested.
- The Annual Report has been reviewed and there are no matters to raise.

Value for Money and Audit Certificate

Based on the findings of their work, KPMG concluded that the Trust has adequate arrangements to secure economy, efficiency and effectiveness in its use of resources.

Quality Report 2017/18

KPMG completed their audit of the Trust's Quality Report and issued the following statements:

- You have achieved a clean limited assurance opinion on the content of your Quality Report which could be referenced to supporting information and evidence provided. This represents an unmodified audit opinion on the Quality Report.
- We have also tested Out of Area Placements and Early Intervention in Psychosis (EIP) as the two mandated indicators. Our detailed testing on the indicators has concluded that we are able to give a clean limited assurance opinion on the presentation and recording of these. However, our testing on the EIP indicator identified minor updates required to be in line with the national reporting definition.
- Our work on the local indicator of personalised discharge care planning as selected by Governors has indicated that if we were to provide an opinion over the indicator we would provide a clean limited assurance opinion.

Over the course of the year, KPMG had made three Level 3 recommendations for 2gether to action. It was noted that these were low priority recommendations and related to changes to ensure best practice. These were noted.

Andrew Lee thanked KPMG colleagues again for their work, noting that this was their first year working with 2gether.

OTHER ITEMS

- The Committee received the "Considerations Prior to Approval of the Accounts and Risk of Material Misstatements" report and agreed that this offered significant assurance on the controls in place to guard against material mis-statements. The Committee considered the evidence presented and was satisfied as to the reliability of the Annual Accounts and the Letter of Representation.
- The Audit Committee approved the Letter of representation
- The Committee reviewed the Annual Governance Statement and approved the document for signature by the Chief Executive.
- The Committee received an updated, tabled version of the Statement of Chief Executive's responsibilities. This had been updated following guidance from KPMG. The Committee approved the Statement and this would be signed by the Chief Executive.

ACTIONS REQUIRED BY THE BOARD

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

SUMMARY PREPARED BY: Marcia Gallagher ROLE: Committee Chair

DATE: 18 July 2018

2gether Making life better

2gether NHS Foundation Trust

PAPER I2

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Development Committee

DATE OF COMMITTEE MEETING: 19 June 2018

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

ENGAGEMENT AND COMMUNICATION STRATEGY TACTICAL PLAN Q4 UPDATE

The Committee discussed the Q4 update for the Engagement and Communication Strategy tactical plan, and noted the progress made under the three main headings of Inform, Involve and Improve. The update set out key achievements during the quarter which included a 50% increase in volunteers recruited, and increased response rate to the staff survey, and the Trust's highest ever rating (90.52%) for staff recommending the Trust as a place to receive care or treatment. The Committee received a verbal update on a 'Function of Engagement' document which had been produced by the Programme Management Executive, and which would be presented to the Executive Committee in due course. The Committee noted that the Social Inclusion Annual report, which would be received by the Board, would include updates on many of the engagement issues covered in this tactical plan report. The Committee approved terms of reference for the Stakeholder Committee, which had been updated as part of a scheduled review, and to reflect the need to engage particularly with minority ethnic and seldom heard groups.

RESEARCH

The Committee received a verbal update on research developments. Two commercial trials in which 2gether had been involved had now closed as the companies had met their threshold target. The Trust had screened some 900 patients for the CREAD2 study, and this had resulted in 2 patients being recruited to this international trial. The Trust had been commended by the company for its handling of the process. The Trust had not been able to recruit any patients to the other study. One further study was in the pipeline and the Trust's involvement would be confirmed following a site visit by the company in the coming weeks. The Committee noted that the draft Cobalt report received at its last meeting had been well received by the Cobalt Board of Directors. The report comprised a review of the partnership between 2gether and Cobalt over the past 18 months. The review covered studies undertaken by 2gether's Research Team in association with Cobalt for the benefit of dementia patients and their carers; further developments; and engagement and communication activities to meet the objectives of the partnership.

The Committee noted that the Head of Research was now in post, and that interviews were planned to recruit a new Director of Clinical Research. The Committee welcomed the work done by the research team and asked that the team be added to the schedule of Board visits when this was next drawn up. The Committee approved terms of reference for the Research Overview Committee.

CAPITAL EXPENDITURE

The Committee received the month 1 update for capital expenditure which showed expenditure at £109k against a forecast of £50k. The Committee noted the difficulty in profiling expenditure, but was assured that the Trust planned to spend the full £5.6 million allocated. However, this expectation was based on progressing major schemes; should these not progress to schedule, the anticipated spend may be lower that £5.6m. The Committee would monitor variance against forecast at each meeting, and asked that the capital report be amended to clarify further forecast and actual expenditure.

DEVELOPMENT COMMITTEE ANNUAL REPORT

The Committee received the draft annual report outlining its activities during 2017/18 in delivering against the Committee's terms of reference. This was the first full year of operation under the Committee's revised remit. The Committee noted the work done and endorsed the annual report for presentation to the Board (Appendix A).

ACTIONS REQUIRED BY THE BOARD

The Board is asked to note the content of this report, and specifically the Committee's annual report.

SUMMARY PREPARED BY: Duncan Sutherland ROLE: Committee Chair
DATE: 19 June 2018

2gether NHS Foundation Trust

Development Committee Annual Report 2017-18

1 Introduction

1.1 The Development Committee was established to hold the Executive Directors to account in order to provide assurance that proposals for service development, meet the current and future needs of the Trust, patients and the local health and social care economy, and that engagement and other relevant enabling activities to inform and achieve these service developments have been considered. In carrying out its role, the Committee has regard to relevant regulatory and contractual requirements, and national and local standards of good practice and equality and diversity as well as the views of service users, carers and staff.

1.2 Two designated Non-Executive Directors are members of the Committee, along with the Director of Finance and the Director of Engagement and Integration, who is the designated lead Executive Director for the Committee. The Trust Chair and Chief Executive are *ex officio* members of the Committee and may attend meetings as they see fit, as may other Non-Executive Directors.

1.3 The Trust Secretariat is in regular attendance at the meeting to produce the minutes. A number of officers attend regularly, while others attend less frequently, for example when there is a relevant item of business on the agenda. The Committee Chair provides a summary report of the Committee's activities to the next Board meeting.

1.4 The Committee met 5 times in 2017-18, in order to discharge its duties as set out in the Committee's Terms of Reference. Each meeting was quorate.

1.5 Attendance by members and others at the Committee during the period is shown in the table at Figure 1 below.

Figure 1: Attendance	**2017**				**2018**
	17 May	16 August	18 October	13 December	7 February
Jonathan Vickers (Chair)	✓	✓	✓	✓	✓
Duncan Sutherland (Vice Chair)	✓	✓		✓	✓
Andrew Lee, Director of Finance			✓		✓
Jane Melton, Director of E&I	✓	✓	✓	✓	✓
Stephen Andrews, Deputy Director of Finance**	✓	✓		✓	
Marcia Gallagher, Non-Executive					✓
Colin Merker, Director of Service Delivery			✓		
John McIlveen, Trust Secretary		✓		✓	✓
Anna Hilditch, Asst. Trust Secretary	✓				
Lisa Evans, Board Committee Officer	✓	✓	✓	✓	✓
Alan Bourne-Jones, Risk Manager		✓		✓	
Lauren Edwards, Deputy Director of Engagement	✓	✓			✓
Kate Nelmes, Communications Manager	✓				
Jen Green, Head of Contracts		✓			✓
Said Hansdot (Governor)	✓	✓			✓
Euan McPherson (Governor)				✓	✓

*** Stephen Andrews attended the Committee to deputise in the absence of the Director of Finance, and was therefore recorded as a full member of the Committee on these occasions*

2 Principal Review Areas

2.1 Terms of Reference and Committee Remit

2.1.1 As reported in last year's Annual Report, work took place during 2016 to review the remits of some of the Board's Committees, in order to align the work of those Committees more closely to the Trust's agreed strategic priorities. The remit of the Development Committee was subject to the greatest change, moving from an oversight and assurance role in terms of commercial business development to one of assurance around engagement and sustainability in terms of service development and redesign, both internal and external. In particular the Committee now seeks assurance that proposals for service development (including those originated by task and finish groups established by the Executive Committee), are fit for purpose and have been the subject of appropriate engagement with stakeholders. The responsibility for the oversight and monitoring of capital expenditure was also transferred to the Executive Committee.

2.1.2 During 2017/18 discussions took place regarding the revised arrangements for monitoring capital expenditure, and it was agreed that there was a need to consider the mechanisms for increasing Non-Executive Director oversight of this outside formal meetings of the Board. On reflection, the Board agreed at its March 2018 meeting that the monitoring of capital expenditure would revert back to the Development Committee, and revised terms of reference setting out this change were subsequently approved.

2.1.3 The frequency of Development Committee meetings changed at the start of 2017 to bi-monthly, while recognising that the Committee may convene between scheduled meetings in order to conduct any urgent business.

2.2 Review of Strategies

2.2.1 A key part of the Committee's role has been to provide oversight of a number of the Trust's key enabling strategies. During the year the Committee has overseen the development and/or review of the following strategies:

- Finance Strategy (August 2017)
- Corporate Strategy (August 2017)
- Commercial and Partnerships Strategy (February 2018)
- Quality Strategy (February 2018)

2.2.2 The Committee's involvement in the development of these key documents has ensured that each is aligned with the strategic priorities of the Trust, and presents sufficient clarity, ambition and direction to support the Trust's achievement of its strategic plan objectives. A particular focus for the Committee has been to ensure each strategy is appropriately aligned not only to the strategic plan, but also to other strategies, and in particular to cross-functional strategies such as Organisational Development. The Committee has also sought assurance that staff and other appropriate stakeholders have been adequately engaged in the development of each strategy. Refinements to these strategies suggested by the Committee have ensured that time spent by the Board is focussed on larger strategic considerations rather than line by line review and correction when approving these strategies.

2.2.3 Once approved by the Board, the Committee undertakes a review of each strategy after 2 years or sooner if changes in the external environment, health economy or the Trust's strategy make a change necessary before the scheduled review date. These reviews ensure that strategies remain fit for purpose and aligned with the strategic direction of the Trust. However, in relation to strategy development overall, the

Committee agreed that it would be sensible to pause all but those strategies which were needed urgently, pending further clarity on the merger with GCS. This was subsequently approved by the Board.

2.3 Research Developments

2.3.1 By way of providing better assurance and oversight of the Trust's Research activity, the Development Committee now receives a quarterly research update. The Chair and Deputy Chair of the Development Committee are also listed as ex-officio members of the Research Overview Committee, in order to receive papers and to attend the meetings on a periodic basis.

2.3.2 Key research developments and activity during 2017/18 included:

- An engagement with the CEO at Cobalt aimed at staff involvement in dementia care research.
- An AHPP Conference was held on 6th October and this was well attended with presentations from the Trust's Head of Research and Development, from Professor Crone at the University of Gloucestershire and from a Speech and Language Therapist from GCS who was also a research fellow with National Institute for Health Research.
- Regular meetings with the Head of Research and Development are held to discuss priorities, including team capacity and future research studies and commercial clinical trials.
- A new Director of Clinical Research was appointed, on a one day a week year-long contract.
- 2gether was selected as a partner site to undertake the TACKling chronic depression (TACK) study which was an academic study being led by East London NHS Foundation Trust research over a 5 year period and income would come in to the Trust to pay for the project.
- Good progress had been made against the objectives set out in the Research Strategy Tactical Plan. The Committee noted that £4k funding had been awarded to the Trust by the Clinical Research Network (CRN) who were investing in good performing Trusts. This could lead to a 25% increase in investment in the next financial year.
- An updated Research Risk Register had been reviewed
- Commercial Trials with pharmaceutic companies had commenced this year.
- The KPIs set by the local NHS research commissioner, the West of England Clinical Research Network, had been achieved and an increase in research funding allocation had been provided to 2gether as a result.
- The Committee reviewed finances associated with the research portfolio.

2.3.3 The Development Committee asked that an annual update of research activity be provided to the Trust Board and a report was prepared and presented at the May meeting.

2.4 Engagement and Communication

2.4.1 The Development Committee has the lead oversight for implementation of the Engagement and Communication strategy and receives regular updates on progress with the objectives and actions set out in the associated Tactical Plan. The plan focuses where possible on measurable engagement indicators.

2.4.2 Some examples of recent engagement activities included;

- Presentations had been made to NHS Improvement, to Local Councillors in Gloucestershire and Herefordshire and to the Rotary Club.

- Conversations were taking place with Public Health Gloucestershire about extending the scope of the Tackling Stigma work through a bid to Time to Change.
- The Director of E&I had represented 2gether and other local agencies working in Mental Health at a reception at Buckingham Palace on World Mental Health Day. The prestigious event was held to acknowledge significant campaign work undertaken to tackle the stigma around mental illness.

2.4.3 More work is being carried out to look at the development of a system of measuring engagement with the Trust's internal newsletter, ByteSize, and increase readership through the year. The introduction of an audit tool was being planned which would enable the Communications Team to measure 'clicks'.

2.4.4 The Development Committee has received significant assurance throughout the year on progress against the Engagement and Communications Strategy tactical plan.

2.5 Stakeholder Committee

2.5.1 The Committee received and approved the TOR for the Stakeholder Committee (formerly the Service Experience Committee), which would report in as a formal sub-Committee of the Development Committee. The Chair and Deputy Chair of the Development Committee were listed as ex officio members of the Stakeholder Committee, and would aim to attend at least one meeting of the Stakeholder Committee annually, once the Committee was well established.

2.6 Scrutiny of Business Cases

2.6.1 The Committee received the updated "Procedure for Business Cases" which had been revised as a key recommendation arising from the Pullman Place (Gloucester Hub) Review. The Executive Committee would approve all Business Cases for Capital and Revenue projects going forward; and these decisions would then be reported through the Development Committee.

2.7 Other matters worthy of note

2.7.1 In line with other Board Committees, the Development Committee has throughout 2017/18 received quarterly reports on the risks allocated to it for monitoring and assurance. In addition the Committee follows up risk items previously identified to ensure that it remains informed of progress against previously agreed actions. A rolling programme of actions is maintained and monitored accordingly for all Committee meetings. Currently the Development Committee does not own any of the Top 5 Risks.

2.7.2 The Committee received the draft Service Plan for 2018/19, and suggested that the timetables for service planning ought to allow for earlier consideration of draft plans by the Board, to enable Governors to then consider a more complete version. The Committee also asked that Governors have early sight of the plan ahead of the next scheduled Council of Governors' meeting, so as to be able to read and comment on the document at the meeting. This was actioned and Governors commented that they had found it helpful to receive the draft plan in a more timely way to enable them to read and feel able to provide comment on the proposed service objectives.

3 Conclusion

3.1 This report gives an overview of the work of the Committee in delivering against the Committee's Terms of Reference. Its work during the year has enabled the

Committee to recognise good work and achievements and provide more robust assurance on matters to the Trust Board.

PAPER I3a

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Delivery Committee

DATE OF COMMITTEE MEETING: 23 May 2018

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

U18 ADMISSIONS TO ADULT ACUTE WARDS

The recorded number of children and young people who were admitted to adult mental health wards in the year 2017/18 was noted. The report profiled the reason for admission, length of stay and the onward inpatient journey and compared data collated for 2016/17 and 2017/18. The Trust reported 11 inpatient admissions during 2017/18: 5 CYPS Gloucestershire cases and 6 CAMHS Herefordshire cases. The total number of bed days for 2017/18 was 85, the average length stay on ward was 7.7 days.

PERFORMANCE DASHBOARD

Outturn Performance Dashboard Report for the contract year 2017-18

Of the 139 reportable measures, 123 were compliant and 16 were non-compliant at year-end. Of the remaining 40 indicators, 9 were for baseline information to inform future reporting, 7 had either no activity or insufficient activity recorded against them during the year to support reliable performance reporting and 24 were not yet available of which 20 were new Gloucestershire CCG Contractual measures. The Information Department was working with services to ensure data capture and reporting processes which would enable performance against these indicators to be reported during 2018/19.

Performance Dashboard for the Period to the end of April 2018

Of the 202 performance indicators, 89 were reportable in April with 79 being compliant and 10 non-compliant at the end of the reporting period. Where performance was not compliant, Service Directors were taking the lead to address issues with a particular focus continuing to be on IAPT service measures.

E-ROSTERING UPDATE REPORT

The Committee received an update on the implementation of electronic rostering (eRostering), across inpatient services. Key highlights included NHSI's 90 day Improvement initiative implemented by 2gether, subsequent action plans, associated financial efficiencies and future development. The report also demonstrated the increased demand within the eRostering service since commencement.

HR INDICATORS

The Committee received an update on Q4 performance against the Trusts Workforce Key Performance Indicators (KPI).

Compliance for statutory and mandatory training had reached an average of 89% for Q4 2017/18. Managers and staff continued to work hard to enhance and develop the Learn2gether system and in April 2018 the system was upgraded with improvements to ensure it remained in line with end user requirements. The Committee noted that the target of 85% for Q4 2017/18 had been met and exceeded.

Appraisal compliance had remained above the target of 85% for the last 3 months. The Q4 average compliance was 89%; 4% above the compliance achieved for the same period in 2016/17.

Sickness absence had decreased for both in-patients and other services during February and March 2018 allowing the target to be met in March for both areas. However, in March 2018 the Trust 12 month rolling average sickness absence rate was 5.04% which was 0.13% above the same period in 2017. It was anticipated that continued monitoring and support for managers and staff would help to reduce sickness further over time. Additional breakdown of sickness absence would be provided in the next

report with short/long term absence separated.

Turnover was monitored on a monthly basis and although there was no key performance indicator for turnover it was important to ensure that turnover was maintained within reasonable levels. The Trust maintained a good performance for turnover with Q4 2017/18 reporting at 9.40% compared with a national average of 11.4%.

LOCAL SECURITY MANAGEMENT SERVICES (LSMS) ANNUAL REPORT

Last year (2017/18) had seen a significant increase in the reporting of incidents of violence and aggression (V&A). Whilst this could be perceived as negative, the Committee agreed that it was positive that staff now felt encouraged to report incidents. Robust action had been taken wherever it was perceived that the assailant had capacity and the act had been deliberate resulting in around 25 successful prosecutions or "sanctioned police resolutions" (caution etc.). Throughout the year work had progressed on working with teams to ensure that they had all completed their V&A risk assessments. The next phase was for the teams to provide assurance that their staff had all read the assessments; these results would be shared via the health and safety audit results later this year.

The Committee noted the report previously submitted to the Security Resilience Board and ratified the Security Management Strategy for the period 2018-21.

IAPT SERVICE IMPROVEMENT PLAN

The report identified risks relating to the delivery of the Trust's agreed recovery plan. The key issues included:

- In stage waiting list backlog clearance: The change in recording methodology and the reclassification of assessment appointment to assessment / treatment appointments moved the majority of the waiting list to in stage waiting for a second treatment appointment. The Service was now actively managing this backlog using agency staffing and digital provision.
- Access rates in Gloucestershire for April 2018 were met and were just below target for Herefordshire. Maintaining access rates for 2018/19 would present a significant monthly challenge.
- Recovery rates for April 2018 were above the national 50% target for Gloucestershire and just below for Herefordshire.

IAPT funding for 2018/19 was now clearer in both counties. In Gloucestershire recurrent funding for a range of new developments in 2018/19 had been agreed. This included £540k recurrent investment required for IAPT to achieve the 19% Access rate. The full year commitment of recurrent funding would be honoured by the CCG in 2019/20 and onwards. Additionally, £300k had been secured to address the current waiting list backlog. In Herefordshire recurrent funding of an additional £295k had been agreed to achieve the 19% Access rate.

Recruitment remained a challenge. However, a full time IAPT Clinical Lead for Gloucestershire and Herefordshire had been appointed and an additional locality clinical lead would be appointed in Gloucester city to strengthen leadership.

OTHER ITEMS

The Delivery Committee also received and discussed:

- The Trusts IT Delivery Plan 2017/18 - 2020/21 was received and the Committee noted that this was progressing work to support service delivery and the business objectives of the Trust overall.
- The Procurement Annual Report 2017/18 was received and noted
- The Heatwave Plan Assurance Report was received and the Committee was significantly assured of the of the systems, processes and controls in place to ensure the Trust was prepared for and able to respond to prolonged periods of excessive heat.
- The Committee received the locality exception reports from the Gloucestershire Localities and the Countywide Service Directors
- The Committee reviewed the Trust's Top 5 risks, noting that these were reviewed and updated by the Executive Committee before being reported to each Board Committee. There were no Top 5 risks for the Delivery Committee.
- The Committee received a report setting out the ongoing challenges with demand and capacity within CYPS and CAMHS services

PAPER I3b

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Delivery Committee

DATE OF COMMITTEE MEETING: 27 June 2018

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

STAFF SURVEY RESULTS

The Committee received an overview and analysis of the most recent 2017 NHS Annual Staff Survey which had been sent to all staff in post on 1st September 2017. The results were published in March 2018. Nationally 487,227 NHS staff members took part. The Trust's response rate was 45%, a 5% improvement on last year. The number of respondents rose from 777 to 921. While this was a great improvement, the rate still remained lower than the national average for Mental Health Trusts (26 organisations) of 52%.

The survey responses were grouped into 32 Key Findings. Staff rated us as follows:

- Better than average in 17 Key Findings (53%)
- Better than average or average in 27 Key Findings (84%), and,
- Worse than average in 5 Key Findings (16%)

The score for overall staff engagement (3.88) remained steady but the component parts that made up this result were all shown to be better than average (3.79). Overall staff engagement within the wider NHS nationally had declined for the first time since 2014, and although staff engagement remained steady at the Trust there was a risk that this could go down following the merger. The Committee noted that currently GCS's scores were significantly lower than this Trust's. There was a Working Group looking at where learning could be shared.

The Trust was focusing on three priority areas corporately over the coming year. These included:

- Improving Staff Health and Well-being
- Improving Reporting of Incidents
- Making more effective use of patient and service user feedback

PERFORMANCE DASHBOARD - Period to the end of May2018

Of the 202 performance indicators, 90 were reportable in May with 80 being compliant and 10 non-compliant at the end of the reporting period. Where performance was not compliant, Service Directors were taking the lead to address issues with a particular focus continuing to be on IAPT service measures.

LOCALITY EXCEPTION REPORTS

In Herefordshire during April, 273 bank and 64 agency shifts were worked, a ratio of 81:19. Agency and bank shifts for the wards increased by 9.5% compared to March. The main pressures on the service were around agency usage. The Committee noted that of the M1 pay spend on the three Stonebow wards, 35% related to expenditure on temporary staffing. Significant work was taking place to manage e-rostering, recruitment and bank and agency use to reduce spends across the unit. This was balanced against high levels of acuity at present. The Executive Committee would be asked to provide assurance around the scrutiny of medical locum spend.

The Trust was looking at it how it could incentivise people to choose to work in Herefordshire; however it was also important that the Trust developed its own staff. A discussion may be required with Herefordshire CCG around how to create a sustainable work force in the area.

CAMHS Locality (Herefordshire)
The relocation of the CAMHS team from the Linden Centre to Belmont was ongoing. The team was ready to move and would look to move in the school summer holidays to limit any disruption. A briefing had been prepared for the Council of Governors to address the issues raised around transportation and location.

IAPT SERVICE IMPROVEMENT PLAN

This report identified risks relating to the delivery of the Trust's agreed recovery plan. The key issues for the Committee to be aware of this month were:

- In stage waiting list backlog clearance: The change in recording methodology and the reclassification of assessment appointment to assessment / treatment appointments moved the majority of the waiting list to 'in stage waiting' for a second treatment appointment. Recovery plans had been modelled in both counties to reduce the backlog waiting list. These plans would require additional investment or a reduction in Access rates which was to be discussed with Commissioners.
- Access rates in Gloucestershire for May 2018 were met and were just below target for Herefordshire. Maintaining Access rates to our plan for 2018/19 would present a significant monthly challenge – largely related to staffing capacity.
- Recovery rates for May 2018 were above the national 50% target for Gloucestershire (55.4%) and below for Herefordshire (42.1%). A focussed piece of work had been undertaken in Herefordshire to address the recovery rate issue, which had subsequently improved to above the 50% national target.
- Waiting time thresholds – Nationally, waiting time thresholds were reported against 2 measures (First Treatments and Discharges). Trust performance against these targets in May 2018 was noted.

The Committee received good assurance around the Trust's understanding of the IAPT position; noting that a lot of good work had been carried out with the information team on data.

Digital access was moving forward. This therapy had been proven to work and documents had been acquired from another Trust where they had been used successfully. The digital option would help to avoid travel; providing easier access to services for service users and the possibility of therapists working from home particularly during bad weather. The service could provide a combination of face to face clinical work and over skype.

PERSONALITY DISORDERS PRESENTATION

The Committee received a presentation on personality disorders. Personality Disorders was a category of mental health, difficulties which originated early in life and persisted through every area of life including work, social, community and family settings.

It was reported that 4.4% of the general population had a personality disorder and 4 - 6% of those in primary care had Borderline PD. 0.7 - 2% of the general population had Borderline personality disorder. More females than males had borderline personality disorder; however, it was noted that Borderline Personality Disorder could present as other forms of mental illness. Those with personality disorders would often present with substance misuse issues or eating disorders; they would be known to the Criminal Justice system and were more likely to self-harm or attempt suicide (60-70% attempt suicide and 9-10% complete suicide).

The Committee noted that management of personality disorders involved regular appointments with MH professionals, coping skills for anxiety management, current problems focus, utilising effective strategies from past episodes and enabling instead of prescribing. There was no medication or treatment for Borderline personality disorder and GPs were advised to treat the symptoms while limiting the use of medication. There were no specialist personality disorder services available at 2gether; however, it was noted that there was no evidence that a dedicated service would improve outcomes.

OTHER ITEMS

- The Committee received a verbal update on Financial Performance at the end of May 2018. The Trust Board would now meet every other month and it had been agreed that assurance around financial performance would be presented at the Delivery Committee in the intervening months.

- The Committee received the review of progress for Q4 against the Trust Service Plan Objectives for 2017/2018. Overall, at the end of Q4 2017/18, there were 2 Red, 5 Amber and 41 Green objectives, which was a significant improvement on the same quarter the previous year.
- The Committee received a report on Demand Management in Crisis /MHARS. The Committee noted that with the exception of response times, all the indicators were being met.
- The Committee received an update on new and revised HR Policies and procedures. All policies had been reviewed and agreed by the director responsible and were now scheduled to be ratified by JNCC formally at its next meeting in July 2018. In view of the merger taking place, it was reported that there was a joint 2Gether/GCS trade union meeting taking place next month and a meeting was to take place with solicitors around harmonisation and management of change. The HR Working Group was already undertaking work on merging policies.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to note the content of this report, and specifically the assurances received around the financial position.

SUMMARY PREPARED BY: Maria Bond **ROLE: Chair**
DATE: 18 July 2018

PAPER I4

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Governance Committee

DATE OF COMMITTEE MEETING: 29 June 2018

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

PATIENT SAFETY AND SERIOUS INCIDENT REPORT

The Committee received an overview and analysis of serious incident reporting to commissioners and high level monthly trend analysis, including Never Events. There had been 4 new serious incidents (SIs) reported during May 2018. 3 SIs were reported for Gloucestershire and 1 in Herefordshire. No Never Events had occurred within Trust services and the Committee was significantly assured that the Trust had robust processes in place to report and learn from serious incidents.

The Committee noted the good progress made in the closure of SI actions, noting that the 2016/17 action plan was now fully complete which was excellent.

INFORMATION GOVERNANCE ANNUAL REPORT

The Committee received the 2017/18 Information Governance Annual Report. An update on IG training compliance and a change in the timescales for reporting of incidents was noted.

There had been a significant increase in the number of FOI requests received during the year. This increase and the subsequent impact on staff resources was highlighted as a key issue. It was noted however, that 2gether was one of the top performing Trust's locally in terms of FOI response rates.

AGGREGATED LEARNING REPORT

The Committee received the second edition of the Aggregated Learning Newsletter. It was suggested that the Top Tips for Staff section be updated to include the need to be aware of changes in risk. The Committee discussed the "low risk paradox" and the current approach to risk within the Trust. It was agreed that work would be carried out to review this approach and to see what other organisations had adopted.

The Committee asked that a rolling programme of sessions take place at future meetings, with operational colleagues being invited to attend and present on how they were embedding some of the aggregated learning work into practice.

NHSLA CLAIMS

It was reported that 2gether currently had 15 open claims; 8 non-clinical and 7 clinical. Assurance was received that detailed discussion about claims took place at the Executive Committee, where these were robustly monitored.

OTHER ITEMS

- The Committee received an update on Learning from Deaths, noting that a report had been received at both the Board and the QCR Committee. The resource requirements and time

commitment for carrying out this work was highlighted.

- The Committee reviewed its key risks, noting that of the Top 5 organisational risks, 3 of these had been allocated to the Governance Committee for oversight. The Committee discussed Medical staffing and it was noted that this was monitored and would be reported via the Temporary Staffing report received at the Committee. A meeting would be set up to drill down in more detail to the new risks that had been identified.
- The Committee received the Greenlight Toolkit and acknowledged the excellent work taking place.
- The Quarter 4 Service Experience report was received and the areas of assurance were noted. The full report would be presented at the July Board meeting.
- The Committee received the first annual report from the NED Audit of Complaints. It was agreed that this was a helpful report, which would be presented to the Board. The key theme identified from the audits related to learning and more was still needed to see whether this learning had been embedded.

ACTIONS REQUIRED BY THE BOARD

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

SUMMARY PREPARED BY: Nikki Richardson **ROLE: Chair**

DATE: 18 July 2018

PAPER I5

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Charitable Funds Committee

DATE OF COMMITTEE MEETING: 11th July 2018

KEY POINTS TO DRAW TO THE BOARD OF TRUSTEE'S ATTENTION

CHARITABLE FUND EXPENDITURE REQUESTS

The Committee received 2 requests for Expenditure:

- To undertake improvements to the Wotton Lawn Hospital main courtyard garden and to provide a variety of outdoor gym equipment for patient use at a cost of £43.4k
- To upgrade and improve Charlton Lane Hospital main reception inner courtyard garden and Chestnut Ward garden. The reception courtyard garden improvements were estimated at £25.2k, Chestnut Ward garden improvements were estimated at £5.52k.

The Committee agreed the principle of both requests, however, some elements of the requests related to the fabric of the building and the Committee questioned why this was not being funded through the Capital Programme. The Committee was supportive of paying for enhancements but not for fixed works. It was agreed that the Capital Review Group would be asked to cost any necessary fixed costs for both requests which should be allocated to the Capital Programme with the Charitable Fund to pay for the enhancements. The Chair of the Charitable Fund would be asked to approve the spending outside of the meeting once the funding split had been agreed. The Committee noted that there would be £2.3k of recurring costs for the Wotton Lawn Outdoor Gym which would need to be added as a cost pressure.

The Committee noted that a legacy of £68.5k had been received by the Charitable Fund and it was felt that the Outdoor Gym would be an appropriate use of that money. Consideration would be given to how those responsible for the estate which provided this legacy could be acknowledged.

UPDATE ON THE FUNDRAISER PROPOSAL

It was reported that although there was some initial interest, no formal tender had been received for the fundraiser post. The Committee asked for further feedback at the next meeting on what it was felt had put people off applying.

The Committee noted the options for moving forward with the fundraiser position which included re-advertising the tender or offering the post as a senior position on a fixed term basis. The Chair expressed some concerns about offering the position as a fixed term post and recommended waiting until after the summer then look to employ a recruitment professional. The Committee agreed that the Executive Committee would be asked to consider all options again and make recommendations on how to move forward.

ACTIONS REQUIRED BY THE BOARD OF TRUSTEES

The Board of Trustees is asked to note the content of this report.

SUMMARY PREPARED BY: Duncan Sutherland ROLE: Chair

DATE: 19 July 2018

2gether NHS Foundation Trust

PAPER I6

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Mental Health Legislation Scrutiny Committee

DATE OF COMMITTEE MEETING: 11 July 2018

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

CQC REVIEW OF USE OF THE MHA – GLOUCESTERSHIRE PERSPECTIVE

The Review of the use of the MHA for Gloucestershire was likely to be completed in the autumn and a report would be brought to the November meeting.

UPDATE ON AMHP COVER

It was reported that out of hours support would be provided by the Local Authority Emergency Duty Team (EDT). However, recruitment was an issue in the service and discussions were taking place at a high level in the Local Authority. A proposal had been made to secure current funding and it was anticipated that this would be successful. The EDT was being supported in finding locum AMHPs for out of hours cover. A written report on Gloucestershire AMHP cover would be received at the next meeting along with an update on Herefordshire AMHP cover.

KEY PERFORMANCE INDICATORS

Key performance information for January – March 2018 was provided to enable the Committee to monitor compliance with the Mental Health Act and Code of Practice. The Committee was assured by the information provided and noted the trends which may require further investigation in the future. The Committee also considered whether any differences between Gloucestershire and Herefordshire should be followed up.

The trend for use of Section 136 in Herefordshire was downward; however numbers of those detained remained static. The difference in the trends in both counties was noted; although the numbers involved were very small and the services offered were different. The Committee asked the Operations Group to review how holding powers were used in each county and report back to the next Committee.

REVIEW OF (CQC) INPATIENTS MONITORING VISITS

For the period 1 February 2018 to 29 June 2018 there had been unannounced CQC visits to Charlton Lane Hospital, Mulberry Ward and to Stonebow Unit, Mortimer Ward. Areas of good practice identified by the CQC in recent visits and areas judged to have not been managed following previous visits were noted.

The Committee was concerned that past actions identified at Mortimer Ward remained unresolved. A sub group had been set up in Herefordshire to look at these actions and it was agreed that Leigh Clarke would provide assurance to the Committee that learning had been embedded into practice.

The Committee was significantly assured that systems and processes were in place to review, measure, analyse, improve and monitor the Trust's compliance with CQC monitoring framework, Domain 2: Detention in Hospital**.**

REVIEW OF ISSUES ARISING AT MHA REVIEWS

Two MHA Managers Hearing issue forms had been received by the MHA Administration Team between 21st February 2018 and 27 June 2018, issues raised, included:

- Attendance and Reports
- Treatment
- Reports

All of the issues raised had been reviewed and investigated. Actions to address shortfalls or improvements in processes, structures, procedures, practice or lines of accountability were documented and monitored.

The Committee agreed that there was significant assurance that processes and structures were in place to manage and monitor MHA Manager issues.

ROLLING AUDIT OF DETAINED PATIENTS AND THE REMINDER OF THEIR RIGHTS

The Committee received an audit of the recording of the provision of rights to patients subject to the Mental Health Act. Compliance rates for both detained and CTO patients showed an upward trend. In inpatient units there was a record of 94% of detained patients having been informed of their rights and 81% of these reminders were made within Trust policy timescales.

In community teams there was a record 87% of CTO patients having been informed of their rights since starting on their current CTO. 50% of CTO patients were recorded as having been reminded of their rights within Trust policy timescales. 50% of CTO patients had no up-to-date record of a reminder and 27% of these had no record of having been informed of their rights since their CTO started. The remaining 73% had a recorded reminder which was outside the Trust policy of 2-monthly.

It was noted that the reminder of rights was not always recorded in the right place on RiO and Locality representatives would take this issue back for discussion at Locality Boards.

The Committee agreed that there was a significant level of assurance of the provision/reminder of rights to detained inpatients but a more limited level of assurance in relation to Community Treatment Order patients.

MHA POLICIES – MHLSC MONITORING

The Head of Health Records had checked the health records of a random selection of CTO patients for evidence of carers'/relatives' concerns being acted upon. The health records of 20 (out of 54) current CTO patients had been reviewed and no evidence of concerns being made and not followed up was found.

HEALTH BASED PLACE OF SAFETY ASSURANCE REPORT

The Committee received a report on the Health Based Place of Safety. There appeared to be a downward trend for detentions for 2017/18 with a 30% reduction in detentions in comparison with the same quarter of 2016/17. However, it was noted that since the introduction of the MH triage car there had been a reduction of around 20% in activity over the 11 month period. The Street Triage Scheme and the work of the High Intensity Case Worker in reviewing repeat attendees had had a positive impact on attendance at the Place of Safety.

The Committee noted that no detentions required additional holding time. Appropriate protocols had been put in place by the Trust and Gloucestershire CCG and detentions were being well-managed.

IMPACT OF THE STREET TRIAGE SCHEME

The Committee received an update on the impact of the Street Triage Scheme. There had been a significant increase in S136 detentions in 2016/17 and the initial plan of staff co-located in Police HQ Control Room had limited affect. The feedback from the police was that staff were reluctant to make decisions over the phone and evidence from Leicester Model suggested that the presence of an MH Clinician at the scene had better results.

The Street Triage Scheme commenced in June 2017. The Scheme covered the whole county of Gloucestershire; it was operational Monday – Thursday 14:00 – Midnight (these hours were found to be when the scheme was most needed). The Street Triage Scheme was staffed by 1 band 6 Nurse from a small pool of trained staff and 1 response officer. The nurse had access to RiO on the road.

It was reported that 60% - 70% of people seen were currently open to a MH Service and that around one third of all calls received had threatened suicide. The benefits of the scheme included the reduction of S136 detentions including those by Frequent attenders, an increased confidence of officers to deal with MH incidents, better outcome for Service users and improved working relationships with front line Police officers.

The Committee noted that the number of calls to the Police remained the same but the reduction in detentions was due to the High Intensity Worker providing an evaluation at 1st point of contact. There was no evidence to suggest that those managed in the street had a worse outcome.

UPDATE FROM THE OPERATIONAL GROUP

The minutes of the last meeting of Operational Group on 20th June 2018 were noted. The Terms of Reference of the Operational Group were approved at that meeting.

REPORTS OF ISSUES ARISING AT MHA FORUM

The forum had discussed placements and accommodation noting the reliance on the Local Authority panel. This prevented people moving quickly and discussions were taking place on how funding for placements could be managed, to ensure they were not delayed while funding splits were agreed.

The Forum's Terms of Reference were being discussed to ensure that time was well managed and key issues addressed at meetings.

ACTIONS REQUIRED BY THE BOARD

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

SUMMARY PREPARED BY: Duncan Sutherland ROLE: Committee Chair

DATE: 11 July 2018

Agenda item 15 **Enclosure Paper J**

Report to: Trust Board, 26 July 2018
Author: Ingrid Barker, Trust Chair
Presented by: Ingrid Barker, Trust Chair

SUBJECT: **CHAIR'S REPORT**

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

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

INTRODUCTION AND PURPOSE

Recognising the Strategic Intent work and my role as both Chair of ²gether and Gloucestershire Care Services this report format has been revised to reflect the breadth of my activities across both Trusts. The production of a joint report does not impact on my existing accountability as the appointed Chair of each Trust.

The Report also provides an overview of 2gether Non-Executive Director (NED) activity.

RECOMMENDATIONS

This report is for information and the Board is invited to note the report.

1. INTRODUCTION AND PURPOSE

This report seeks to provide an update to both Boards on Chair and Non-Executive Director activities in the following areas:

- Strategic Intent
- Board Development
- Working with our partners
- Working with our colleagues
- National and Regional Meetings attended and any issues highlighted

1.1 Strategic Intent Update – Moving towards developing an integrated physical and mental health care offer with Gloucestershire Care Services

[2]gether continues to work with GCS NHS Trust to take forward its ambition. The work is being overseen by the Strategic Intent Leadership Group with the operational processes being led by the Programme Management Executive. The Strategic Intent Leadership Group is focusing particularly on ensuring the focus remains on the two Trusts' overarching strategic ambition of delivering improved services for our service users as well as ensuring the required governance and programme processes are in place. The Group maintains an ongoing oversight on ensuring that stakeholders are fully involved in this key development and that their feedback informs and drives our plans.

Regular briefings to update colleagues on the Strategic Intent activity has continued to support ongoing engagement. [2]gether Governors have received a detailed briefing on their role in relation to the transaction. Governors will continue to be fully informed and engaged in the process.

I was pleased to support the Joint Chief Executive in hosting two stakeholder meetings to progress wider engagement in the Transformation theme. One was held in Gloucester at the Guildhall and the other in Hereford at the Kindle Centre.

1.2 [2]gether and Gloucestershire Care Services Trust AGMs –19th July 2018

The [2]gether NHS Foundation Trust AGM will be preceded by the Gloucestershire Care Services NHS Trust AGM. This will provide an opportunity to update on the planned merger and joint working plans as well as meeting both Trusts' individual statutory responsibilities. We are pleased to be hosted this year by our partner, the University of Gloucestershire, which has a key role to play in supporting the development of the future workforce required by both Trusts. As always, the AGM will showcase services and the work of colleagues.

1.3 Board Development

A **Joint Board Seminar** event took place on 28th June and a **Joint Board Development** session took place on 11th July. These sessions are an important part of the work we are doing to bring [2]gether and GCS together ensuring that our shared values stay at the heart of what we are working to achieve and that knowledge of both organisations is maintained and enriches our working practices. A full programme of Board development is planned.

1.4 Working with our Partners

Maintaining **business as usual** remains a priority across both organisations. As part of this I have continued my regular meetings including:

- Together with the Joint Chief Executive, individual meetings with Gloucestershire MPs – David Drew, Sir Geoffrey Clifton-Brown, Laurence Robertson, Mark Harper, Richard Graham and Alex Chalk. Meetings with the two Hereford MPs, Bill Wiggin and Jesse Norman, are planned.
- Gloucestershire County Council Corporate Peer Challenge on 13th June (represented by GCS Vice-Chair, Sue Mead)
- NHS Providers Chairs and Chief Executives meeting, London on 19th June
- NHS Providers Board in London on 4th July

- Gloucestershire Strategic Forum on 26th June
- Sustainability and Transformation Partnership Advisory Group on 26th June (represented by GCS Vice-Chair, Sue Mead)
- Forest of Dean Health Forum on 3rd July Health and Social Care Overview and Scrutiny Committee meeting on 10th July.
- Gloucestershire Health and Wellbeing Board on 17th July
- I have been represented at the Herefordshire and Worcestershire STP Chairs' meeting by Marcia Gallagher, 2gether NED.
- I have been represented at the Herefordshire health and wellbeing Board workshop by Duncan Sutherland, 2gether NED.

On Friday 29th June, **Mark Harper, MP for the Forest of Dean**, spent time at the Dilke Hospital visiting the Children's Physiotherapy team, before going on to Colliers Court in Cinderford, where 2gether's Forest of Dean community services are based, including children's mental health, dementia and memory assessment. Mr. Harper has advised how informative and helpful he found the session, which built on his previous visits.

The Chief Executive and I were invited to attend the **Forest of Dean Health Forum** on 3rd July where we gave updates on the proposed merger with GCS, the Forest of Dean Community Hospitals and Integrated Locality Boards.

A **regular meeting of the Health Care Overview and Scrutiny Committee (HCOSC)** took place on 10th July where items discussed included how Integrated Care Systems will benefit Gloucestershire and the proposed Stroke Rehabilitation unit at the Vale Hospital in Dursley. It was a helpful meeting, supporting the progress of these important matters.

The **quarterly meeting of the County's Health and County Council Chairs** took place on 10th July where we discussed the current issues facing the NHS and future plans.

The Gloucestershire Health and Wellbeing Board met on 17th July 2018. This discussed the Joint Health and Wellbeing Strategy for Gloucestershire, the Draft Children's Partnership Framework, Adverse Childhood Experiences, Permanent Exclusion Task Group Report, Restorative Practice in Schools and the Joint Commissioning Annual Report. The focus on working to overcome inequalities is a key part of the work of this group and the agenda helped to give a real sense of how as organisations we can work together to make a difference.

This meeting was followed by a special event to sign up to the consensus statement introduced by the national **Prevention Concordat for Better Mental Health** to make a local collective commitment to promoting good mental wellbeing and preventing mental illness. We heard examples of inspirational activity already taking place in Gloucestershire and officially launched the local approach to delivering the Prevention Concordat and making good mental wellbeing everybody's business.

I held one of my quarterly meetings with the **Chair of Gloucestershire Hospitals NHS Foundation Trust**. This meeting was held at Alexandra House in Cheltenham. These sessions reflect the interdependencies of our organisations and are an opportunity to ensure we are working together effectively to support provision of seamless care to our community.

2. Working with the Communities and People We Serve

I attended the **Bishop of Gloucester's Summer Garden Party** which was held at Bishopscourt in Gloucester on 19th July.

Lydney League of Friends held their annual fete at the Hospital on Saturday 21st July. Richard Cryer, GCS NED, attended.

The Joint Chief Executive and I held our regular **quarterly meeting** with **Chairs of Leagues of Friends** relating to the community hospitals.

3. Engaging with our Trust Colleagues

3.1 NHS70 celebrations

I have been delighted to be part of a range of celebrations marking the key part the NHS has played, and continues to play, in so many lives. The NHS continues to be an organisation at the heart of the community which makes a real difference because of the commitment, caring and compassion of colleagues – I am proud to continue to have a role ensuring the needs of service users, the NHS Constitution and its founding tenets are central to everything we do as Trusts.

I attended the 2gether Exhibition and Open Day at Blackfriars Priory which brought to life the support that has been provided people with a range of difficulties over the last 70 years, and indeed before then. Graham Russell (GCS NED) attended the celebrations at Cirencester Hospital and Sue Mead (GCS NED) attended celebrations at North Cotswolds Hospital – both advised that they were heart-warming occasions – a testament to colleagues and also service users.

I attended and spoke at the Cirencester Hospital NHS70 Service held at the Church of St. John the Baptist in Cirencester on Sunday 15th July and also attended the Herefordshire NHS Thanksgiving Service at Hereford Cathedral on 10th July.

I continue to meet regularly with Trust colleagues at 2gether and GCS and visit services at both Trusts to inform my triangulation of information. I have undertaken service visits with 2gether Governors to Wotton Lawn and Stonebow inpatient units. I also attended part of the Gloucestershire Care Services Conference on Children's Safeguarding. The Joint Chief Executive and I were pleased to attend a meeting of the Herefordshire Psychiatric Division at Stonebow Unit.

3.2 2gether ROSCAs Awards Evening, Friday 20th July

At the time of writing I am looking forward to attending the ROSCAs at which we will recognise and celebrate the contribution of ²gether colleagues in

delivering excellent services. We will also recognise our longest serving colleagues, including those who have served the NHS for 40 years.

4. NED Activity

Regular 2gether NED meetings are now being held throughout the year, taking place in service settings in both Trusts so that we also have an opportunity to visit services and grow understanding of each other's organisations. Quarterly joint meetings with GCS Trust NEDs have also been arranged. A list of all NED activity since the last Board meeting in May is listed at Appendix A.

APPENDIX A

NED'S KEY ACTIVITIES (June and July 2018)

Jonathan Vickers (Chair of Development Committee)
Since his last report Jonathan has;

- Prepared for and attendee two joint board seminars
- Prepared for and attended a NEDs meeting
- Prepared for and attended a meeting of the Charitable Funds committee
- Prepared for and attended a meeting of the Council of Governors
- Prepared for and attended a Serious Incident review
- Prepared for and attended a stakeholder meeting
- Attended the AGM
- Prepared for and attended a Board meeting

Nikki Richardson (Deputy Trust Chair/SID/Chair of Governance Committee)
Since her last report Nikki has;

- Prepared for and attended Board Meeting
- Prepared for and attended Closed Board Meeting
- Prepared for and attended Appointments and Terms of Service Meeting
- Prepared for and attended MHAM Forum
- Prepared for and attended Strategic Intent Leadership Group
- Prepared for and attended STP Advisory Group
- Prepared for and Chaired Governance Committee
- Prepared for and attended MHLS Committee
- Prepared for and attended Charitable Funds Committee
- Attended Board Development session
- Attended Council of Governors meeting
- Met with Trust Chair
- Visits to LD services
  - IHOT
  - CDLT North
  - Berkeley House
  - CDLT South
- Visit to Oak House
- Meeting with Director of Quality
- Attended AGM
- Attended ROSCAS
- Observed GCS Board meeting

Marcia Gallagher (Chair of Audit Committee)
Since her last report Marcia has;
<u>June</u>

- Booked call with the Audit Chair of the Somerset Partnership Trust
- Attended the MHAM Forum at Charlton Lane
- Prepared for and attended an SI Review
- Met with the Audit Chair and Finance Director of GCS and Deputy Director of Finance, 2G
- Met with Deputy Director of Finance to discuss the May Finance report
- Met with the Audit Chair of Gloucestershire Hospitals NHS FT
- Prepared for and attended the Delivery Committee

- Prepared for and attended a Joint Board Development session with GCS

July

- Attended the 2G FT 70th Anniversary open day at Blackfriars Priory
- Prepared for and attended the Herefordshire and Worcestershire STP Chairs meeting in Malvern
- Prepared for and attended the MHLS Committee
- Prepared for and attended the Charitable Funds Committee
- Attended a joint Board Development session
- Prepared for and attended the July Council of Governors meeting
- Attended the Wye Valley Trust AGM in Hereford
- Undertook a follow up visit to Oak House in Hereford
- Attended the joint 2GFT and GCS AGM
- Observed the GCS July Board meeting
- Prepared for and attended the Development Committee
- Met to discuss Security Management with Ian Leese
- Booked call with Director of Finance
- Prepared for and attended the July Board meeting

Duncan Sutherland (Chair of MH Legislation Scrutiny Committee/Charitable Funds)

Verbal update to be given at the meeting.

Maria Bond (Chair of Delivery Committee)

Since her last report, Maria has:

June

- Attended a MHAM forum
- Prepared for and Chaired the Delivery Committee
- Prepared for and attended a Joint Board Seminar
- Prepared for and attended a NED meeting
- Prepared for and attended a Governance Committee

July

- Read & commented on ATOS papers for virtual meeting.
- Attend a GCS board meeting
- Prepared for and Chaired a Delivery Committee
- Met with John Campbell, Director of Service Delivery
- Prepared for and attended a Board Meeting

Dominique Thompson

Dominique commenced in post on 1 May 2018. Since that time she has been carrying out local induction visits with Board members and has attended a Council of Governors meeting. Dominique also attended an NHS Providers NED Induction session in London. Other activities include:

- Attended 2 induction meetings with Executive Directors
- Participated in a Governors visit to Children and Young People's Services in Gloucester
- Prepared for and attended a Delivery Committee
- Prepared for and attended a Joint Board Seminar
- Prepared for and attended a NED meeting
- Prepared for and attended a Governance Committee
- Had an induction meeting with the Deputy CEO
- Prepared for and attended a Board meeting

[2]GETHER NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS MEETING
TUESDAY 8 MAY 2018
BUSINESS CONTINUITY ROOM, RIKENEL, GLOUCESTER

PRESENT:

Rob Blagden	Vic Godding	Ingrid Barker (Chair)
Katie Clark	Xin Zhao	Stephen McDonnell
Jan Furniaux	Mervyn Dawe	Ann Elias
Jenny Bartlett	Hazel Braund	Mike Scott
Jo Smith	Jennifer Thomson	Kate Atkinson
Svetlin Vrabtchev		

IN ATTENDANCE: Marcia Gallagher, Non-Executive Director
Paul Roberts, Chief Executive
John Campbell, Interim Director of Service Delivery
Dominique Thompson, Non-Executive Director
Marie Crofts, Director of Quality
Neil Savage, Director of Organisational Development
Jane Melton, Director of Engagement & Integration
John McIlveen, Trust Secretary
Colin Merker, Deputy Chief Executive
Kate Nelmes, Head of Communications
Nikki Richardson, Non-Executive Director

1. WELCOMES AND APOLOGIES

1.1 Apologies for the meeting had been received from Faisal Khan, Hilary Bowen, Said Hansdot, Cherry Newton, Bren McInerney, Euan McPherson and Lawrence Fielder.

1.2 Ingrid Barker welcomed Dominique Thompson, Paul Roberts and John Campbell to their first meeting of the Council of Governors since taking up their posts. Ingrid informed the Council that elections for staff Governors in the 'Clinical and Social Care & Support Staff' constituency had been completed and that Nic Matthews and Susan Steer would begin their tenure as staff Governors on June 1st.

2. DECLARATION OF INTERESTS

2.1 There were no new declarations of interest.

3. COUNCIL OF GOVERNOR MINUTES

3.1 The minutes of the Council meeting held on 8 March 2018 were agreed as a correct record.

4. MATTERS ARISING, ACTION POINTS AND EVALUATION FORM

4.1 The Council reviewed the actions arising from the previous meeting and noted that these were now complete or progressing to plan.

4.2 Following an action from the last Council meeting in March, a briefing had been circulated to Governors describing 2gether's procedures for dealing with overseas patients. Jenny Bartlett asked whether any additional checks on eligibility for treatment were being made in light of the Windrush issue. Colin Merker informed the Council that a briefing paper had been issued to staff to identify any support needs or concerns. No concerns had been raised and there was no evidence that anyone had been denied services, and Colin gave an example of services being received by failed asylum seekers, as the Trust was morally obliged to do. Mervyn Dawe welcomed this approach. Mike Scott expressed an interest in hearing more about this topic, and the Council agreed a suggestion by Jan Furniaux that a presentation could be given to the Council in the autumn.

ACTION: ***Council to receive a presentation on Overseas Patients in the autumn.***

4.3 Jane Melton tabled a briefing on the National Patient Survey results. This closed action 6.4 from the January Council meeting.

4.4 The Council noted that the minutes from the extraordinary Council meeting in April had not been included with the paper, and agreed to receive these at the next meeting.

ACTION: ***Minutes of the extraordinary meeting on 4 April 2018 to be presented to the July Council meeting.***

4.5 The Council received and noted the Meeting Evaluation feedback from the last meeting in March.

5. INTRODUCTION FROM PAUL ROBERTS, JOINT CHIEF EXECUTIVE

5.1 Paul Roberts introduced himself to the Council and provided some background information about his career to date. Paul has been in the NHS all his working life, having joined the NHS straight from University. Paul had taken up his first Chief Executive position at Grantham Hospital, and subsequent appointments at Plymouth and latterly in the Welsh health service have given Paul a wealth of experience in developing and integrating services and place-based care, and thereby removing the boundary between mental and physical health services. Paul commented on the different set up in Wales, where integrated services were the model which the English NHS was looking to emulate. Paul is excited to be the Chief Executive of two good and well-rated organisations and is looking forward to integrating the services of both organisations to serve the local community even better.

5.2 Ingrid Barker noted that Paul had issued a weekly briefing to staff since his arrival, and the Council agreed that it would be helpful for Governors to receive those briefings.

ACTION: Chief Executive's weekly briefings would be emailed out to all Governors

5.3 Mervyn Dawe asked about the scope for further integration with Social Services. Paul Roberts replied that 2gether already does a lot of work with social care services, and Gloucestershire Care Services has in the past done so too. Joining up services with social care is an important part of the picture, but it was equally important to work more closely with primary care and the third sector, where value can be added for patients by developing a more integrated service model.

5.4 The Council of Governors welcomed Paul to the organisation.

6. UPDATE ON JOINT WORKING WITH GLOUCESTERSHIRE CARE SERVICES

6.1 Paul Roberts provided a verbal update to the Council about joint working with Gloucestershire Care Services (GCS). A series of engagement events had already taken place with clinical and non-clinical leaders from both organisations, as it is important that the merger makes sense to, and has the support of, services on the ground. Paul had been pleased to note that even at the first of these meetings, colleagues had engaged with their counterparts to start thinking about how service design could be improved.

6.2 Paul informed the Council that the merger would have three strands, referred to as the '3 Ts'. The Transaction element comprises the legal and due diligence part of the process. The Transition element is about making the necessary changes to organisational structures and governance frameworks to create a new organisation; these are important, but not necessarily for patients. Transformation is about service redesign, and identifying what we can do better for the people who use our services. Paul referred to the recently published Learning Disability Mortality Review Annual Report as an example of why improving services through integration is important.

6.3 Paul informed the Council that his focus was on doing as much as possible together. He currently has a Deputy Chief Executive in each organisation, and he had asked Sandra Betney in GCS to oversee the Transaction and Transition pieces of work, while Colin Merker would oversee the Transformation work. A programme manager had been appointed to support both organisations.

6.4 Mike Scott asked how the benefits of the merger would be identified and measured. Paul replied that one important aim of the Transformation work would be to identify benefits by service/client group, which would form the basis of a measurable 3-5 year plan. Once benefits and timings were defined these would be shared with Governors.

6.5 Svetlin Vrabtchev asked about timescales, and how the Council would be involved in the merger process. Paul replied that Philip Baillie, the new programme manager, had been asked to develop a detailed plan which would identify critical paths and set out timings for the process. There would be scope for a wider group of people to get involved in the transformation work, and helping to identify benefits, agree culture and values, etc. Colin Merker noted that Governors would also form part of the Transition work, as a new Council of Governors would need to be formed for the new organisation.

6.6 Neil Savage informed the Council that a set of Frequently Asked Questions had been published to staff to inform them about progress. The Council agreed that it would be helpful to circulate these FAQs to Governors.

ACTION: ***Frequently Asked Questions about the merger to be circulated to Governors***

7. CHIEF EXECUTIVE'S REPORT

7.1 Colin Merker delivered the Chief Executive's report, and informed the Council that the Trust had ended the year with a financial surplus which was slightly above plan. This meant not only that 2gether ended the year in balance as planned, but would also receive an additional £1m in Sustainability & Transformation Funding, which would be added to the capital budget this year. Colin noted that the Trust's agency staff spend for the year was £4.123m. While this is above the Trust's agency control total, it is almost £1.4m lower than last year, and the agency costs for March 2018 were the lowest in three years of monitoring. If agency spend was maintained at the March level, this would mean that the Trust would meet its agency control total in 2018/19.

7.2 Colin referred to the relocation of Herefordshire CAMHS services to Belmont, following receipt of a notice to vacate the Linden Centre in the city centre. Governors had previously expressed concern about the potential difficulty of accessing services at Belmont. John Campbell informed the Council that an audit of service users had shown that 20% of CAMHS service users would need access to services in the city centre. Accordingly discussions had taken place with the CLD Trust in Hereford, who would be willing to make some clinical space available at their city centre premises, subject to cost. Refurbishment of Belmont to accommodate the main CAMHS service would be complete in the autumn, and communications would be issued to service users and families at the appropriate time.

7.3 Jenny Bartlett remained concerned about access to services from rural towns such as Bromyard, where public transport links were poor, and asked whether transport issues should have been examined earlier. John Campbell said that the Trust needed to vacate the Linden Centre quickly, and there were limited options and limited time to provide services and explore logistics. However, access to city centre services would be monitored, as would services at Belmont. Hazel Braund confirmed that outreach services at Ross and Leominster would be unaffected. John agreed to work with Sarah Batten, Service Director for the Children and Young People Service, to provide a fuller briefing to Jenny on her issues of concern.

ACTION: ***Briefing to be provided to Jenny Bartlett on issues relating to the relocation of CAMHS services in Herefordshire***

7.4 Colin Merker informed the Council that a good funding settlement this year had enabled the Trust to plan a number of service developments for 2018/19, which were listed in the Chief Executive's report. More details of these developments would be made available to Governors as it became available. Colin drew the Council's attention in particular to new funding for perinatal services which would

see the continuation of services in Gloucestershire, and the establishment of a new core service in Herefordshire.

7.5 Finally, Colin drew the Council's attention to a leaving 'do' for Shaun Clee, which would be held in the Business Continuity Room at Rikenel from 12.30 on Friday 11 May. Governors were welcome to attend. Mervyn Dawe queried the use of the phrase 'stood down' in relation to Shaun's departure. Neil Savage confirmed that Shaun's post had become redundant when the new Chief Executive was appointed, and that the Trust had gone through an appropriate redundancy process in respect of Shaun. This would be reflected in the Annual Report.

8. FEEDBACK FROM NED APPRAISAL PROCESS

8.1 The Council of Governors received the summary report from the Trust Chair outlining the outcome of Non-Executive Director appraisals. The report provided assurance that all Non-Executive Directors have made valuable contributions to the governance of the Trust over the past year, and are performing effectively at Board, as Committee chairs, and in their broader roles.

8.2 Rob Blagden agreed with the conclusions in the report, and commended the hard work which the NEDs had put in over the past year. Rob raised an issue from Bren McInerney, who was unable to attend the meeting, but who had asked whether development issues were covered in the appraisal process. Ingrid Barker confirmed that development areas were discussed in 1:1 appraisal meetings as part of the objective-setting process for NEDs, but that because these issues were confidential in nature, they were not referenced in this general report which was a public document.

9. PROVIDER LICENCE DECLARATIONS

9.1 The Trust Secretary reported that the Trust Board is required each year to self-certify regarding compliance with the conditions of its provider licence and the systems and processes for ensuring such compliance.

9.2 The Council noted that it is the Board which is responsible for ensuring compliance with the Trust's licence and any constitutional, statutory and contractual obligations placed upon the Trust. It is therefore a matter for the Board scrutinise the detail of any supporting evidence of compliance ahead of making these declarations. The Board is asked to make these declarations 'having regard to the views of Governors', and Governors should receive sufficient assurance to be satisfied about the robustness of the Board's own assurance processes in coming to a decision.

9.3 This report sought to provide that assurance to Governors by setting out the processes in place to enable the Board to receive assurance about its corporate governance systems and any risks to compliance with its licence conditions, both through the year and at year end when these declarations must be made. Governors were invited to comment about the declaration process to allow the May Board meeting to take account of Governors' views when making these declarations.

9.4 Mike Scott commented that the appendix stated that 'no unmitigated risks had been identified' whereas the heading suggested that risks and mitigation should be listed. John McIlveen replied that risks were well documented and highly visible to the Trust Board and its Committees, and thus the use of this phrase helped to keep the report to a manageable size when the issue was being considered by the Board.

9.5 Marcia Gallagher confirmed that NEDs were well-sighted on the Trust's risks, which were reviewed regularly by each of the Board Committees. Marcia offered to speak to Mike at the next Audit Committee meeting to provide further assurance if required. Rob Blagden noted that those Governors who sit as observers of Board Committees will see major risks being presented to and reviewed by those Committees.

9.6 Rob Blagden raised a point made by Bren McInerney, regarding a Governor skills audit. The Council noted this would be a useful tool in the coming months to inform the development of a new Council of Governors as part of the merger transformation work.

10. HOLDING TO ACCOUNT – GOVERNANCE COMMITTEE

10.1 Nikki Richardson delivered a presentation to Governors which set out the work of the Governance Committee in holding the Executive Directors to account for the safe and effective delivery of services, and highlighted some of the issues which the Committee has progressed and challenged during the past year.

10.2 Nikki highlighted the ways in which the NEDs in general fulfil their responsibilities, by scrutinising the actions of Trust management, by requesting and receiving assurance and reporting that assurance on to the Board, and by triangulating information from a variety of sources in order to obtain that assurance. The Council noted that Maria Bond, vice Chair of the Governance Committee, also chairs the Delivery Committee, meaning that there was a good level of triangulation of information and assurance across these two Committees in particular.

10.3 Nikki summarised some of the key issues which the Committee had covered in the past 12 months, including safe staffing, patient safety, and clinical audit, and where the Committee's input had helped to secure performance improvements such as an increased use of bank staff (as opposed to agency staff) to fill shifts, and a much improved closure rate for Serious Incident review actions. The Committee had undergone an element of restructuring in 2017 with the establishment of a Quality and Clinical Risk (QCR) sub-committee, which took on much of the operational detail work that the Governance Committee previously had to do itself, and provided assurance back to the Governance Committee on those areas within its remit. The detailed scrutiny provided by QCR had brought about a significant improvement in recording of information on RiO, in line with the Trust's Assessment and Care Management policy. The Council noted that until the establishment of QCR, progress on this issue had been extremely difficult.

10.4 Vic Godding and Jo Smith are the Governor observers on the Committee, and they explained how they undertook their observation using a tick sheet

developed by Vic to record key actions and behaviours. Vic and Jo commended the work done by Nikki and Maria Bond as Chair and Deputy Chair of the Committee. Vic agreed to share the observation sheet with other Governors to aid the observation process in their respective Committees.

10.5 Rob Blagden commented that while the Holding to Account process had been difficult at first, it has now evolved into a collaborative and supportive process, informed by having Governor observers at each of the Board' s key Committees.

10.6 The Council thanked Nikki, Jo and Vic for their presentation.

11. FEEDBACK FROM GOVERNOR OBSERVATION AT BOARD COMMITTEES

11.1 A number of Board and Board Committee meetings had taken place since the Council of Governors last met in March 2018 and Governors had been present in an observation capacity at some of these meetings.

- No Governors were available to observe the Mental Health Legislation Scrutiny Committee meeting on 14 March, or the Audit Committee meeting on 4 April.
- Said Hansdot attended the Development Committee meeting on 18 April. Said was not present at the Council meeting, however John McIlveen reported that Said had indicated after the Development Committee that he felt that it had been thorough in reviewing all matters on the agenda.
- Xin Zhao had observed the Delivery Committee meeting on 29 March. She said that this had been a well-managed meeting and the Chair and other members of the Committee made her feel welcome and acknowledged the importance of Governor observation of the Committee.
- Jo Smith had attended the Governance Committee on 27 April. Jo said that this had been a complex and detailed meeting but had been managed well by Nikki Richardson (Chair) and Maria Bond (Vice Chair).

12. ANNUAL MEMBERSHIP ACTIVITY REPORT

12.1 The Council received and noted the Annual Membership Report which provided a brief update to inform the Council of Governors about information for members, Governor Engagement Events and information about membership for the 2017/18 financial year.

12.2 Membership at the end of the year stood at 7805, an increase of 362 members (5%) over the year. 320 of those new members are in public constituencies. A Membership Advisory Group had met 3 times during the year, and a further 4 meetings were planned this year. The Group comprises Governors and members, and has reviewed the Trust's membership form and explored ideas for a new membership pack, as well as new methods of engaging with existing and prospective members. A survey, conducted in April 2017, had helped to inform the membership programme.

12.3 Work has also been done to cleanse the membership database, and to amend processes in order to comply with new data protection rules taking effect at the end of May 2018. One impact of these changes will mean that staff members who leave the organisation will no longer be automatically transferred to a public

constituency, but must submit a membership form instead. This is likely to impact on membership figures.

12.4 The Council noted the key performance indicators for 2018/19 which included increasing membership in those constituencies and groups which are currently under-represented. The Communications Team would also review the Membership Strategy as the merger with GCS progresses.

13. GOVERNOR ACTIVITY

13.1 Mike Scott had with the help of Kate Nelmes issued an email to all members in the Greater England constituency, in order to promote awareness of his role as a Governor.

14. ANY OTHER BUSINESS

14.1 Rob Blagden reported that the Herefordshire Governors meet regularly to discuss issues relating to Herefordshire. He asked whether reports could make it clearer whether issues covered related to the whole Trust, or specifically to one area. This would make it easier for Herefordshire Governors to pick up relevant issues. Jenny Bartlett noted that this would also help to celebrate the diversity of services across the two counties, and commended the Chief Executive's report as a good example.

14.2 Rob Blagden highlighted issues caused by the late cancellation of meetings, and requested that as much notice as possible be given when a meeting needed to be cancelled.

14.3 Ingrid barker informed the Council that following its recent Care Quality Commission inspection, Gloucestershire Care Services had had its rating increased to 'Good'.

15. DATE OF NEXT MEETINGS

Council of Governor Meetings

Business Continuity Room, Trust HQ, Rikenel		
Date	**Governor Pre-meeting**	**Council Meeting**
2018		
Thursday 12 July	9.00 – 10.00am	10.30 – 12.30pm
Tuesday 11 September	4.00 – 5.00pm	5.30 – 7.30pm
Thursday 8 November	1.30 – 2.30pm	3.00 – 5.00pm

Public Board Meetings

2018		
Thursday 26 July	10.00 – 1.00pm	Business Continuity Room, Rikenel
Wednesday 26 September	10.00 – 1.00pm	Business Continuity Room, Rikenel
Thursday 29 November	10.00 – 1.00pm	Hereford

Council of Governors
Action Points

Item	Action	Lead	Progress
8 March 2018			
6.17	Governor Working group to be arranged to carry out a more detailed review of the Staff Survey Results 2018	Neil Savage / Anna Hilditch	**Complete** Meeting to take place on 19 June
9.4	Quarterly Service Planning report received at the Delivery Committee to be made available to Governors for information	Anna Hilditch	Reports to be made available to Governors once received at the Delivery Committee
8 May 2018			
4.2	Council to receive a presentation on Overseas Patients in the autumn.		Presentation scheduled for November 2018 meeting
4.4	Minutes of the extraordinary meeting on 4 April 2018 to be presented to the July Council meeting.	Anna Hilditch	There was no extraordinary meeting held on 4 April. Governors carried out an electronic "vote" on the appointment of a new NED
5.2	Chief Executive's weekly briefings would be emailed out to all Governors	Anna Hilditch	**Complete**
6.6	Frequently Asked Questions about the merger to be circulated to Governors	Anna Hilditch	**Complete**
7.3	Briefing to be provided to Jenny Bartlett on issues relating to the relocation of CAHMS services	John Campbell, Sarah Batten	**Complete**

Agenda item **17** **Enclosure** **Paper L**

Report to: Trust Board, 26 July 2018
Author: John McIlveen, Trust Secretary
Presented by: John McIlveen, Trust Secretary

SUBJECT: **USE OF THE TRUST SEAL**

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

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

PURPOSE

To present the Board with a report on the use of the Trust Seal for the period April - June (Q1 2018/19).

SUMMARY OF KEY POINTS

Section 10.3 of the Trust's Standing Orders requires that use of the Trust Seal is reported to the Board on a quarterly basis.

"10.3 Register of Sealing - The Chief Executive shall keep a register in which he/she, or another manager of the Authority authorised by him/her, shall enter a record of the sealing of every document. Use of the seal will be reported to the Board quarterly."

During Quarter 1 2018/19, the Seal was used on two occasions, as follows:

Seal 1
Sale of Fieldview to Holmleigh Care Ltd for £675,000.
Signed by: Director of Finance and Director of Service Delivery
Date: 24 May 2018

Seal 2
Sale of Coleford House to Mike Etheridge Construction Ltd for £357,550.
Signed by: Director of OD and Deputy Chief Executive
Date: 20 June 2018

RECOMMENDATIONS

The Board is asked to note the use of the Trust seal for the reporting period.