2GETHER NHS FOUNDATION TRUST
BOARD MEETING
WEDNESDAY 28 MARCH 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 Meetings** • 30 January 2018 • 22 February 2018	**PAPER A1** **PAPER A2**
	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 – January 2018**	**PAPER B**
10.45	8	**Service Experience Report – Quarter 3**	**PAPER C**
10.55	9	**Quality Report – Quarter 3**	**PAPER D**
11.05	10	**Quality Strategy**	**PAPER E**
11.15	11	**Learning from Deaths – Quarter 3**	**PAPER F**
11.25	12	**Non-Executive Director Audit of Complaints – Quarter 3**	**PAPER G**
11.35	13	**Safe Staffing 6 Monthly Update**	**PAPER H**
BREAK – 11.45AM			
IMPROVING ENGAGEMENT			
11.55	14	**Chief Executive's Report**	**PAPER I**
12.05	15	**National Staff Survey Results 2017**	**PAPER J**
IMPROVING SUSTAINABILITY			
12.15	16	**Summary Financial Report**	**PAPER K**
12.25	17	**Arrangements for monitoring capital expenditure**	**PAPER L**
12.30	18	**Gender Pay Gap**	**PAPER M**
12.40	19	**Joint Strategic Intent Update**	**PAPER N**
12.50	20	**Board Committee Summaries** • Audit Committee – 7 February • Development Committee – 7 February • Delivery Committee – 21 February • Governance Committee – 23 February • MH Legislation Scrutiny Committee – 14 March	**PAPER O1** **PAPER O2** **PAPER O3** **PAPER O4** **PAPER O5**

INFORMATION SHARING (TO NOTE ONLY)			
	21	**Chair's Report**	**PAPER P**
	22	**Council of Governor Minutes – January 2018**	**PAPER Q**
1.00	23	**Any Other Business**	
	24	**Date of Next Meeting** Thursday 31 May 2018 at The Kindle Centre, Hereford	

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
TRUST HQ, RIKENEL
30 JANUARY 2018

PRESENT

Ingrid Barker, Trust Chair
Maria Bond, Non-Executive Director
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
Quinton Quayle, Non-Executive Director
Nikki Richardson, Non-Executive Director
Neil Savage, Director of Organisational Development
Dr Amjad Uppal, Medical Director
Jonathan Vickers, Non-Executive Director

IN ATTENDANCE

Mervyn Dawe, 2g Trust Governor
Tony Foster, Gloucestershire Hospitals NHSFT
Anna Hilditch, 2g Assistant Trust Secretary
Frances Martin, Director of Transformation
John McIlveen, 2g Trust Secretary
Bren McInerney, 2g Trust Governor
Kate Nelmes, 2g Head of Communications
Ian Stead, Healthwatch Herefordshire
William Thomas, Liaison
Xin Zhao, 2g Trust Governor
2 x Members of the Public

1. WELCOMES, APOLOGIES AND INTRODUCTIONS

1.1 Apologies were received from Shaun Clee and Duncan Sutherland.

1.2 The Board formally welcomed Ingrid Barker and Amjad Uppal to their first Board meeting.

2. DECLARATIONS OF INTERESTS

2.1 Quinton Quayle informed the Board that he had been appointed as a Non-Executive Director for Cotsway Housing Association.

2.2 The Board noted that Ingrid Barker was also the Chair of Gloucestershire Care Services.

3. MINUTES OF THE MEETING HELD ON 30 NOVEMBER 2017

3.1 The minutes of the meeting held on 30 November 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.

5.2 A member of the public raised a question regarding complaints. She said that her personal experience of making a complaint with 2gether did not tally up with the experience reported in Trust reports and previous minutes. She said that making a complaint was hard, and noted that very few complaints made it to the Public Health Services Ombudsman (PHSO) for full investigation as people would often lose heart due to the time and effort it took. Her complaint had been referred to the PHSO. The Acting Chief Executive said that he would welcome a meeting with the complainant to talk about her specific concerns in more detail and to see if any learning could be drawn from this. The complainant advised that she would be open to meeting with the Trust, but said that this was often more helpful to be done as a reflective exercise rather than meeting during the complaint investigation. Quinton Quayle said that he had carried out the latest Non-Executive Audit of Complaints. He said that he felt 2gether was very good at handling complaints; however, an area of weakness identified related to the learning from complaints and the process for picking this up and disseminating it. The Director of E&I agreed to link with the complainant by way of arranging a meeting.

ACTION: Director of E&I to link with the member of the public/complainant in attendance at the Board by way of arranging a meeting to discuss her concerns in more detail with the Trust

5.3 A second member of the public said that she had also gone through the PHSO process and noted that her complaint had been fully upheld by the PHSO. She said that it had taken 3 years. On hearing the outcome, she said that this had ignited her emotions as she had been made to feel for the past 3 years that she had no right to be making a complaint. She said that there had been no evidence of the Trust taking on board the learning from her complaint and subsequent PHSO investigation. The Acting Chief Executive said that an invitation to meet with the Trust to talk through the issues together had been extended to this member of the public previously, and he said that this would still be welcomed. She was also in communication with the Trust about presenting her patient story at a future Board meeting. The Board noted that an action plan to address the recommendations from the PHSO investigation of this complaint had been produced and had been reviewed by the Governance Committee. This action plan had also been shared with both the CQC and NHSi. The Acting Chief Executive informed the Board that the Trust's Risk Management and Care Management Policies had been updated to address the specific concerns and a Practice Notice had been issued to all staff.

5.4 Bren McInerney expressed his thanks to Ingrid Barker for chairing the Board in such an open and transparent way and for giving members of the public the opportunity to speak at meetings.

6. SERVICE PRESENTATION – STROUD RECOVERY TEAM

6.1 The Board welcomed Alex Hudman (OT) and Jo Greenwood (Team Manager) from the Stroud Recovery Team to the meeting. Alex was in attendance to tell "Kim's" story to the Board. Kim had been unable to attend today's meeting in person but was keen for her experiences to be heard.

6.2 Kim had been in mental health services for over 10 years and was referred to the Stroud Recovery Team 4 years ago. Kim had been diagnosed and treated for bi-polar disorder before coming to 2gether, and was then subsequently diagnosed with borderline personality disorder. This had had a major impact on Kim's day to day life. Kim had started to make good progress with the Stroud Team and she said that this was down to the continuity of staff and care, the ability to build trust, access to 1-2-1 telephone contact with Alex and

therapy. Kim had seen huge improvements over the past 6 months with her personal life and she was holding down a job and had joined a local rugby team. Kim was also in the process of developing an app to assist people with MH problems.

6.3 Kim had written about her experience of medication, noting that she had been put on medication instead of being offered therapy. She said that she would have liked a more informed decision as she was now on multiple medications.

6.4 Marcia Gallagher said that she had been on a recent Board visit to the Stroud Recovery Team and had been very impressed. However, she asked about the issue of providing patients with coping strategies/therapy versus prescribing medication and where in the care pathway that was discussed. Jo Greenwood said that Kim had been re-assessed when she came to 2gether 4 years ago and at that time she had her diagnosis revised from bi-polar to personality disorder. On receiving that re-diagnosis Kim entered into therapy which had worked well for her. Jo said that she was unable to comment on Kim's initial diagnosis and how this was treated due to it being done outside of the Trust.

6.5 The Acting Chief Executive said that staff within the Stroud Recovery Team should take great strength from Kim's story. Alex Hudman agreed, but added that unfortunately not all patients seen by the Trust's recovery teams had such a positive outcome. However, she said that since writing her story for the Board, Kim had actually been awarded a scholarship from Google which was an outstanding achievement. Due to the time commitment of this, Kim had put her development of the MH app on hold; however, Board members agreed that the Trust should support Kim in developing the app, once she returned to it.

6.6 Jonathan Vickers asked for assurance from the Medical Director that clinicians these days would look at all options and broader holistic treatments before simply prescribing medication to patients. The Medical Director said that this did happen; however, it depended on how the patient presented. The Trust followed NICE guidelines carefully and on presentation of bi-polar disorder, the guidelines recommend patients are given specific bi-polar medication to manage the condition. Other presentations, such as personality disorders may be better managed through therapy. Each case was managed separately and individuals treated in a way best suited for them and their condition. The Medical Director added that 2gether reviewed its clinical practice annually to ensure that it continued to be in line with best practice evidence.

6.7 In terms of patients being involved in decisions around their medication, the Director of E&I referred the Board to the recent National Patient Survey results, where 2gether was performing well in terms of involving patients in their care.

6.8 The Director of Quality informed the Board that the Stroud Recovery team was a very cohesive team and had excellent team leadership. She said that the team needed to take some credit for the positive story that Kim had shared.

6.9 The Board thanked Alex and Jo for attending the meeting, and Kim for letting the Board hear about her story. There were some potential learning points from this and the Board would discuss this further in its afternoon session.

7. PERFORMANCE DASHBOARD

7.1 The Board received the performance dashboard report which set out the performance of the Trust's Clinical Services for the period to the end of November 2017 of the 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 155 performance indicators, 85 were reportable in November with 80 being compliant and 5 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 which accounted for 4 of the non-compliant indicators.

7.3 It was noted that the Trust had a compliance rate of 94% which was excellent. The Acting Chief Executive said that services were working very hard and action plans continued to be scrutinised and monitored to ensure that this level of compliance continued.

7.4 The Board was asked to note that unfortunately the annual performance threshold for "Under 18 admissions to adult wards" was zero and it has not been met therefore the performance for the year will be non-compliant. Historic performance indicates that without changes in the tier 4 services arrangements - outside of the remit of 2gether - we will not be able to meet this indicator. The Acting Chief Executive said that 2gether was not licensed to admit Under 18s; however, if young people became unwell then the Trust would make the least worst option to keep them safe and would admit them to an adult ward. The Board noted that the CQC had reviewed the protocols and safeguarding arrangements in place for these admissions and had provided positive feedback. The Acting Chief Executive said that despite the concerns around these admissions, young people placed at Wotton Lawn could continue to work with the CYPS Team locally and there had been occasions when the young person has been able to go home with the support of CYPS, rather than being transferred to an age appropriate out of county inpatient unit which was often elsewhere in the country. The Board was offered assurance that the Trust challenged all decisions to admit Under 18s and follow up reviews were carried out to make sure that these admissions were appropriate.

7.5 The Board noted the dashboard report and the assurance that this provided.

8. GUARDIAN OF SAFE WORKING REPORT

8.1 The Board welcomed Dr Nader Abassi, Guardian of Safe Working to the meeting.

8.2 All new Psychiatry Trainees, Foundation Trainees and GP Trainees rotating into a Psychiatry placement from 1st February and consequently 2nd August 2017 are now on the new 2016 Terms and Conditions of Service. There are currently 33 trainees working in 2gether on the new Terms and Conditions of Service on different sites.

8.3 The exception reporting process, allowing variations from the trainees contractually agreed service requirements and training opportunities to be resolved is now in place. The trainees can raise exception reports for hours worked, missed breaks, or missed educational opportunities. 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 raised against the directorates by the Guardian.

8.4 The Board noted that this quarterly report from the Guardian summarised all exception reports, work schedule reviews and rota gaps, and provided assurance on compliance with safe working hours by both the employer and Doctors in approved training programs. The Board noted that exceptions around working hours were reported to the Guardian and

exceptions around missed training opportunities were reported to the Director of Medical Education.

8.5 Dr Abassi informed the Board that this was a new process that the Trust was working hard to implement. His role as Guardian was to support the Trainees and the role sat independently from the Trust to enable him to hold the Trust to account.

8.6 The Director of Organisational Development welcomed this report. He said that this was new territory for the Trust but this report demonstrated that 2gether had a very good understanding, with the appropriate processes and links in place, both locally and nationally by way of networking.

8.7 The Director of Finance asked for clarification around the exceptions marked as "still open" and whether there was a target timescale for closing these on the system. The Medical Director advised that a number of the "still open" exceptions related to issues logged by Trainees who had now moved away and had forgotten to close them down. This was something that the Trust was looking to tighten up. It was agreed that the next quarterly report would separate out those genuine "still open" exceptions from those where it was clear that Trainees had simply forgotten to close down before they left the Trust.

ACTION: Future Guardian of Safe Working quarterly reports to separate out those genuine "still open" exceptions from those where it was clear that Trainees had simply forgotten to close down before they left the Trust

8.8 Nikki Richardson said that she would welcome seeing the learning from this as the work developed. The Medical Director said that there had already been some changes, for example, the timing of some clinics had changed due to regular exceptions being reported around extra working hours.

8.9 The Acting Chief Executive noted the reference in the report at 5.2 "There is a 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." Dr Abassi said that this situation had improved and people from a good spread of specialties were now regularly reporting.

8.10 At 3.3 of the report, it stated that "The Trust also failed to attract enough trainees for the recent rota….." The Acting Chief Executive asked the Board to note that this related to an issue with Deanery allocation, not 2gether being unable to find enough people. The Medical Director confirmed that he would be meeting with the Director of Medical Education to look at the issue of trainee allocation further.

8.11 The Board thanked Dr Abassi for attending the meeting and presenting his first quarterly report. The Board supported the recommendations set out within the report.

9. CQC UPDATE

9.1 The Director of Quality confirmed that 2gether's Well-Led CQC inspection would be taking place on 14th and 15th March 2018. The core services inspection would be taking place during late February; however, this would be an unannounced visit.

9.2 Assurance was provided that quality improvement meetings were taking place regularly and "must do" actions were being tested.

9.3 The Director of Quality said that a lot of work was taking place and staff throughout the Trust were working very hard in preparation for the inspection.

10. CHIEF EXECUTIVE'S REPORT

10.1 The Acting Chief Executive presented his report to the Board which provided an update on key national communications via the NHS England NHS News and a summary of key progress against organisational major projects.

10.2 The Board 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; however, it only offered limited assurance on the effectiveness of that engagement.

10.3 The Board noted the Chief Executive's report and a request was made that the use of acronyms be reviewed for future reports.

11. SUMMARY FINANCIAL REPORT

11.1 The Board received the Finance Report that provided information up to the end of December 2017. The month 9 position was a surplus of £597k in line with the planned surplus before impairments. The Trust has had a revaluation of its asset base conducted which has resulted in a £1.033m impairment. The month 9 forecast outturn was an £883k surplus before the impairment, 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 2.

11.2 Agency spend at the end of December was £3.242m. On a straight line basis the forecast for the year would be £4.322m, which would be a reduction of £1.169m on last year's expenditure level, but above the agency control total by £0.918m. It is estimated however that with the initiatives currently being introduced to reduce agency usage further the year end forecast will be £4.059m (£1k lower than last month's forecast).

11.3 The Trust completed a mid-year review of its financial position in October. Revenue budgets, capital expenditure, savings schemes, cash, balance sheet provisions and potential risks and opportunities were all reviewed. The actions identified in the review have been implemented and the Trust remains on track to meet the control total. There remain a number of risks in the Trusts financial position however.

11.4 The Board noted that the Trust was undertaking an Alternative Site Modern Equivalent Asset (MEA) revaluation of its land and buildings and an early draft report indicated that the Trust should receive a significant recurring saving from this exercise. The Trust is working through the details of the report to assure itself of the accuracy and validity of the proposed revaluation. It was noted that this MEA revaluation was being nationally driven for all provider Trusts.

11.5 The Trust was progressing well with budget setting for next year, and has updated its financial projections for the next five years in the report.

11.6 The Director of Finance drew the Board's attention to the cumulative Public Sector Payment Policy (PSPP) performance, noting that month 9 remained at 90% of invoices paid in 10

days and 98% paid in 30 days. The Trust has a strong cash position which enables it to continue to consistently pay suppliers promptly.

11.7 Marcia Gallagher noted that NHS England had been allocating additional winter pressure funding to acute trusts and asked whether MH Trusts had been included in this allocation round. The Acting Chief Executive advised that 2gether did bid for winter monies in December and was successful. However, he noted that this was a national allocation that would flow through the CCGs.

11.8 Nikki Richardson noted that the cost of complex care had increased and asked for the reasoning behind this. The Director of Finance advised that there had been an impact on this budget earlier in year with a challenging placement which had meant that the Trust had not been able to use all of its PICU beds for a period of time. However, he informed the Board that the 2018/19 allocation for the complex care budget had increased and this had been agreed as part of commissioning discussions.

11.9 Maria Bond said that the Trust had carried out some excellent work to look at reducing agency expenditure over the past year; however, she asked whether this effort had now been saturated. The Director of Quality said that there was still more the Trust could do, and a workstream was underway to look at developing a medical staff bank. The Medical Director noted that this workstream would focus on reviewing the job descriptions for medical staff to make these more attractive for potential applicants, and would meet with HR weekly to review locum positions within the Trust. The Board agreed that it would be good to see a full year effect of the initiatives that had been put in place to reduce agency expenditure, noting that many of these had been introduced in Q3 and Q4 and had not yet had the time to fully embed.

11.10 The Board noted the month 9 financial position.

12. JOINT STRATEGIC INTENT UPDATE

12.1 Work was continuing with Gloucestershire Care Services NHS Trust on the proposal to bring our two organisations together. Ingrid Barker, Joint Chair across both Trusts took up her post formally from 1st January 2018. The interviews for the joint Chief Executive post have been arranged to take place on 21st February 2018.

12.2 A new joint group has been set up between the two Trusts to progress the planning and progress of our joint strategic proposal to 'merge'. This group is called the Strategic Intent Leadership Group (SILG). The Group is chaired by Ingrid Barker and includes Non-Executive and Executive Director representation from both Trusts. We have also agreed that a joint Programme Management Executive Group (PMEG) will sit below the SILG to deliver the detailed work programme required to achieve a successful merger. Both of these groups are beginning in January 2018 and a Project Director is currently being appointed to coordinate our joint work overall.

12.3 To avoid splits in organisations, duplication of effort, or impacts on business as usual, it was important that people not on the groups did not feel "outside of the tent". The Programme Management Executive will carefully consider their involvement and communication needs for example through joint Board plenary sessions. In addition, it is proposed that each member also has the responsibility of briefing their opposite number in the other organisation and ensure their line manager is briefed about any potential impacts on them or their teams and work tasks they need to complete. This is expected to be in addition to programme communication and reports to Boards and will aid Executive to Executive

relationship building. Jonathan Vickers said that he felt that the proposed governance structure showed excellent pre-thinking and stressed the importance of opposite numbers keeping each other up to date. To aid with this it was suggested whether, for example, if the Director of Finance from GCS was unable to attend a SILG meeting, whether the Director of Finance from 2gether should attend as their deputy, rather than a deputy from GCS. It was agreed that this would be worth thinking about.

12.4 The Board would continue to receive regular updates on progress with developments.

13. BOARD COMMITTEE REPORTS – DELIVERY COMMITTEE

13.1 Maria Bond presented the summary report from the Delivery Committee meeting held on 24 November. This report and the assurances provided were noted.

14. BOARD COMMITTEE REPORTS – DEVELOPMENT COMMITTEE

14.1 Jonathan Vickers presented the summary report from the Development Committee meeting held on 13 December. This report and the assurances provided were noted.

14.2 The Development Committee received a draft update of the Quality Strategy, covering the period 2017-2019. The Committee welcomed the conciseness of the strategy and its overall vision, and made a number of suggestions to improve the format of the document, to bring the vision through in each section, to improve clarity and to ensure that aims are achievable and measurable. The comments would be fed back to the Director of Quality, and the Committee would review the draft strategy again in February before it went to the open Board in March. The Board agreed that once the Strategy was endorsed by the Development Committee in February, the Quality Strategy could be circulated throughout the Trust in draft form, in advance of its final sign off at the March Board meeting.

15. BOARD COMMITTEE REPORTS – GOVERNANCE COMMITTEE

15.1 Nikki Richardson presented the summary report from the Governance Committee meeting that had taken place on 15 December.

15.2 Following on from earlier discussions, Nikki Richardson advised that the Governance Committee had received the action plan that had been produced in response to the PHSO recommendations. She said that the Committee was assured by the progress made against the key recommendations. However, Nikki Richardson said that the Governance Committee would take additional assurance from knowing that the complainant had had the opportunity to meet and discuss the issues from the complaint with Trust staff. The complainant said that she did want to meet with the Trust but she wanted to meet with a senior member of staff who had not been previously involved in her complaint investigation.

15.3 Marcia Gallagher noted reference in the summary report to a change in timescales for referring complaints to the PHSO and she asked about the number of previous complainants the Trust would need to contact to advise of this change. The Director of Engagement and Integration said that there were some 130 complainants; however, this work had already been completed.

15.4 The Committee had discussed the current Information Governance committee structure within the Trust and agreed that the Information Governance and Health Records (IG&HR) committee be dissolved and the Information Governance Advisory Committee would remain as the Trust's sole IG committee, with enhanced membership from patient-facing services to

complement its current corporate-only membership. Jonathan Vickers asked whether the Trust had considered the opportunity of starting a joint IG committee with Gloucestershire Care Services. The Trust Secretary advised that 2gether did participate in a Gloucestershire wide IG forum; however, for the current time is was important to retain the Trust's sovereignty and operate as a separate organisation. Further consideration of this would take place at a later date.

16. BOARD COMMITTEE REPORTS – MH LEGISLATION SCRUTINY COMMITTEE

16.1 Quinton Quayle presented the summary report from the MH Legislation Scrutiny Committee meeting held on 10 January 2018. This report and the assurances provided were noted.

16.2 Quinton Quayle took the opportunity to express his thanks to the Trust's MH Act Managers for their work. MHAMs had a very important and sensitive role and it was important to recognise this.

17. INFORMATION SHARING REPORTS

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

- Chair's Report
- Council of Governors Minutes – November 2017
- Use of the Trust Seal – Quarter 3 2017/18

17.2 The Board noted the full assurance regarding engagement activities provided by the Chair's report.

18. ANY OTHER BUSINESS

18.1 There was no other business.

19. DATE OF THE NEXT MEETING

19.1 The next Board meeting would take place on Wednesday 28 March 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
30 Jan 2018	5.2	Director of E&I to link with the member of the public/complainant in attendance at the Board by way of arranging a meeting to discuss her concerns in more detail with the Trust	Jane Melton	Feb	**Complete**
	8.7	Future Guardian of Safe Working quarterly reports to separate out those genuine “still open” exceptions from those where it was clear that Trainees had simply forgotten to close down before they left the Trust	Amjad Uppal / Dr Abassi	April	To be actioned in next report to Board

[2]GETHER NHS FOUNDATION TRUST

EXTRAORDINARY BOARD MEETING
TRUST HQ, RIKENEL
22 FEBRUARY 2018

PRESENT Ingrid Barker, Trust Chair
Maria Bond, Non-Executive Director (via Phone)
Andrew Lee, Director of Finance
Jane Melton, Director of Engagement and Integration
Colin Merker, Acting Chief Executive
Nikki Richardson, Non-Executive Director
Amjad Uppal, Medical Director

IN ATTENDANCE Anna Hilditch, 2g Assistant Trust Secretary

1. WELCOMES, APOLOGIES AND INTRODUCTIONS

1.1 Apologies were received from Marie Crofts, Neil Savage, Marcia Gallagher, Jonathan Vickers, Duncan Sutherland and Quinton Quayle.

2. APPOINTMENT OF A JOINT CHIEF EXECUTIVE

2.1 The Board will recall the Trust's agreement with Gloucestershire Care Services NHS Trust (GCS) to commit to a Strategic Intent, Memorandum of Understanding and Heads of Terms. These aim to achieve the delivery of a successful business case for an organisational integration. The associated vision is to create a single provider of streamlined physical, mental health and learning disabilities services.

2.2 As part of the agreed process, both Trusts approved appointments processes for a Joint Chair and a Joint Chief Executive Officer. The former process was completed during 2017, with Ingrid Barker commencing in January 2018. Following an unsuccessful internal ring-fenced process for the Joint CEO Appointment, a national recruitment campaign was initiated.

2.3 The job description and person specification for this post were agreed previously by the Appointments and Terms of Service Committee and GCS. The process used for the appointment was comprehensive and included national advertising using on-line media and active searches through the Trust's Executive Search Agency – Gatenby Sanderson. The selection process included preliminary interviews with Gatenby Sanderson, Trust discussion groups (i.e. Board members from both 2g and GCS, Stakeholders, Governors, Experts By Experience, Service Heads and Staff Side), psychometric testing, and formal panel interview.

2.4 The panel interview included the following voting members – Ingrid Barker (2g and GCS Joint Chair), Nikki Richardson (2g Deputy Chair and Senior Independent Director) and Sue Mead (GCS Senior Independent Director). Additional non-voting members included Jennifer Howells (NHSE Regional Director – South Region), Ron Shields (CEO, Dorset – External Assessor), Rob Blagden (Lead Governor) and Dan Beale Cox (Expert by Experience). The process was supported by Neil Savage (Director of Organisational Development).

2.5 Five candidates were interviewed on 21st February 2018 and Ingrid Barker advised that two of the candidates had been identified as particularly strong candidates, with extensive and relevant experience which set them apart from the other applicants. Further discussions about the "fit" with the Board, the chemistry with the Chair and the relevance of experience in the context of the overall agenda facing the Trusts and the Gloucestershire Health Care system took place, from which Paul Roberts was identified as the strongest candidate who should be offered preferred candidate status.

2.6 Paul is the former Chief Executive of Abertawe Bro Morgannwg University Health Board (2011 to 2017). Prior to this, he was the Chief Executive of Plymouth Hospitals NHS Trust, the Chief Executive of Plymouth Community Services NHS Trust covering mental health and community services, Acting CEO of Northampton General Hospital NHS Trust and the Chief Executive of Grantham and District Hospital.

2.7 Paul has held a variety of national roles across the NHS which have included being a Trustee of the NHS Confederation, being Vice-chair of the Association of UK University Hospitals and a member of the Independent Reconfiguration Panel. He is a Graduate of Oxford University and holds a Diploma in Health Services Management and a Post Graduate Certificate in Public Administration from Warwick University.

2.8 The full suite of pre re-employment checks are continuing for the appointment and will need to be completed before an unconditional offer can be made to Paul Roberts, however Ingrid Barker advised that Paul had indicated acceptance of the post. The Trust is working towards a provisional start date of 16th April 2018.

2.9 Paul is seeking a salary of £172,450 per annum. In his most recent post Paul's salary was £200,000 per annum. The suggested offer of £172,450, the 6th point of the range, would reflect Pauls 20 years' plus experience of working as an Executive Director and Chief Executive in a wide range of roles and organisations across the NHS.

2.10 Ingrid Barker informed the Board that further due diligence had been carried out on the preferred candidate before the offer of the post was made. This included discussions with referees. It was noted that Paul Roberts had left his former position of Chief Executive of Abertawe Bro Morgannwg University Health Board in 2017 and the panel therefore sought assurance around the reasons for his leaving. Ingrid Barker said that those people that she, and Jennifer Howells from NHSE had spoken to, spoke very highly of Paul, his experience, his reputation and offered assurance around the reasons for Paul leaving Wales in 2017. Ingrid noted that some of the people that were contacted were very senior people in the NHS system who had highlighted Paul's achievements and corroborated the issues raised at interview.

2.11 Ingrid Barker added that Paul Roberts had also made extensive efforts in advance of the interviews to go out and visit services and key stakeholders in both Gloucestershire and Herefordshire and had carried out a good level of research about the Trust, the environment it was operating in and its future agenda.

2.12 The Board noted the decision of the Appointments and Terms of Service Committee to approve of the appointment of Paul Roberts to the post of Joint Chief Executive from a provisional start date of 16th April 2018 (to be confirmed).

2.13 The Board also noted that this appointment was subject to Council of Governor approval, a meeting for which would be taking place on 23rd February 2018. Ingrid Barker advised that Gloucestershire Care Services Remuneration Committee had earlier in the day fully supported the appointment of Paul as preferred candidate, subject to the completion of all final employment checks.

3. ANY OTHER BUSINESS

3.1 There was no other business.

4. DATE OF THE NEXT MEETING

4.1 The next Board meeting would take place on Tuesday 27th February 2018 at Trust HQ, Rikenel, Gloucester.

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

Agenda item **7** **Paper B**

Report to: 2gether NHS Foundation Trust Board – 28th March 2018
Author: Chris Woon, Head of Information Management and Clinical Systems
Presented by: Colin Merker, Acting Chief Executive

SUBJECT: **Performance Dashboard Report for the period to the end of January 2018 (month 10)**

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 January 2018 (month 10) of the 2017/18 contract period, against our NHSI, Department of Health, Herefordshire and Gloucestershire CCG Contractual and CQUIN key performance indicators.

Of the 178 performance indicators, 88 are reportable in January with 75 being compliant and 13 non-compliant at the end of the reporting period.

Gloucestershire CCG Contractual Indicators (Schedule 4) have been finalised with Commissioners and 23 new indicators are shown from ID 3.54 onwards.

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:

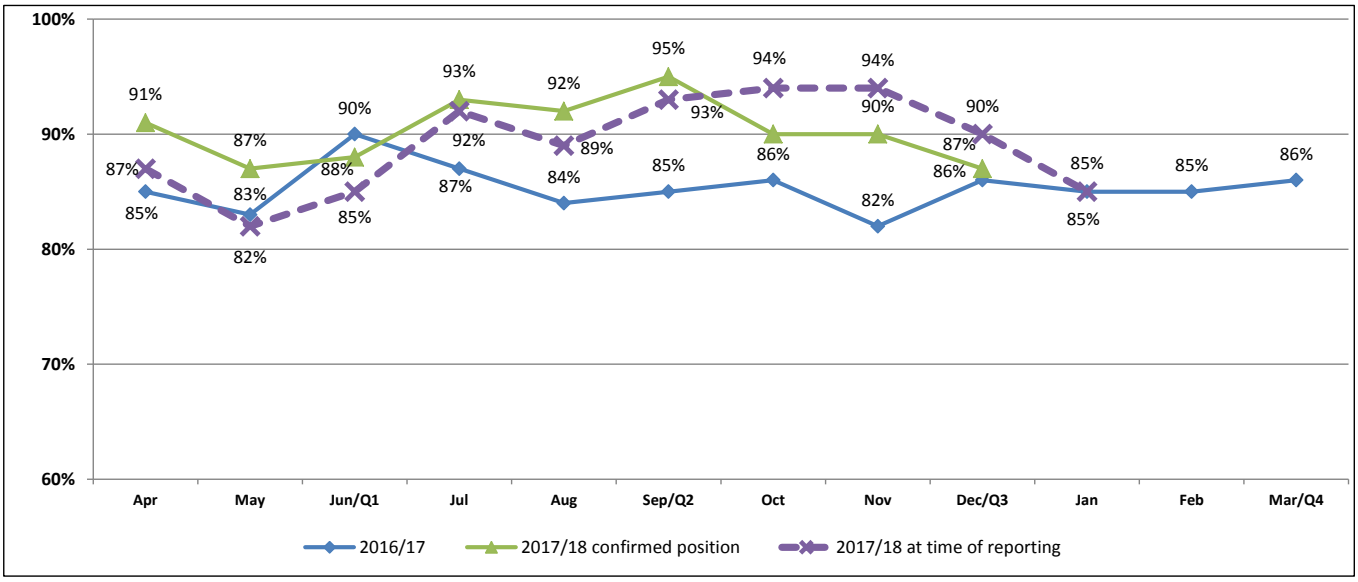
Work is ongoing in accordance with our agreed Service Delivery Improvement Plans to address the underlying issues affecting this performance.

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.

The following table summarises our performance position as at the end of January 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	NYA / UR
NHSi Requirements	14	13	11	2	15	1	0
Never Events	17	17	17	0	0	0	0
Department of Health	10	8	7	1	13	2	0
Gloucestershire CCG Contract	75	22	16	6	27	49	4
Social Care	15	13	12	1	8	2	0
Herefordshire CCG Contract	22	15	12	3	20	7	0
CQUINS	25	0	0	0	0	25	0
Overall	178	88	75	13	15	86	4

The following graph shows our percentage compliance by month and the previous year's compliance for comparison. The line "2017/18 confirmed position" shows the position of our performance reported a month in arrears to enable late data entry and late data validation to be taken into account.



October, November and December's previously reported position has changed due to new indicators now being reported for Gloucestershire CCG Contract and also indicators previously reported as Not Yet Available that can now be reported.

- October: Previously reported at 94%, confirmed position is 90%
- November: Previously reported at 94%, confirmed position is 90%
- December : Previously reported at 90%, confirmed position is 87%

Compliant indicators now reported for these months :

- 3.08: To reduce the numbers of detained patients absconding from inpatient units
- 3.17: AKI – 95% of patients to have an EWS score within 12 hours
- 3.31: Service Users supported to formulate vocational goals through individual plans
- 3:54: Children in crisis urgently referred from CYPS receive support within 24 hours
- 3.57: Women in the perinatal period showing reliable improvement in outcomes (IAPT)

Non-compliant indicators now reported for these months:

- 3.50: Adolescent Eating Disorders: Urgent referral to NICE treatment within 1 week
- 3.52: Adolescent Eating Disorders: Routine referral to NICE treatment within 4 weeks
- 3.53: Adolescent Eating Disorders: Routine referral to Non-NICE treatment within 4 weeks
- 3.64: Adult Eating Disorders: Referral to Assessment within 4 weeks

- 3.72: Perinatal: Number asked if they have a carer
- 3.73: Perinatal: Number with a carer offered a carer's assessment

Summary Exception Reporting

The following 13 key performance thresholds were not met for the Trust for January 2018:

NHS Improvement Requirements

- 1.09 – IAPT: Waiting times - Referral to Treatment within 6 weeks
- 1.10 – IAPT: Waiting times - Referral to Treatment within 18 weeks

DoH Requirements

- 2.21 – No children under 18 admitted to adult inpatient wards

Gloucestershire CCG Contract Measures

- 3.18 – IAPT: Recovery rate
- 3.19 – IAPT: Access rate
- 3.29 – Working age Adults: MDT assessments to have been completed within 4 weeks
- 3.52 – Adolescent Eating Disorders: Routine Referral to NICE treatment within 4 weeks
- 3.53 – Adolescent Eating Disorders: Routine Referral to Non-NICE treatment within 4 weeks
- 3.64 – Adult Eating Disorders: Wait time for assessments will be 4 weeks

Gloucestershire Social Care Measures

- 4.02 – Percentage of people receiving long-term services reviewed/ assessed in last year

Herefordshire CCG Contract Measures

- 5.07 – VTE risk assessment for all inpatients
- 5.08 – IAPT: Recovery rate
- 5.09 – IAPT maintain 15% of patients entering the service against prevalence

RECOMMENDATIONS

The Board is asked to:

- Note the Performance Dashboard Report for January 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:		
Colin Merker	Date	February 2018

Where in the Trust has this been discussed before?		
Delivery Committee	Date	21 February 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 CIRG Clinical Information Reference Group CPA Care Programme Approach CPDG Contract Performance and Development Group 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 MHICT Mental Health Intermediate Care Team 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 January 2018, month ten of the 2017/18 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 January 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 Where stated, 'Cumulative Compliance' refers to compliance recorded from the start of this contractual year April 2017 to the current reporting month, as a whole.

2.3 Indicator IDs has been colour coded in the tables to indicate whether a performance measure is a national or local requirement. Blue indicates the performance measure is national, while lilac means the measure is local.

	=	**Target not met**
	=	**Target met**
NYA	=	**Not Yet Available from Systems**
NYR	=	**Not Yet Required by Contract**
UR	=	**Under Review**
N/A	=	**Not Applicable**
Baseline	=	**2017/18 data reporting to inform 2018/19**

DASHBOARD CATEGORY - NHSI REQUIREMENTS

NHS Improvement Requirements				
	In month Compliance			Cumulative Compliance
	Nov	Dec	Jan	
Total Measures	14	14	14	14
	2	2	2	2
	11	11	11	11
NYA	0	0	0	0
NYR	0	0	0	0
UR	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):

 **1.09: IAPT: Waiting times - Referral to Treatment within 6 weeks**

Gloucestershire is compliant for January at 75%. Hereford and the Trust as a whole continue to be non-compliant.

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

 **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

1.09: IAPT: Waiting times - Referral to Treatment within 6 weeks

As above

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

As above

Changes to Previously Reported Figures

None

Early Warnings / Notes

None

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

1.09 & 1.10: IAPT: Waiting times - Referral to Treatment within 6 & 18 weeks

This forecast position will be reviewed when Commissioners discussions around investment and methodology are resolved.

NHS Improvement Requirements

ID	Performance Measure (PM)		2016/17Outturn	November-2017	December-2017	January-2018	(Apr to Jan) Cumulative Compliance	Forecast 17/18 Outturn
1								
1.01	Number of MRSA Bacteraemias	PM	0	0	0	0	0	0
		Gloucestershire	0	0	0	0	0	
		Herefordshire	0	0	0	0	0	
		Combined Actual	0	0	0	0	0	
1.02	Number of C Diff cases (day of admission plus 2 days = 72hrs) - avoidable	PM	0	0	0	0	0	0
		Gloucestershire	0	0	0	0	0	
		Herefordshire	3	0	0	0	0	
		Combined Actual	3	0	0	0	0	
1.03	Care Programme Approach follow up contact within 7 days of discharge	PM	95%	95%	95%	95%	95%	95%
		Gloucestershire	98%	100%	98%	98%	99%	
		Herefordshire	99%	100%	100%	100%	99%	
		Combined Actual	98%	100%	99%	99%	99%	
1.04	Care Programme Approach - formal review within12 months	PM	95%	95%	95%	95%	95%	95%
		Gloucestershire	99%	98%	98%	97%	98%	
		Herefordshire	99%	99%	98%	98%	98%	
		Combined Actual	99%	98%	98%	97%	98%	
1.05	Nationally reported - Delayed Discharges (Including Non Health)	PM	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%
		Gloucestershire	1.6%	3.9%	3.4%	3.2%	3.2%	
		Herefordshire	2.2%	3.5%	2.9%	2.5%	2.1%	
		Combined Actual	1.8%	3.8%	3.2%	3.0%	2.9%	
1.05b	- Delayed Discharges - Outliers	PM						
		Gloucestershire		10.3%	8.5%	9.0%	10.4%	
		Herefordshire		15.0%	10.2%	7.0%	13.0%	
		Combined Actual		11.5%	8.9%	8.5%	11.0%	
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%	98%	100%	99%	
		Herefordshire	100%	100%	100%	100%	100%	
		Combined Actual	99%	100%	98%	96%	99%	
1.07	New psychosis (EI) cases as per contract	PM	72	48	54	60	60	72
		Gloucestershire	67	51	60	64	64	
		PM	24	16	18	20	20	24
		Herefordshire	20	23	26	28	28	
		PM	96	64	72	80	80	96
		Combined Actual	87	74	86	92	92	
1.08	New psychosis (EI) cases treated within 2 weeks of referral	PM	50%	50%	50%	50%	50%	50%
		Gloucestershire	72%	100%	89%	50%	75%	
		Herefordshire	70%	50%	67%	50%	68%	
		Combined Actual	71%	86%	83%	50%	73%	

NHS Improvement Requirements

ID	Performance Measure (PM)		2016/17Outturn	November-2017	December-2017	January-2018	(Apr to Jan) Cumulative Compliance	Forecast 17/18 Outturn
1.09	IAPT - Waiting times: Referral to Treatment within 6 weeks (based on discharges)	PM	75%	75%	75%	75%	75%	75%
		Gloucestershire	35%	70%	70%	75%	68%	
		Herefordshire	49%	60%	77%	58%	58%	
		Combined Actual	38%	68%	71%	73%	66%	
1.10	IAPT - Waiting times: Referral to Treatment within 18 weeks (based on discharges)	PM	95%	95%	95%	95%	95%	95%
		Gloucestershire	86%	88%	87%	91%	88%	
		Herefordshire	85%	74%	83%	68%	75%	
		Combined Actual	86%	85%	86%	88%	85%	
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%	99.9%	
		Herefordshire	99.9%	99.9%	99.9%	99.9%	99.9%	
		Combined Actual	99.9%	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%	100.0%	
		Herefordshire	100.0%	100.0%	100.0%	100.0%	100.0%	
		Combined Actual	100.0%	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%	99.9%	
		Herefordshire	99.9%	99.9%	99.9%	99.9%	99.9%	
		Combined Actual	99.9%	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%	99.9%	99.9%	99.9%	99.9%	
		Herefordshire	99.9%	99.9%	99.9%	99.9%	99.9%	
		Combined Actual	99.9%	99.9%	99.9%	99.9%	99.9%	
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%	100.0%	
		Herefordshire	100.0%	100.0%	100.0%	100.0%	100.0%	
		Combined Actual	100.0%	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%	99.7%	99.8%	99.8%	99.8%	
		Herefordshire	99.8%	99.8%	99.9%	99.9%	99.9%	
		Combined Actual	99.8%	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	99.4%	99.7%	99.7%	99.7%	99.6%	
		Herefordshire	99.7%	99.7%	99.7%	99.7%	99.7%	
		Combined Actual	99.5%	99.7%	99.7%	99.7%	99.6%	

NHS Improvement Requirements

ID	Performance Measure (PM)		2016/17Outturn	November-2017	December-2017	January-2018	(Apr to Jan) Cumulative Compliance	Forecast 17/18 Outturn
1.12	MENTAL HEALTH SERVICES DATA SET PART 2 DATA COMPLETENESS : OVERALL	PM	50%	50%	50%	50%	50%	50%
		Gloucestershire	95.7%	94.3%	94.3%	94.2%	94.6%	
		Herefordshire	92.5%	90.4%	91.2%	91.2%	91.4%	
		Combined Actual	95.1%	93.6%	93.8%	93.7%	94.0%	
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	90.0%	88.8%	88.9%	88.9%	89.3%	
		Herefordshire	89.2%	86.5%	87.5%	87.9%	87.8%	
		Combined Actual	89.9%	88.4%	88.6%	88.7%	89.0%	
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	97.3%	96.3%	96.3%	96.1%	96.5%	
		Herefordshire	89.6%	86.9%	88.3%	88.7%	88.5%	
		Combined Actual	95.9%	94.6%	94.9%	94.7%	95.1%	
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	99.6%	97.9%	97.8%	97.6%	98.0%	
		Herefordshire	98.5%	97.7%	97.7%	97.0%	98.0%	
		Combined Actual	99.4%	97.9%	97.8%	97.5%	98.0%	
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	6	
		Herefordshire	6	6	6	6	6	
		Combined Actual	6	6	6	6	6	

DASHBOARD CATEGORY – DEPARTMENT OF HEALTH PERFORMANCE

DoH Performance				
	In month Compliance			Cumulative Compliance
	Nov	Dec	Jan	
Total Measures	27	27	27	27
	1	1	1	1
	24	24	24	25
NYA	0	0	0	0
NYR	1	1	1	0
UR	0	0	0	0
N/A	1	1	1	1

Performance Thresholds not being achieved in Month

2.21: No children under 18 admitted to adult inpatient wards

There was a single admission of a 17 year old to Stonebow in January 2018.

A plan was in place for admission to a national Eating Disorder unit and the patient was being cared for in the community until the bed became available. However, the patient's condition deteriorated and they were admitted to Wye Valley Trust and detained under S2 to Stonebow. The patient was transferred to a Tier 4 Eating Disorders bed in London 8 days later.

Cumulative Performance Thresholds Not being Met

2.21: No children under 18 admitted to adult inpatient wards

To date there have been 9 under 18s admitted to adult inpatient wards, 5 in Gloucestershire and 4 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)		2016/17Outturn	November-2017	December-2017	January-2018	(Apr to Jan) Cumulative Compliance	Forecast 17/18 Outturn
2								
2.01	Wrongly prepared high risk injectable medications	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.02	Maladministration of potassium containing solutions	PM	0	0	0	0	0	0
		Actual	0	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	0	
2.04	Intravenous administration of epidural medication	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.05	Maladministration of insulin	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.06	Overdose of midazolam during conscious sedation	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.07	Opioid overdose in opioid naive patient	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.08	Inappropriate administration of daily oral methotrexate	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.09	Suicide using non collapsible rails	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.10	Falls from unrestricted windows	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.11	Entrapment in bedrails	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.12	Misplaced naso - or oro-gastric tubes	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	
2.13	Wrong gas administered	PM	0	0	0	0	0	0
		Actual	0	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	0	
2.15	Air embolism	PM	0	0	0	0	0	0
		Actual	0	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	0	
2.17	Mis-identification of patients	PM	0	0	0	0	0	0
		Actual	0	0	0	0	0	

DOH Requirements

ID	Performance Measure (PM)		2016/17Outturn	November-2017	December-2017	January-2018	(Apr to Jan) Cumulative Compliance	Forecast 17/18 Outturn
2.18	Mixed Sex Accommodation - Sleeping Accommodation Breaches	PM	0	0	0	0	0	0
		Gloucestershire	0	0	0	0	0	
		Herefordshire	0	0	0	0	0	
		Combined	0	0	0	0	0	
2.19	Mixed Sex Accommodation - Bathrooms	Gloucestershire	Yes	Yes	Yes	Yes	Yes	
		Herefordshire	Yes	Yes	Yes	Yes	Yes	
		Combined	Yes	Yes	Yes	Yes	Yes	
2.20	Mixed Sex Accommodation - Women Only Day areas	Gloucestershire	Yes	Yes	Yes	Yes	Yes	
		Herefordshire	Yes	Yes	Yes	Yes	Yes	
		Combined	Yes	Yes	Yes	Yes	Yes	
2.21	No children under 18 admitted to adult in-patient wards	PM	0	0	0	0	0	0
		Gloucestershire	10	1	1	0	5	
		Herefordshire	8	0	0	1	4	
		Combined	18	1	1	1	9	
2.22	Failure to publish Declaration of Compliance or Non Compliance pursuant to Clause 4.26 (Same Sex accommodation)	Gloucestershire	Yes	Yes	Yes	Yes	Yes	
		Herefordshire	Yes	Yes	Yes	Yes	Yes	
		Combined	Yes	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	Yes	
		Herefordshire	Yes	Yes	Yes	Yes	Yes	

DOH Requirements

ID	Performance Measure (PM)		2016/17Outturn	November-2017	December-2017	January-2018	(Apr to Jan) Cumulative Compliance	Forecast 17/18 Outturn
2.24	Serious Incident Reporting (SI)	Glos	35	4	3	2	29	
		Hereford	8	0	1	1	16	
2.25	All SIs reported within 2 working days of identification	PM	100%	100%	100%	100%	100%	100%
		Gloucestershire	100%	100%	100%	100%	100%	
		Herefordshire	100%	N/A	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	91%	100%	100%	100%	100%	
		Herefordshire	78%	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	100%	
		Herefordshire	100%	NYR	NYR	NYR	100%	
2.28	SI Report Level 3 - Independent investigations - 6 months from investigation commissioned date	PM	100%	100%	100%	100%	100%	100%
		Gloucestershire	N/A	N/A	N/A	N/A	N/A	
		Herefordshire	N/A	N/A	N/A	N/A	N/A	
2.29	SI Final Reports outstanding but not due	Gloucestershire	2	3	3	2	9	
		Herefordshire	1	0	1	1	3	

DASHBOARD CATEGORY – GLOUCESTERSHIRE CCG CONTRACTUAL REQUIREMENTS

Gloucestershire Contract				
	In month Compliance			Cumulative Compliance
	Nov	Dec	Jan	
Total Measures	75	75	75	75
🔴	5	9	6	8
🟢	18	25	16	30
NYA	4	17	4	16
NYR	46	16	46	15
UR	0	0	0	0
N/A	2	8	3	6

Performance Thresholds not being achieved in Month

🚩 **3.18: IAPT: Recovery rate: Access to psychological therapies should be improved**
This service is subject to an agreed Service Development Improvement Plan which is under specific monthly review by the Delivery Committee.

🚩 **3.19: IAPT: Access rate: Access to psychological therapies should be improved**
This service is subject to an agreed Service Development Improvement Plan which is under specific monthly review by the Delivery Committee.

3.29 – Working age Adults: MDT assessments to have been completed within 4 weeks
There are 35 non-compliant records in January, of which 8 are for the recovery service and 3 for the perinatal service. These are currently being investigated as it is believed there may be missing entries from RiO.

The MUS service has 6 non-compliant records and discussions are ongoing as to whether it is appropriate to include this service within the indicator.

The remaining 18 records are for the Eating Disorder service. Waiting times for both Adults and Adolescents have lengthened due to increased demand.

3.52: Adolescent Eating Disorders: Routine Referral to NICE treatment within 4 weeks

3.53: Adolescent Eating Disorders: Routine Referral to Non-NICE treatment within 4 weeks

Commissioners have recognised the increasing number of referrals and the subsequent increase in severely ill young people with eating disorders. There is opportunity for allocated DH funding on a recurring basis to meet this need and further develop the services. In response an outline business case has been jointly authored with Commissioners and was shared in Dec 2017. This plan will deliver NHS England guidance on service design, access and waiting time standards. It is anticipated that the delivery of this proposal will improve CYP wait time targets.

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

This is the first time we have reported on this indicator and work is ongoing to remodel the Adult pathway and understand the increase in demand on the service.

Cumulative Performance Thresholds Not being Met

3.19: IAPT: Access rate: Access to psychological therapies should be improved

As above

3.38: Transition of CYPS to Adult Mental Health Care within 4 weeks

It is believed these are data quality issues as the progress notes provide positive evidence. The issues are a combination of diagnosis, care coordinator and cluser recovering captured in the correct fields within the period. Our community teams are investigating these but they are not yet resolved within the clinical system.

3.50: Adolescent Eating Disorders: Urgent Referral to NICE treatment within 1 week
3.52: Adolescent Eating Disorders: Routine Referral to NICE treatment within 4 weeks
3.53: Adolescent Eating Disorders: Routine Referral to Non-NICE treatment within 4 weeks

As above

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

As above

3.72: Perinatal: Number of women asked if they have a carer

This the first time this indicator has been reported for a single service and work is ongoing to improve the quality of recording.

3.73: Perinatal: Number of women with a carer that has been offered a carer's assessment

This the first time this indicator has been reported for a single service and work is ongoing to improve the quality of recording.

Changes to Previously Reported Figure

October, November and December's previously reported position has changed due to additional indicators now being reported for Gloucestershire CCG Contract and also indicators previously reported as Not Yet Available that can now be reported.

Compliant indicators now reported for these months:

- 3.08: To reduce the numbers of detained patients absconding from inpatient units
- 3.17: AKI – 95% of patients to have an EWS score within 12 hours
- 3.31: Service Users supported to formulate vocational goals through individual plans
- 3:54: Children in crisis urgently referred from CYPS receive support within 24 hours
- 3.57: Women in the perinatal period showing reliable improvement in outcomes (IAPT)

Non-compliant indicators now reported for these months:

- 3.50: Adolescent Eating Disorders: Urgent referral to NICE treatment within 1 week
- 3.52: Adolescent Eating Disorders: Routine referral to NICE treatment within 4 weeks
- 3.53: Adolescent Eating Disorders: Routine referral to Non-NICE treatment within 4 weeks
- 3.64: Adult Eating Disorders: Referral to Assessment within 4 weeks
- 3.72: Perinatal: Number asked if they have a carer
- 3.73: Perinatal: Number with a carer offered a carer's assessment

3.48: CPI: Referral to Assessment within 4 weeks
The performance threshold has risen from 80% to 85% and performance is measured against this from January 2018 onwards

3.49: CPI: Referral to Treatment within 16 weeks
The performance threshold has risen from 80% to 85% and performance is measured against this from January 2018 onwards

Early Warnings/Notes

3.30: Adult Mental Health Intermediate Care Teams (IAPT/ Nursing Integrated Service): Wait times from referral to screening assessment within 14 days of receiving referral
It is recognised that this indicator no longer gives a meaningful indication of performance within the new pathway model and is therefore now excluded from reporting requirements, while discussions continue with our commissioner.

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

3.18 & 3.19: IAPT Recovery rate and IAPT Access rate:
See earlier note on Page 8.

3.38: Transition- Joint discharge/ CPA reviews meeting within 4 weeks of Adult MH services accepting:
This is a new indicator which still needs to be reported/ agreed so outliers need to be considered when available.

3.39: Number and % of crisis assessments undertaken by the MHARS team on CYP age 16-25 with agreed timescales of 4 hours:
This is a new indicator which still needs to be reported/ agreed so outliers need to be considered when available.

3.50 – 3.53: Adolescent Eating Disorders Waiting Times
Due to the increasing numbers of referrals and the need for further development of the service, this indicator is not expected to be compliant by the end of the financial year.

3.64: 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. This indicator is not expected to be compliant by the end of the financial year.

3.72 & 3.73: Perinatal: Carers indicators
Work is ongoing to improve the quality of recording and it is not yet known if this indicator will be compliant by the end of the financial year.

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2016/17 outturn	November-2017	December-2017	January-2018	(Apr to Jan) Cumulative Compliance	Forecast 17/18 Outturn
	B. NATIONAL QUALITY REQUIREMENT							
3.01	Zero tolerance MRSA	PM	0	0	0	0	0	0
		Unavoidable	1	0	0	0	0	
3.02	Minimise rates of Clostridium difficile	PM	0	0	0	0	0	0
		Unavoidable	1	0	0	0	0	
3.03	Duty of candour	PM	Report	Report	Report	Report	Report	Report
		Actual	Compliant	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	99%	99%	99%	99%	99%	
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%	99%	97%	97%	98%	
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%	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				Q3 Report	Report
		Actual	Complete				Complete	
3.08	To reduce the numbers of detained patients absconding from inpatient units where leave has not been granted	PM	< 144		< 36		<108	< 144
		Actual	96		30		96	
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	Compliant				NYR	
3.10	Minimum of 5% increase in uptake of flu vaccination (15/16 55.3%	PM	>55.3%				Annual	Annual
		Actual	77.2%				NYR	
	Domain 2: Enhancing the quality of life of people with long-term conditions							
3.11	2G bed occupancy for Gloucestershire CCG patients	PM	> 91%	> 91%	> 91%	> 91%	> 91%	> 91%
		Actual	93%	94%	93%	92%	93%	
3.12	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	99%	100%	100%	100%	100%	

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2016/17 outturn	November-2017	December-2017	January-2018	(Apr to Jan) Cumulative Compliance	Forecast 17/18 Outturn
3.13	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%	99%	
3.14	Assessment of risk: % of those 2g service users on CPA to have a documented risk assessment	PM	95%		95%		95%	95%
		Actual	99%		99%		99%	
3.15	Assessment of risk: All 2g service users (excluding those on CPA) to have a documented risk assessment	PM	85%		85%		85%	85%
		Actual	95%		97%		96%	
3.16	Dementia should be diagnosed as early in the illness as possible: 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	95%	96%	89%	94%	93%	
3.17	AKI (previous CQUIN 1516) 95% of pts to have EWS score within 12 hours	PM	95%		95%		95%	95%
		Actual	99%		100%		99%	
	Domain 3: Helping people to recover from episodes of ill-health or following injury							
3.18	IAPT recovery rate: Access to psychological therapies for adults should be improved	PM	50%	50%	50%	50%	50%	50%
		Actual	47%	49%	55%	46%	51%	
3.19	IAPT access rate: Access to psychological therapies for adults should be improved	PM	15.00%	1.25%	1.25%	1.25%	15.00%	15.00%
		Actual	8.20%	1.32%	0.94%	1.06%	12.72%	
3.20	IAPT reliable improvement rate: Access to psychological therapies for adults should be improved	PM	50%	50%	50%	50%	50%	50%
		Actual	73%	69%	71%	67%	70%	
3.21	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	100%	
3.22	To send :Inpatient and day case discharge summaries electronically, within 24 hours to GP	PM	Report		TBC		TBC	Report
		Actual	Compliant		86%		86%	
	Domain 4: Ensuring that people have a positive experience of care							
3.23	To demonstrate improvements in staff experience following any national and local surveys	PM	Report				Annual	Annual
		Actual	Compliant				NYR	
	CYPS							
3.24	Number of children that received support within 24 hours of referral, for crisis home treatment (CYPS)	PM	95%		95%		95%	95%
		Actual	N/A		N/A		N/A	
3.25	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%	99%	99%	99%	

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2016/17 outturn	November-2017	December-2017	January-2018	(Apr to Jan) Cumulative Compliance	Forecast 17/18 Outturn
3.26	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	99%		98%		98%	
3.27	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	89%		79%		89%	
3.28	Level 2 and 3 – Referral to treatment within 10 weeks (excludes LD, YOS, inpatient and crisis/home treatment) (CYPS)	PM	90%		95%		95%	95%
		Actual	96%		92%		96%	
3.29	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	94%	88%	91%	84%	90%	
3.30	Adults Mental Health Intermediate Care Teams (New Integrated service) Wait times from referral to screening assessment within 14 days of receiving referral	PM	85%	85%	85%	85%	85%	85%
		Actual	65%					
	Vocational Services (Individual Placement and Support)							
3.31	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%		100%		100%	
3.32	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	52%				NYR	
3.33	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	66%				NYR	
3.34	The number of people supported to retain employment at 3/6/9/12+ months	PM	50%				50%	50%
		Actual	88%				NYR	
3.35	Fidelity to the IPS model	PM	Report				90%	90%
		Actual	Compliant				NYR	

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2016/17 outturn	November-2017	December-2017	January-2018	(Apr to Jan) Cumulative Compliance	Forecast 17/18 Outturn
	General Quality Requirements							
3.36	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	
3.37	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 4		TBC		TBC	Report
		Actual	Compliant		75%		75%	
3.38	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%		0%		0%	
3.39	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%
		Actual	NYR				NYR	
3.40	MHARS wait time to assessment (4 hours)	PM	TBC				TBC	TBC
		Actual	NYR				NYR	
	New KPIs for 2017/18							
3.41	LD: To deliver specialist support to people with learning disabilities in accordance with specifically developed pathways	PM					95%	95%
		Actual					NYR	
3.42	LD: To demonstrate a reduction in an individual's health inequalities thanks to the clinical intervention provided by 2gether learning disability services.	PM					TBC	TBC
		Actual					NYR	
3.43	LD: People with learning disabilities and their families report high levels of satisfaction with specialist learning disability services	PM					75%	75%
		Actual					NYR	
3.44	LD: To ensure all published clinical pathways accessed by people with learning disabilities are available in easy read versions	PM					95%	95%
		Actual					NYR	
3.45	LD: The CLDT 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%
		Actual					NYR	
3.46	Gloucestershire Sanctuary (Alexandra Road Wellbeing House) dataset available for Commissioners	PM		Report	Report	Report	Report	Report
		Actual		NYA	NYA	NYA	Compliant	
3.47	IAPT DNA rate	PM		<16%	<16%	<16%	<16%	<16%
		Actual		13%	12%	12%	13%	

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2016/17 outturn	November-2017	December-2017	January-2018	(Apr to Jan) Cumulative Compliance	Forecast 17/18 Outturn
3.48	CPI: Referral to Assessment within 4 weeks	PM		80%	80%	85%	85%	85%
		Actual		92%	89%	94%	89%	
3.49	CPI: Assessment to Treatment within 16 weeks	PM		80%	80%	85%	85%	85%
		Actual		100%	100%	100%	98%	
3.50	Adolescent Eating Disorders - Urgent referral to NICE treatment start within 1 week	PM		95%	95%	95%	95%	95%
		Actual		56%	33%	N/A	57%	
3.51	Adolescent Eating Disorders - Urgent referral to non-NICE treatment start within 1 week	PM		95%	95%	95%	95%	95%
		Actual		N/A	N/A	N/A	N/A	
3.52	Adolescent Eating Disorders - Routine referral to NICE treatment start within 4 weeks	PM		95%	95%	95%	95%	95%
		Actual		0%	25%	0%	22%	
3.53	Adolescent Eating Disorders - Routine referral to non-NICE treatment start within 4 weeks	PM		95%	95%	95%	95%	95%
		Actual		0%	N/A	0%	9%	
3.54	Number of children in crisis urgently referred that receive support within 24 hours of referral by CYPS	PM			95%		95%	95%
		Actual			100%		100%	
3.55	MHARS Wait time to Assessment: Triage wait time 1 hour	PM		TBC	TBC	TBC	TBC	TBC
		Actual		NYA	NYA	NYA	NYA	
3.56	MAS Post Diagnostic Support: Time from Referral to Assessment - 4 weeks	PM		85%	85%	85%	85%	85%
		Actual		NYA	NYA	NYA	NYA	
3.57	IAPT treatment outcomes: Women in the Perinatal period showing reliable improvement in outcomes between pre and post treatment	PM		50%	50%	50%	50%	50%
		Actual		85%	76%	69%	76%	
3.58	Patients with Dementia have weight assessments on admission	PM			85%		85%	85%
		Actual			NYA		NYA	
3.59	Patients with Dementia have weight assessments at weekly intervals	PM			85%		85%	85%
		Actual			NYA		NYA	
3.60	Patients with Dementia have weight assessments near discharge	PM			85%		85%	85%
		Actual			NYA		NYA	
3.61	Patients with Dementia have delirium screening on admission	PM			85%		85%	85%
		Actual			NYA		NYA	
3.62	Patients with Dementia have delirium screening at weekly intervals	PM			85%		85%	85%
		Actual			NYA		NYA	
3.63	Patients with Dementia have delirium screening near discharge	PM			85%		85%	85%
		Actual			NYA		NYA	

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2016/17 outturn	November-2017	December-2017	January-2018	(Apr to Jan) Cumulative Compliance	Forecast 17/18 Outturn
3.64	Eating Disorders - Wait time for adult assessments will be 4 weeks	PM		95%	95%	95%	95%	95%
		Actual		29%	44%	28%	33%	
3.65	Eating Disorders - Wait time for adult psychological interventions will be 16 weeks	PM		95%	95%	95%	95%	95%
		Actual		NYA	NYA	NYA	NYA	
3.66	Perinatal: Urgent Referral to Assessment within 4 hours - During working hours (unless otherwise negotiated with referrer or patient) in conjunction with Crisis Team	PM			85%		85%	95%
		Actual			NYA		NYA	
3.67	Perinatal: Out of hours emergencies assessed by MHARS to be discussed with the Specialist Perinatal Service the next working day	PM			85%		85%	95%
		Actual			NYA		NYA	
3.68	Perinatal: Urgent referrals with High risk indicators (following telephone screening) will be seen with 48 working hours	PM			95%		95%	95%
		Actual			NYA		NYA	
3.69	Perinatal: Preconception advice - Referral to assessment within 6 weeks	PM			95%		95%	95%
		Actual			NA		NA	
3.70	Perinatal: Preconception advice - Referral to assessment within 8 weeks	PM			95%		95%	95%
		Actual			NA		NA	
3.71	Perinatal: Routine referral to assessment within 4 weeks	PM			95%		95%	95%
		Actual			NYA		NYA	
3.72	Perinatal: Number of women asked if they have a carer	PM			80%		80%	80%
		Actual			74%		74%	
3.73	Perinatal: Number of women with a carer offered carer's assessment	PM			90%		90%	90%
		Actual			86%		86%	
3.74	Perinatal: Women and families views inform the development of the service via a service user forum	PM			Report		Report	Annual
		Actual			NYA		NYA	
3.75	Perinatal: All to have a Perinatal Care Plan and reviewed within 3 months	PM			95%		95%	95%
		Actual			NYA		NYA	
3.76	Perinatal: Reduction in number of episodes of Crisis	PM			Report		Report	Annual
		Actual			NYA		NYA	

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.

Changes to Previously Reported Figures

None

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

1.09 & 1.10: IAPT: Waiting times - Referral to Treatment within 6 & 18 weeks
See earlier note on Page 8.

2.21: No children under 18 admitted to adult inpatient wards
See earlier note on Page 13.

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

ID	Performance Measure (PM)		2016/17Outturn	November-2017	December-2017	January-2018	(Apr to Jan) Cumulative Compliance	Forecast 17/18 Outturn
NHSI 1.01	Number of MRSA Bacteraemias avoidable	PM	0	0	0	0	0	0
		Actual	0	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	0	0
		Actual	0	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	98%	100%	98%	98%	99%	
NHSI 1.05	Delayed Discharges (Including Non Health)	PM	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%
		Actual	1.6%	3.9%	3.4%	3.2%	3.2%	
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%	98%	100%	99%	
NHSI 1.08	New psychosis (EI) cases treated within 2 weeks of referral	PM	50%	50%	50%	50%	50%	50%
		Actual	72%	100%	89%	50%	75%	
NHSI 1.09	IAPT - Waiting times: Referral to Treatment within 6 weeks (based on discharges)	PM	75%	75%	75%	75%	75%	75%
		Actual	35%	70%	70%	75%	68%	
NHSI 1.10	IAPT - Waiting times: Referral to Treatment within 18 weeks (based on discharges)	PM	95%	95%	95%	95%	95%	95%
		Actual	86%	88%	87%	91%	88%	
DoH 2.18	Mixed Sex Accommodation Breach	PM	0	0	0	0	0	0
		Actual	0	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	10	1	1	0	5	
DoH 2.25	All SIs reported within 2 working days of identification	PM	100%	100%	100%	100%	100%	100%
		Actual	100%	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%	N/A	100%	100%	100%	100%
		Actual	91%	100%	100%	100%	100%	
DoH 2.27	SI Report Levels 1 & 2 to CCG within 60 working days	PM	91%	100%	100%	100%	100%	100%
		Actual	100%	NYR	NYR	NYR	100%	

DASHBOARD CATEGORY – GLOUCESTERSHIRE SOCIAL CARE

Gloucestershire Social Care				
	In month Compliance			Cumulative Compliance
	Nov	Dec	Jan	
Total Measures	15	15	15	15
	0	0	1	1
	13	13	12	12
NYA	0	0	0	0
NYR	0	0	0	0
UR	0	0	0	0
N/A	2	2	2	2

Performance Thresholds not being achieved in Month

4:02: **Percentage of people receiving long-term services reviewed/ assessed in last year**
There are 13 non-compliant records which are currently being investigated by services.

Cumulative Performance Thresholds Not being Met

4.03: Ensure that reviews of new packages take place within 12 weeks
Previous data quality and reporting issues in earlier months has led to this indicator being cumulatively non-compliant. These issues are now being addressed and performance is reported as compliant since September 2017.

Changes to Previously Reported Figures
None

Early Warnings/Notes
None

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

4.03: Ensure that reviews of new packages take place within 12 weeks
Data quality and reporting issues appear to have improved and the year-end performance forecast is regularly reviewed with service delivery colleagues. It remains at amber due to the current cumulative performance not meeting the threshold.

Gloucestershire Social Care

ID	Performance Measure		2016/17 outturn	November-2017	December-2017	January-2018	(Apr to Jan) Cumulative Compliance	Forecast 17/18 Outturn
4.01	The percentage of people who have a Cluster recorded on their record	PM	90%	90%	90%	95%	95%	95%
		Actual	96%	97%	97%	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	95%	97%	98%	92%	92%	
4.03	Ensure that reviews of new packages take place within 12 weeks of commencement	PM	95%	80%	80%	80%	80%	80%
		Actual	22%	100%	100%	100%	73%	
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	12.90	9.36	9.86	9.86	9.39	
4.05	Current placements aged 65+ to residential and nursing care homes per 100,000 population	PM	22	22	22	22	22	22
		Actual	16.55	17.90	17.90	17.90	15.91	
4.06	% of WA & OP service users on caseload asked if they have a carer	PM	100%	80%	80%	80%	80%	100%
			86%	87%	87%	89%	89%	
4.07	% of WA & OP service users on the caseload who have a carer, who have been offered a carer's assessment	PM	100%	90%	90%	90%	90%	100%
		Actual	75%	95%	93%	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	39%	43%	43%	43%	43%	
4.08b	Number of WA & OP service users/carers on caseload who accepted a carers assessment	PM	TBC	TBC	TBC	TBC	TBC	TBC
		Actual	244	508	511	510	510	
4.09	% of eligible service users with Personal budgets	PM	80%	80%	80%	80%	80%	80%
		Actual	100%	95%	94%	94%	94%	

Gloucestershire Social Care

ID	Performance Measure		2016/17 outturn	November-2017	December-2017	January-2018	(Apr to Jan) Cumulative Compliance	Forecast 17/18 Outturn
4.10	% of eligible service users with Personal Budget receiving Direct Payments (ASCOF 1C pt2)	PM	15%	15%	15%	15%	15%	15%
		Actual	18%	21%	20%	19%	19%	
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	89%	88%	88%	88%	88%	
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%	96%	
4.13	Adults subject to CPA receiving secondary mental health service in employment (ASCOF 1F)	PM	13%	13%	13%	13%	13%	13%
		Actual	16%	17%	17%	18%	18%	
4.14	Adults not subject to CPA receiving secondary mental health service in employment	PM	20%	20%	20%	20%	20%	20%
		Actual	24%	22%	22%	23%	23%	

DASHBOARD CATEGORY – HEREFORDSHIRE CCG CONTRACTUAL REQUIREMENTS

Herefordshire Contract				
	In month Compliance			Cumulative Compliance
	Nov	Dec	Jan	
Total Measures	22	22	22	22
	1	3	3	3
	15	13	12	13
NYA	0	0	0	0
NYR	0	0	0	0
UR	0	0	0	0
N/A	6	6	7	6

Performance Thresholds not being achieved in Month

5.07 – VTE risk assessment for all inpatients
There are 2 non-compliant cases for January which are being investigated. Initial findings show that 1 may be a recording error and once confirmed the indicator will become compliant.


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.


5.09: 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.

Cumulative Performance Thresholds Not being

5.08: IAPT: Recovery rate
As above

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

5.17: CYP Eating Disorders: Treatment waiting times for urgent referrals within 1 week – NICE treatments

There was 1 treatment started in June. The client's family were contacted on day 7 with an offer to be seen that day however the service were unable to get a response. When the family did respond an appointment was agreed for the following week and treatment was started at that appointment.

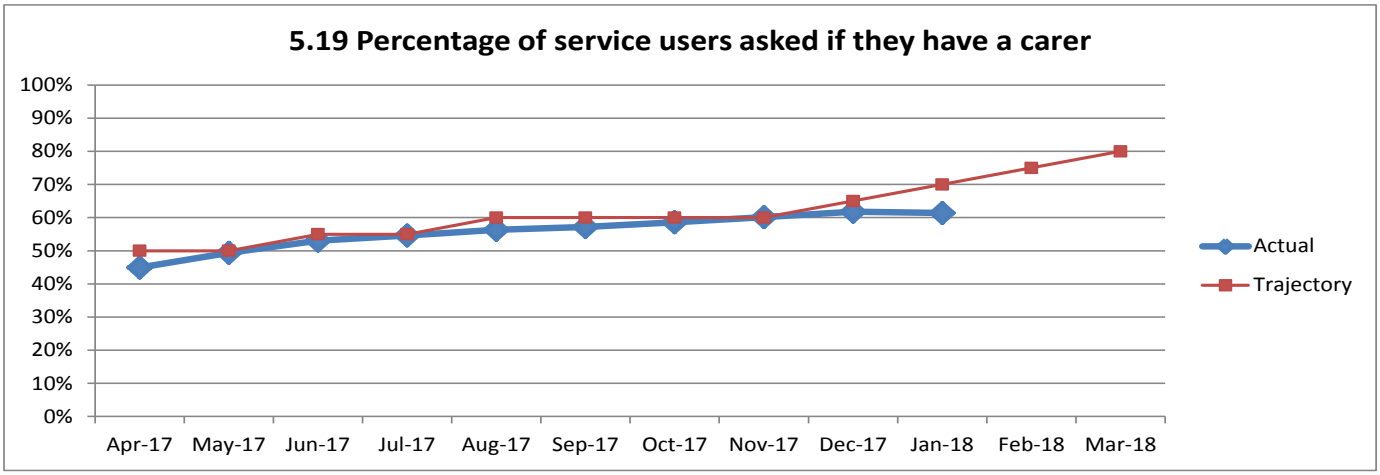
Changes to Previously Reported Figures

None

Early Warnings / Notes

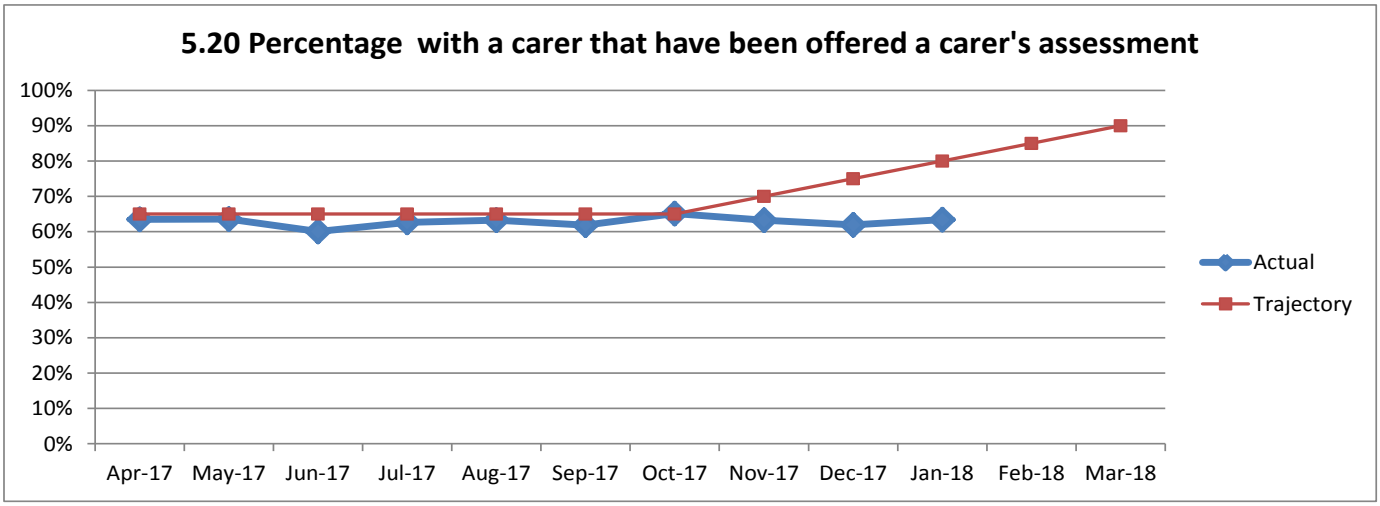
5.19: Percentage of service users asked if they have a carer

The following chart monitors progress against a trajectory to reach 80% by the end of the financial year. Performance has begun to deviate from the desired trajectory.



5.20: Percentage with a carer that have been offered a carer's assessment

The following chart monitors progress against a trajectory to reach 90% by the end of the financial year.



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

5.09: IAPT roll-out (access rate) – IAPT maintain 15% of patient entering the service against prevalence:
See earlier note on Page 8.

5.15 & 5.16: 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 & 5.18: 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		2016/17 Outturn	November-2017	December-2017	January-2018	(Apr to Jan) Cumulative Compliance	Forecast 17/18 Outturn
5.01	Duty of Candour	Plan	Report	Report	Report	Report	Report	Report
		Actual	Compliant	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	99%	99%	99%	99%	99%	
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%	100%	96%	99%	
5.04	Completion of IAPT Minimum Data Set outcome data for all appropriate service users	Plan	90%	90%	90%	90%	90%	90%
		Actual	99%	100%	100%	100%	99%	
5.05	Zero tolerance MRSA	Plan	0	0	0	0	0	0
		Unavoidable	0	0	0	0	0	
5.06	Minimise rates of Clostridium difficile	Plan	0	0	0	0	0	0
		Unavoidable	1	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	99%	100%	100%	93%	98%	
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	43%	57%	46%	46%	49%	
5.09	IAPT Roll-out (Access Rate) - IAPT maintain 15% of patient entering the service against prevalence	Plan	2178	1,452	1,634	1,815	1,815	2178
		Actual	1,191	1,369	1,453	1,602	1,602	

Herefordshire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2016/17 Outturn	November-2017	December-2017	January-2018	(Apr to Jan) Cumulative Compliance	Forecast 17/18 Outturn
5.10a	Dementia Service - number of new patients aged 65 years and over receiving an assessment	Plan	540	45	45	45	450	540
		Actual	572	68	33	60	533	
5.10b	Dementia Service - total number of new patients receiving an assessment	Plan						
		Actual	610	75	34	63	568	
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%	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	98%	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	88%	86%	86%	82%	86%	
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	98%	97%	100%	97%	96%	

Herefordshire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2016/17 Outturn	November-2017	December-2017	January-2018	(Apr to Jan) Cumulative Compliance	Forecast 17/18 Outturn
New KPIs for 2017/18								
5.15	CYP Eating Disorders: Treatment waiting time for routine referrals within 4 weeks - NICE treatments	Plan		95%	95%	95%	95%	95%
		Actual		100%	100%	100%	96%	
5.16	CYP Eating Disorders: Treatment waiting time for routine referrals within 4 weeks - non-NICE treatments	Plan		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%
		Actual		100%	100%	NA	80%	
5.18	CYP Eating Disorders: Treatment waiting time for urgent referrals within 1 week - non-NICE treatments	Plan		95%	95%	95%	95%	95%
		Actual		N/A	N/A	N/A	N/A	

Herefordshire Carers Information

ID	Performance Measure		2016/17 Outturn	November-2017	December-2017	January-2018	(Apr to Jan) Cumulative Compliance	Forecast 17/18 Outturn
5.19	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	41%	60%	62%	61%	61%	
5.20	Working Age and Older People service users on the caseload who have a carer who have been offered a carer's assessment. (Only includes people referred since 1st March 2016, when the new Carers Form went live on RiO).	Plan						
		Actual	58%	63%	62%	63%	63%	
5.21	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	35%	35%	34%	34%	34%	

Schedule 4 Specific Measures that are reported Nationally

Performance Thresholds not being achieved in Month

NHS Improvement

1.09: IAPT Waiting times: Referral to Treatment within 6 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.

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 a single admission of a 17 year old to Stonebow in January 2018.

A plan was in place for admission to a national Eating Disorder unit and the patient was being cared for in the community until the bed became available.

However the patient's condition deteriorated and they were admitted to Wye Valley Trust and detained under S2 to Stonebow. The patient was transferred to a Tier 4 Eating Disorders bed in London 8 days later.

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

1.09 & 1.10: IAPT: Waiting times - Referral to Treatment within 6 & 18 weeks
See earlier note on Page 8.

2.21: No children under 18 admitted to adult inpatient wards
See earlier note on Page 13.

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

ID	Performance Measure (PM)		2016/17Outturn	November-2017	December-2017	January-2018	(Apr to Jan) Cumulative Compliance	Forecast 17/18 Outturn
NHSI 1.01	Number of MRSA Bacteraemias avoidable	PM	0	0	0	0	0	0
		Actual	0	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	0	0
		Actual	3	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%	99%	
NHSI 1.04	Care Programme Approach - formal review within12 months	PM	95%	95%	95%	95%	95%	95%
		Actual	99%	99%	98%	98%	98%	
NHSI 1.05	Delayed Discharges (Including Non Health)	PM	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%
		Actual	2.2%	3.5%	2.9%	2.5%	2.1%	
NHSI 1.08	New psychosis (EI) cases treated within 2 weeks of referral	PM	50%	50%	50%	50%	50%	50%
		Actual	70%	50%	67%	50%	68%	
NHSI 1.09	IAPT - Waiting times: Referral to Treatment within 6 weeks (based on discharges)	PM	75%	75%	75%	75%	75%	75%
		Actual	49%	60%	77%	58%	58%	
NHSI 1.10	IAPT - Waiting times: Referral to Treatment within 18 weeks (based on discharges)	PM	95%	95%	95%	95%	95%	95%
		Actual	85%	74%	83%	68%	75%	
DoH 2.18	Mixed Sex Accommodation Breach	PM	0	0	0	0	0	0
		Actual	0	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	8	0	0	1	4	

DASHBOARD CATEGORY – GLOUCESTERSHIRE CQUINS

Gloucestershire CQUINS				
	In month Compliance			Cumulative Compliance
	Nov	Dec	Jan	
Total Measures	12	12	12	12
	0	0	0	0
	0	7	0	9
NYA	0	0	0	0
NYR	12	5	12	3
UR	0	0	0	0
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)		2016/17Outturn	November-2017	December-2017	January-2018	(Apr to Jan) Cumulative Compliance	Forecast 17/18 Outturn
	CQUIN 1							
7.01a	Improvement of health and wellbeing of NHS Staff	PM			Report		Report	Report
		Actual			NYR		NYR	
7.01b	Healthy food for NHS staff, visitors and patients	PM			Report		Report	Report
		Actual			NYR		NYR	
7.01c	Improving the update of flu vaccinations for frontline clinical staff	PM			Report		Report	Report
		Actual			NYR		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			Report		Qtr 1	Report
		Actual			NYR		Awarded	
7.02b	Improving Physical healthcare to reduce premature mortality in people with SMI: Collaboration with primary care clinicians	PM			Report		Qtr 3	Report
		Actual			Compliant		Compliant	
	CQUIN 3							
7.03	Improving services for people with mental health needs who present to A&E	PM			Report		Qtr 3	Report
		Actual			Compliant		Compliant	
	CQUIN 4							
7.04	Transition from Young People's Service to Adult Mental Health Services	PM	Qtr 4		Report		Qtr 2	Report
		Actual	Compliant		NYR		Compliant	
	CQUIN 5							
7.05a	Preventing ill health by risky behaviours - alcohol and tobacco: Tobacco screening	PM			Report		Qtr 3	Report
		Actual			Compliant		Compliant	
7.05b	Preventing ill health by risky behaviours - alcohol and tobacco: Tobacco brief advice	PM			Report		Qtr 3	Report
		Actual			Compliant		Compliant	
7.05c	Preventing ill health by risky behaviours - alcohol and tobacco: Tobacco referral and medication	PM			Report		Qtr 3	Report
		Actual			Compliant		Compliant	
7.05d	Preventing ill health by risky behaviours - alcohol and tobacco: Alcohol screening	PM			Report		Qtr 3	Report
		Actual			Compliant		Compliant	
7.05e	Preventing ill health by risky behaviours - alcohol and tobacco: Alcohol brief advice or referral	PM			Report		Qtr 3	Report
		Actual			Compliant		Compliant	

DASHBOARD CATEGORY – LOW SECURE CQUINS

Low Secure CQUINS				
	In month Compliance			Cumulative Compliance
	Nov	Dec	Jan	
Total Measures	1	1	1	1
	0	0	0	0
	0	1	0	1
NYA	0	0	0	0
NYR	1	0	1	0
UR	0	0	0	0
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)		2016/17Outturn	November-2017	December-2017	January-2018	(Apr to Jan) Cumulative Compliance	Forecast 17/18 Outturn
	CQUIN 1							
8.01	Reducing the length of stay in specialised MH services	PM	Qtr 4		Report		Qtr 3	Report
		Actual	Compliant		Compliant		Compliant	

DASHBOARD CATEGORY – HEREFORDSHIRE CQUINS

Herefordshire CQUINS				
	In month Compliance			Cumulative Compliance
	Nov	Dec	Jan	
Total Measures	12	12	12	12
🔴	0	0	0	0
🟢	0	7	0	9
NYA	0	0	0	0
NYR	12	5	12	3
UR	0	0	0	0
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)		2016/17Outturn	November-2017	December-2017	January-2018	(Apr to Dec) Cumulative Compliance	Forecast 17/18 Outturn
	CQUIN 1							
9.01a	Improvement of health and wellbeing of NHS Staff	PM	Qtr 4		Report		Report	Report
		Actual	Compliant		NYR		NYR	
9.01b	Healthy food for NHS Staff, Visitors and Patients	PM	Qtr 4		Report		Report	Report
		Actual	Compliant		NYR		NYR	
9.01c	Improving the uptake of Flu vaccinations for Front Line Clinical Staff	PM	Qtr 4		Report		Report	Report
		Actual	Compliant		NYR		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 3		Report		Report	Report
		Actual	Compliant		NYR		Awarded	
9.02b	Improving Physical healthcare to reduce premature mortality in people with SMI: Collaborating with primary care clinicians	PM			Report		Qtr 3	Report
		Actual			Compliant		Compliant	
	CQUIN 3							
9.03	Improving services for people with mental health needs who present to A&E	PM			Report		Qtr 3	Report
		Actual			Compliant		Compliant	
	CQUIN 4							
9.04	Transition from Young People's Service to Adult Mental Health Services	PM			Report		Qtr 2	Report
		Actual			NYR		Awarded	
	CQUIN 5							
9.05a	Tobacco screening	PM			Report		Qtr 3	Report
		Actual			Compliant		Compliant	
9.05b	Tobacco brief advice	PM			Report		Qtr 3	Report
		Actual			Compliant		Compliant	
9.05c	Tobacco referral and medication offer	PM			Report		Qtr 3	Report
		Actual			Compliant		Compliant	
9.05d	Alcohol screening	PM			Report		Qtr 3	Report
		Actual			Compliant		Compliant	
9.05e	Alcohol brief advice or referral	PM			Report		Qtr 3	Report
		Actual			Compliant		Compliant	

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

Report to: 2gether NHS Foundation Trust Board – 28 March 2018
Author: Angie Fletcher, Service Experience Clinical Manager
Presented by: Jane Melton, Director of Engagement and Integration

Subject: **Service Experience Report Quarter 3 2017/18**

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

EXECUTIVE SUMMARY

This Service Experience Report provides a high level overview of feedback received from service users and carers in Quarter 3 2017/18. The Trust continues to seek feedback about service experience from multiple sources on a continuous basis.

Learning from people's experiences is the key purpose of this paper. It provides assurance that service experience information has been reviewed, scrutinised for themes, and considered for both service-specific and general learning across the organisation.

An update on complaints referred for external review following investigation by our Trust is included within this report including recent recommendations by the PHSO in Q3 and assurance of Trust subsequent learning and action.

(1) Areas of assurance

Significant assurance that the organisation has listened to, heard and understood Service User and carer experience of 2gether's services.
This assurance is offered following a triangulation of information gathered across all domains of feedback including complaints, concerns, comments and compliments. Local and National survey information about 2gether's services has been considered to understand people's experience of our service.

Significant assurance that service users value the service being offered and would recommend it to others.
During Quarter 3, 85% of people who completed the Friends and Family Test said that they would recommend 2gether's services. This score is lower than the previous quarter although is relatively consistent with that received in 2016/17. Response rates have increased this quarter which may have an impact on the overall FFT score. Importantly, we have had higher numbers of responses from people who have had contact with our inpatient services. Overall, the Trust continues to maintain a high percentage of people who would recommend our services.

<u>Limited assurance</u> 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. The SED are working with operational colleagues to raise awareness of the importance of encouraging feedback about our services using this survey. The SED are also exploring additional ways in which clinical services can be supported to increase service experience feedback.

<u>Significant assurance</u> that services are consistently reporting details of compliments they have received.
Compliments continue to be reported to the Service Experience Department. Numbers have increased during Quarter 3 and work continues to increase reporting by colleagues throughout the Trust.

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

<u>Limited assurance</u> that all people who complain have their complaint dealt with by the initially agreed timescale.
67% of complaints were closed within timescales agreed with the complainant. This is a decrease from previous Quarters. The SED are working with Trust colleagues to identify the reason for delay and ensure that future complaints are managed in a timely way.

<u>Significant assurance</u> that all complainants receive regular updates on any potential delays in the response being provided.

(2) Recommended learning and improvement
Examples of learning and mechanisms adopted to assure action are integrated throughout this report (eg Pages 9, 11, 13 and 16). A dedicated section on learning and assurance of action is provided in Section three, pages 20, 21, 22).

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 developing practice in this area – the continued implementation of the Triangle of Care is an example of this.

Other learning themes identified following triangulation of all types of service experience information include the following:

- We must write information in health records that is based on fact. If opinion is written it must be clearly labelled as such.
- We must listen carefully to families and carers. We must answer their questions fully whenever we can.

Further mechanisms for assurance of learning throughout the organisation will be discussed at the Quality and Clinical Risk Sub-Committee.

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 Q3 2017/18 and makes key recommendations for actions to enhance quality of care.
Resource Implications	The Service Experience Report offers assurance to the Trust that leadership is in place to drive development in delivery of best service experience.
Equalities Implications	Delivering best services experience to people across all communities who access / need to access services is important.
Risk Implications	Feedback on service experience offers an insight into how services are received. The information provides a mechanism for identifying clinical, performance and reputational risks. This paper offers limited assurance on 2 aspects covered by the report. The SED are taking action with operational and clinical colleagues in order to identify and mitigate risks associated with this. The SED monitor performance indicators particularly those relating to areas of limited assurance and regularly review the mitigating actions. Failure to learn from service experience feedback risks continuing a cycle of poor service experience in some circumstances.

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	March 2018

Where in the Trust has this been discussed before?		
Governance Committee		February 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
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 3

1st October 2017 to 31st December 2017

> **"**I felt as if the individuals I saw cared and wanted to help. If I felt like I needed more support or help from someone else, something was always organised to help.**"**
>
> *CAMHS, Herefordshire*

> **"**The service/help we received is real time and tailored for our family's needs. We are grateful for the help we receive.**"**
>
> *CYPS, 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
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)

Service Experience Report

1st October 2017 to 31st December 2017

Complaints 	**15** complaints (65 separate issues) were made this quarter. This is less than last time (n=19). We want people to tell us about any worries about their care. This means we can make it better.	↓
Concerns 	**44** concerns were raised through PALS. This is the same as last time (n=44).	↔
Compliments 	**454** people told us they were pleased with our service. This is more than last time (n=449). We want teams to tell us about every compliment they get.	↑
FFT 	**85%** of people said they would recommend our service to their family or friends. This is less than last time (n=90%). Lots more people answered the question.	↓
Quality Survey 	Gloucestershire: **29 people told us what they thought** Herefordshire: **43 people told us what they thought** Some people are telling us what they think about their care. We need to ask more people for their thoughts and views.	↔ (number of replies)
We must listen 	We must write information in health records that is based on fact. We must listen carefully to families and carers. We must fully answer their questions.	

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 October 2017 and 31st December 2017**. 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 brought together through service experience reporting and 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) (please see below). The Service Experience Strategy will be reviewed and updated during 2017/18 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

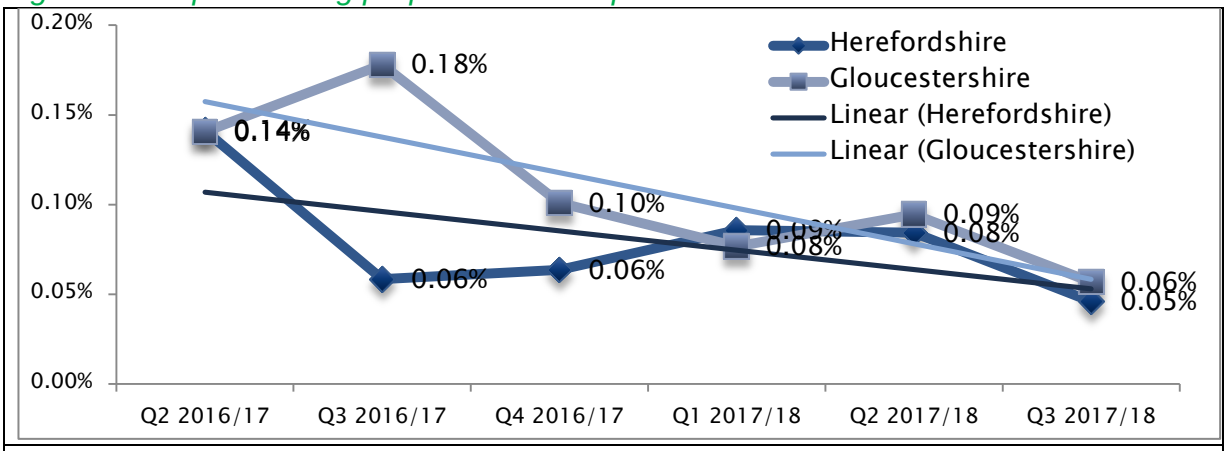
2.1 Complaints

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 Complaints Policy). 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	↓	A small decrease in the number of complaints has been reported in Gloucestershire (Q2 n=16)	Significant
Herefordshire	2	↓	A small decrease in the number of complaints has been reported in Herefordshire (Q2 n=3).	Significant
Total	15	↓	The total number of complaints received is slightly lower than the previous quarter (Q2 n=19)	Significant

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



The proportion of complaints to contacts has fluctuated minimally over time, remaining very low and relatively consistent

Table 2: Responsiveness

Target	Number (numerical direction)		Interpretation	Assurance
Acknowledged with three days	100%	↔	**All** complaints were acknowledged within target timeframes (Q2=100%)	Full
Response received within agreed timescales	67%	↓	This is lower than last quarter (Q2=93%). 6 letters of response were delayed and were not received by the complainant by the date agreed.	Limited
Concerns escalated to complaint	2%	↓	Of 44 concerns received (Q2=44), one was escalated; this is less than last quarter (Q2=11%)	Significant

2.1.2 The Service Experience Department (SED) acknowledged all complaints within the national standards for response times for this quarter (Table 2).

2.1.3 The timeliness to close complaints within the initially agreed timescale decreased this quarter for the first time in a year (Table 2). The 6 delays were due to: 2 complex investigations that required more time to fully investigate the issues raised; 2 signed service-level checklists approving the investigations were received late and delayed the response being sent; and a further 2 complaint responses were delayed due to issues related to final review and approval. The SED continue to monitor delayed responses carefully as well as ensuring that the complaints policy is adhered to in relation to all aspects of complaint handling. When delays were encountered the SED apologised and kept complainants informed of the progress in relation to the response to their complaint.

Table 3: Satisfaction with complaint process

Measure	Number (numerical direction)		Interpretation	Assurance
Reopened complaints	2	↑	This figure is slightly higher than the previous quarter (Q2 n=1)	Significant
Local Resolution Meetings	1	↓	This figure is lower than the previous quarter (Q2 n=4).	Significant
Referrals to PHSO	1	↓	One complaint was referred to the PHSO this quarter. (Q2 n=2).The PHSO reviewed this complaint and have closed the case with no further action.	Significant

2.1.4 Quarter 3 has seen a continued decrease in the number of complaints requiring additional action following investigation and detailed response to the complainant. This could suggest that the complaint investigation process continues to be generally robust and that complaint response letters explain and answer the queries raised by complainants without the need for further clarification.

Table 4: Outcome of complaints closed this quarter

Outcome	No.	%	
Not upheld *No element of the complaint was upheld*	4	20%	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 formal reporting purposes.
Partially upheld *Some elements of the whole complaint were upheld*	13	65%	In total 20 complaints were closed this quarter, this is similar to Q2 (n=19).
Upheld *All elements of the whole complaint were upheld*	2	10%	65% of the complaints closed this quarter had some but not all of the issues within the complaint upheld; 20% had all issues of complaint fully upheld. This differs slightly to the previous quarter (74% partially upheld, 0% upheld).
Withdrawn *Complaint was withdrawn*	1	5%	

**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*

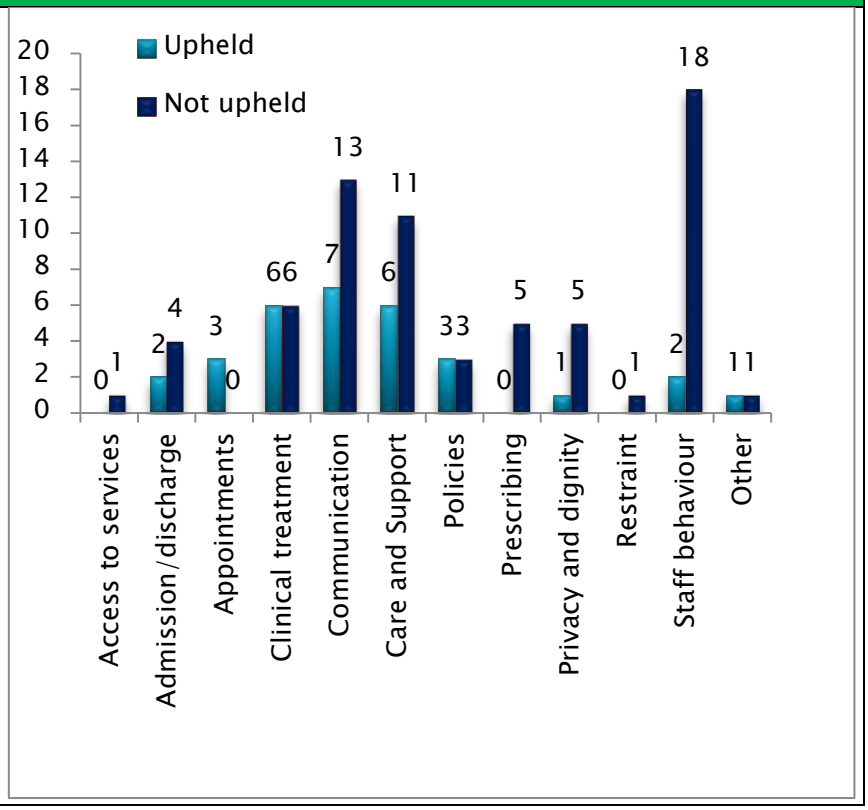
Table 5: Breakdown of closed complaints by staff group for this quarter

Outcome	Total No.*	Upheld	Not upheld	Comments
Medical	19	6	13	The number of complaint issues involving different disciplines and staff groups is recorded for *NHS Digital*. Quarter 3 data is presented in Table 5. The SED have continued to refine Datix to capture all disciplines identified within complaints, hence numbers this quarter may be higher than reported previously. Quarter 3 figures show Nursing as the main staff group identified within complaints. This has increased from the previous quarter (n=50) and is likely to be reflective of increased number of issues contained within individual complaints closed in Quarter 3. Nursing continues to represent 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.
Nursing	59	19	40	
Social Worker	1	0	1	
Psychology	8	1	7	
HCA	5	2	3	
Admin staff	4	2	2	
Other	7	0	0	
None	3	1	2	

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

2.1.5 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 3 is shown in table 6.

Table 6: Overarching closed complaint themes

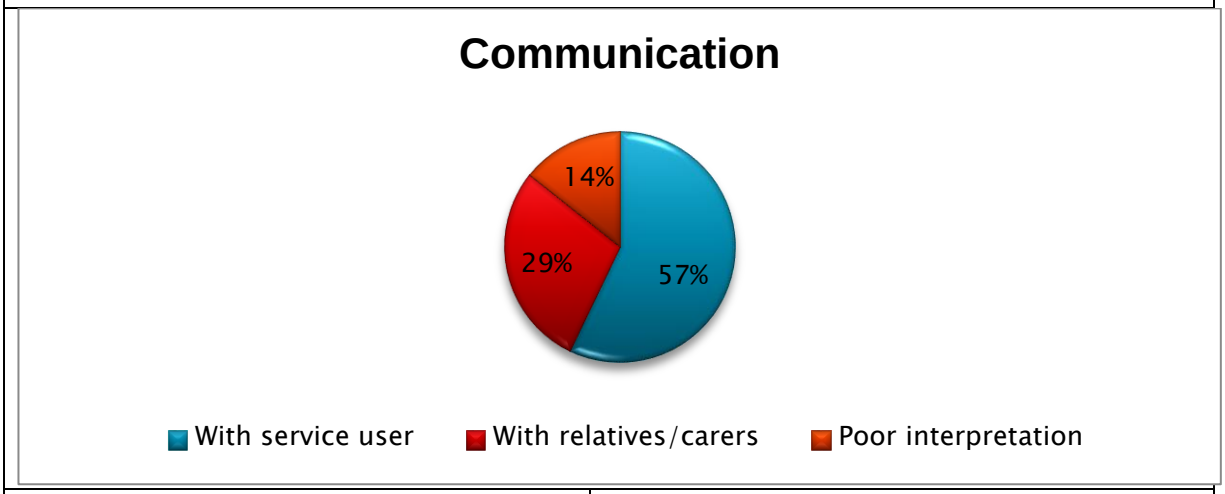
Theme	Chart showing number of issues raised and their outcome
Access to services *Access to treatment/drugs*	
Admission/discharge *Poor planning*	
Appointments *Waiting for/at an appointment*	
Clinical treatment *e.g. diagnosis, medication*	
Communication *Internal and external*	
Care and Support *e.g. observation, support*	
Policies *e.g. not followed*	
Prescribing *e.g. refusal to prescribe*	
Privacy and dignity *e.g. general wellbeing*	
Restraint *e.g. all aspects of restraint*	
Staff behaviour *Values and attitude*	
Other *Any other issue*	

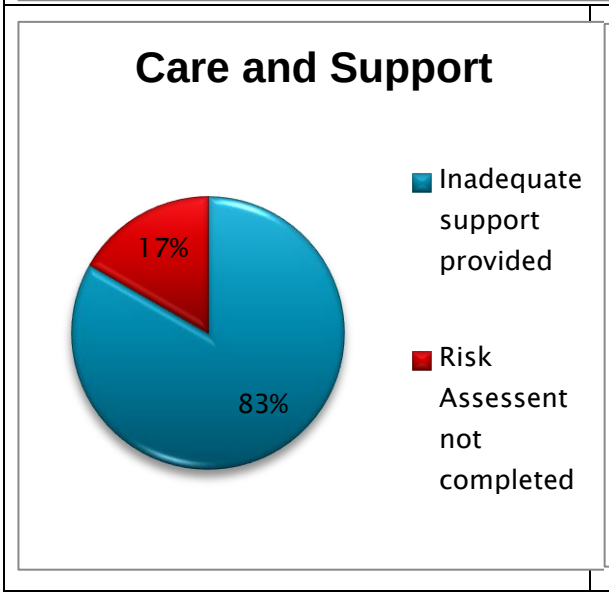
2.1.6 Thematic analysis shows that the areas of complaint investigated and upheld during Q3 relate to Communication, Care and support and Clinical treatment (Table 7).

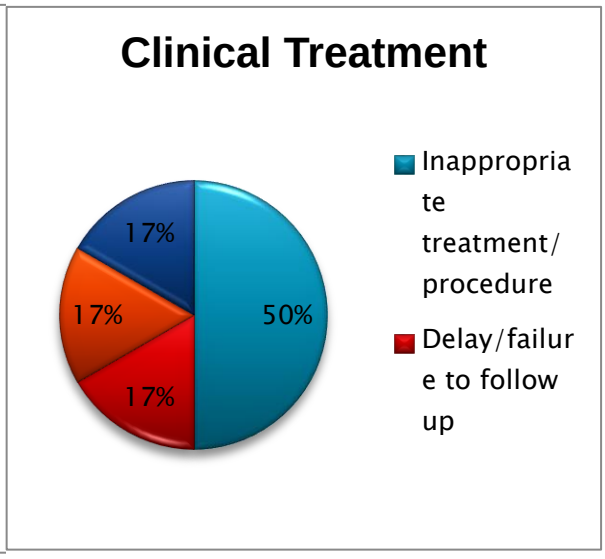
Table 7: Review of identified complaint themes

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 themes relate to areas of ***communication, care and support, and clinical treatment.*** They are shown in greater detail below:







Communication continues to dominate complaint thematic data. Colleagues across the Trust are working to develop and improve practice in this area and lower number of complaint issues relating to communication this quarter may suggest that these actions are beginning to have an impact.

This quarter *Care and Support* and *Clinical Treatment* have featured within thematic complaint data. These two areas are very closely linked to the main theme of communication. A large proportion of complaint investigations found that the care, support and/or treatment that the team were able to provide was not clearly explained to those accessing the services along with the role and remit of the service

provided by our Trust. This led to people feeling that the care, support and/or treatment they were receiving was inadequate and not as some expected.

Examples and actions taken linked to the thematic data are demonstrated in Table 8.

Table 8: Examples of complaints and action taken

Example	You said – Our LEARNING	We did – our ACTION	Assurance
Discharge arrangements	Your daughter was discharged and was told she would have daily input from another team, which did not happen.	We apologised for this and have reminded staff that any amendments to an agreed discharge plan should be discussed with the service user and their family.	Significant
Recording of information	You told us that you had been asked for details of people living in your household but were not told why this information was required.	We apologised for this and have asked managers to work with staff to ensure they have a clear understanding of what information is required, and why it is needed.	Significant
Communication	You told us that your brother was detained in hospital and you were not informed of this until the following day.	We apologised and have requested that in future staff ensure they have exhausted all options to obtain details for a person's family or next of kin.	Significant

2.2 Concerns

2.2.1 Resolve concerns with people at the point at which they are raised is a standard set across the organisation. This may be influencing the low level of complaint numbers and a corresponding increase in the number of PALS contacts. **DatixWeb**, a service experience recording and reporting system, has continued to be used for Quarter 3.Themes and trends have been analysed for Quarter 3 and are reflected below:

Table 9: Number of concerns received this quarter

County	Number (numerical direction)		Interpretation	Assurance
Gloucestershire	37	↔	There are similar numbers of Gloucestershire concerns compared to last quarter (n=38)	Significant
Herefordshire	2	↔	There are similar numbers of Herefordshire concerns compared to last quarter (n=3)	Significant
Corporate	4	↔	There are similar numbers of Corporate concerns compared to last quarter (n=3)	Significant
Other organisation	1	↑	There was one concern relating to another organisation this quarter (n=0)	Significant
Total	44	↔	There are the same number of concerns as last quarter (n=44)	Significant

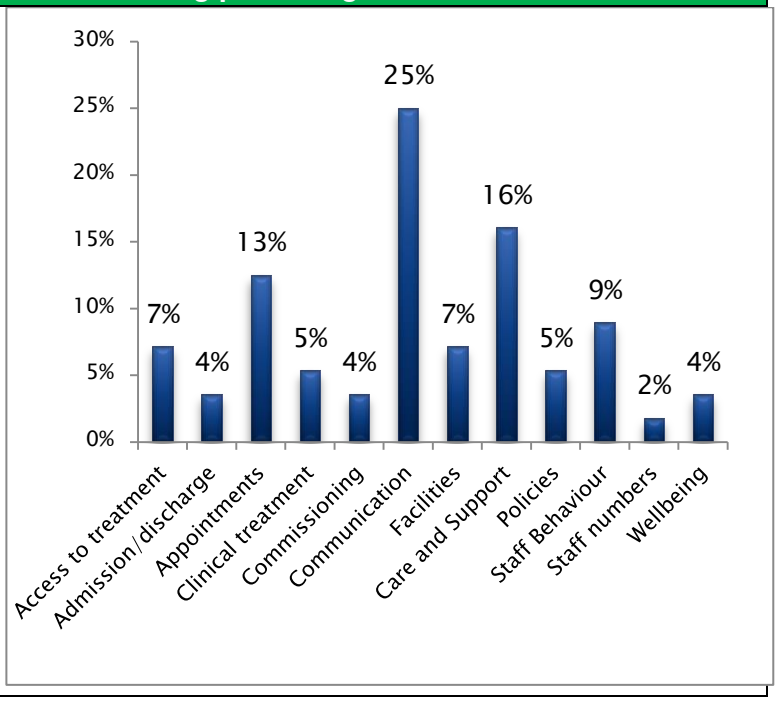
2.2.2 The number of concerns remains relatively consistent with previous quarters. There were 61 other contacts with the Service Experience Department (Q2=79) covering a range of topics: people asking advice about our services

and requesting contact from their team. A person contacted the Service Experience Department with a concern about another organisation was supported to raise their concern with that service.

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*	4	
Admission/discharge *Community or inpatient*	2	
Appointments *e.g. cancelled, staff DNA*	7	
Clinical treatment *e.g. diagnosis, medication*	3	
Commissioning *e.g. lack of services*	2	
Communication *Internal and external*	14	
Facilities *e.g. temperature*	4	
Care and Support *e.g. observation, support*	9	
Policies *e.g. Health Records, MHA*	3	
Staff Behaviour *Attitude and actions*	5	
Wellbeing *e.g. privacy and dignity*	1	



2.2.3 The main themes identified from concerns raised are “Communication” and “Care and Support”; this is consistent with the main themes reported from formal complaints. Examples of concerns and actions taken during Quarter 3 are shown in Table 12.

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

Outcome	No	%
Admin	3	5%
Medical	10	18%
Nursing	29	52%
PWP (Psychological Wellbeing Practitioner)	3	5%
Psychology	1	2%
Manager (non-clinical)	1	2%
Physiotherapy	1	2%
No staff identified	8	14%

As previously reflected in complaint analysis, nursing represents the largest staff group in the Trust. Nursing also has the greatest number of contacts with people so it could be anticipated that this professional group features most frequently within feedback data.

The percentage of nurses identified within concerns continues to dominate the staff group identified within concerns. Work is ongoing to ensure that professional leads are made aware of any themes relating to their staffing group.

Table 12 Examples of LEARNING from concerns and ACTION taken:

Example	You said - LEARNING	We did – OUR ACTION	Assurance
Admission	You told us that your daughter is awaiting a Mental Health Act Assessment and that you were worried that she would be sent home and that you would be unable to keep her safe	We contacted the team to pass along your concerns, and the team arranged for a short-term voluntary admission for your daughter.	Significant
Appointments	You said that your son had experienced a psychotic episode for the first time and that you were unable to get an appointment for him until two weeks' time.	We were able to arrange an earlier appointment for your son due a cancellation of an existing appointment.	Significant
Care and Treatment	You informed us that you were assessed and given a treatment plan in another area of this County. You have now moved and have been reassessed as not requiring the treatment any more, you are were unhappy about this decision.	The team apologised to you and clarified the rationale behind the reassessment decision. You were able to agree a mutually acceptable treatment plan going forward	Significant
Support from services	You explained that your ex-partner is spending money inappropriately and requested that staff prevent her from doing so	We clarified the remit and limitations of mental health services and explained actions that we had taken and alternative options that may benefit you.	Significant

2.2.4 PALS Visits

Patient Advice and Liaison Service (PALS) visits are undertaken in clinical services to ensure that concerns are raised and resolved as soon as possible. Visits to Wotton Lawn Hospital, Gloucestershire, and Stonebow Unit, Herefordshire, were undertaken during Quarter 3. During each visit the SED PALS Officers visited the designated ward and speak 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, and Deputy Director of Nursing. SED have successfully recruited a PALS volunteer to support PALS to visit all Trust inpatient areas in the coming months.

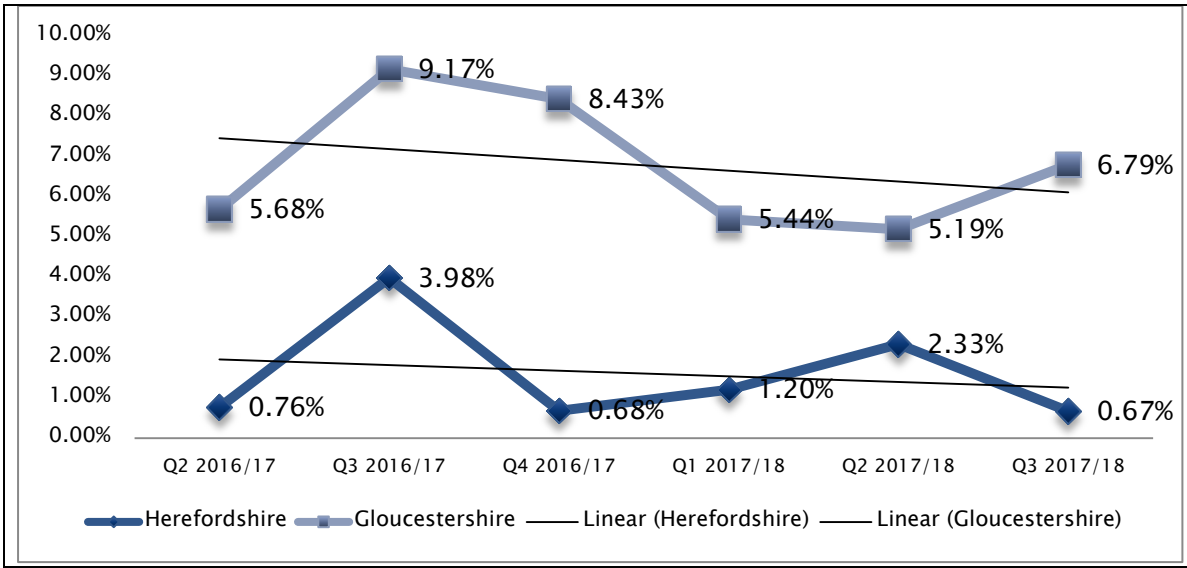
PALS provided the following types of support and assistance during visits undertaken during Quarter 3:

- Assisting Service Users to resolve queries relating to the ward environment.
- Providing information 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. A dedicated email address is set up to simplify the process for staff to report compliments that they have received: 2gnft.compliments@nhs.net. Figure 2 shows the percentage of compliments to contacts as reported during Quarter 3.

Figure 2: Graph showing proportion of compliments to number of 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 3:

Abbey Ward is a lovely ward where nothing is too much trouble and the staff keep everyone safe. *Abbey Ward, Wotton Lawn*

I thought the crisis worker was really good and really listened to [Service User]. I was very grateful that she actually did what she said she would. *CRHTT, Gloucestershire*

Service User's partner would like to thank everyone at Honeybourne for all their support; he is very appreciative of it. *Honeybourne*

This is [Service User's] third admission and his partner said that she felt all of the staff involved in his care were fantastic. *Mortimer Ward, Stonebow*

I was ready to walk down a path of no return but you saved me from that and saved me from who I was becoming, I'm a better me now, just only half way there but that's a lot better than where I was before. *Early Intervention, Herefordshire*

THANK YOU for being so patient, and understanding, because I always seem to need lots of reassurance when something 'new' and 'unfamiliar' is presented or suggested to me. *IAPT, Herefordshire*

2.4 – Complaints referred for external review following local investigation

2.4.1 Current open referrals for external review:

Table 13 – current open referrals for externa review

Reviewing organisation	Date of first contact from the reviewing organisation	Date official investigation confirmed	Date official investigation completed	Current status of referral
PHSO	25/01/2017	07/08/2017	N/A	Investigation ongoing.
PHSO	01/12/2016	07/08/2017	N/A	Investigation ongoing
PHSO *	18/07/2017	03/08/2017	31/10/2017	Trust action plan ongoing. PHSO awaiting confirmation of completed Trust actions before closure of case.
CQC	14/09/2017	17/09/2017	10/01/2018	Trust action plan ongoing. CQC awaiting confirmation of completed Trust actions before closure of case.
LGO	23/01/2018	N/A	N/A	Ongoing LGO review to inform decision to investigate or not.

PHSO - Parliamentary and Health Service Ombudsman, CQC - Care Quality Commission, LGO - Local Government Ombudsman

2.4.2 Referrals to PHSO in Q3

There was one referral to the PHSO this quarter. The PHSO have reviewed this and closed the case with no further action recommended for our Trust.

2.4.3 Completed PHSO investigation (See* in Table 13)

The PHSO have concluded one investigation during Q3. The outcome of their investigation upheld the complaint and made recommendations for our Trust.

The Trust has apologized to the individual concerned and offered to meet to seek resolution. The Trust has accepted the recommendations made by the PHSO in full and has implemented and completed an action plan in response to this. Information has been disseminated throughout the Trust in a variety of ways (see footnote, Section 3.2).

Recommendations identified by the findings of the PHSO investigation:

The complaint concerned two particular aspects of information recorded in RiO records:

- The PHSO found some of the information in the Service User's risk summary was incorrect, which they consider amounted to a failing. They found this caused distress and outrage to the Service User and may also have affected the way in which the Service User was dealt with by staff at the Trust.

- The PHSO found that the Trust should have removed information from the Service User's clinical records before the records were shared with them after they were requested. They found this was a failing. This caused distress to the Service User which was not put right.

An action plan was compiled to cover all areas of the recommendations made by the PHSO and to ensure Trust learning from the feedback. All recommendations have now been implemented and progressed within our Trust. The complainant and the PHSO have received communication updating them about the progress of our action plan. This complaint is pending closure with the PHSO once they are provided with updated and ratified copies of two of our Trust policies.

The learning identified and action taken by our Trust in response to the PHSO recommendations is captured in Section 3 of this report.

2.5 Surveys

2.5.1 'How did we do?' Survey

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.

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.

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

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.

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 Q3

	Number of responses	FFT Score (%)
October 2017	190	86%
November 2017	422	85%
December 2017	252	83%
Total	**864 (Q2 = 466)**	**85% (Q2 = *90%)**

**Previously reported as 88% in Quarter 2 SED report as CYPS figures were not added to the Trust total and were reported separately. Combined FFT responses will be reported for all Trust services from Quarter 3 17/18 onwards*.

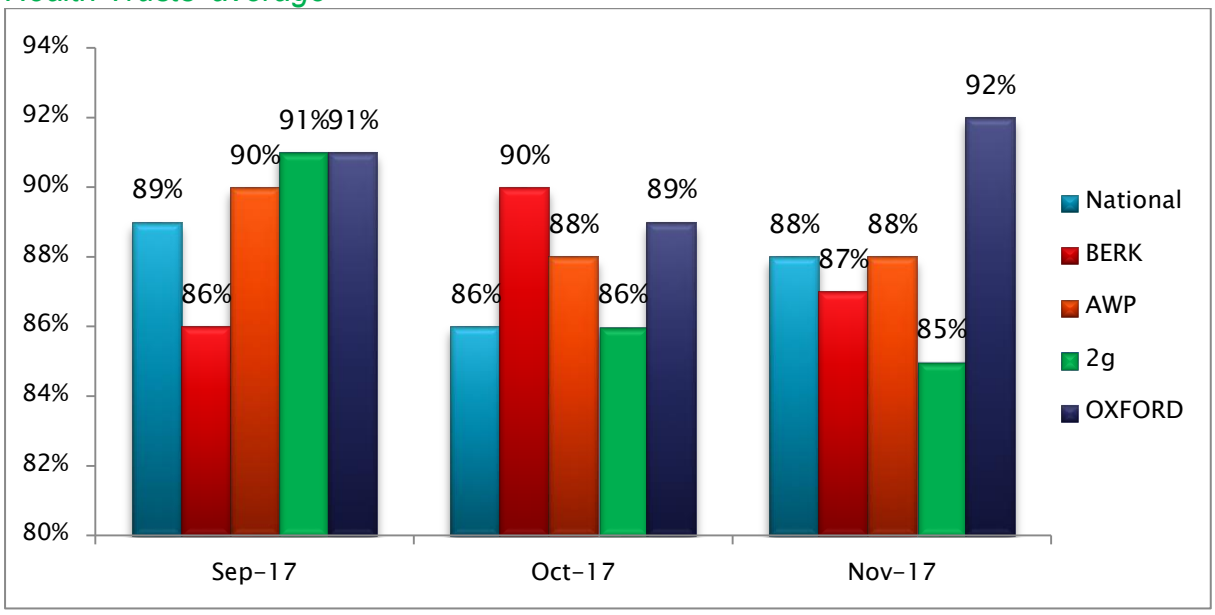
Some challenges have arisen when sending text messages to people due to mobile telephone numbers not always being recorded in the appropriate way on RiO. The SED along with locality colleagues have taken steps to raise awareness of how to record mobile telephone numbers within RiO. The response rate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

Quarter 3 FFT response rates are significantly higher than those reported in quarters 1 and 2. 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 challenging to obtain.

The FFT score for Quarter 3 is lower than the previous quarter although has remained relatively consistent with that received in 2016/17. This Quarter response rates have increased this meaning that more feedback was received. This may have an impact on the FFT score. The Trust continues to maintain a high percentage of people who would recommend our services.

Figure 3 shows the FFT Scores for September, October, and November 2017 (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 has consistently received a high percentage of recommendation in comparison with other Mental Health Trusts in the region but shows a small dip in result this quarter in comparison with other local organisations[2].

Figure 3: Friends and Family Test Scores – comparison between the [2]gether 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

[2] *December 2017 data was not available at time of writing*

Friends and Family Test Comments

Comments are fed-back to services in order that LEARNING 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?

They helped me with housing and obtaining medication.
MHLT, Gloucester

I feel very fortunate to have been able to access this support which has been invaluable to my well-being.

Amazing NHS. Best in the world.
Oak House, Herefordshire

I loved it there. It's a holiday camp for me. *Priory Ward, Wotton Lawn*

Top quality care and attention.
Eating Disorder Team, Gloucestershire

Really supportive and proactive approach to talk about life's obstacles, feelings, anxieties, and concerns.
Let's Talk, Herefordshire

What would have made the visit better?

It was a waste of my time. CBT is not adequate treatment.
Let's Talk, Herefordshire

I was told when suicidal that this is not an emergency line.
CRHTT, Gloucestershire

Did not get the support needed.
Maxwell Suite, Gloucestershire

Too long to wait. Not tailored for individual. General forms. *Let's Talk, Gloucestershire*

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 therefore FFT figures are not available for inclusion in the quarter's report.

2.5.4 How did we do?

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.

The How did we do? survey 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.

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	24 (13 positive)	75% TARGET 92%
	Herefordshire	43 (37 positive)	
Have you been given information about who to contact outside of office hours if you have a crisis?	Gloucestershire	29 (25 positive)	85% TARGET 74%
	Herefordshire	39 (33 positive)	
Have you had help and advice about taking part in activities that are important to you?	Gloucestershire	24 (14 positive)	76% TARGET 69%
	Herefordshire	38 (33 positive)	
Have you had help and advice to find support for physical health needs if you have needed it?	Gloucestershire	26 (18 positive)	77% TARGET 76%
	Herefordshire	35 (29 positive)	

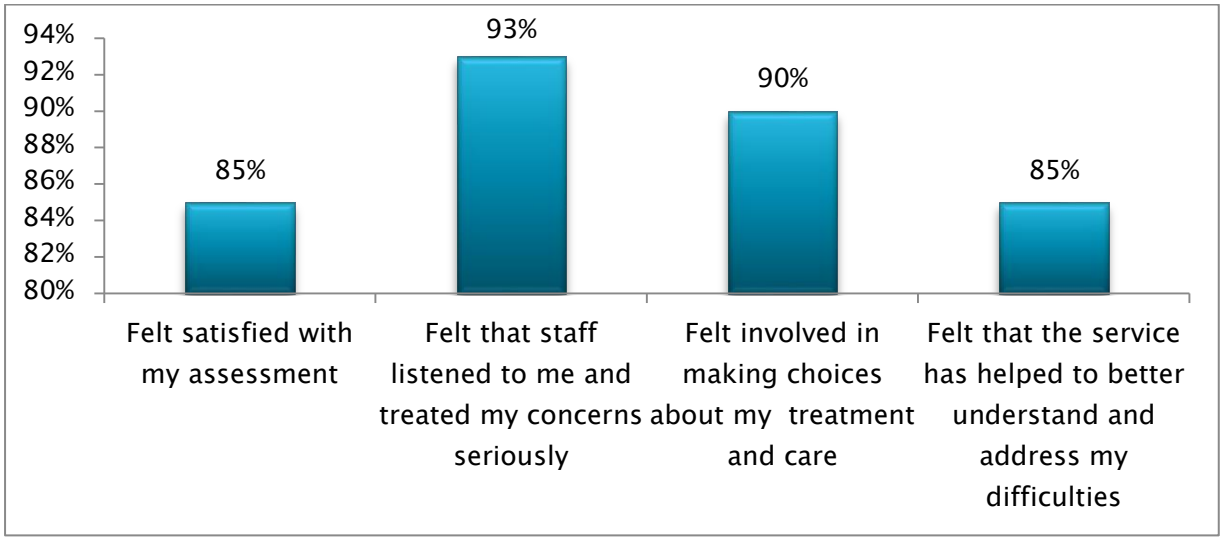
The response rates for the survey continue to be disappointing. The SED along with locality managers are working to raise awareness of the survey and encourage Service Users and Carers to give feedback in this way. Work is also underway to focus on these areas as part of the implementation of the action 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)

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. Due to this Q3 IAPT PEQ feedback includes responses to both the old and new versions of the questionnaires.

Feedback questionnaires are sent to people following the initial assessment and after discharge from the service. Quarter 3 feedback shows that people are largely satisfied with these elements of the Let's Talk service.

Figure 5: IAPT PEQ Satisfaction scores



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

Everyone was so easy to talk to, made me feel comfortable to answer the questions. I feel I was given hope.

It's a shame it is a limited number of sessions as in my case for example I have further work to do. on my condition (though I appreciate a break)!

The counselling that I received was delivered well and I can't think of any way it could have been improved.

My practitioner was very informative and this has helped me to get the help I need to get better.

Message reminder service very good. When I needed to phone direct there was no difficulty. Thorough responses from counsellor.

More out of hours appointments.

Having more rooms available to talk in and shorter waiting times to see a therapist.

I was free to make decisions about my treatment and if I wanted to change this was always possible. I was always put first even when I was struggling.

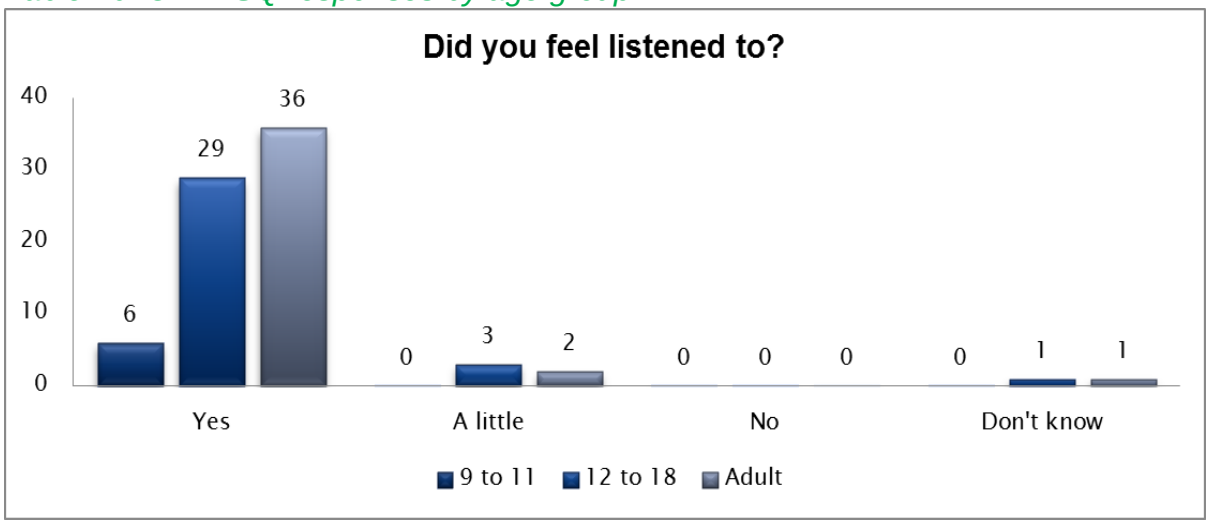
2.5.6 Children and Young People service (CYPS)

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. They are three versions of the CHI-

ESQ survey used, these are identified by age and role type as follows: CHI-ESQ Age 9 -11yrs, CHI-ESQ Age 12 -18yrs and CHI-ESQ Adult &Carer. All the surveys ask questions based upon the same theme but are presented differently in age appropriate format.

Table 16 reflects responses across all three surveys asking if people felt listened to by the CYPS/CAMHS services during Quarter 3**: 97%** of adults and carers,**97%** of 12-18 year olds, and **100%** of 9-11 year old respondents said they felt that they **had been listened to.**

Table 16: CHI-ESQ responses by age group



Examples of some feedback given:

They always listened to me and let me feel comfortable with secrets that made me embarrassed in public.

They were very supportive.

You help me and care for me.

The person I saw really cares about me, she takes me and my problems very seriously.

They really made an effort with my daughter. She is very patient and understanding.

Behaviour is a lot better.

They all listened and were kind about my problems.

The sessions made my daughter feel better and…that eased my worries as a mother.

Section 3 – Learning from Service Experience Feedback

Section 3.1 – Learning themes emerging from individual complaints, concerns in Q3

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. 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, learning and action. Examples of such learning features on page 9 and 11 of this report.

Section 3.2 - Aggregated learning themes emerging from feedback from this Quarter 3

This section illustrates aggregated lessons learnt from complaints and concerns including feedback this quarter from the PHSO.

Table 17: Points of learning from Service Experience feedback Q3 closed complaints– action plan to be sought from locality leads

Organisational Learning from Individual Complaints	Action Plan[3] (to be sought and reported in next SE Report)
LEARNING 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 into health care records 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 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, wherever possible, to ensure the information is correct.	

[3] * 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.

Organisational Learning from Individual Complaints	Action Plan[3] (to be sought and reported in next SE Report)
Action should be taken to amend any inaccuracies identified.	
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.	
Involvement of the Service Experience Department at an early stage when staff receive concerns or complaints should be considered for advice and support for all involved and assistance to resolve issues in a timely way.	
The Trust's Complaint and Concern Handling and Resolution 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.	
All wards and teams should date stamp paper-based information received and have a system for recording and following up written correspondence where required.	

Section 3.3 – Assurance of learning and action from previous quarter Q2

Effective dissemination of learning across the organisation is vital to ensure [2]gether's services are responsive to people's needs and that services continue to improve. Service Experience feedback has contributed to the *Learning [2]gether from Incidents, Complaints and Claims* report issued within the Trust on 1st December 2017. Table 18 below illustrates the assurance that Locality Services have provided of completed actions as a result of previous aggregated lessons learnt.

Table 18: Points of learning from Service Experience feedback Q2 2017/18 – action plan has been completed

Organisational Learning – Q2	Action Plan of assurance received from Localities	Date received
LEARNING When a member of staff is absent at short notice a	**Gloucestershire Localities**: Each Team Manager will review the caseload commitment of a member of staff when they are absent – escalating to the relevant CSM if there are cover issues.	

Organisational Learning – Q2	Action Plan of assurance received from Localities	Date received
system should be in place to ensure their caseload/workload is reviewed and a plan made to manage existing commitments	Teams will be reminded of this process via Forums and team meetings.	**Jan 2018**
	Countywide Locality: The system of care in the main inpatient setting provides all Service Users with a team approach to their care which includes 2 registered nurses who can cross cover for each other along with 1 Health Care Assistant. By providing a team of 3 staff this ensures where possible that short term absence is covered. If this system breaks down this will be addressed by the ward manager. Within the smaller units, where there is often not 2 qualified staff on duty, there is a unit diary where tasks, appointments, meetings etc are captured and delegated to the nurse in charge to ensure they are allocated and completed.	
	Herefordshire Localities: Protocol developed, ratified and implemented across services.	
	CYPS and CAMHS Localities: There is an existing system in place through team managers. The need for a contingency plan to be put in place if the team manager is absent will be raised at Delivery Committee for further action.	
LEARNING When a person is discharged from a hospital ward or a clinical team it is essential that they are involved in the discharge planning process and that plans are shared with family/carers involved whenever possible.	**Gloucestershire Localities:** Via Forums and Team Meetings, team members will be reminded of the importance of Service User / family involvement in discharge planning.	**Jan 2018**
	Countywide Locality: All patients being discharged from in-patient care will have a discharge planning meeting. This meeting must include the service user and where appropriate, with consent, family/carers or other persons of significant support.	
	Herefordshire Localities: All staff will be reminded to ensure that this happens.	
	CYPS and CAMHS Localities: The trust has a clear process for involving families and carers in the discharge planning process. To ensure this process is not rushed or omitted this will be raised with Team Managers and the Delivery Committee to support staff to ensure that families and carers are involved whenever possible.	

Agenda Item 9 **Enclosure Paper D**

Report to: Trust Board – 28 March 2018
Author: Gordon Benson, Assistant Director of Governance & Compliance
Presented by: Marie Crofts, Director of Quality

SUBJECT: **Quality Report: Report for 3rd Quarter 2017/18**

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

EXECUTIVE SUMMARY

This is the third review of the Quality Report priorities for 2017/18. The quarterly report is in the format of the annual Quality Report format.

Assurance

- The report shows the progress made towards achieving targets, objectives and initiatives identified in the Annual Quality Report.

- Overall, there are 3 targets which are consistently not being met:

    1. 1.2 – Personalised discharge care planning
    2. 2.1 – Numbers of service users being involved in their care
    3. 3.3 – Reduction in the use of prone restraint.

- There is limited assurance that target 3.1 – Reduction in the numbers of reported deaths by suspected suicide will be met by year end.

- At their January 2018 Council meeting, Trust Governors indicated that they would like CPA follow up (mandated indicator) and local indicator 1.2 - Personalised discharge care planning subject to the statutory external assurance audit. In addition, the Executive Team indicated that the remaining mandated indicator for auditing will be Crisis Team Gatekeeping admissions. Since this time, however, NHSI Guidance regarding the external assurance audit for Quality Report was further updated in February 2018 and the list of mandated indicators for audit revised. As such, the mandated indicators subject to external audit this year via KPMG will be.

    1. Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a National Institute for Health and Care Excellence (NICE)-approved care package within two weeks of referral.

2. inappropriate out-of-area placements for adult mental health services

The local indicator 1.2 - Personalised discharge care planning as chosen by the Governors, will continue to be audited.

Improvements

- There continues to be a sustained focus on the unmet targets, particularly in discharge care planning as completion of the necessary documentation is within the gift of staff to accomplish. This target has been referred to the Delivery Committee and Locality Management Boards for action. Regarding prone restraint, an analysis of the numbers of supine restraint being used will be included in the final report at year end.

- A section on Learning from Deaths is now included as per the requirement of the quality account regulations 2017. This will be further updated following publication of Quarter 3 data.

- NHSI published the 'Detailed requirements for quality reports 2017/18' in January 2018. This includes a requirement to publish performance against updated indicators (which form part of the Single Oversight Framework). The indicators relevant for [2]gether are included in Appendix 1 and will be included in the final report at year end.

- Consultation with both internal and external stakeholders commenced in March 2018 to identify and agree quality priorities for 2018/19.

RECOMMENDATIONS

The Board is asked to:

- Note the progress made to date and actions in place to improve/sustain performance where possible.

- Approve the report for circulation to stakeholders

Corporate Considerations	
Quality implications:	By the setting and monitoring of quality targets, the quality of the service we provide will improve.
Resource implications:	Collating the information does have resources implications for those providing the information and putting it into an accessible format
Equalities implications:	This is referenced in the report
Risk implications:	Specific initiatives that are not being achieved are highlighted in the report.

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:		
Marie Crofts, Director of Quaity	Date	20 March 2018

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

What consultation has there been?		
	Date	

Explanation of acronyms used:	

1. CONTEXT

1.1 Every year the Trust is obliged by statute to produce a Quality Report, reporting on activities and targets from the previous year's Account, and setting new objectives for the following year. Guidance regarding the publication of the Quality Report is issued by NHS Improvement (incorporating the Department of Health Guidance for Quality Accounts) and the Quality Report checked for consistency against the defined regulations.

Appendix 1

Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral	Trusts providing relevant mental health services	Available within Performance Dashboard
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas: a) inpatient wards b) early intervention in psychosis services c) community mental health services (people on care programme approach)	Trusts providing relevant mental health services	CQUIN – Audit - Available within Performance Dashboard.
Improving access to psychological therapies (IAPT): a) proportion of people completing treatment who move to recovery (from IAPT dataset) b) waiting time to begin treatment (from IAPT minimum dataset): i. within 6 weeks of referral ii. within 18 weeks of referral	Trusts providing relevant mental health services	Available within Performance Dashboard
Care programme approach (CPA) follow-up: proportion of discharges from hospital followed up within seven days	Trusts providing relevant mental health services	Available within Performance Dashboard
Inappropriate out-of-area placements for adult mental health services	Trusts providing relevant mental health services	Available via Bed Management Team
Admissions to adult facilities of patients under 16 years old	Trusts providing relevant mental health services	Available within Performance Dashboard – See under 18 year KPI

2gether
Making life better

2gether
NHS Foundation Trust

Quality Report 2017/18

CONTENTS

Part 1: Statement on Quality from the Chief Executive

Introduction

This will be included at year-end

Part 2.1: Looking ahead to 2018/19

Quality Priorities for Improvement 2018/19

These will be developed during Quarter 4 under the following domains.

Effectiveness

User Experience

Safety

Part 2.2: Statements relating to the Quality of NHS Services Provided

Review of Services

This will be included at year-end

Participation in Clinical Audits and National Confidential Enquiries

This will be included at year-end

Participation in Clinical Research

This will be included at year-end

Use of the Commissioning for Quality & Innovation (CQUIN) framework

A proportion of 2gether NHS Foundation Trust's income in 2016/17 was conditional on achieving quality improvement and innovation goals agreed between 2gether NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2017/18 and for the following 12 month period are available electronically at http://www.2gether.nhs.uk/cquin

2017/18 CQUIN Goals

Gloucestershire

Gloucestershire Goal Name	*Description*	*Goal weighting*	*Expected value*	*Quality Domain*
1a (a) National CQUIN – Staff health and wellbeing	To achieve a 5 percentage point improvement in 2 of the 3 NHS annual staff survey questions on Health and Wellbeing	0.3	£72261	Effectiveness
1b National CQUIN – Staff health and wellbeing	Healthy food for NHS staff, visitors and patients		£72261	Effectiveness
1c National CQUIN - Staff health and wellbeing	Improving the uptake of flu vaccinations for front line staff		£72261	Safety
2 National CQUIN - Improving Physical Healthcare 3a	- To reduce premature mortality by demonstrating cardio metabolic assessment and treatment for patients with psychoses.	0.3	£173426	Effectiveness
2 National CQUIN - Improving Physical Healthcare 3b	- To reduce premature mortality - Improved communication with GPs		£43357	Effectiveness
3. Improving Services for people with mental health needs who present to A & E.	Care and management for frequent attenders to Accident and Emergency	0.3	£216783	Safety
4. Transitions out of Children and Young People's Mental Health Services.	To improve the experience and outcomes for young people as they transition out of (CYPMHS)	0.3	£216783	Effectiveness
5.Preventing ill health by risky behaviours – Alcohol and Tobacco	To offer advice and interventions aimed at reducing risky behaviour in admitted patients	0.3	£216783	Effectiveness

Herefordshire

Herefordshire Goal Name	*Description*	*Goal weighting*	*Expected value*	*Quality Domain*
1a (a) National CQUIN – Staff health and wellbeing	To achieve a 5 percentage point improvement in 2 of the 3 NHS annual staff survey questions on Health and Wellbeing	0.3	£17231	Effectiveness
1b National CQUIN – Staff health and wellbeing	Healthy food for NHS staff, visitors and patients		£17231	Effectiveness
1c National CQUIN - Staff health and wellbeing	Improving the uptake of flu vaccinations for front line staff		£17231	Safety
2 National CQUIN - Improving Physical Healthcare 3a	- To reduce premature mortality by demonstrating cardio metabolic assessment and treatment for patients with psychoses.	0.3	£41354	Effectiveness
2 National CQUIN - Improving Physical Healthcare 3b	- To reduce premature mortality - Improved communication with GPs		£10339	Effectiveness
3. Improving Services for people with mental health needs who present to A & E.	Care and management for frequent attenders to Accident and Emergency	0.3	£51693	Safety
4. Transitions out of Children and Young People's Mental Health Services.	To improve the experience and outcomes for young people as they transition out of (CYPMHS)	0.3	£51693	Effectiveness
5.Preventing ill health by risky behaviours – Alcohol and Tobacco	To offer advice and interventions aimed at reducing risky behaviour in admitted patients	0.3	£51693	Effectiveness

Low Secure Services

Low Secure Goal Name	*Description*	*Goal weighting*	*Expected value*	*Quality Domain*
Reduction in length of stay	Aim to reduce lengths of stay of inpatient episodes and to optimise the care pathway. Providers to plan for discharge at the point of admission and to ensure mechanisms are in place to oversee the care pathway against estimated discharge dates.	2.5	£45000	Effectiveness

The total potential value of the income conditional on reaching the targets within the CQUINs during 2016/17 is £2,219,300 of which we anticipate £2,219,300 will be achieved.

In 2015/16, the total potential value of the income conditional on reaching the targets within the CQUINs was £2,107,995 of which £2,107,153 was achieved.

2018/19 CQUIN Goals

These will be added at year-end.

Statements from the Care Quality Commission

The Care Quality Commission (CQC) is the independent regulator of health and adult social care services in England. From April 2010, all NHS trusts have been legally required to register with the CQC. Registration is the licence to operate and to be registered, providers must, by law, demonstrate compliance with the requirements of the CQC (Registration) Regulations 2009.

[2]gether NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is to provide the following regulated activities:

- Assessment or medical treatment to persons detained under the Mental Health act 1983;
- Diagnostic and screening procedures;
- Treatment of disease, disorder or injury.

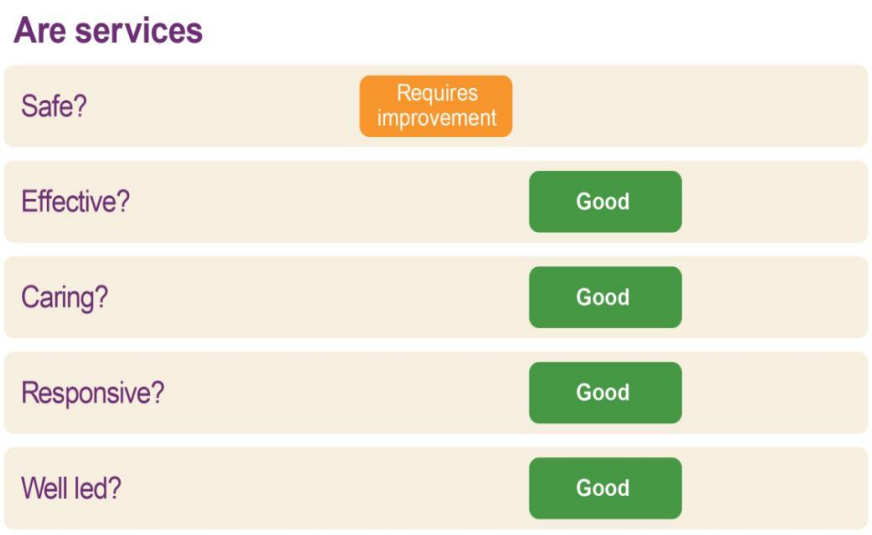
[2]gether NHS Foundation Trust has no conditions on its registration.

The CQC has not taken enforcement action against [2]gether NHS Foundation during 2016/17 or the previous year 2015/16.

CQC Inspections of our services

[2]gether NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

The Care Quality Commission last undertook a planned comprehensive inspection of the Trust week commencing 26 October 2015 and published its findings on 28 January 2016. The CQC rated our services as GOOD, rating **2** of the **10** core services as "outstanding" overall and **6** "good" overall.



The inspection found that there were some aspects of care and treatment in some services that needed improvements to be made to ensure patients were kept safe. However, the vast majority of services were delivering effective care and treatment.

The Trust developed an action plan in response to the **15** "must do" recommendations, and the **58** "should do" recommendations identified by the inspection and is managing the actions through to their completion.

	Safe	Effective	Caring	Responsive	Well led	Overall
Community-based mental health services for older people	Good	Requires improvement	Good	Good	Requires improvement	Requires improvement
Long stay/rehabilitation mental health wards for working age adults	Requires improvement	Good	Good	Good	Good	Good
Wards for older people with mental health problems	Requires improvement	Good	Good	Good	Good	Good
Community-based mental health services for adults of working age	Requires improvement	Good	Good	Good	Good	Good
Specialist community mental health services for children and young people	Good	Good	Good	Good	Good	Good
Acute wards for adults of working age and psychiatric intensive care units	Outstanding ☆	Good	Good	Good	Outstanding ☆	Outstanding ☆
Wards for people with learning disabilities or autism	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Mental health crisis services and health-based places of safety	Good	Good	Outstanding ☆	Outstanding ☆	Good	Outstanding ☆
Forensic inpatient/secure wards	Good	Good	Good	Good	Good	Good
Community mental health services for people with learning disabilities or autism	Good	Good	Good	Good	Requires improvement	Good

A full copy of the Comprehensive Inspection Report can be seen here.

The Trust has been informed of an unannounced CQC inspection during Quarter 4 2017/18 and a Well Led review on 21st & 22nd March 2018.

Changes in service registration with Care Quality Commission for 2017/18

This will be included at year-end.

Quality of Data

This will be included at year-end.

Learning from Deaths

From 1 April 2016 the Trust has collected detailed information regarding the deaths of patients open to our services, and deaths within 6 months of their discharge from services in preparation for the "Single Framework for Reviewing Deaths in the NHS" requirement which was published in March 2017. To date, there is limited assurance that the data collected is of good quality. However, several improvements have been made to both Datix and the technology available for collecting information relating to patient deaths.

An administrator has been employed in a full-time capacity from October 2016 to begin to complete initial screening of the reported patient death information and the categorisation of patient deaths within the Mazars categories of Expected Natural 1, Expected Natural 2, Expected Unnatural, Unexpected Natural 1, Unexpected Natural 2, and Unexpected Unnatural. The pro-forma review tool based on the Learning Disabilities Mortality Review Programme (LeDer) format has been utilised within the Datix system to assist with desktop reviews of healthcare records, and red flag indicators are being developed by the Clinical Directors involved with the mortality work to identify deaths which should be more closely investigated.

The 'active' review of patient information commenced from 1 April 2017 and our 'Learning from Deaths Policy' was approved by the Board and published in September 2017 in line with the requirements of the "National Guidance on Learning from Deaths".

Information provided below shows the first analysis of our mortality review data which was reported to the Trust Board at its public meeting in November 2017. During this period there were 161 patient deaths recorded, of which 129 (80.1%) required table-top review only, 20 (12.5%) were closed after a case record review and 12 (7.5%) were notified as Serious Incidents. No deaths were considered to have involved problems in care either within this or partner organisations.

Closed Mortality Reviews											
Month	Closed Following Table-Top Review Only			Closed Following Care Record Review			Closed Following Serious Incident Review			Total	Quarterly Total
	Category 1: Not Due to Problems in Care	Category 2: Possibly Due to Problems in Care within 2gether	Category 3: Possibly Due to Problems in Care Within an External Organisation	Category 1: Not Due to Problems in Care	Category 2: Possibly Due to Problems in Care within 2gether	Category 3: Possibly Due to Problems in Care Within an External Organisation	Category 1: Not Due to Problems in Care	Category 2: Possibly Due to Problems in Care within 2gether	Category 3: Possibly Due to Problems in Care Within an External Organisation		
Apr-17	31	0	0	10	0	0	4	0	0	45	
May-17	46	0	0	7	0	0	3	0	0	56	140
Jun-17	36	0	0	1	0	0	2	0	0	39	
Jul-17	15	0	0	2	0	0	2	0	0	19	
Aug-17	1	0	0	0	0	0	1	0	0	2	21
Sep-17										0	
Oct-17										0	
Nov-17										0	0
Dec-17										0	
Jan-18										0	
Feb-18										0	0
Mar-18										0	
	129	0	0	20	0	0	12	0	0	161	

Part 2.3: Mandated Core Indicators 2017/18

There are a number of mandated Quality Indicators which organisations providing mental health services are required to report on, and these are detailed below. The comparisons with the national average and both the lowest and highest performing trusts are benchmarked against other mental health service providers.

1. Percentage of patients on CPA who were followed up within 7 days after discharge from psychiatric inpatient care

	Quarter 3 2016-17	Quarter 4 2016-17	Quarter 1* 2017-18	Quarter 2* 2017-18	Quarter 3* 2017-18
[2]gether NHS Foundation Trust	98.3%	99.2%	99.2%	98.5%	99.6%
National Average	96.8%	96.8%	96.7%	96.7%	95.4%
Lowest Trust	73.3%	84.6%	71.4%	87.5%	69.2%
Highest Trust	100%	99.4%	100%	100%	100%

The [2]gether NHS Foundation Trust considers that this data is as described for the following reasons:

- During 2015/16 we reviewed our practices and policies associated with both our 7 day and 48 hour follow up of patients discharged from our inpatient services, the changes were introduced in 2016/17. This has strengthened the patient safety aspects of our follow up contacts.

The [2]gether NHS Foundation Trust has taken the following action to improve this percentage, and so the quality of its services, by:

- Clearly documenting follow up arrangements from Day 1 post discharge in RiO;
- Continuing to ensure that service users are followed up within 48 hours of discharge from an inpatient unit whenever possible.

2. Proportion of admissions to psychiatric inpatient care that were gate kept by Crisis Teams

	Quarter 3 2016-17	Quarter 4 2016-17	Quarter 1* 2017-18	Quarter 2* 2016-17	Quarter 3* 2017-18
[2]gether NHS Foundation Trust	99.4%	100%	100%	100%	99.5%
National Average	98.7%	98.8%	98.7%	98.6%	98.5%
Lowest Trust	88.3%	90%	88.9%	94%	84.3%
Highest Trust	100%	100%	100%	100%	100%

The [2]gether NHS Foundation Trust considers that this data is as described for the following reasons:

- Staff respond to individual service user need and help to support them at home wherever possible unless admission is clearly indicated;

The [2]gether NHS Foundation Trust has taken the following action to improve this percentage, and so the quality of its services, by:

- Continuing to remind clinicians who input information into the clinical system (RiO) to both complete the 'Method of Admission' field with the appropriate option when admissions are made via the Crisis Team and ensure that all clinical interventions are recorded appropriately in RiO within the client diary.

* Activity published on NHS England website via the NHS IC Portal is revised throughout the year following data quality checks. Activity shown for 2017/18 has not yet been revised and may change. Quarter 2 data has not been published.

3. The percentage of patients aged 0-15 & 16 and over, readmitted to hospital, which forms part of the Trust, within 28 days of being discharged from a hospital which forms part of the trust, during the reporting period

	Quarter 3 2016-17	Quarter 4 2016-17	Quarter 1 2017-18	Quarter 2 2017-18	Quarter 3 2017-18
[2]gether NHS Foundation Trust 0-15	0%	0%	0%	0%	0%
[2]gether NHS Foundation Trust 16 +	8%	6%	5.9%	7.3%	10.4%
National Average	Not available	Not available	Not available	Not available	Not available
Lowest Trust	Not available	Not available	Not available	Not available	Not available
Highest Trust	Not available	Not available	Not available	Not available	Not available

The [2]gether NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust does not have child and adolescent inpatient beds;
- Service users with serious mental illness are readmitted hospital to maximize their safety and promote recovery;
- Service users on Community Treatment Orders (CTOs) can recalled to hospital if there is deterioration in their presentation.

The [2]gether NHS Foundation Trust has taken the following action to improve this percentage, and so the quality of its services, by:

- Continuing to promote a recovery model for people in contact with services;
- Supporting people at home wherever possible by the Crisis Resolution and Home Treatment Teams.

4. The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends

	NHS Staff Survey 2013	NHS Staff Survey 2014	NHS Staff Survey 2015	NHS Staff Survey 2016
[2]gether NHS Foundation Trust Score	3.46	3.61	3.75	3.84
National Median Score	3.55	3.57	3.63	3.62
Lowest Trust Score	3.01	3.01	3.11	3.20
Highest Trust Score	4.04	4.15	4.04	3.96

The [2]gether NHS Foundation Trust considers that this data is as described for the following reasons:

- For the first time, all staff in post on 1 September 2016 were invited to take part in the survey, confidentially online. Previously the survey had only been sent to a random sample of **750** staff. The overall response rate was **40%,** equal to the previous year but **777** staff took the time to respond and give their views, a significant increase on the **298** responses in

the previous year. The 2016 survey has provided the most accurate picture of the Trust obtained to-date.

- Staff have reported an increase in the level of motivation at work. Whilst the improved level of staff satisfaction is encouraging, the trust is very careful to also take note of feedback from colleagues who are less satisfied and where possible to address these concerns.

The [2]gether NHS Foundation Trust has taken the following actions to improve this score and so the quality of its services, by:

- Encouraging staff to report any incidents which affect patient and staff safety or morale in the workplace;
- Acting to make the best use of service user feedback and highlighting how this feedback is used;
- Promoting the health and wellbeing of Trust staff.

5. "Patient experience of community mental health services" indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period.

	NHS Community Mental Health Survey 2014	NHS Community Mental Health Survey 2015	NHS Community Mental Health Survey 2016	NHS Community Mental Health Survey 2017
[2]gether NHS Foundation Trust Score	8.2	7.9	8.0	8.0
National Average Score	Not available	Not available	Not available	Not available
Lowest Score	7.3	6.8	6.9	6.4
Highest Score	8.4	8.2	8.1	8.1

The [2]gether NHS Foundation Trust considers that this data is as described for the following reasons:

- [2]gether is categorised as performing 'better' than the majority of other mental health Trusts in 5 of the 10 domains and 'about the same' as the majority of other mental health Trusts in the remaining 5 domains.

The [2]gether NHS Foundation Trust has taken the following actions to improve this score and so the quality of its services, by:

- Supporting people at times of crisis;
- Involving people in planning and reviewing their care;
- Involving family members or someone close, as much as the person would like;
- Giving people information about getting support from people with experience of the same mental health needs as them;
- Helping people with their physical health needs and to take part in an activity locally;
- Providing help and advice for finding support with finances, benefits and employment.

6. The number and rate* of patient safety incidents reported within the Trust during the reporting period and the number and percentage of such patient safety incidents that resulted in severe harm or death.

	1 April 2016 – 30 September 2016				1 October 2016 – 31 March 2017			
	Number	Rate*	Severe	Death	Number	Rate*	Severe	Death
[2]gether NHS Foundation Trust	1,900	54.85	4	30	2,474	72.05	2	17
National	162,954	-	562	1240	157,141	-	538	1233
Lowest Trust	40	10.28	0	0	68	11.17	0	0
Highest Trust	6,349	88.97	50	84	6,447	88.21	72	100

* Rate is the number of incidents reported per 1000 bed days.

The [2]gether NHS Foundation Trust considers that this data is as described for the following reasons:

- NRLS data is published 6 months in arrears; therefore data for severe harm and death will not correspond with the serious incident information shown in the Quality Report.

The [2]gether NHS Foundation Trust has taken the following action to improve this rate, and so the quality of its services, by:

- Re-auditing its Incident Reporting Systems (DATIX) to improve the processes in place for the timely review, approval of, and response to reported patient safety incidents;

- Creating an additional part time DATIX Administrator post to enhance data quality checks and further promote timeliness of reporting. This post commenced in 2017/18.

Part 3: Looking Back: A Review of Quality during 2017/18

Introduction

The 2017/18 quality priorities were agreed in May 2017.

The quality priorities were grouped under the three areas of Effectiveness, User Experience and Safety.

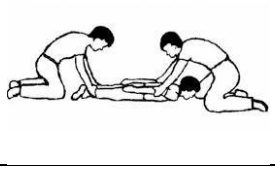
The table below provides a summary of our progress against these individual priorities. Each are subsequently explained in more detail throughout Part 3.

Summary Report on Quality Measures for 2017/2018

		2016 - 2017	2017 -2018
Effectiveness			
1.1	To improve the physical health of patients with a serious mental illness on CPA by a positive cardio metabolic health resource (Lester Tool). This will be used on all patients who meet the criteria within the inpatient setting and all community mental health teams. In accordance with national CQUIN targets we aim to achieve 90% compliance for inpatients and early intervention teams and 65% compliance for all other community mental health teams.	**Achieved**	**Achieved**
1.2	To further improve personalised discharge care planning in adult and older peoples wards, including the provision of discharge information to primary care services within 24hrs of discharge.	**Achieved**	**Not achieved**
1.3	To ensure that joint Care Programme Approach reviews occur for **all** service users who make the transition from children's to adult services.	**Not achieved**	**Achieved**
User Experience			
2.1	Were you involved as much as you wanted to be in agreeing what care you will receive? **> 92%**	**83%**	**75%**
2.2	Do you know who to contact out of office hours if you have a crisis? **>74%**	**74%**	**85%**
2.3	Has someone given you advice about taking part in activities that are important to you? **> 69%**	**69%**	**76%**
2.4	Have you had help and advice to find support to meet your physical health needs if you needed it? **> 76%**	**76%**	**77%**
Safety			
3.1	Reduce the proportion of patients in touch with services who die by suspected suicide when compared with data from previous years. This will be expressed as a rate per 1000 service users on the Trust's caseload.	**-**	**Achieved**
3.2	Detained service users who are absent without leave (AWOL) will not come to serious harm or death. We will report against 3 categories of AWOL as follows; harm as a consequence of: 1. Absconded from escort 2. Failure to return from leave 3. Left the hospital (escaped)	**-**	**Achieved**
3.3	To reduce the number of prone restraints by 5% year on year (on all adult wards & PICU) based on 2016/17 data.	**211**	**187**

Easy Read Report on Quality Measures for 2017/2018

Quality Report 	This report looks at the quality of [2]gether's services. We agreed with our Commissioners the areas that would be looked at.	
Physical health 	We increased physical health tests and treatment for people using our services. We met the target.	↑
Discharge Care Plans 	Less people had all parts of their discharge care plan completed at the end of the quarter than previously.	↓
Care (CPA) Review 	Everyone moving from children's to adult services had a care review. We met the target.	↑
Care Plans 	75% of people said they felt involved in their care plan. This is less than the target (92%). We have not met the target. We are doing lots of work to get better at this.	↓
Crisis 	85% of people said they know who to contact if they have a crisis. This is more than the target (74%). We met the target.	↑
Activity 	76% of people said they had advice about taking part in activities. This is more than the target (69%). We met the target.	↑
Physical Health 	77% of people said they had advice about their physical health This is more than the target (76%). We met the target.	↑

Suicide 	There have been less suicides compared to this time last year. We have met the target. We are working hard to keep people safe.	
AWOL 	Inpatients who were absent without leave did not come to serious harm or death. We met the target.	
Face down restraint 	We have not reduced the number of face-down restraints this year. We have not met the target. We are doing lots of work to get better at this.	

Key

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

Effectiveness

In 2017/18 we remained committed to ensure that our services are as effective as possible for the people that we support. For the second consecutive year we set ourselves 3 targets against the goals of:

- Improving the physical health care for people with schizophrenia and other serious mental illnesses;
- Ensuring that people are discharged from hospital with personalised care plans;
- Improving transition processes for child and young people who move into adult mental health services.

Target 1.1 To increase the number of service users (all inpatients and all SMI/CPA service users in the community, inclusive of Early Intervention Service, Assertive Outreach and Recovery) with a LESTER tool intervention (a specialist cardio metabolic assessment tool) alongside increased access to physical health treatment

A two year Physical Health CQUIN was announced for 2017/19. This CQUIN includes all service users with an active diagnosis of psychosis (using the CQUIN specified ICD-10 codes) who were either an inpatient or who had accessed community services including; Assertive Outreach Team (AOT), Recovery Teams, Community Learning Disability Teams (CLDT's), Older Age Services (OP's) and Children and Young Persons Services (CYPS). The sample group has now been extended to include service users from both counties.

Within quarter three, an audit to ensure that patients had either an up to date care plan approach (CPA), care plan or a comprehensive discharge summary shared with their GP. The results of this audit will be reported in quarter four, however initial reports are promising and show that this process of both completing the necessary screening, along with sharing the information has been embedded within practice for both community and inpatient staff.

We are working closely with our training department to ensure that both initial and refresher training on the importance of physical health for patients with a SMI, and the screening and recording of these results is built into mandatory training programmes.

Quarter three also required our Trust to look closely at the process of information sharing between [2]gether and primary care. A clear protocol for sharing the results of physical health checks for people with an SMI, and the appropriate follow up was established. Currently, [2]gether NHS Foundation Trust uses secure email to ensure that these results which are contained within CPA reports and discharge letters are sent to individual GP practices within the recommended timeframes; 24 hours for discharge letters and 2 weeks for CPA's. All staff have been supplied with up to date details of GP email addresses and a process is in place to keep these up to date.

Work continues to improve the ease of both sharing and exchanging this information via electronic patient records across secondary and primary interfaces. It is hoped this may be via the RiO interoperability function, we are working closely with our IT department as well as contacts within both Gloucestershire and Herefordshire CCG's to enable these improvements to our services.

Alongside the CQUIN work, the Trust continues to increase access to physical health treatment for its' service users. Following the successful secondment of a general trained nurse working within the Wotton Lawn Hospital in Gloucestershire, the matron has advertised for a substantive position for this role to continue. This will ensure patients to access services normally only available from a practice nurse at a GP surgery.

Following the successful launch of [2]gether NHS Foundation Trust becoming a "Smoke-Free" environment in our Gloucestershire sites, we are pleased to announce that our Herefordshire sites became "Smoke-free" in January 2018. Later this month we are holding a "Reducing Smoking in Mental Health" event. We have opened this to all interested staff within the South-West and the day will focus on reducing harm from smoking in mental health services and how different teams are implementing the smoke free challenge across the South West.

A "Physical Health" study day for [2]gether NHS Foundation Trust staff has been developed and dates set for 2018, it will cover a broad range of physical healthcare topics and will reinforce the importance of screening for, and improving our patients' physical health.

We are currently meeting this target.

Target 1.2 To further improve personalised discharge care planning in adult and older peoples wards, including the provision of discharge information to primary care services within 24hrs of discharge.

Discharge from inpatient units to the community can pose a time of increased risk to service users. During 2016/17 we focused on making improvements to discharge care planning to ensure that service users are actively involved in shared decision making for their discharge and the self-management care planning process. Identical criteria are being used in the services across both counties as follows:

1. Has a Risk Summary been completed?
2. Has the Clustering Assessment and Allocation been completed?
3. Has the Pre-Discharge Planning Form been completed?
4. Have the inpatient care plans been closed within 7 days of discharge?
5. Has the patient been discharged from the bed?
6. Has the Nursing Discharge Summary Letter to Client/GP been sent within 24 hours of discharge?
7. Has the 48 hour follow up been completed?

We will also be looking to ensure that discharges summaries and medication information for service users discharged from hospital are sent to their GP within 48 hours of Discharge.

We are also including discharge care planning information from within our Recovery Units, as they too discharge people back into the community.

Results from the quarterly audit against these standards are seen below.

Gloucestershire Services

Criterion	Year End Compliance (2015/16)	Year End Compliance (2016/17)	Quarter 1 Compliance (2017/18)	Quarter 2 Compliance (2017/18)	Quarter 3 Compliance (2017/18)
Overall Average Compliance	**69%**	**72%**	**73%**	**71%**	**72%**
Chestnut Ward	84%	85%	**81%**	**87%**	**83%**
Mulberry Ward	75%	79%	**73%**	**76%**	**71%**
Willow Ward	59%	71%	**69%**	**65%**	**69%**
Abbey Ward	72%	75%	**78%**	**83%**	**67%**
Dean Ward	79%	73%	**69%**	**71%**	**79%**
Greyfriars PICU	50%	62%	**62%**	**59%**	**61%**

Kingsholm Ward	75%	72%	**69%**	**74%**	**73%**
Priory Ward	80%	80%	**87%**	**76%**	**77%**
Montpellier Unit	50%	57%	**67%**	**50%**	**71%**
Honeybourne	N/A	70%	**70%**	**60%**	**50%**
Laurel House	N/A	65%	**75%**	**80%**	**88%**

* Data for Honeybourne and Laurel House (Recovery Units) was not collected in 2015/16 – only hospital wards were audited to reflect comparable data across both Gloucestershire and Herefordshire.

Quarter 3 overall average compliance in Gloucester for these standards during this year is **72%** which is the same as year-end compliance for 2016/17, it is noted that several inpatient areas have reduced in this area. There will be an increased focus on ensuring that these standards are met throughout the year.

Herefordshire Services

Criterion	**Year End compliance (2015/16)**	**Year End Compliance 2016/17)**	**Quarter 1 Compliance (2017/18)**	**Quarter 2 Compliance (2017/18)**	**Quarter 3 Compliance (2017/18)**
Overall Average Compliance	**N/A**	**74%**	**70%**	**66%**	**74%**
Cantilupe Ward	**N/A**	85%	**78%**	**77%**	**89%**
Jenny Lind Ward	**N/A**	71%	**71%**	**62%**	**72%**
Mortimer Ward	**N/A**	69%	**64%**	**58%**	**68%**
Oak House	**N/A**	70%	**67%**	**67%**	**67%**

Quarter 3 overall average compliance in Herefordshire for these standards during this year is **74%** which is the same as year-end compliance for 2016/17. There will be an increased focus on ensuring that these standards are met throughout the year.

Trustwide compliance for each of the individual criteria assessed is outlined in the table below. For future audits, services will focus on the criteria scoring an **AMBER** or **RED** RAG rating to promote improvement.

		Current compliance (Q3)	**Direction of travel and previous compliance (Q2)**
1.	Has a Risk Summary been completed?	100%	⇔ (100%)
2.	Has the Clustering Assessment and Allocation been completed?	83%	⇧ (81%)
3.	Has HEF been completed? (LD only)	0%	⇔ (0%)
4.	Has the Pre-Discharge Planning Form been completed?	33%	⇧ (32%)
5.	Have the inpatient care plans been closed within 7 days of discharge?	22%	⇧ (21%)
6.	Has the patient been discharged from bed?	100%	⇔ (100%)
7.	Has the Nursing Discharge Summary Letter to Client/GP been sent within 24 hours of discharge?	86%	⇧ (79%)
8.	Has the 48 hour follow up been completed if the Community Team are not doing it?	96%	⇧ (93%)

Of the eight individual criteria assessed, overall compliance has improved or remained the same in both counties.

This target has not been met.

Target 1.3 To ensure that joint Care Programme Approach reviews occur for all service users who make the transition from children's to adult services.

The period of transition from children and young people's services (CYPS) to adult mental health services is often daunting for both the young person involved and their family or carers. We want to ensure that this experience is as positive as it can be by undertaking joint Care Programme Approach (CPA) reviews between children's and adult services every time a young person transitions to adult services.

Results from 2016-17 transitions are also included below so that historical comparative information is available.

Gloucestershire Services

2016-17 Results

Criterion	Compliance Quarter 1 (2016/17)	Compliance Quarter 2 (2016/17)	Compliance Quarter 3 (2016/17)	Compliance Quarter 4 (2016/17)
Joint CPA Review	86%	100%	100%	N/A

2017-18 Results

During Quarter 3, there were 2 young people who transitioned into adult services, they both had a joint CPA review.

Criterion	Compliance Quarter 1 (2017/18)	Compliance Quarter 2 (2017/18)	Compliance Quarter 3 (2017/18)	Compliance Quarter 4 (2017/18)
Joint CPA Review	100%	100%	100%	

Herefordshire Services

2016-17 Results

Criterion	Compliance Quarter 1 2016/17)	Compliance Quarter 2 (2016/17)	Compliance Quarter 3 (2016/17)	Compliance Quarter 4 (2016/17)
Joint CPA Review	33%	50%	100%	100%

2017-18 Results

Criterion	Compliance Quarter 1 (2017/18)	Compliance Quarter 2 (2017/18)	Compliance Quarter 3 (2017/18)	Compliance Quarter 4 (2017/18)
Joint CPA Review	100%	100%	Not applicable	

During Quarter 3, there were no transitions of young people into adult services.

To improve our practice and documentation in relation to this target, a number of measures were developed during 2016-17 as follows:

- Transition to adult services for any young person will be included as a standard agenda item for teams, to provide the opportunity to discuss transition cases;
- Transition will be included as a standard agenda item in caseload management to identify emerging cases;
- Teams are encouraged to contact adult mental health services to discuss potential referrals;
- There is a data base which identifies cases for transition;
- SharePoint report identifies those young people who are 17.5 years open to CYPS. Team Managers will monitor those who are coming up to transition and discuss in supervision.

These measures continued to be used to promote good practice.

We are currently meeting this target.

User Experience

In this domain, we have set ourselves 1 goal of improving service user experience and carer experience with 4 associated targets.

- Improving the experience of service users in key areas. This was measured though defined survey questions for both people in community and inpatient settings.

The Trust's **How did we do?** survey combines the NHS Friends and Family Test and the Quality Survey. The Quality Survey questions encourage people to provide feedback on key aspects of their care and treatment.

The two elements of the **How did we do?** survey will continue to be reported separately as Friends and Family Test and Quality Survey responses by county. A combined total percentage for both counties is also provided to mirror the methodology used by the CQC Community Mental Health Survey.

Data for Quality Survey (Quarter 1 - July to September 2017) results:

Target 2.1 Were you involved as much as you wanted to be in agreeing the care you will receive? > 92%

Question	County	Number of responses	Target Met?
Were you involved as much as you wanted to be in agreeing the care you receive?	Gloucestershire	24 (13 positive)	75% TARGET 92%
	Herefordshire	43 (37 positive)	
	Total	67 (50 positive)	

This target has not been met.

Target 2.2 Have you been given information about who to contact outside of office hours if you have a crisis? > 74%

Question	County	Number of responses	Target Met?
Have you been given information about who to contact outside of office hours if you have a crisis?	Gloucestershire	29 (25 positive)	85% TARGET 74%
	Herefordshire	39 (33 positive)	
	Total	68 (58 positive)	

This target has been met.

Target 2.3 Have you had help and advice about taking part in activities that are important to you? >69%

Question	County	Number of responses	Target Met?
Have you had help and advice about taking part in activities that are important to you?	Gloucestershire	24 (14 positive)	76% TARGET 69%
	Herefordshire	38 (33 positive)	
	Total	62 (47 positive)	

This target has been met.

Target 2.4 Have you had help and advice to find support for physical health needs if you have needed it? > 76%

Question	County	Number of responses	Target Met?
Have you had help and advice to find support for physical health needs if you have needed it?	Gloucestershire	26 (18 positive)	77% TARGET 76%
	Herefordshire	35 (29 positive)	
	Total	61 (47 positive)	

This target has been met.

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 is good news and 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 has not been fully achieved this quarter continues to receive a high percentage of positive responses. The increase in the target set for 2017/18 is demonstrative of our desire to consistently improve our services and although the target has not yet been met, the responses are more positive than the previous quarter.

Friends and Family Test (FFT)

FFT responses and scores for Quarter 3

The FFT involves service users being asked "*How likely are you to recommend our service to your friends and family if they needed similar care or treatment?*"

Our Trust 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.

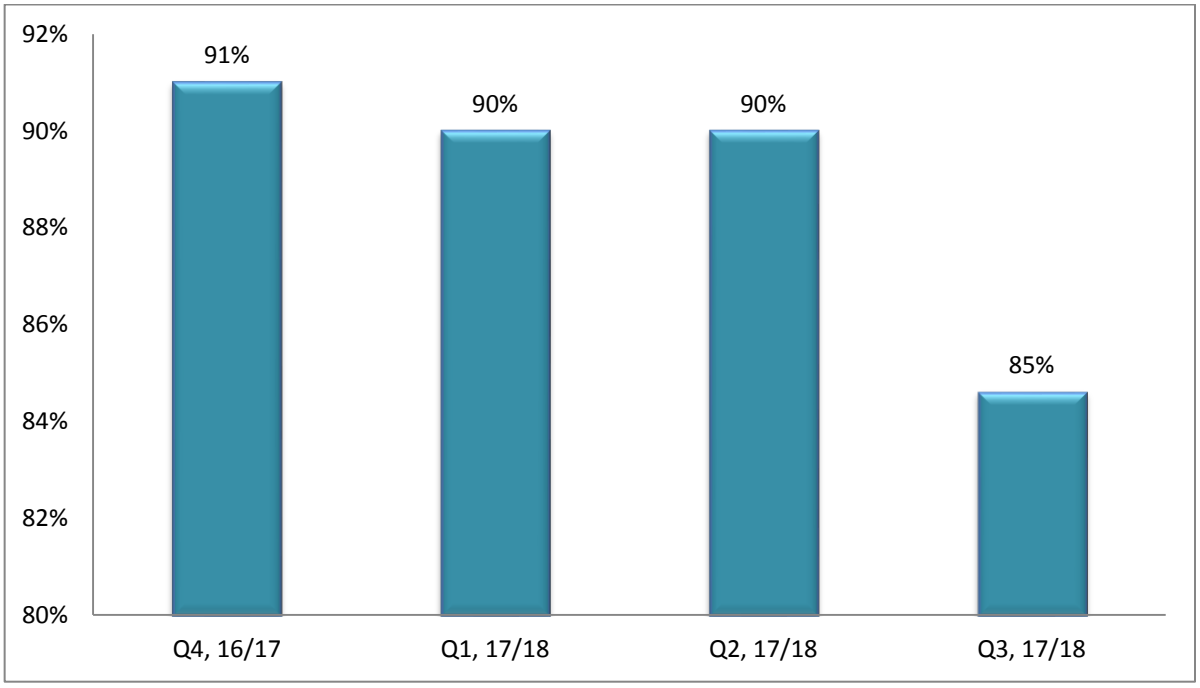
The table overleaf details the number of combined total responses received by the Trust each month in quarter 3. The FFT score is the percentage of people who stated that they would be 'extremely likely' or 'likely' to recommend our services. These figures are submitted for national reporting.

	Number of responses	FFT Score (%)
October 2017	190 (164 positive)	86%
November 2017	422 (359 positive)	85%
December 2017	252 (208 positive)	83%
Total	**864** (731 positive) **(last quarter = 623)**	**85%** **(last quarter = 90%)**

The Quarter 3 response rates are higher than the previous quarter. The **How did we do?** Survey was initially launched as a paper based survey. From 1 November 2017 the survey was distributed via text message to those people discharged from our community and inpatient services. The text messages ask the FFT questions and provide a link for people to complete additional Trust Quality Survey questions. 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. The Service Experience Department along with 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 9%. It is hoped that this will increase as time progresses and systems are updated

FFT Scores for [2]gether NHS Foundation Trust for the past year. The following graph shows the FFT Scores for the past rolling year, including this quarter. The Trust receives consistently positive feedback.

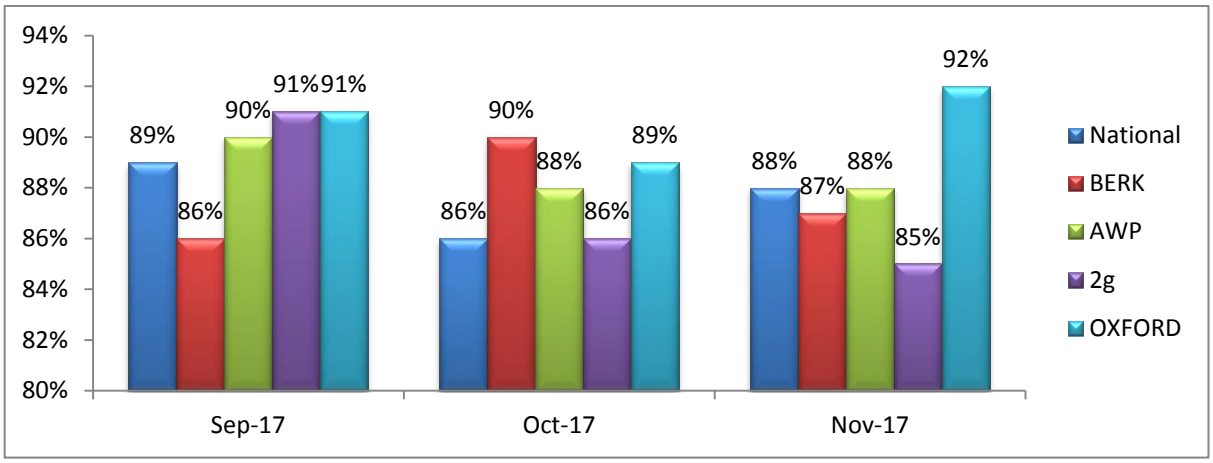
Figure 1



The FFT score for Quarter 3 has dropped slightly compared with previous quarters. The Trust continues to maintain a high percentage of people who would recommend our services.

Friends and Family Test Scores – comparison between 2gether NHS Foundation Trust and other Mental Health Trusts across England

The chart below shows the FFT scores for September, October, and November 2017 (the most recent data available) compared to other Mental Health Trusts in our region and the national average. Our Trust consistently receives a high percentage of recommendation in line with other Mental Health Trusts in the region although our scores have dropped slightly throughout the quarter. (December 2017 data is not yet available).



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

Safety

Protecting service users from further harm whilst they are in our care is a fundamental requirement. We seek to ensure that we assess the safety of those who use our services as well as providing a safe environment for service users, staff and everyone else that comes into contact with us. In this domain, we have set ourselves 3 goals to:

- Minimise the risk of suicide of people who use our services;
- Ensure the safety of people detained under the Mental Health Act;
- Reduce the number of prone restraints used in our adult inpatient services:

There are 3 associated targets.

Target 3.1 **Reduce the proportion of patients in touch with services who die by suspected suicide when compared with data from previous years. This will be expressed as a rate per 1000 service users on the Trust's caseload**.

We aim to minimise the risk of suicide amongst those with mental disorders through systematic implementation of sound risk management principles. In 2013/14, during which year we reported **22** suspected suicides, we set ourselves a specific quality target for there to be fewer deaths by suicide of patients in contact with teams and we have continued with this important target each year. Sadly the number increased and during 2016/17 we reported **26** suspected suicides. At the end of Quarter 3 2017/18 the number of reported suspected suicides was **22,** 1 less than at the end of the same quarter last year. This is seen in Figure 4.

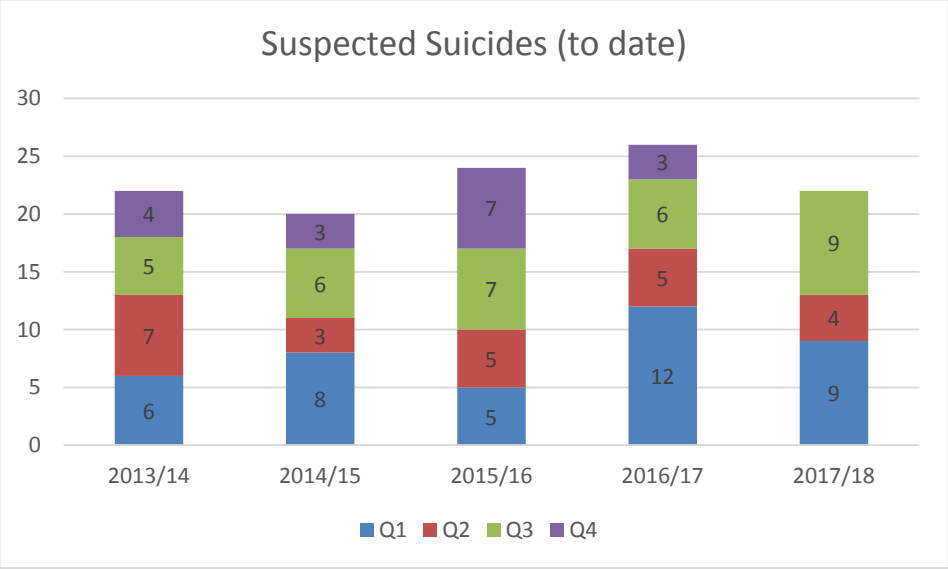


Figure 4

What we also know is that we are seeing more and more service users on our caseload year on year, so we are going measure this important target differently this year. This will be as reported as a rate per 1000 service users on the Trust caseload. The graph in Figure 5 shows this rate from 2014/15 onwards for all Trust services covering Herefordshire and Gloucestershire, and we are aiming to see the median value (green line) get smaller. During both 2015/16 and 2016/17 the median value was 0.09. At the end of Quarter 2 2017/18, the median value remains at 0.09.

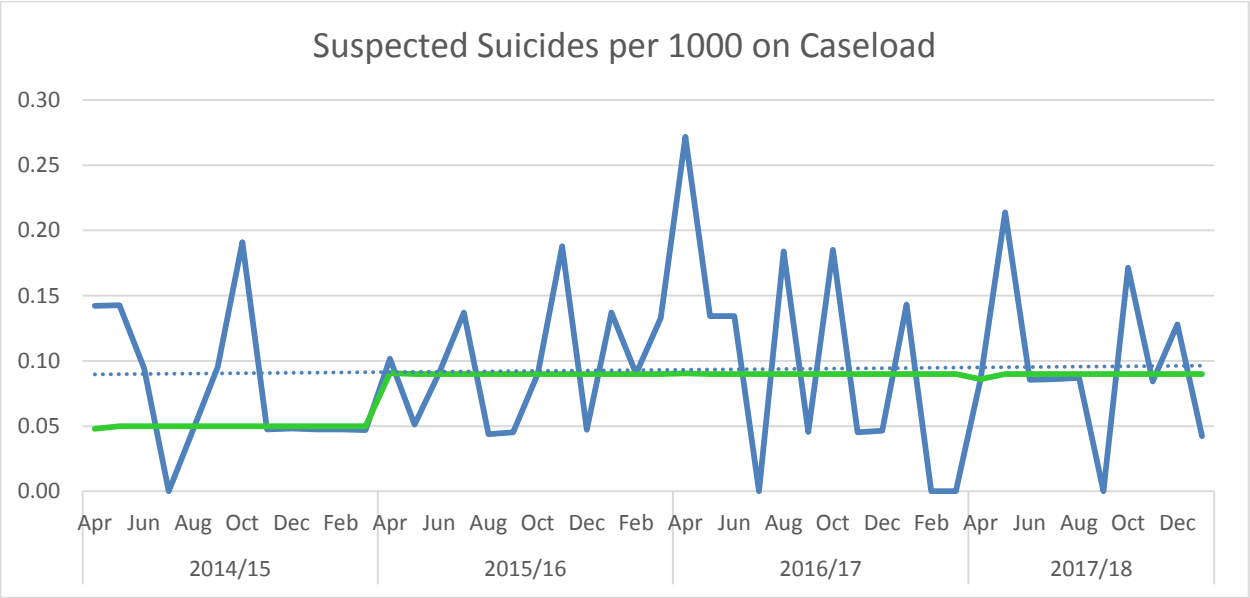


Figure 5

In terms of the inquest conclusions, these are shown in Figure 6 below. It is seen that the majority of reported suspected suicides are determined as such by the Coroner.

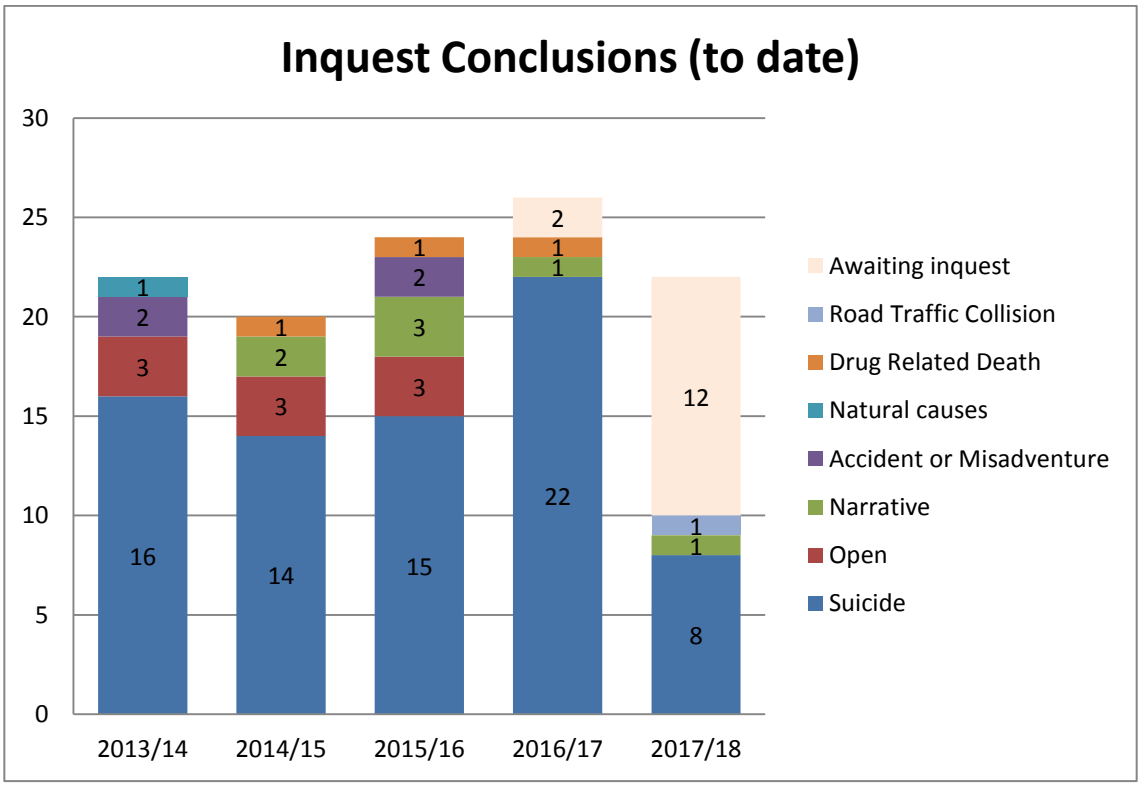


Figure 6

Information is provided below in Figures 7 & 8 for both Gloucestershire and Herefordshire services separately. It is seen that greater numbers of suspected suicides are reported in Gloucestershire services. There is no clear indication of why the difference between the two counties is so marked, but it is noted that the population of people in contact with mental health services in Gloucestershire is greater, and the overall population of Gloucestershire is a little over three times that of Herefordshire (based on mid -2015 population estimates).

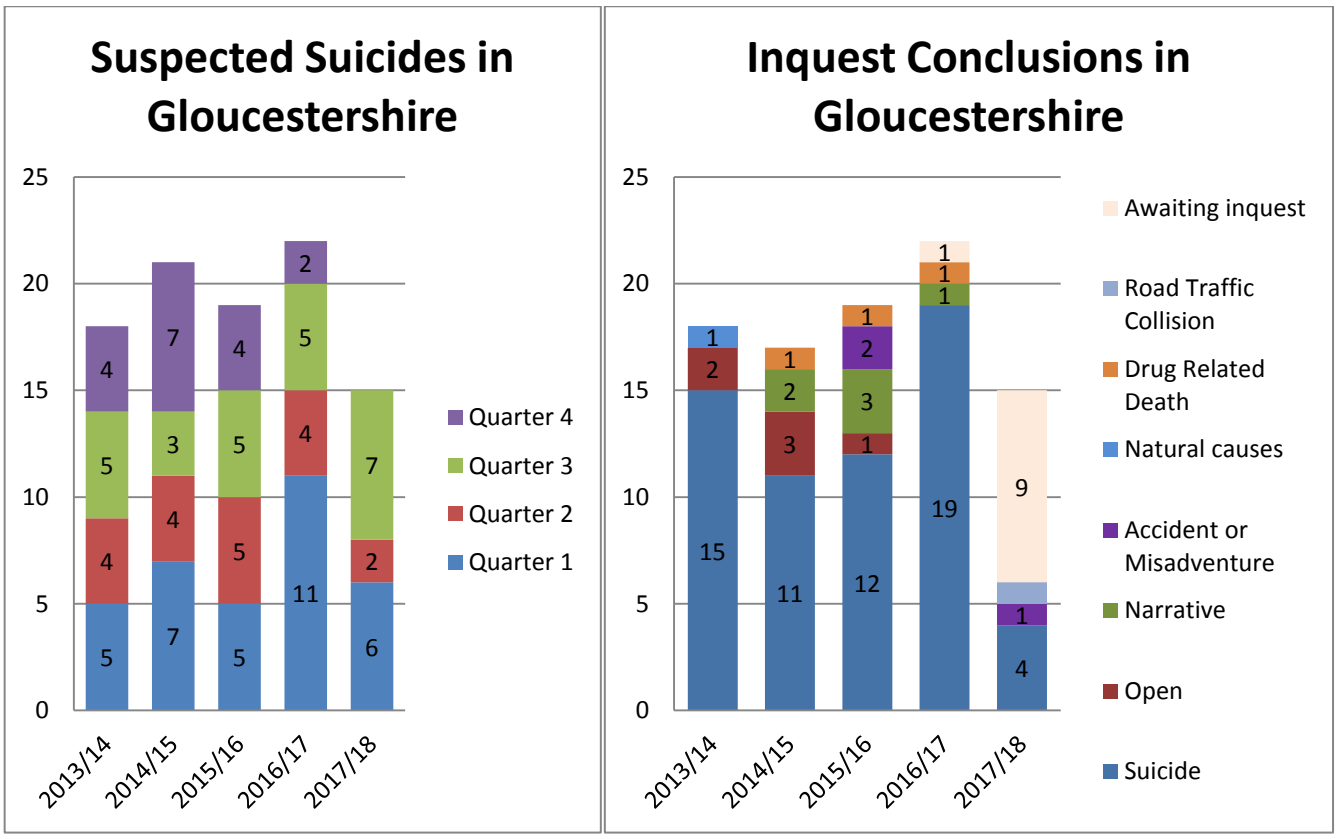


Figure 7

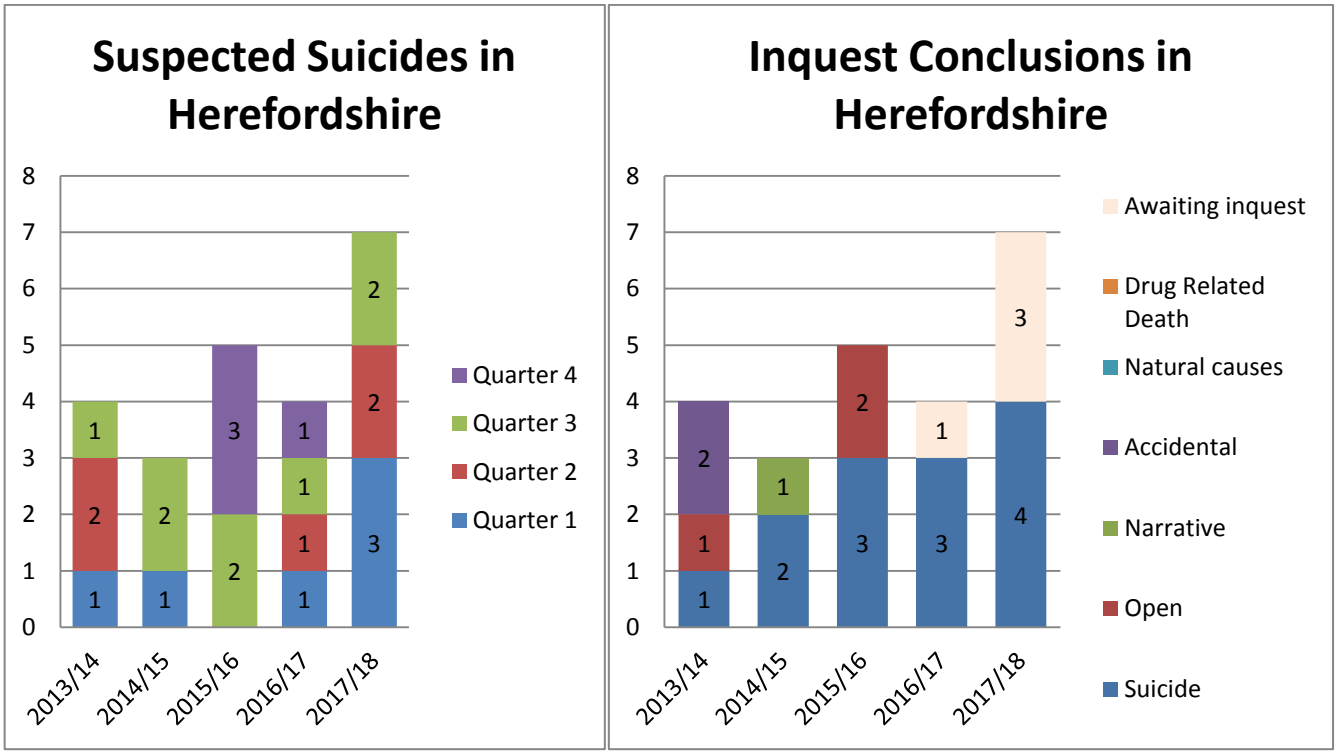


Figure 8

We are currently meeting this target but there remains a risk that this will not be achieved.

Target 3.2 Detained service users who are absent without leave (AWOL) will not come to serious harm or death.

Much work has been done to understand the context in which detained service users are absent without leave (AWOL) via the NHS South of England Patient Safety and Quality Improvement Mental Health Collaborative. AWOL reporting includes those service users who:

1. Abscond from a ward,
2. Do not return from a period of agreed leave,
3. Abscond from an escort.

What we want to ensure is that no service users who are AWOL come to serious harm or death, so this year we are measuring the level of harm that people come to when absent.

In **2015/16** we reported **114** occurrences of AWOL (83 in Gloucestershire and 31 in Herefordshire as seen in the table below.

	Absconded from a ward	Did not return from leave	Absconded from an escort	Total
Gloucestershire	55	19	9	**83**
Herefordshire	23	4	4	**31**
Total	**78**	**23**	**13**	**114**

None of these incidents led to serious harm or death.

In **2016/17** we reported **211** occurrences of AWOL (162 in Gloucestershire and 49 in Herefordshire detailed in the table below) so there was a considerable increase in the numbers of people who were AWOL. There are a number of factors which influence this, including open wards, increased numbers of detained patients in our inpatient units, increased acuity, and on occasion, service users who leave the hospital without permission multiple times.

	Absconded from a ward	Did not return from leave	Absconded from an escort	Total
Gloucestershire	95	49	18	**162**
Herefordshire	40	4	5	**49**
Total	**135**	**53**	**23**	**211**

None of these incidents led to serious harm or death.

At the end of Quarter 3 **2017/18** the following occurrences of AWOL have been reported

	Absconded from a ward	Did not return from leave	Absconded from an escort	Total
Gloucestershire	64	42	9	**115**
Herefordshire	19	0	5	**24**
Total	**83**	**42**	**14**	**136**

None of these incidents led to serious harm or death.

We are meeting this target.

Target 3.3 To reduce the number of prone restraints by 5% year on year (on all adult wards & PICU)

During 2015/16, the Trust developed an action plan to reduce the use of restrictive interventions, in line with the 2 year strategy – Positive & Safe: developed from the guidance Positive and Proactive Care: reducing the need for restrictive interventions. This strategy offered clarity on what models and practice need to be undertaken to support sustainable reduction in harm and restrictive approaches, with guidance and leadership by the Trust Board and a nominated lead.

The Trust developed its own Positive & Safe Sub-Committee during 2015/16 which is a sub–committee of the Governance Committee. The role of this body is to:

- Support the reduction of all forms of restrictive practice;
- Promote an organisational culture that is committed to developing therapeutic environments where physical interventions are a last resort;
- Ensure organisational compliance with the revised Mental Health Act 1983 Code of Practice (2015) and NICE Guidance for Violence and Aggression;
- Oversee and assure a robust training programme and assurance system for both Prevention & Management of Violence & Aggression (PMVA) and Positive Behaviour Management (PBM);
- Develop and inform incident reporting systems to improve data quality and reliability;
- Improve transparency of reporting, management and governance;
- Lead on the development and introduction of a Trust wide RiO Physical Intervention Care Plan/Positive Behavioural Support.

As use of prone restraint (face down) is sometimes necessary to manage and contain escalating violent behaviour, it is also the response most likely to cause harm to an individual. Therefore, we want to minimise the use of this wherever possible through effective engagement and occupation in the inpatient environment. All instances of prone restraint are recorded and this information was used to establish a baseline in 2015/16. Overall, there were **121** occasions when prone restraint was used in our acute adult wards and PICU.

At the end of 2016/17, **211** instances of prone restraint were used as seen in Figure 8 which was an overall increase.

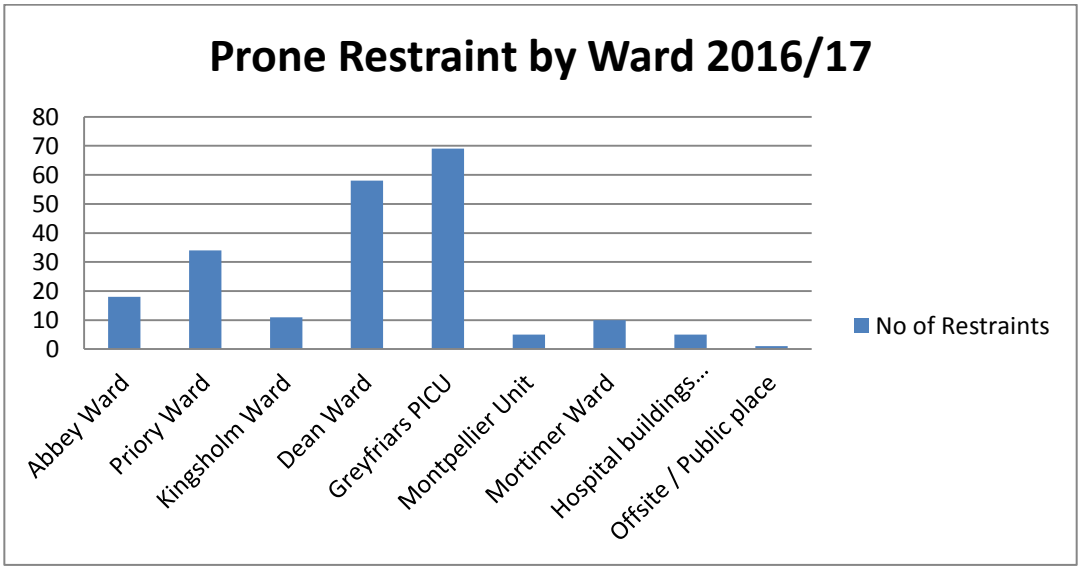
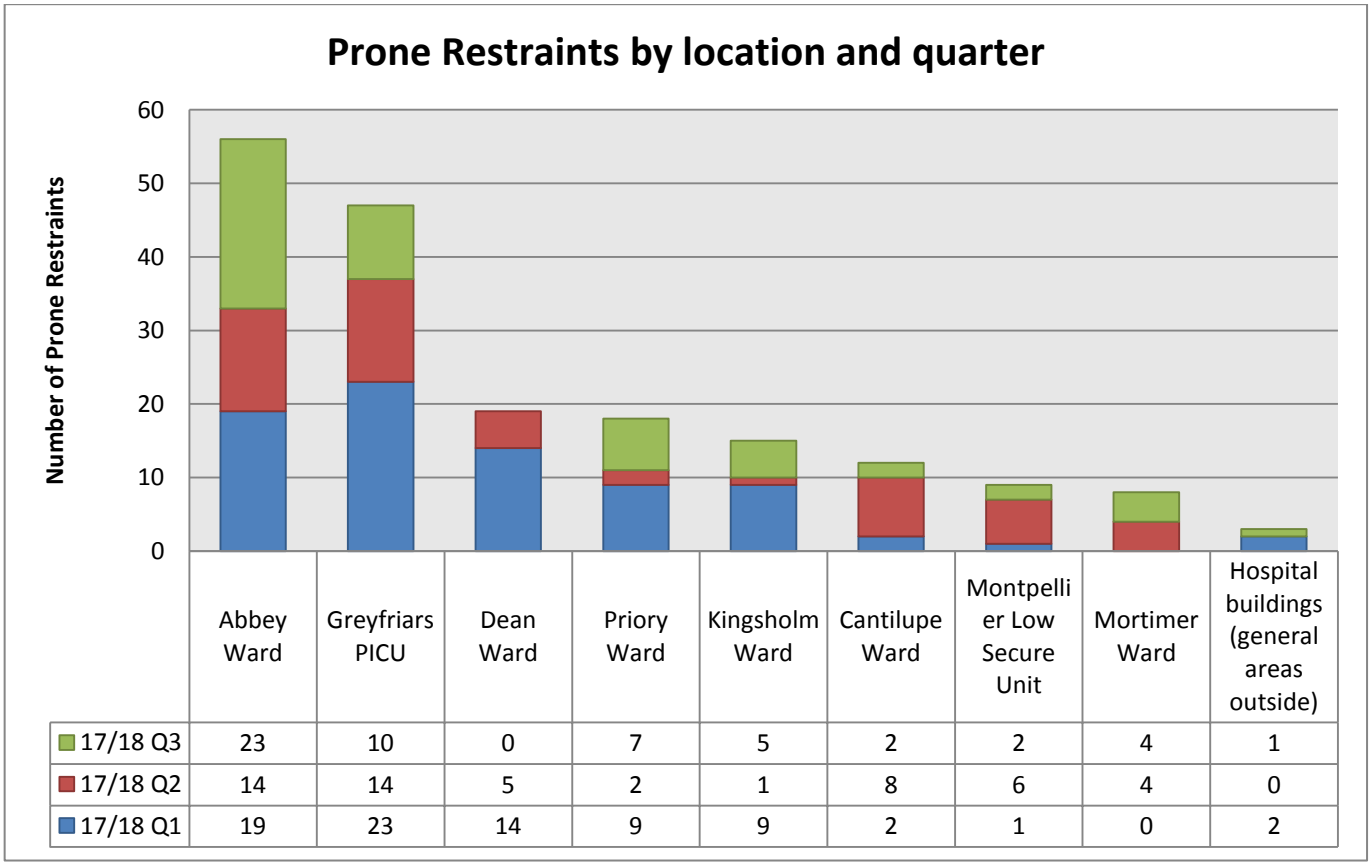


Figure 10

In terms of further developments to minimise the use of prone restraint, injection sites for the purpose of rapid tranquillisation have been reviewed. Historically, staff have been trained to provide rapid tranquillisation intramuscularly via the gluteal muscles, this necessitates the patient being placed into the prone restraint position if they are resistant to the intervention. New training is in the process of being rolled out to all inpatient nursing and medical staff to be able to inject via the quadriceps muscles. This requires the patient to be placed in the supine position which poses less risk. These important changes are being implemented during 2017/18 and it is anticipated that we will ultimately see a corresponding reduction in the use of prone restraint.

By the end of Quarter 3, **187** instances of prone restraint were used so we are not on target to see a 5% reduction by year end.



	Abbey Ward	Greyfriars PICU	Dean Ward	Priory Ward	Kingsholm Ward	Cantilupe Ward	Montpellier Low Secure Unit	Mortimer Ward	Hospital buildings (general areas outside)
17/18 Q3	23	10	0	7	5	2	2	4	1
17/18 Q2	14	14	5	2	1	8	6	4	0
17/18 Q1	19	23	14	9	9	2	1	0	2

Figure 11

We have not yet met this target.

Serious Incidents reported during 2017/18

By the end of Quarter 3 2017/18, **42** serious incidents were reported by the Trust, **5** of which were subsequently declassified; the types of these incidents reported are seen below in Figure 10.

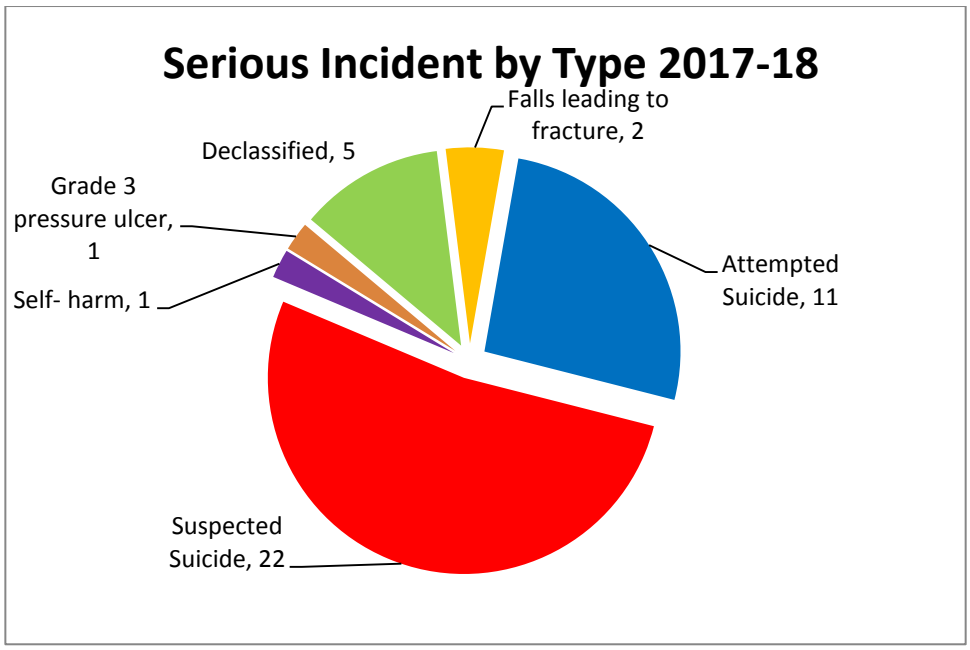


Figure 10

Figure 11 shows a 4 year comparison of reported serious incidents. The most frequently reported serious incidents are “suspected suicide” and attempted suicide which is why we continue to focus on suicide prevention activities in partnership with stakeholders. All serious incidents were investigated by senior members of staff, all of whom have been trained in root cause analysis techniques. To further improve consistency of our serious incident investigations we have seconded a whole time equivalent Lead Investigator for 12 months who commenced this important work in May 2017, and a further dedicated Investigating Officer is now available via the Trust’s Staff Bank. This arrangement will be reviewed during Quarter 4 2017/18.

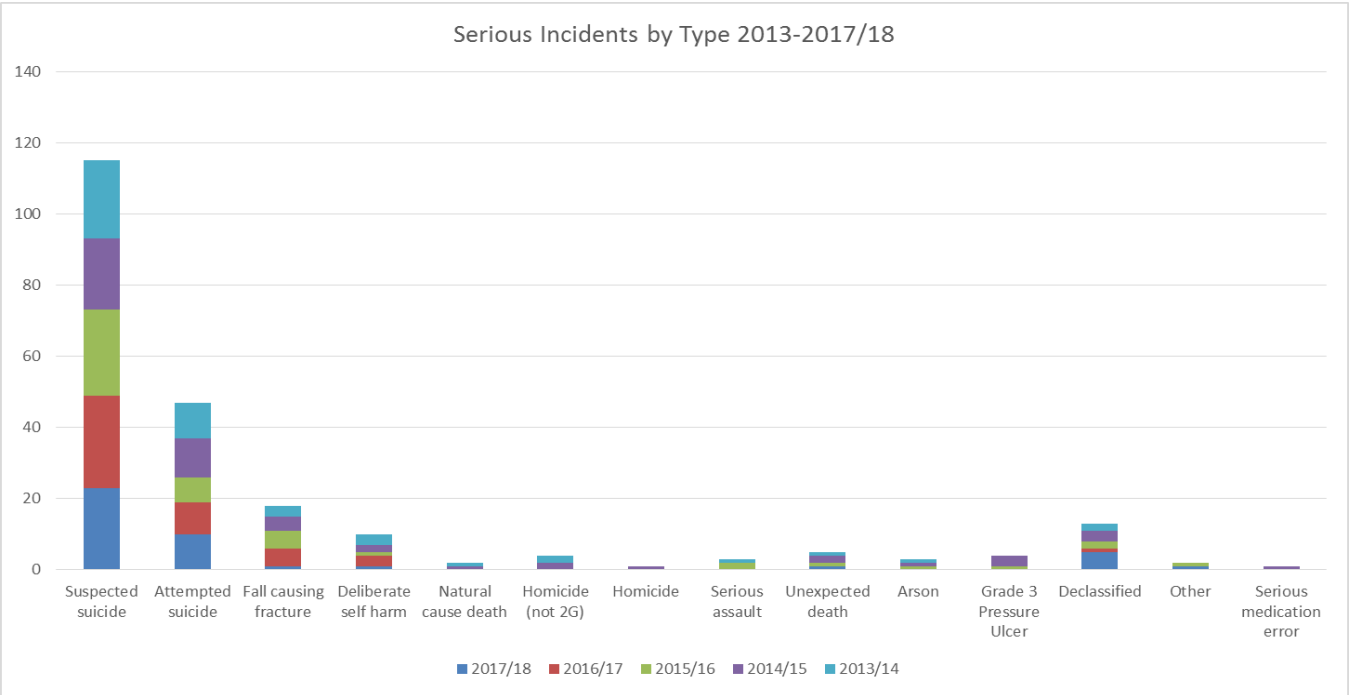


Figure 11

Wherever possible, we include service users and their families/carers to ensure that their views are central to the investigation, we then provide feedback to them on conclusion. During 2016/17 we engaged the Hundred Families organisation to deliver 'Making Families Count' training to 51 staff to improve our involvement of families and a further 20 staff attended an additional Hundred Families workshop regarding 'Involving Families in Serious Incidents' in November 2017. During 2017/18 we will also be developing processes to provide improved support to people bereaved by suicide. The Trust shares copies of our investigation reports regarding "suspected suicides" with the Coroners in both Herefordshire and Gloucestershire to assist with the Coronial investigations.

There have been no Department of Health defined "Never Events" within the Trust during 2017/18. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

Duty of Candour

The Duty of Candour is a statutory regulation to ensure that providers of healthcare are open and honest with services users when things go wrong with their care and treatment. The Duty of Candour was one of the recommendations made by Robert Francis to help ensure that NHS organisations report and investigate incidents (that have led to moderate harm or death) properly and ensure that service users are told about this.

The Duty of Candour is considered in all our serious incident investigations, and as indicated in our section above regarding serious incidents, we include service users and their families/carers in this process to ensure their perspective is taken into account, and we provide feedback to them on conclusion of an investigation. Additionally, we review all reported incidents in our Datix System (incident reporting system) to ensure that any incidents of moderate harm or death are identified and appropriately investigated.

To support staff in understanding the Duty of Candour, we have historically provided training sessions through our Quality Forums and given all staff leaflets regarding this. There is also a poster regarding this on every staff notice board. During the CQC comprehensive inspection of our services, they reviewed how the Duty of Candour was being implemented across the Trust and provided the following comments in their report dated 27 January 2016.

"Staff across the trust understood the importance of being candid when things went wrong including the need to explain errors, apologise to patients and to keep patients informed."

"We saw how duty of candour considerations had been incorporated into relevant processes such as the serious investigation framework and complaints procedures. Staff across the trust were aware of the duty of candour requirements in relation to their role."

Our upgraded Incident Reporting System (Datix) has been configured to ensure that any incidents graded moderate or above are flagged to the relevant senior manager/clinician, who in turn can investigate the incident and identify if the Duty of Candour has been triggered. Only the designated senior manager/clinician can "sign off" these incidents.

Sign up to Safety Campaign – Listen, Learn and Act (SUP2S)

[2]gether NHS Foundation Trust signed up to this campaign from the outset and was one of the first 12 organisations to do so. Within the Trust the campaign is being used as an umbrella under which to sit all patient safety initiatives such as the NHS South of England Patient Safety and Quality Improvement Mental Health Collaborative, the NHS Safety Thermometer, Safewards interventions and the Reducing Physical Interventions project. Participation in SUP2S webinars has occurred, and webinar recordings are shared with colleagues. A Safety Improvement Plan has been developed, submitted and

approved. Monitoring of progress as a whole is completed every 6 months via the Trust Governance Committee, but each work stream has its own regular forum and reporting mechanisms.

Indicators & Thresholds for 2017/2018

The following table shows the metrics that were monitored by the Trust during 2017/18 up to the end of Quarter 3. New guidance from NHS Improvement published in January 2018 requires additional indicators to be reported on, so the indicators below will be refreshed and updated to make reference to new requirements at year end.

		2015-2016 Actual	2016-2017 Actual	National Threshold	2017-2018 Actual
1	Clostridium Difficile objective	0	**3**	0	**0**
2	MRSA bacteraemia objective	0	**0**	0	**0**
3	7 day CPA follow-up after discharge	95.63%	**98%**	95%	**99%**
4	CPA formal review within 12 months	99.35%	**99%**	95%	**98%**
5	Delayed transfer of care	1.02%	**1.7%**	≤7.5%	**2.9%**
6	Admissions gate kept by Crisis resolution/home treatment services	99.74%	**99%**	95%	**99%**
7	EIP: Receipt of NICE approved care within 2 weeks	-	**71.3%**	50%	**75%**
8	MHMDS data completeness: identifiers	99.57%	**99.9%**	97%	**99.9%**
9	MHMDS data completeness: CPA outcomes	97.42%	**94.7%**	50%	**93.7%**
10	Learning Disability – six criteria	6	**6**	6	**6**
11	Admissions to adult facilities of patients under 18 years old.	-	**-**	0	**8**
12	Improving access to psychological therapies - treated within 6 weeks of referral - treated within 18 weeks of referral		**37.8%**	75% 95%	**66%** **85%**

Commissioner Agreed Developments

This will be included at year-end.

Community Survey 2016

The Care Quality Commission (CQC) requires that all mental health Trusts in England undertake an annual survey of patient feedback. [2]gether NHS Foundation Trust has, for several years, commissioned Quality Health to undertake this work.

The 2017 survey of people who use community mental health services involved 56 providers in England. The data collection was undertaken between February and June 2017 using a standard postal survey method. The sample was generated at random using the agreed national protocol for all clients on the CPA and Non-CPA Register seen between 1st September and 30th November 2016. [2]gether NHS Foundation Trust received one of the highest percentage response rates at 33% (national average of 26%).

Full details of this survey questions and results can be found on the following website: http://nhssurveys.org/Filestore/MH17_bmk_reports/MH17_RTQ.pdf

[2]gether NHS Foundation Trust is categorised as performing 'better' than the majority of other mental health Trusts in 5 of the 10 domains and 'about the same' as the majority of other mental health Trusts in the remaining 5 domains. [2]gether NHS Foundation Trust is not categorised as performing 'worse' than the majority of other mental health Trusts for any of the domains or any of the evaluative questions. The results are tabulated below together with the scores out of 10 for [2]gether NHS Foundation Trust calculated by the CQC.

[2]gether's scores and comparison with other Trusts

Score (out of 10)	Domain of questions	How the score relates to other trusts
8.0	Health and social care workers	Same as others
8.9	Organising Care	Better than others
7.3	Planning care	Same as others
7.8	Reviewing care	Same as others
7.3	Changes in who people see	Better than others
6.5	Crisis care	Same as others
7.9	Treatment	Better than others
5.7	Support and Wellbeing	Better than others
7.9	Overall view of care and services	Better than others
7.5	Overall experience	Same as others

[2]gether NHS Foundation Trust obtained the highest score achieved by **any** Trust on 5 of the 32 evaluative questions:

- *Have you agreed with someone from NHS mental health services what care you will receive?*
- *Were these treatments or therapies explained to you in a way that you could understand?*
- *Do the people you see through NHS mental health services help you with what is important to you?*
- *In the last 12 months, do you feel you have seen NHS mental health services often enough for your needs?*
- *Overall experience*

Next Steps

[2]gether NHS Foundation Trust scored well this year overall by comparison to other Trusts, being one of only three English mental health Trusts classed as 'better than expected'. However, there continue to be areas where further development and continued effort would enhance the experience of people in contact with [2]gether NHS Foundation Trust's services. For example, the results in the crisis care domain suggest that further work is required in this area. It would appear from the CQC 2017 scores and information from a range of other service experience information (reported to Board quarterly) that actions being taken to enhance service experience over recent years are having a positive impact. However, areas for further development are evident and these will be reflected in an action plan

The **priority areas** to undertake further work have been identified by considering where the scores suggest a lower degree of satisfaction overall. As such, the following areas for further practice development are proposed:

- Supporting people at times of crisis
- Involving people in planning and reviewing their care
- Involving family members or someone close, as much as the person would like
- Giving people information about getting support from people with experience of the same mental health needs as them
- Helping people with their physical health needs and to take part in an activity locally
- Providing help and advice for finding support with finances, benefits and employment

The 2017 results have already been provided for all colleagues through a global email which celebrates our successes and thanks them for their dedication. Further cascade will be undertaken through Team Talk across Herefordshire and Gloucestershire. The results will be cascaded to Service Directors for sharing with Teams and for generating ideas for continued practice development. An infographic has been developed to share the local results in a more accessible format and this is seen overleaf.

2017 CQC Survey of people who use community mental health services
Gloucestershire and Herefordshire

²gether NHS Foundation Trust

822 people were sent the survey

271 people returned the survey

18 years plus

26% National response rate

33% Trust response rate

32 questions → **10** domains → ²gether's results: In the top 20% of Trusts in 5 out of the 10 domains. 'About the same' as other Trusts in 5 domains.

Results of 10 domains

Each domain compared to other trusts

Better | About the same | Worse

Health and social care workers	8.0/10
Organising care	8.9/10
Planning care	7.3/10
Reviewing Care	7.8/10
Changes in who people see	7.3/10
Crisis care	6.5/10
Treatments	7.9/10
Support and well-being	5.7/10
Overall views of care and services	7.9/10
Overall experience	7.5/10

Rated nationally as amongst the highest performing trusts for:

- Organising people's care
- Involving people in agreeing what care they will receive
- Formally meeting with people every 12 months to discuss how their care is working
- Managing changes in who people see
- Clearly explaining and reviewing treatments or therapies
- Helping people with what is important to them
- Seeing people enough to meet their needs
- People's overall experience

Areas for further focus:

- Supporting people at times of crisis
- Involving people in planning and reviewing their care
- Involving family members or someone close, as much as the person would like
- Giving people information about getting support from people with experience of the same mental health needs as them
- Helping people with their physical health needs and to take part in an activity locally
- Providing help and advice for finding support with finances, benefits and employment

Staff Survey 2016

This will be included at year-end.

PLACE Assessment 2017

In April 2013, Patient Led Assessments of the Care Environment (PLACE) were introduced in England. PLACE are self-assessments carried out voluntarily that involve local people who go into hospitals as part of teams to assess how the environment supports patient's privacy and dignity, food, cleanliness, general building maintenance, Dementia friendly environments and for the first time this year a disability domain has been added. PLACE focuses entirely on the care environment and does not cover clinical care provision or how well staff are doing their job. It is only concerned about the non-clinical activities. The Trust has achieved very positive results placing us above the national average for Mental Health and Learning Disability settings in seven of the eight domains. PLACE is now in its fifth year and the 2017 outcome is seen below.

Site Name	Cleanliness	Food Overall	Organisational Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
Overall 2gether Trust Score: (taken from Organisation Average)	**97.21%**	**88.69%**	**90.32%**	**88.21%**	**97.55%**	**97.93%**	**97.53%**	**95.31%**
HOLLYBROOK	**100.00%**	**90.72%**	**88.87%**	**93.49%**	**100.00%**	**99.59%**	**N/A**	**99.00%**
CHARLTON LANE	**100.00%**	**91.57%**	**90.41%**	**92.75%**	**98.41%**	**99.41%**	**100.00%**	**96.55%**
WOTTON LAWN	**100.00%**	**93.26%**	**90.44%**	**96.74%**	**98.99%**	**99.54%**	**N/A**	**97.71%**
HONEYBOURNE	**100.00%**	**94.23%**	**90.44%**	**98.91%**	**100.00%**	**100.00%**	**N/A**	**100.00%**
LAUREL HOUSE	**100.00%**	**94.00%**	**89.56%**	**100.00%**	**100.00%**	**99.63%**	**N/A**	**100.00%**
STONEBOW UNIT	**89.78%**	**71.30%**	**90.44%**	**55.77%**	**93.67%**	**96.06%**	**94.50%**	**91.81%**
OAK HOUSE	**79.87%**	**N/A**	**N/A**	**N/A**	**88.57%**	**78.46%**	**N/A**	**68.42%**
National Average MH/LD	98.00%	89.68%	87.70%	91.50%	90.60%	95.20%	84.80%	86.30%

Key

At or above MH/LD National Average	
Below England MH/LD average	

The condition, appearance and maintenance PLACE scores are very high in the Trust across with every unit, apart from Oak House, above the National Average. A programme of refurbishment for Oak House commenced in November 2017. The poor cleanliness scores for the Stonebow unit were the consequence of a reduced input from Sodexo, following the Trust serving notice on the contract. Quality has significantly improved following the TUPE of the staff over to Trust Management.

On the day of assessment the quality of the food at the Stonebow Unit was very poor, which brought down the overall score for the site, and the Trust below the national average for mental health and Learning disability units. The food at the Stonebow unit was CookFreeze from Tilery Valley Foods, supplied by Sodexo. The food has consistently scored poorly in the PLACE assessments over recent years. Since the PLACE assessment the catering staff have transferred to the Trust and we have changed the food supplier to Apetito, in line with Charlton Lane and Wotton Lawn which scored 92.75% and 96.74% respectively.

Annex 1: Statements from our partners on the Quality Report

This will be included at year-end.

The Royal College of Psychiatrists

This will be included at year-end.

Annex 2: Statement of Directors' Responsibilities in respect of the Quality Report

This will be included at year-end.

Annex 3: Glossary

ADHD	Attention Deficit Hyperactivity Disorder
BMI	Body Mass Index
CAMHS	Child & Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CHD	Coronary Heart Disease
CPA	Care Programme Approach: a system of delivering community service to those with mental illness
CQC	Care Quality Commission – the Government body that regulates the quality of services from all providers of NHS care.
CQUIN	Commissioning for Quality & Innovation: this is a way of incentivising NHS organisations by making part of their payments dependent on achieving specific quality goals and targets
CYPS	Children and Young Peoples Service
DATIX	This is the risk management software the Trust uses to report and analyse incidents, complaints and claims as well as documenting the risk register.
GriP	Gloucestershire Recovery in Psychosis (GriP) is ^{2}gether's specialist early intervention team working with people aged 14-35 who have first episode psychosis.
HoNOS	Health of the Nation Outcome Scales – this is the most widely used routine Measure of clinical outcome used by English mental health services.
IAPT	Improving Access to Psychological Therapies
Information Governance (IG) Toolkit	The IG Toolkit is an online system that allows NHS organisations and partners to assess themselves against a list of 45 Department of Health Information Governance policies and standards.
MCA	Mental Capacity Act
MHMDS	The Mental Health Minimum Data Set is a series of key personal information that should be recorded on the records of every service user
Monitor	Monitor is the independent regulator of NHS foundation trusts. They are independent of central government and directly accountable to Parliament.
MRSA	Methicillin-resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans. It is also called multidrug-resistant

MUST	The Malnutrition Universal Screening Tool is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan.
NHS	The National Health Service refers to one or more of the four publicly funded healthcare systems within the United Kingdom. The systems are primarily funded through general taxation rather than requiring private insurance payments. The services provide a comprehensive range of health services, the vast majority of which are free at the point of use for residents of the United Kingdom.
NICE	The National Institute for Health and Care Excellence (previously National Institute for Health and Clinical Excellence) is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health.
NIHR	The National Institute for Health Research supports a health research system in which the NHS supports outstanding individuals, working in world class facilities, conducting leading edge research focused on the needs of patients and the public.
NPSA	The National Patient Safety Agency is a body that leads and contributes to improved, safe patient care by informing, supporting and influencing the health sector.
PBM	Positive Behaviour Management
PHSO	Parliamentary Health Service Ombudsman
PICU	Psychiatric Intensive Care Unit
PLACE	Patient-Led Assessments of the Care Environment
PROM	Patient Reported Outcome Measures (PROMs) assess the quality of care delivered to NHS patients from the patient perspective.
PMVA	Prevention and Management of Violence and Aggression
RiO	This is the name of the electronic system for recording service user care notes and related information within ^{2}gether NHS Foundation Trust.
ROMs	Routine Outcome Monitoring (ROMs)
SIRI	Serious Incident Requiring Investigation, previously known as a “Serious Untoward Incident”. A serious incident is essentially an incident that occurred resulting in serious harm, avoidable death, abuse or serious damage to the reputation of the trust or NHS. In the context of the Quality Report, we use the standard definition of a Serious Incident given by the NPSA
SMI	Serious mental illness
VTE	Venous thromboembolism is a potentially fatal condition caused when a blood clot (thrombus) forms in a vein. In certain circumstances it is known as Deep Vein Thrombosis.

Annex 4: How to Contact Us

About this report

If you have any questions or comments concerning the contents of this report or have any other questions about the Trust and how it operates, please write to:

Mr Shaun Clee
Chief Executive Officer
2gether NHS Foundation Trust
Rikenel
Montpellier
Gloucester
GL1 1LY

Or email him at: shaun.clee@nhs.net

Alternatively, you may telephone on 01452 894000 or fax on 01452 894001.

Other Comments, Concerns, Complaints and Compliments

Your views and suggestions are important us. They help us to improve the services we provide.

You can give us feedback about our services by:

- Speaking to a member of staff directly
- Telephoning us on 01452 894673
- Completing our Online Feedback Form at www.2gether.nhs.uk
- Completing our Comment, Concern, Complaint, Compliment Leaflet, available from any of our Trust sites or from our website www.2gether.nhs.uk
- Using one of the feedback screens at selected Trust sites
- Contacting the Patient Advice and Liaison Service (PALS) Advisor on 01452 894072
- Writing to the appropriate service manager or the Trust's Chief Executive

Alternative Formats

If you would like a copy of this report in large print, Braille, audio cassette tape or another language, please telephone us on 01452 894000 or fax on 01452 894001.

Agenda Item **10** **Enclosure** **Paper E**

Report to: Trust Board – 28th March 2018

Author: Marie Crofts, Director of Quality

Presented by: Marie Crofts, Director of Quality

SUBJECT: **Quality Strategy 2018-2020**

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

EXECUTIVE SUMMARY

The Director of Quality has in conjunction with the Director of Engagement and Integration and the Medical Director revised our Quality Strategy.

The strategy has been reviewed at both the Executive Committee and the Development Committee.

All feedback has been taken into account to produce this final version. In addition clinical colleagues at the Quality and Clinical Risk sub- committee were asked to note its contents and feedback their views. An addition indicator for learning Disability is yet to be confirmed by the Clinical Director and professional leads.

RECOMMENDATIONS

The Board is asked to:

- Endorse the Quality Strategy for 2018-2020 subject to a Learning Disability indicator being includes

Corporate Considerations	
Quality implications	The Quality Strategy is a key plank of our clinical priorities. This forms the basis of our Quality report for the year ahead and ensures we focus on indictors for improvement
Resource implications:	No additional resource is necessary at the current time
Equalities implications:	All indictors apply to all service users / carers
Risk implications:	It is a requirement of our regulators that the Trust has a Quality strategy and ensures the Trust focuses on improving services

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

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	

Reviewed by:		
Marie Crofts, Director of Quality	Date	23rd March 2018

Where in the Trust has this been discussed before?		
Executive Committee	Date	December 2017
Development Committee		February 2017
Quality and Clinical Risk subcommittee		March 2017

What consultation has there been?		
See above	Date	

Explanation of acronyms used:	

2gether
Making life better

2gether
NHS Foundation Trust

Quality Strategy

Our vision is to gain and maintain ***outstanding*** *quality services through assuring safety, effectiveness and best service experience* ***to make life better.***

Summary on a page

Why do we need a Quality Strategy?

Successful services are those which people value . Achieving our strategy will enable us to continue to deliver high quality services at a time when NHS resources are challenged and there is increasing competition to deliver services.

What is the vision of our Quality Strategy?

Our vision is to gain and maintain ***outstanding*** *quality services through assuring safety, effectiveness and best service experience* ***to make life better.***

Who is included in our Quality Strategy?

This Quality strategy will enable us to reach out to colleges who deliver our services, people who use our services and others to share our common purpose to make life better and to maximise the use of all resources to deliver best quality care.

What will our Quality Strategy change?

We will build on our current achievements to deliver the best quality possible to ensure safety, inspire confidence in our services, tackle stigma, promote access, evidence our progress and foster hope, belonging, co-operation and teamwork.

How will we know that we have delivered our Quality Strategy?

We will set out a number of ways by which we will monitor and measure the delivery of this strategy. Above all, if successfully delivered this strategy will mean that **we continue to deliver services** that our commissioners want to purchase, service users and carers want to use and staff would recommend.

Monitoring and reporting the success of this strategy will be led by the Director of Quality at the Trust Governance Committee.

When will our Quality Strategy be delivered?

Our strategy will be **implemented between 2018 – 2020**. It will be delivered incrementally, year on year through a range of action plans. These plans will be flexible and able to meet the new challenges and opportunities that will inevitably occur.

Our Quality Framework

: 3 Pillars of Quality

The guiding principle of our Quality Strategy is to ensure we deliver high quality, effective services which improve the lives of our service users and their families.

A high quality service is defined by the Darzi principles (2008) through the **three key pillars of quality**:

- Pillar 1 - SAFETY
- Pillar 2 - EFFECTIVENESS
- Pillar 3 - USER EXPERIENCE

These three pillars of quality will be underpinned by a number of **quality goals** outlined in this document

This strategy is the framework and cornerstone for delivery of such an approach and seeks to bring together all aspects that contribute to a high quality experience - this includes our Business Plan, Quality Report, Service User and Carer Involvement, Individual professional strategies and our Organisational Development strategy.

This will be enacted through a whole system focus on ***continuous quality improvement and robust and meaningful engagement with staff to create compassionate leaders.***

Through the South West of England Patient Safety/Quality Improvement programme alongside the Quality Service Improvement and Redesign (QSIR) national programme, a culture of continuous quality improvement will be embedded throughout the organisation.

Our Quality Strategy is presented in several parts to reflect the overarching framework for quality. The Trust vision and values underpin our enabling approach, the quality pillars are the foundations. Other key areas informing quality developments which are outlined in this strategy include leadership and culture development, Governance for quality assurance, and partnership working. These will be presented in this strategy .

Our Quality Strategy Framework

Our Vision and Values

Quality Pillars – Safety; Effectiveness and User Experience

Quality Goals 1,2,3

and how will we measure our progress

Quality Goal 4 - Leadership & Culture Development

Partnership Working

Quality Governance - Roles & Responsibilities

How we plan to achieve our quality goals

What success will look like

2gether's Vision and values

About us

2gether NHS Foundation Trust provides mental and social health care services to a combined population of 805,000 across Gloucestershire and Herefordshire's 1,900 square miles. We employ over 2,300 members of staff (including staff bank) and deliver services to 19,000 people at any one time.

Our vision

To be the:
Provider and employer of choice delivering sustainable high quality, cost effective, inclusive services

Our values

S	Seeing from a service user perspective
E	Excelling and improving
R	Responsive
V	Valuing and respectful
I	Inclusive, open and honest
C	Can do
E	Efficient, effective, economic and equitable

What we seek to achieve

Our purpose is to make life better through:

- Continuously improving the **Quality** of our service to service users, their families and carers.
- Ensuring the **Sustainability** of services to people in our communities
- **Engaging with people** to best support the delivery of an integrated approach to care.

Quality Goal 1 – Safe services

Services will be safe and people will feel safe in our care

This will be measured by;

- ✓ Reducing the proportion of patients in touch with our services who die by suicide
- ✓ Reducing the number of prone restraints by 5% year on year (on all adult wards and PICU) based on 2016/17 data
- ✓ Ensuring those patients who become absent without leave (AWOL) do not come to serious harm
- ✓ People using our services and their carers will report feeling involved in their care

Quality Goal 2 – Effective Services

Effective care means doing the right thing, at the right time with the right skills

Quality care encourages recovery and enables the best possible outcomes.

.

This will be measured by:

- ✓ Improving the physical health of patients with a serious mental illness on Care Programme Approach (CPA) [in line with the national CQUIN for 2017/18]
- ✓ LD indicator to be confirmed
- ✓ Services being informed by and involved research and evaluation
- ✓ Making every contact count with approaches which prevent illness, promote health and encourage self-management

Quality Goal 3 – Positive user experience

Service users and carers will report that they are treated with dignity, respect and compassion

This will be measured by:

- ✓ The national service user survey results, with the Trust being in the top 20% of comparator organisations
- ✓ Local Friends and Family Tests (FFT)
- ✓ Service users feeling involved in their care
- ✓ Involvement of family members and carers

Quality Goal 4 - Leadership & Culture Development

We will maintain and further develop a **culture of openness and transparency with compassionate leaders** who give permission to colleagues to act to improve services (based on NHSI 'Developing People– Improving Care' 2016)

We will deliver this by:

- ✓ Embedding a culture of continuous quality improvement at all levels of the organisation through credible tried and tested methodology (Plan, Do, Study, Act) and coaching staff to have permission to act to improve patient care.
- ✓ Working with 'Hundred Families' and other stakeholders to build on our communication with families and **Duty of Candour** to ensure learning from adverse events
- ✓ Listening to our staff and volunteers and making improvements based on a number of initiatives collecting staff feedback
- ✓ Developing our leaders to lead with skill; compassion and courage

Partnership Working

We are committed to working with those who use our services, their carers, partner organisations and commissioners to achieve our stated purpose.

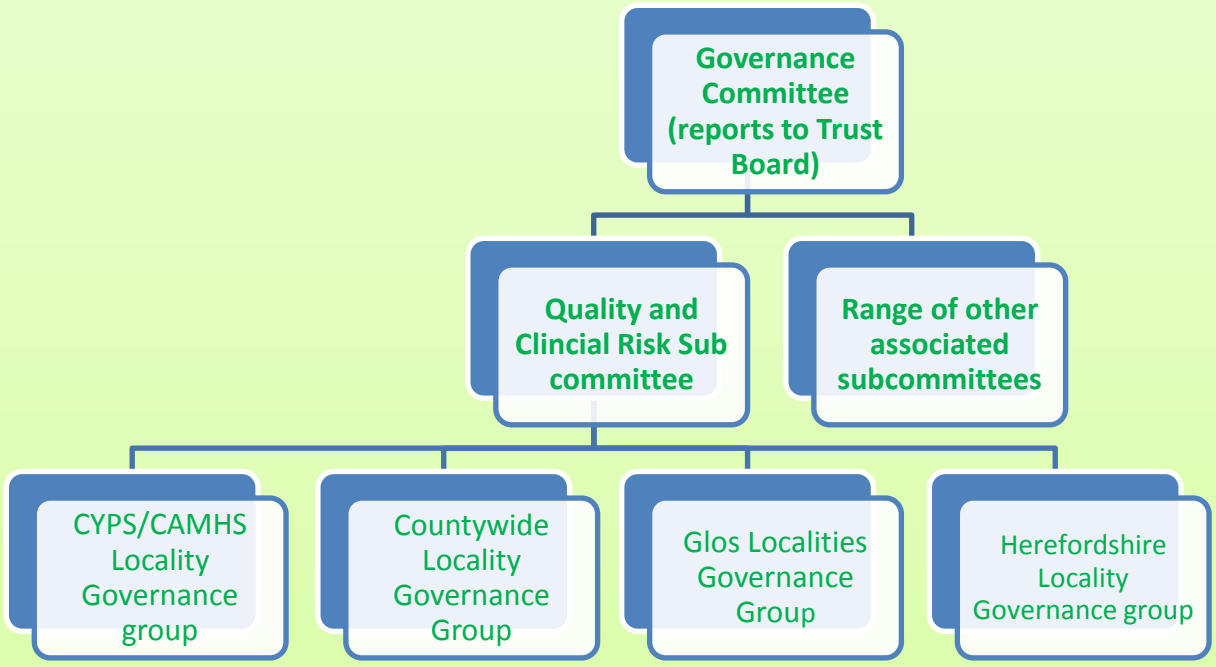
Given the current system wide approach to transformation and the vehicle of the Sustainability and Transformation Plans (STP) now in place we will actively work across organisational boundaries to improve the care of our population.

Our first steps on this journey have been to set out in our strategic intent to develop an integrated physical and mental health care provision in Gloucestershire by bringing together Gloucestershire Care Services and 2gether NHS Foundation Trust.

Quality Governance: Roles & Responsibilities

The Board is ultimately accountable for ensuring that services are safe and of the highest quality that can be achieved with available resources. This is delivered through ***visible leadership and appropriate robust governance structures*** which includes:

- ✓ Board visits to all teams and services
- ✓ Patient Safety Walk rounds by all Executive Directors
- ✓ Developing the organisational culture through openness and transparency ensuring continuous learning and quality improvement
- ✓ Monitoring the effectiveness of this strategy through the Governance structure modelled below:



QUALITY IMPROVEMENT STRATEGY FOR ²gether NHS FOUNDATION TRUST

*Our **driver diagram** illustrates how we are working to embed a culture of continuous improvement and learning across the organisation.*

AIM

To gain and maintain outstanding quality services through assuring safety, effectiveness and best service experience through a culture of continuous quality improvement to make life better by 2020

Build the will

- Care and Compassion conferences
- GSQIA Bronze Level QI training
- South of England QI Mental Health Collaborative (Learn level)
- Show casing real examples internally & Share externally

Build improvement capability

- Always Events
- QSIR & Gloucestershire Academy Learning options
- South of England QI Mental Health Collaborative (Live & Lead levels)
- GSQIA Silver Level QI training
- WEAHSN Educational pathway
- Clinical Audit
- Develop QI Coaches
- Bespoke learning including Board sessions and commissioners.

Alignment

- Embed local structures and processes to support QI
- Align QI projects with Trust priorities
- Support employees, service users and families to find space and time for QI work
- Support team managers and leaders to champion QI

QI Projects

- Reduce harm and improve quality & safety.
- Offer and provide the right care in the right place at the right time.

Leadership - What success will look like

Triangle of Care MEMBER

Best quality service experience

We are proud to be supporting Time to Change

2gether Making life better

2gether NHS Foundation Trust NHS

Agenda item **11** **Enclosure** **Paper F**

Report to: Trust Board, 28 March 2018
Author: Dr Amjad Uppal, Medical Director and Paul Ryder, Patient Safety Manager
Presented by: Dr Amjad Uppal, Medical Director

SUBJECT: **Learning from Deaths 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**

EXECUTIVE SUMMARY

The data presented represents those available for the period April to December 2017 (end Q3 2017/18). During this period there were 569 patient deaths recorded, of which 198 (34.8%) received a table-top review only, 51 (9%) were closed after a case record review and 23 (4%) were notified as Serious Incidents.

Of the 569 patient deaths notified, 297 remain open (52.2%) and require a Mortality Review. 294 of those (98.9%) await a table-top review, 3 (0.7%) require additional discussion at MoReC (a Care Record Review).

This, the second iteration of mortality review data under the Learning from Deaths policy provides further assurance about the progress of this process within 2gether.

The Board is asked to note the contents for information and to recognise that this is at an early stage and that processes in partner organisations, and in primary care are less developed to date. A work-stream is being developed by the Strategic Transformation Partnership.

RECOMMENDATIONS

The Board is asked to note the contents of this Mortality Review Report which covers quarter 2 & 3 of 2017-18.

Corporate Considerations	
Quality implications	Required by National Guidance to support system learning
Resource implications:	Significant time commitment from clinical and administrative staff
Equalities implications:	None
Risk implications:	None

WHICH TRUST STRATEGIC OBJECTIVE(S) DOES THIS PAPER PROGRESS OR CHALLENGE?	
Continuously Improving Quality	Yes
Increasing Engagement	No
Ensuring Sustainability	No

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

Reviewed by:		
Dr Amjad Uppal	Date	21 March 2018

Where in the Trust has this been discussed before?		
Mortality Review Committee (MoReC) *Sadly, this committee was postponed due to illness*	Date	16 March 2018

What consultation has there been?		
	Date	

Explanation of acronyms used:	

1. INTRODUCTION

1.1 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.

1.2 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.

1.3 From Quarter 3 2017, the Trust Board will receive a quarterly (or as prescribed nationally) dashboard report to a public meeting, following the format of Appendix D, including:

- number of deaths
- number of deaths subject to case record review
- number of deaths investigated under the Serious Incident framework (and declared as serious incidents)
- number of deaths that were reviewed/investigated and as a result considered more likely than not to be due to problems in care
- themes and issues identified from review and investigation (including examples of good practice)
- actions taken in response, actions planned and an assessment of the impact of actions taken.

1.4 From June 2018, the Trust will publish an annual overview of this information in Quality Accounts, including a more detailed narrative account of the learning from reviews/investigations, actions taken in the preceding year, an assessment of their impact and actions planned for the next year

1.5 This paper offers the subsequent iteration of data for the period April to December 2017.

2. PROCESS

2.1 All 2gether Trust staff are required to notify, using the Datix process, the deaths of any Trust patients. This comprises anyone who dies within 30 days of receiving care from 2gether. Deaths recorded on Datix are collated for discussion at the monthly Mortality Review Meeting chaired by the lead Clinical Directors. The Trust's Information Department also provides a monthly report detailing any patients discharged from inpatient care who have died within a 30 day period after discharge. These data are compiled from RiO and provided to the Mortality Review Meeting.

2.2 For each reported death, a table-top review is conducted, identifying the following information: cause of death (from e.g. GP or Coroner), location of death, who certified death, any family concerns, any known details of health deterioration immediately prior to death.

2.3 Based upon the information provided, patient deaths are assigned to one of the six categories developed by the Mazars report into Southern Health NHS Foundation Trust (2015).

2.4 Expected Natural deaths (EN1 & EN2) are sorted into those where there may be concerns and those where no possible concerns are identified. Unexpected Natural deaths (UN1 & UN2) are subjected to a case record review and sorted into those where there may be concerns and those where no possible concerns are identified.

Type	Description
Expected Natural (EN1)	A group of deaths that were expected to occur in an expected time frame. E.g. people with terminal illness or in palliative care services. These deaths would not be investigated but could be included in a mortality review of early deaths amongst service users.
Expected Natural (EN2)	A group of deaths that were expected but were not expected to happen in that timeframe. E.g. someone with cancer but who dies much earlier than anticipated These deaths should be reviewed and in some cases would benefit from further investigation
Expected Unnatural (EU)	A group of deaths that are expected but not from the cause expected or timescale E.g. some people on drugs or dependent on alcohol or with an eating disorder These deaths should be investigated.
Unexpected Natural (UN1	Unexpected deaths which are from a natural cause e.g. a sudden cardiac condition or stroke These deaths should be reviewed and some may need an investigation.
Unexpected Natural (UN2)	Unexpected deaths which are from a natural cause but which didn't need to be e.g. some alcohol dependency and where there may have been care concerns These deaths should all be reviewed and a proportion will need to be investigated
Unexpected Unnatural (UU)	Unexpected deaths which are from unnatural causes e.g. suicide, homicide, abuse or neglect These deaths are likely to need investigating

2.5 All Unnatural deaths (EU & UU) are discussed, individually with the Patient Safety manager to identify those that fall into the category of serious incidents requiring investigation, within statute, and according to the relevant Trust policy. Where there appears to be further information required or learning to be derived, incidents that do not require a serious incident review are notified to the relevant team manager for a clinical incident review. The remaining incidents are sorted into those where there may be concerns and those where no possible concerns are identified.

2.6 Where no concerns are identified, the Datix incident is closed without further action.

2.7 Where concerns are raised, the case is be elevated to the clinical leads for review and, depending upon the outcome, can be treated as a serious incident, referred for multiagency review or notified to the relevant team manager for a clinical incident review.

2.8 The data obtained will be subjected to a modified version of the structured judgement review methodology defined by the Royal College of Physicians and assigned to one of three categories:

Category 1: "not due to problems in care"

Category 2: "possibly due to problems in care within ^{2}gether"

Category 3: "possibly due to problems in care within an external organisation"

2.9 For those deaths that fall into Category 2, learning is collated and an action plan developed to be progressed through operational and clinical leads and reported to Governance Committee. For Category 3, the issues identified are escalated to local partner organisations through the relevant Clinical Commissioning Group lead for mortality review. For distant organisations, issues will be shared with the local lead for learning from deaths within the organisation.

2.10 All deaths of patients with a learning disability will be also reported through the appropriate Learning Disabilities Mortality Review Program (LeDeR) process, and deaths of people under the age of 18 will be reported through the current child death reporting methodology.

3. DATA

3.1 The data presented below represents those available for the period April to December 2017 (end Q3 2017/18). During this period there were 569 patient deaths recorded, of which 198 (34.8%) received a table-top review only, 51 (9%) were closed after a case record review and 23 (4%) were notified as Serious Incidents.

3.2 Of the 569 patient deaths notified, 297 remain open (52.2%) and require a Mortality Review. 294 of those 297 (98.9%) await a table-top review, 3 (0.7%) require additional discussion at MoReC (a Care Record Review).

3.3 Overall, 1 death was considered to have involved problems in care within this Trust (a Serious Incident) and 2 deaths raised concerns regarding care delivered by partner organisations.

4. CONCLUSION

4.1 This, the second iteration of mortality review data under the Learning from Deaths policy, provides additional assurance about the progress of this process within 2gether.

4.2 The Patient Safety Manager has expressed concerns with regard to the growing number of overdue table-top reviews. These deaths largely occur within the Community Dementia Nursing teams, predominantly the ACI Monitoring Caseload. Additional administration support has been sourced to address this, and there is ongoing dialogue with both Primary Care and the CCG regarding which provider is best placed to undertake these reviews, as whilst 2gether is currently completing these, contact with this patient cohort is limited and opportunities for learning marginal. The Trust view is that these should be led by Primary Care with input from 2gether where appropriate.

4.2 The Board is asked to note the contents for information and to recognise that this is still at a developmental stage and that processes in primary care in particular are less developed to date. A multi-provider mortality work-stream is being 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. These Mortality Process Review Group meetings are attended by both a Clinical Director (Dr Scheepers) and the Patient Safety Manager and/or Assistant director of Governance & Compliance.

Closed Mortality Reviews

Month	Closed Following Table-Top Review Only			Closed Following Care Record Review			Closed Following Serious Incident Review			Total	Quarterly Total
	Category 1: Not Due to Problems in Care	Category 2: Possibly Due to Problems in Care within 2gether	Category 3: Possibly Due to Problems in Care Within an External Organisation	Category 1: Not Due to Problems in Care	Category 2: Possibly Due to Problems in Care within 2gether	Category 3: Possibly Due to Problems in Care Within an External Organisation	Category 1: Not Due to Problems in Care	Category 2: Possibly Due to Problems in Care within 2gether	Category 3: Possibly Due to Problems in Care Within an External Organisation		
Apr-17	36	0	0	11	0	0	4	0	0	51	
May-17	51	0	0	12	0	0	4	0	0	67	166
Jun-17	42	0	0	4	0	0	2	0	0	48	
Jul-17	29	0	0	9	0	0	2	0	0	40	
Aug-17	22	0	0	3	0	0	1	1	0	27	90
Sep-17	18	0	0	4	0	1	0	0	0	23	
Oct-17	0	0	0	5	0	0	3	0	0	8	
Nov-17	0	0	0	2	0	0	2	0	0	4	16
Dec-17	0	0	0	0	0	0	4	0	0	4	
Jan-18											
Feb-18											
Mar-18											
	198	0	0	50	0	1	22	1	0	272	

Open Mortality Reviews

Month	Awaiting Table-Top Review	Awaiting Care Record Review (MoReC)	Awaiting Clinical Review (SI's)	Total	Quarterly Total
Apr-17	0	0	0	0	
May-17	3	0	0	3	13
Jun-17	9	1	0	10	
Jul-17	15	0	0	15	
Aug-17	22	1	0	23	66
Sep-17	28	0	0	28	
Oct-17	60	1	0	61	
Nov-17	90	0	0	90	218
Dec-17	67	0	0	67	
Jan-18					
Feb-18					
Mar-18					
	294	3	0	297	

Total Deaths (Open and Closed)

Month	Total Deaths (Open and Closed)	Quarterly Total
Apr-17	51	
May-17	70	179
Jun-17	58	
Jul-17	55	
Aug-17	50	156
Sep-17	51	
Oct-17	69	
Nov-17	94	234
Dec-17	71	
Jan-18		
Feb-18		
Mar-18		
	569	

Quarter One – Learning from Deaths

- INC9326 - Consideration of Mental Capacity Act Assessments and completion of such should be documented clearly on clinical systems. There were concerns that social care needs were not being met following onward referral. This issue is to be raised with the trust social care lead for consideration.
- INC8209 - For patients with physical disabilities reasonable adjustments should be considered and support offered where appropriate to enable patients to attend all possible interactions with clinical staff. If a team makes contact with a GP surgery to request a patient receives a physical health check the team should be following this up and documenting outcomes on the patient's record.
- INC8238 - It is essential that post diagnostic letters are uploaded to the patient's record after being sent to the patient and their GP

There are also the lessons learned from the following SIs (these are attached)

- SI-04-18
- SI-08-18
- SI-09-18
- SI-12-18
- SI-15-18
- SI-34-18

Quarter 2 – Learning from Deaths

- INC10276 - Teams to be reminded around discharge processes and if patients do not need to be on a caseload to ensure that they are discharged appropriately. If patients are to stay on caseload even when not having annual ACI reviews then this reasoning should be documented.
- INC12740 - It is important that patients are discharged from caseload as soon as possible following the decision to discharge from care.
- INC11825 - It is important for all expected deaths in inpatient units to have a Clinical Review Following Expected Death document completed and uploaded to Datix.
- INC11251 - For all inpatient expected deaths a clinical review following expected death document should be completed and uploaded to Datix.
- INC10384 – It is important that all staff understand the importance of patients being place on the floor or a hard flat surface to administer basic life support (CPR).
- INC10152 - Patients who choose to engage with substance misuse services out of area should be asked for consent for the treating team to communicate with that service and where appropriate for information to be shared. Teams should be routinely checking all clinical systems when informed of a patient death to ensure that all teams are aware of the deaths.
- INC10505 - When consultants are communicating to GP's they should ensure that dosage of medication is always included and not just the medication name. Even if there has not been a change the dose should still be stated.

Risk assessments should be reviewed and updated a minimum of once a year. The death was caused by choking where there were behaviours associated with food intake in addition to the patient being prescribed anti-psychotic medication. The trust has referred the case to the Speech and Language Therapy lead as part of the ongoing review of antipsychotic medications being linked to swallowing difficulties and the need for a provision for SLT assessments in working age adults.

- IN10957 - There was evidence of good team working and communication between services and external professionals.
- INC10314 - It is imperative that annual care reviews are completed and documented in the patients' health record. Section 4.2 of the Assessment and Care Management Policy states:
    - A review of all aspects of the individual's needs and risks, covering the same range of issues as the initial assessment, must take place annually and be recorded as such in the health and social care notes. At review, the lead professional will consider the following options:
        a. Discharge from services
        b. Change in care level
        c. Transfer to another team or agency
    - A summary letter of the review to the services user copied to the GPs/Referrers will provide evidence that a review has taken place. This review will then be recorded in the health and social care record
    - It was noted that when reviewing patients who are lower risk and on standard care it may be worth considering requesting the GP's input for the annual review.

There are also the lessons learned from the following SIs (these are attached)

- SI-21-18
- SI-17-18
- SI-24-18
- SI-25-18

2gether Making life better

2gether NHS Foundation Trust NHS

SERIOUS INCIDENT INVESTIGATION

LESSONS LEARNED SUMMARY SI-04-18

Incident Category:

Patient death

What happened? ***(Describe the incident)***

- **The patient was found hanged at home.**

What did the Investigation find? ***(What was done well? Did anything go wrong?)***

- **Mental Health Liaison were provided with a multi-use room on a ward in which to complete a thorough mental health assessment. The room was in constant use by ward staff, which did not help with gaining the patient's trust or encouraging them to talk freely. Confidentiality could have been compromised. Regardless, the patient received an excellent standard of clinical care and a well conducted mental health assessment in spite of less than ideal circumstances.**
- **The patient had contact with a private consultant who made changes to the patient's prescription. This was not shared with the 2G treating team, nor were possible risk factors discussed with the patient or her mother.**
- **The patient never fully engaged with mental health services who struggled to speak with her. The patient's mother acted as a go-between between her daughter and mental health services, including making and cancelling appointments maintaining that her daughter was reluctant to do so. The patient was a capacitous adult.**

What can we learn from this incident? ***(What does this remind us about good practice? What can we change?)***

- **Mental Health Liaison staff are advised that it is appropriate to discontinue assessments if there is no appropriate place or area in which to hold a proper, confidential conversation with a patient.**
- **If family or friends make decisions for your patient, you should discuss this with the patient making them aware of the decision that has been made on their behalf, in writing if necessary.**
- **At the time of the incident, the Recovery team was awaiting information from the private mental health assessment before offering engagement in a way that would support, and be informed by, the patient's choice of clinical input.**

2gether Making life better

2gether NHS Foundation Trust NHS

SERIOUS INCIDENT INVESTIGATION

LESSONS LEARNED SUMMARY SI-08-18

Incident Category:

Patient Death

What happened?

- **Patient was found hanged in their home.**

What did the Investigation find?

- **The patient suffered a psychotic disorder with depressive features that resulted in severe anxiety. They received support from in-patient services, Crisis Team and Recovery Team and the approach was flexible and responsive to their needs.**
- **Risk assessments were completed.**
- **Concerns were raised around the lack of flexibility of how carers information is given to them and a lack of opportunities for them to discuss recovery progress with health care professionals.**
- **Correspondence was sent to the patient several weeks after their death, due to admin error and lack of training.**
- **The process of how Health Records are notified of deaths needs to be reviewed to improve its integrity.**
- **Not all risk information was pulled through to the risk formulation, but this did not affect the risk assessment or management plan.**

What can we learn from this incident?

- **We need to review how information aimed towards families and carers is given out and how information provided by those carers can be better used by teams.**
- **RiO training must include how the system highlights that someone is deceased.**
- **The process of how Health Records are informed of patients deaths to be reviewed, so that clinical systems can be updated in a timely manner.**
- **Staff are reminded that risk-relevant progress notes are marked to ensure that this information is pulled through to the risk information section on RiO.**

SERIOUS INCIDENT INVESTIGATION

LESSONS LEARNED SUMMARY SI-09-18

Incident Category:

Patient death

What happened?

- **The patient was found hanged in his bedroom by staff in supported housing.**

What did the Investigation find?

- **The patient had been diagnosed with an unspecified non-organic psychosis and had delusional beliefs which did reduce but did not stop.**
- **The patient had a number of external stressors including his mother being unwell, his family lived abroad and he had a supervision order from probation services.**
- **The patient had planned to end his life but had not disclosed any information to any of the staff involved in his care.**
- **There was good communication between staff and external support agencies which led to a high level of care being provided.**
- **Following the incident staff were made aware that Police had seized what was thought to be a suicide note. Staff didn't have sight of this information and it would have been useful as part of the staff de-brief and the investigation.**

What can we learn from this incident? (What does this remind us about good practice? What can we change?)

- **Staff are reminded that 2Gether IT are able to allow trust telephones to make oversea calls if there is a specific clinical purpose, including the involvement of families in the provision of care.**
- **Probation services have informed the trust that they would engage in joint working for patient's on their caseload and where beneficial they would be willing to undertake joint visits with healthcare staff.**
- **The care provided to the patient was of a high standard and in line with the service specification.**

2gether Making life better

2gether NHS Foundation Trust NHS

SERIOUS INCIDENT INVESTIGATION

LESSONS LEARNED SUMMARY SI-12-18

Incident Category:

Patient Death

What happened?

- **Patient was found hanged in a barn at their home address.**

What did the Investigation find?

- **Patient had a long history of anxiety and depression and their reaction to stressors could be impulsive and dramatic. The clinical team involved went to significant lengths to engage and work with the patient and recognised the need for in-patient services and Crisis involvement.**
- **It would have been helpful for clinicians to have re-engaged with the patient after the recent discharge from services and the GP to be notified of this, rather than advising the GP that they needed to formally refer back to the team.**
- **Much good practice was recognised, including documentation and review of changing risks on a frequent basis and the active engagement of the patient's family in the care provided.**
- **The patients' family were very complimentary of the care received from all of the staff involved, but especially that of the care co-ordinator.**

What can we learn from this incident?

- **Teams and clinicians are reminded to act in the best interests of the patient if they contact services after discharge in the event of a relapse. Interventions should not depend upon seeking a further referral from primary care, although the GP should always be kept informed of further clinical interventions and their return to active caseload.**

SERIOUS INCIDENT INVESTIGATION

LESSONS LEARNED SUMMARY SI-15-18

Incident Category:

Patient Death

What happened?

- **Patient was found hanged in a field.**

What did the Investigation find?

- **Crisis Teams have read only access to IAPTus and were only able to view the patients current risk screen and not to the full risk screens / assessments.**
- **2gether clinicians do not routinely check if a patient is receiving alternative therapy, including online resources or treatments outside of 2gether.**
- **The teams involved saw the patient promptly within agreed timeframes, and correspondences regarding decisions / follow up arrangements were sent to the appropriate places. The patient was able to self-refer to CRHTT at a time of increased need and was promptly assessed following that self-referral.**

What can we learn from this incident?

- **It was clarified that Crisis Teams with "Read-Only" access to IAPTus can see the full risk screens and the associated assessments. A training need was identified and this is being taken forward by the Clinical Systems Team.**
- **Staff are reminded to ask patients for contact details of therapists external to the trust and for consent to share information with that therapist, particularly about risks and the management of risks.**

SERIOUS INCIDENT INVESTIGATION

LESSONS LEARNED SUMMARY SI-17-18

Incident Category:

Patient Death

What happened? ***(Describe the incident)***

- **The patient was discovered hanged in an outbuilding.**

What did the Investigation find? ***(What was done well? Did anything go wrong?)***

- **The patient suffered with low mood with anxiety regarding physical health problems, which caused them distress. Suicidal intent was never voiced.**
- **The last risk assessment indicated a low risk of suicide, but on reflection it should have been medium. However changing the risk level would have not changed the intervention.**
- **It is important that we focus on all areas that increase risk including physical ill health and the potential difficulties that ill health can cause. Simply because the patient is not talking about suicide does not indicate a low risk.**
- **It is important that GP surgeries contribute to the Trust Serious Incident Investigations.**

What can we learn from this incident? ***(What does this remind us about good practice? What can we change?)***

- **The previously identified need to revise risk management training will continue.**
- **Staff are reminded of the potential impact of chronic ill health on a patient's ability to cope with additional life stressors leading to helplessness and hopelessness, which will contribute to the risk of completed suicide.**

SERIOUS INCIDENT INVESTIGATION

LESSONS LEARNED SUMMARY SI-21-18

Incident Category:

Patient death

What happened?

- **The patient was found hanged.**

What did the Investigation find?

- **The patient had suffered with depression for several years. The patient had tried a number of anti-depressant medications and had also received ECT treatment.**
- **The patient had continued expressed suicidal ideation and often talked of taking own life by means of hanging and felt the only way to stay safe was for the partner to be present 24 hours a day.**
- **The patient was considered to be a long term medium risk of suicide. Risk had been considered and referred to in letters but not formally documented on RiO.**
- **The patient also had a number of ongoing physical health complaints that caused pain and had a negative impact on mental health.**

What can we learn from this incident?

- **Services offered the patient a flexible approach to treatment to best meet identified needs, due to fluctuating presentation.**
- **The team had considered, appropriately referred to and initiated medical and psychological approaches to the patient's care.**
- **The team had considered the impact that the patient's condition was having on their partner, who was the main carer. Appropriate referrals and support were offered and accepted by the partner.**

SERIOUS INCIDENT INVESTIGATION

LESSONS LEARNED SUMMARY SI-24-18

Incident Category:

Patient death

What happened?

- **The patient was reported missing by their partner after they failed to return home.**
- **The following day the patient was discovered hanged.**

What did the Investigation find?

- **The patient had a number of dysfunctional personality traits and had struggled with an eating disorder and self-harming behaviours in the form of cutting.**
- **The patient had a pattern of behaviour and would present in crisis and would briefly engage with services and the support offered, but would disengage once the initial period of stress had passed. The patient would not engage in work to reduce the risk of future crisis.**
- **The patient would make risky self-harm choices but would do this in public places and help was always provided through statutory or non-statutory services.**

What can we learn from this incident?

- **All acts of deliberate self-harm and the strategies used to reduce them should be documented in line with the Trust Risk Management Policy.**
- **Clinical summaries on IAPTus should be completed by course facilitators, even if the patient has not completed the course.**
- **If a patient is referred to services and onward referral is required then this should be completed as an internal referral and not through advising patients to go back to their GP.**

2gether Making life better

2gether NHS Foundation Trust NHS

SERIOUS INCIDENT INVESTIGATION

LESSONS LEARNED SUMMARY SI-25-18

Incident Category:

Patient death

What happened? ***(Describe the incident)***

- **The patient was found hanged.**

What did the Investigation find? ***(What was done well? Did anything go wrong?)***

- **There was insufficient documentation of Risk Assessment and Review by the MDT on 9 August 2017 and the MDTs changes in Risk Management were not well communicated to the wider ward team at subsequent handovers.**
- **There was limited understanding of the team's expected response to finding that this patient was not where he was expected to be during the afternoon of 14 August 2017 and assumptions were made that he was LOW risk.**
- **The Agency Registered Nurse in charge was not able to access RiO records and did not know the patient.**
- **There was limited clarity amongst the ward staff with regard to which Engagement & Observation Policy was in effect; the 'new' policy had been rolled out in June 2017.**
- **The patient did not have a HIGH RISK care plan, or in fact any risks documented in any care plans.**

What can we learn from this incident? ***(What does this remind us about good practice? What can we change?)***

- **While giving a history of previous suicidal behaviour in the context of clinical depression, it was difficult to match the patient's expressions of distress with his behaviour. He was therefore considered at HIGH risk on the basis of limited acquaintance rather than a full assessment of suicidality as this had not been possible. This was good practice.**
- **The 'new' Observation & Engagement Policy had not been implemented in a managed way, there was no consideration of training needs, or subsequent audit of the implementation. There will be a clarified method for the implementation of significant policy and process changes across the trust.**
- **Major structural changes have been agreed by Estates and work on the garden area is planned to complete by March 2018.**
- **Further work is needed to ensure appropriate access to clinical records by Agency Registered Nursing staff, particularly where they are expected to act as the nurse in charge of the ward.**

SERIOUS INCIDENT INVESTIGATION

LESSONS LEARNED SUMMARY SI-34-18

Incident Category:

Patient Death

What happened?

- **Patient drove at speed into brick wall with the intention of causing harm to himself and was admitted to a general hospital out of county. When the patient was assessed as medically fit, they were transferred to 2gether inpatient services. The patient needed immediate transfer back to a general hospital, where he sadly died.**

What did the Investigation find?

- **The patient had a short history of low mood and had been prescribed an anti-depressant. The patient also had an extensive cancer history, was widowed and retired.**
- **The patient had been assessed as a LOW risk of Suicide and was waiting for STEP 2 psychological input to start.**
- **Appropriate channels had been used to repatriate the patient when he had been assessed as medically fit.**
- **It was reported that the patient purposely drove into a wall at speed in an attempt to end their life (removed seatbelt prior to crashing).**

What can we learn from this incident?

- **Although the patient's risk of Suicide was assessed as LOW, his actuarial risks were HIGH. Actuarial risks are not detailed in the IAPTus risk screen, so it is important that practitioners remain aware of these and that this aspect of risk assessment is re-emphasised during the Trust's clinical risk training.**
- **Actions taken on the admitting ward when the patient deteriorated were in keeping with the Trust's expectations and allowed the patient to be transferred back to a general hospital in a timely way.**

Agenda Item	**12**	**Enclosure**	**Paper G**

Report to: 2gether NHS Foundation Trust Board – 28 March 2018
Author: Maria Bond, Non-Executive Director
Presented by: Maria Bond, Non-Executive Director

SUBJECT: **NON EXECUTIVE DIRECTOR AUDIT OF COMPLAINTS QUARTER 3 2017/18**

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

EXECUTIVE SUMMARY

A Non-Executive Director Audit of Complaints was conducted covering three complaints that had been closed between 1 October and 31 December 2017.

RECOMMENDATIONS

The Board is asked to note the content of this report and the assurances provided.

1. INTRODUCTION

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

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

1.2 Under the new system agreed in November 2016, following the random selection of three files, the Service Experience Department completes section 1 of the template, and provides the auditor with copies of the initial complaint letter, the investigation report and the final response letter. Having studied the files, the auditor then completes sections 2-4.

2. SUMMARY OF FINDINGS

2.1 Case 1

2.1.1 This case was a highly sensitive situation. The service user did not give consent for the complainant to see the full response. The essence of this

complaint was that the complainant was not being listened to. The complaint was dealt with in a timely manner and we responded in the timescales set-out albeit there was an error in the date given in the original letter, this was quickly corrected. There were a number of issues raised but they covered only a few points needing investigation. It would have been helpful to consolidate the issues into the points which actually needed investigating whilst clearly providing the claimant with visibility of this process. This consolidation would help the investigator and the response by the CEO.

2.1.2 The investigation appeared to be rushed in that not all the standard questions at the end of each issue were answered; there were typos and inaccurate information, with the incorrect name consistently used. One of the issues raised was not referred to in the investigation.

2.1.3 In regard to the CEO letter of response, the wording used for explanations was very generic and didn't appear sincere. Learning was identified and mentioned at the end of the letter after all the generic replies. It would have been more helpful and empathic to the reader had the learning been referred to at the beginning of the letter and what action was being taken by the Trust to embed the learning.

2.1.4 It is difficult to gauge whether the team's actions were influenced by the domestic situation and this is not identified in the investigation.

2.1.5 I would offer limited assurance overall on the approach to investigating and responding to this complaint, and the learning aspects being embedded in the Trust.

2.2 Case 2

2.2.1 This case was straight forward with clear communication errors identified and accepted. The service user did not want to make a complaint but the responding letter provided a choice of route options 1) Concern and 2) Complaint with examples of both. Given the descriptions for either option the reader would opt for 2) Complaint to ensure a full investigation as opposed to option 1) Concern, noted. The language used here could be improved to provide assurance to the reader that if they opt for 1) Concern a proper investigation will be carried out.

2.2.2 The complaint was dealt with in a timely manner and we responded in the timescales set-out. The investigation whilst shorter was thorough and clearly articulated the issues, the reasons why and the lessons to be learnt. This was a clear case of lack of communication with the service user and family over support after discharge and the lack of checking that what is said/meant is fully understood by everyone and documented.

2.2.3 The CEO letter was much better which probably reflected the more comprehensive investigation and report. Less generic language with fuller answers to each issue, however, issue two did identify learning but this was not highlighted in the response. Again there was no assurance given around how learning would be embedded in the Trust.

2.2.4 I would offer full assurance overall on the approach to investigating and responding to this complaint but limited assurance on the learning aspects being embedded in the Trust.

2.3 Case 3

2.3.1 Again this case didn't want a formal complaint process but for some reason this turned into an official complaint. This case was relatively simple with some key learning identified. The complaint was dealt with in a timely manner and we responded in the timescales set-out.

2.3.2 The investigation was thorough and identified some key learning although I believe there is further learning not identified in the way Trust Policy is communicated to lay-people who do not understand NHS jargon. We also need to be mindful of the impact that some of the terminology casually used can have on service users and their family/friends/carers. Words such as "Safeguarding" can be worrying if not explained why that word is being used and in what context.

2.3.3 The CEO letter was defensive in its response to issue 2 and the error clearly made, we should just be clear we have identified an error and what learning has been planned/embedded to prevent this occurring again. No learning or training was referred to in the response to issue 2 yet this was identified in the investigation report. There was no need to mention that the claimant was "upset and angry". Again, the learning was identified at the end of the letter and would have been more beneficial to the reader if presented at the beginning of the letter.

2.3.4 I would offer Full assurance overall on the approach to investigating and responding to the complaint but limited assurance on learning aspects being embedded in the Trust.

3. GENERAL

3.1 All three cases upheld core complaints which raises some important strategic issues of communication and care. I would like to see a more structured strategy for learning through complaints with an assurance route for embedding the learning.

3.2 The Board is asked to note the content of this report and the assurances provided.

Agenda Item	**13**	**Enclosure**	**Paper H**
Report to:	Trust Board – 28th March 2018		
Author:	Marie Crofts, Director of Quality		
Presented by:	Marie Crofts, Director of Quality		
SUBJECT:	**6 monthly safe staffing update**		

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

EXECUTIVE SUMMARY

This paper will give an update on the revised safe staffing guidance issued by the National Quality Board (NQB) in July 2016.

This 6 monthly update outlines :

- An update on all the expectations within the new guidance (see Appendix 1)
- Initial Quality dashboard for inpatient units (Appendix 2)
- National reporting requirements, latest developments and the latest data in their required format (Appendix 3)
- Local Trust exception reporting
- Update of agency use across wards

National reporting with regards to fill rates continues to be uploaded monthly and reported to the Governance Committee on behalf of the Board. From April 2018 the Trust is mandated to also include the Care Hours Per patient Day (CHPPD) within the upload. The Trust continues to have high compliance with planned v actual fill rates - over 95% compliant for January 2018. Appendix 3 details the latest figures presented at the Governance Committee in February 2018. Use of agency continues with a significant reduction in the use of nursing agency spend during 2017/18. The nursing control total will be met this financial year although the overall control total will not. However there has been a marked reduction of over £1.2m from 2016/17.

This paper also includes an initial quality dashboard for the inpatient wards which is requirements of the NQB guidance – ensuring triangulation of both staffing; workforce indicators and patient experience. This indicates some wards which have higher rates of sickness and turnover and the Director of Quality will work with the Director of Organisational Development to explore this further.

ASSURANCE

This update paper gives significant assurance on current progress and monthly reporting.

RECOMMENDATIONS

The Board is asked to:

- Note the current progress and assurance against the revised NQB guidance
- Note monthly reporting and compliance with fill rates

Corporate Considerations	
Quality implications	Safe staffing is fundamental to ensuring high quality safe services are delivered. This guidance ensures that all relevant triangulation regarding safe services is highlighted and noted for the Board
Resource implications:	No resource implications currently have been identified
Equalities implications:	No equalities implications as this guidance applies to all population groups
Risk implications:	If all the expectations are not met fully there may be some level of risk regarding delivery of safe and effective services.

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

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	
Valuing and respectful		Efficient	

Reviewed by:		
Marie Crofts, Director of Quality	Date	23rd March 2017

Where in the Trust has this been discussed before?		
Every 6 months at Board	Date	September 2017

What consultation has there been?		
N/A	Date	

Explanation of acronyms used:	
NQB	National Quality Board
CHPPD	Care Hours Per Patient Day
NHSI	

HCA HEI HEE	NHS Improvement Health Care Assistant Higher Education Institution Health Education England

1. CONTEXT

The Trust Board is mandated to receive a 6 monthly report outlining the requirements of the NHS National Quality Board (NQB) guidance on safe staffing levels (2013). This guidance was updated in July 2016 *"Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time"* and outlines three main expectations below:

Safe, Effective, Caring, Responsive and Well Led Care		
Measure and Improve -patient outcomes, people productivity and financial sustainability- -report investigate and act on incidents (including red flags) - -patient, carer and staff feedback-		
-implement Care Hours per Patient Day (CHPPD) - develop local quality dashboard for safe sustainable staffing		
Expectation 1	**Expectation 2**	**Expectation 3**
Right Staff 1.1 evidence based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	**Right Skills** 2.1 mandatory training, development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	**Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

The Trust Board received the last 6 monthly update in September 2017. The Governance Committee continues to receive bi-monthly reports detailing staffing levels across all inpatient sites as well as updates regarding the use of temporary staffing.

This 6 monthly update outlines :

- An update on all the expectations within the new guidance (see Appendix 1)
- Initial Quality dashboard for inpatient units (Appendix 2)
- National reporting requirements, latest developments and the latest data in their required format (Appendix 3)
- Local Trust exception reporting
- Update of agency use across wards

2. PROGRESS ON THE NQB REVISED KEY EXPECTATIONS

Appendix 1 attached to this report details each expectation and progress to date. In summary the Trust has made significant progress against each expectation. The Director of Quality has led the development of a quality dashboard to triangulate staffing; workforce indictors and patient experience. This is an initial dashboard for inpatient areas only. This indicates some wards which have higher rates of sickness and turnover and the Director of Quality will work with the Director of Organisational Development to explore this further and understand the impact.

3. NATIONAL GUIDANCE

The National Quality Board (NQB) and NHSI have led on a number of toolkits in relation to safe staffing for both inpatient and community services. The guidance for mental health and learning disability has recently been published and the Director of Quality and deputy Director of Nursing will be reviewing all staffing in teams and wards over the coming months.

Currently the Trust continues to publish the fill rates as directed by the previous national guidance. This is uploaded on to Unify and the Trust website. From April 2018 the Trust is mandated to publish the Care Hours Per Patient Day (CHPPD) for all wards. A process is in place to do this as required.

Appendix 3 outlines the national safe staffing requirement for January 2018. Actual fill rates continue to remain high and over 95% compliant against planned levels.

4. LOCAL TRUST EXCEPTION REPORTING

In line with previous internal Trust reporting, we have continued to collect and collate the reasons where core planned staffing levels have not been met through the internal exception codes. It is important to note that these are relatively rare events (in terms of percentages of overall fill rates). This local reporting is in addition to the national reporting and supports analysis of any issues which may arise regarding skill mix within the units and how the nurse in charge mitigates these risks.

4.1 Ward specific information

There are shifts where the core actual staffing hours may not exactly reflect the core planned staffing levels - the main reasons are outlined below:

• Increase in staff on duty to provide one to one care for patients (specialling);
• Decrease in staff, if the patient need does not require it e.g. patients on leave, or staff supporting other wards where the need is higher;
• The planned staffing numbers are based on pre-empted activity and dependency levels. This is determined by the nurse in charge for a set time frame and these may vary, for example; decisions may be made to replace a qualified nursing staff member with a health care assistant who knows the patients and the ward, rather than a bank or agency nurse who may not. National Quality Board

guidance states that the nurse in charge must use their professional judgement alongside the planned staffing requirements to meet the needs of the patients on the ward at any particular time.
• The reasons for internal exceptions will only be reported where they are significantly high in number

In summary for January 2018:

- No staffing issues were escalated to the Director of Quality or the Deputy Director
- Where staffing levels dipped below the planned fill rates of 100% for qualified nurses this was usually offset by increasing staffing numbers of unqualified nurses based on ward acuity and dependency and the professional judgement of the nurse in charge of the shift
- **95.84%** of the hours exactly complied with the planned staffing levels
- **3.34%** of the hours during January had a different staff skill mix than planned staffing however overall the staffing numbers were compliant and the needs of patients were met
- **0.82%** of the hours during January had a lower number of staff on duty than the planned levels, however this met the needs of the patients on the ward at the time

Exception reporting per unit: (only those reporting high levels)

Wotton Lawn:

- Greyfriars

The Code 1 exceptions were due to 2 x qualified nurse vacancies plus redeployment of staff to cover the hospital. In addition it relates to qualified and unqualified sickness absence rates; 2 x HCA vacancies.

- Abbey Ward

The code 1 exceptions are due to vacancies. However the ward has recruited into posts so this should improve.

- Priory Ward

The code 1 was due to ward vacancies for Band 5 nurses.

Berkeley House January 2018

Significant Code 2 exceptions owing to vacancies

Herefordshire January 2018

- Cantilupe Ward – owing to issues well documented with rota. Director of Quality to review

Exception reporting in hours – all wards January 2017

			Exception Code 1	Exception Code 2	Exception Code	Exception Code 4	Exception Code
Ward	Bed number	Number of required staff hours in the month	Minimum staff numbers met – skill mix non-compliant but met needs of patients	Minimum staff numbers not compliant but met needs of patients	Minimum staff numbers met – skill mix non-compliant and did not meet needs of	Minimum staff numbers not compliant and did not meet needs of patients	Minimum staffing # and skill mix not met. Resulting in clinical incident / harm to
Dean	15	3255	20	0	0	0	0
Abbey	18	3255	327.50	0	0	0	0
Priory	18	3255	225	0	0	0	0
Kingsholm	15	3255	10	0	0	0	0
Montpellier	12	3565	67.5	15	0	0	0
Greyfriars	10	4030	370	0	0	0	0
Willow	16	4495	0	0	0	0	0
Chestnut	14	3022.5	22.5	0	0	0	0
Mulberry	18	3255	15	0	0	0	0
Laurel	12	2015	210	15	0	0	0
Honeybourne	10	2015	127.5	0	0	0	0
Berkeley House	8	8680	7.5	410	0	0	0
Mortimer	21	3208.5	0	0	0	0	0
Cantilupe	10	2991.5	368	0	0	0	0
Jenny Lind	8	1782.5	23	0	0	0	0
Oak House	10	1782.5	0	0	0	0	0
Total		53,712	1793.5	440	0	0	0

5. USE OF TEMPORARY NURSING STAFFING

- The Director of Quality continues to chair the Temporary Staffing Project Board on a monthly basis and meet with the key leaders / Matrons on a fortnightly basis as an implementation team – ensuring close monitoring of all actions related to the Temporary Staffing Board.

- Month 9 figures below demonstrate the actual reduction to date within inpatient nursing and the forecast spend at year end. It also identifies the areas which still need focus:

AGENCY SPEND INFORMATION UPTO 31st DECEMBER 2017						
	Actual 2016-17	NHS Ceiling	Spend to date 2017-18	Forecast 2017-18	As a % of 2016/17	As a % of Ceiling
151MED - Medical Agency	2,041,540	1,265,426	1521534.84	2,028,713	99.4%	160.3%
153NMHV - Nursing Agency	2,379,314	1,474,792	1043473.84	1,391,298	58.5%	94.3%
154STT - Scientific Therapeutic and Technical Agency	694,451	430,448	488411.67	651,216	93.8%	151.3%
160ADM - Admin and Clerical Agency	197,484	122,409	130776.69	174,369	88.3%	142.4%
161HCA - HCA and other support agency	122,081	75,670	57532.82	76,710	62.8%	101.4%
164OTH - Other employees Agency	56,878	35,255	-0.44	-1	0.0%	0.0%
Total	5,491,748	3,404,000	3,241,729	4,322,306	78.7%	127.0%

- The Trust will not meet the agency reduction of £283K for medical agency this financial year however the focus next year will be on medical and admin agency.
- The Trust has made significant progress with regards to use of agency for inpatient nursing which will result in a reduction of around £1.2m for the year.

6. CONCLUSION:

In summary the Trust is progressing well with all of the expectations within the revised NQB guidance and will use the initial quality dashboards to further triangulate quality indicators.

7. RECOMMENDATIONs

The Board is asked to:

- Note the current progress and assurance against the revised NQB guidance
- Note monthly reporting and compliance with fill rates

Appendix 1 - Updated NQB Expectations (March 2018)

Expectation 1: Right staff (8 standards)

1. The organisation uses evidence-based guidance such as that produced by NICE, Royal Colleges and other national bodies to inform workforce planning, within the wider triangulated approach in this NQB resource.

The Trust has established planned ward staffing levels which have been reviewed on a number of occasions since the initial guidance in 2013. These were based upon the RCN and other relevant guidance. During 2018 the Director Quality and Deputy Director of Nursing will be reviewing all clinical areas, using local expertise, in terms of staffing using the newly published safe staffing guidance from NHSI for MH and LD settings https://improvement.nhs.uk/resources/safe-staffing-improvement-resources-learning-disability-services

https://improvement.nhs.uk/resources/safe-staffing-mental-health-services

2. The organisation uses workforce tools in accordance with their guidance and does not permit local modifications, to maintain the reliability and validity of the tool and allow benchmarking with peers.

We have previously used Keith Hurst tool to establish initial staffing levels. We continue to work regionally and nationally to develop an appropriate MH acuity and dependency tool. We are progressing with the implementation of SafeCare within inpatients services from the Allocate system and working with national partners to share good practice. We are piloting a caseload management tool within Community Learning Disability services currently. We are part fot he Carter Review for MH and Community Trusts and will report the Care Hours Per Patient Day (CHPPD) from 1st April 2018.

3. Workforce plans contain sufficient provision for planned and unplanned leave, eg sickness, parental leave, annual leave, training and supervision requirements.

Workforce plans for the wards contain provision for leave; sickness and training and appropriate and relevant supervision. We have increased the level of Band 6 management time within our Herefordshire inpatient services to ensure robust supervision takes place in a timely manner. This has had a very positive impact.

4. Clinical and managerial professional judgement and scrutiny are a crucial element of workforce planning and are used to interpret the results from evidence-based tools, taking account of the local context and patient needs. This element of a triangulated approach is key to bringing together the outcomes from evidence-based tools alongside comparisons with peers in a meaningful way.

Ensuring the nurse in charge of the shift has ultimately the responsibility to ensure there are sufficient and appropriate numbers and skills of staff on duty on every shift. We have an escalation policy in place to ensure nurses can raise any concerns directly to the Director of Quality if necessary. We compare favourably with local peers and the Director of Quality is part of a MH and LD Directors of Nursing national forum.

5. Professional judgement and knowledge are used to inform the skill mix of staff. They are also used at all levels to inform real-time decisions about staffing taken to reflect changes in case mix, acuity/dependency and activity.
   The organisation compares local staffing with staffing provided by peers, where appropriate peer groups exist, taking account of any underlying differences.

Where acuity has increased and cannot be safely managed with the numbers and skill mix of planned staff on any shift the nurse in charge will seek to gain additional staff for that shift. This is part of our internal escalation process for access to temporary staffing. We hold a monthly temporary staffing Board chaired by the Director of Quality and a fortnightly meeting of the Matrons and the DoQ regarding the use of temporary staffing. Significant progress has been made during the last 6 months. As part of this we have made improvements to the form and function of our staff bank.

6. The organisation compares local staffing with staffing provided by peers, where appropriate peer groups exist, taking account of any underlying issues

   The Director of Quality is part of a MH and LD Directors of nursing forum where work-force issues are discussed; including sharing good practice through national events and workshops. From April 2018 we will be reporting on the CHPPD and compared to other MH Trusts. As part of the recent Carter Review we have had feedback form the NHSI lead on our CHPPD data collection which was positive. We have also introduced confirm and challenge roster review meetings internally and have compared rota management with others in the cohort.

7. The organisation reviews comparative data on actual staffing alongside data that provides context for differences in staffing requirements, such as case mix (eg length of stay, occupancy rates, caseload), patient movement (admissions, discharges and transfers), ward design, and patient acuity and dependency

As part of the daily recording planned against actual numbers of staff on shift- including skill mix changes and any exceptions with regards to increased acuity or dependence or any additional risk factors are noted using our exception reporting process. This forms part of the monthly safe staffing report to Governance Committee. Any patient safety issues are highlighted immediately through our internal escalation process to the Director of Quality. Our PICU and low secure services have developed planned levels based on additional levels of acuity. A part of the newly established quality dashboard we are collecting occupancy rates and other key indictors to triangulate information for each ward.

8. The organisation has an agreed local quality dashboard that triangulates comparative data on staffing and skill mix with other efficiency

   The Director of Quality has developed a draft quality dashboard (appendix 2) which triangulates staffing levels with workforce indictors and other quality indicators. Initially this

has been produced for the inpatient areas only but we will be developing this for all services over the coming months.

Expectation 2: Right skills (13 standards)

1. Frontline clinical leaders and managers are empowered and have the necessary skills to make judgements about staffing and assess their impact, using the triangulated approach outlined in this document.

Clinical leaders and local managers using the escalation process actively manage their staffing levels using the triangulated approach described. Matrons make decisions regarding staffing at their sites and if additional staffing is required that will be discussed at a local level. At a locality directorate level senior management teams review and monitor all quality indictors and performance KPI's . Significant concerns are raised through the Governance structures and via the risk register

2. Staffing establishments take account of the need to allow clinical staff the time to undertake mandatory training and continuous professional development, meet revalidation requirements, and fulfil teaching, mentorship and supervision roles, including the support of preregistration and undergraduate students.

Numbers of days required to undertake all training has been scoped and staffing rotas are constructed in a way that enables staff to be released to undertake training without impacting on clinical numbers. We have recently increase Band 6 management time at our Herefordshire inpatient units to allow for more robust supervision time to be available. All relevant nurses have revalidated and received support with this.

3. Those with line management responsibilities ensure that staff are managed effectively, with clear objectives, constructive appraisals, and support to revalidate and maintain professional registration.

The Trust has in place a number of policies supporting this. These include the appraisal policy; Supervision policy and revalidation policy. Compliance against these policies is closely monitored through both our Delivery and Governance Committees. All registered nurses during this year have revalidated appropriately.

4. The organisation analyses training needs and uses this analysis to help identify, build and maximise the skills of staff. This forms part of the organisation's training and development strategy, which also aligns with Health Education England's quality framework.

This work is continuing through the STP workforce structures led by our Trust. New roles such as the Trainee Nursing Associates; Advanced Nurse Practitioners; Physicians Assistants etc are part of this plan In addition continuing professional development for staff has been considered through STP workforce transformation plan has been developed to respond to local needs.

5. The organisation develops its staff's skills, underpinned by knowledge and understanding of public health and prevention, and supports behavioural change work with patients, including self-care, wellbeing and an ethos of patients as partners in their care.

The STP in both Counties is predicated on self-care and prevention at its core. For the Trust we continue to deliver the national CQUINs in relation to improving physical health of our service users. Linked with this is the smoking cessation work we are currently undertaking now in both Counties. In Wotton Lawn we have developed a pilot which is now moving to a permanent physical health lead post which delivers screening for women on the wards as well as general health checks. WE continue to train staff and embed the Making Every Contact Count (MECC) work. The co-production work including the Triangle of Care and the work in care plan development continues. We are also participating in NHSE 'Always Events' programme.

6. The workforce has the right competencies to support new models of care. Staff receive appropriate education and training to enable them to work more effectively in different care settings and in different ways. The organisation makes realistic assessments of the time commitment required to undertake the necessary education and training to support changes in models of care.

The workforce changes which will take place over the coming years will need additional or changed competencies and skills. This work is currently underway as part of the STP workforce work-stream. New and alternative roles for staff are being developed to ensure we have the workforce fit for the future- as described previously.

7. The organisation recognises that delivery of high quality care depends upon strong and clear clinical leadership and well-led and motivated staff. The organisation allocates significant time for team leaders, professional leads and lead sisters/charge nurses/ward managers to discharge their supervisory responsibilities and have sufficient time to coordinate activity in the care environment, manage and support staff, and ensure standards are maintained.

Following a review of the supervision policy work has been underway to ensure robust supervision is in place for all AHPPs and nurses. Additional time has been put into the inpatient services in Herefordshire following this review to ensure sufficient time for supervision of junior staff. Ensuring excellent and effective and engaging leadership is a priority of the STP work streams. All professional groups continue to have profession specific best practice and networking groups in addition to Multi-disciplinary meetings and discussion. Each locality has a regular governance meeting alongside their management meetings where issues and concerns can be raised.

8. The organisation demonstrates a commitment to investing in new roles and skill mix that will enable nursing and midwifery staff to spend more time using their specialist training to focus on clinical duties and decisions about patient care.

We are currently part of the Trainee Nurse Associate (TNA) pilots in both Counties- commencing April 2017. We are now recruiting for a further cohort of TNA's in each County. In addition we are working to establish new and innovative roles including physicians assistants and advanced nurse practitioners.

9. The organisation recognises the unique contribution of nurses, midwives and all care professionals in the wider workforce. Professional judgement is used to ensure that the team has the skills and knowledge required to provide high-quality care to patients. This stronger multi-professional approach avoids placing

demands solely on any one profession and supports improvements in quality and productivity, as shown in the literature.

A multi professional approach is evident from Board to ward. The Trust Board has three clinical executives and actively promotes an MDT approach in all teams. This is highlighted in our Assessment and Care Management policy in terms of care co-ordination and our Risk Assessment policy. We have an ethos of continuous quality improvement which is one of our strategic priorities which is threaded through our Quality Strategy and Quality Improvement work within the South of England collaborative.

10. The organisation works collaboratively with others in the local health and care system. It supports the development of future care models by developing an adaptable and flexible workforce (including AHPs and others), which is responsive to changing demand and able to work across care settings, care teams and care boundaries.

Work continues across the health and social care economy through the STP in both Counties. Within Gloucestershire our proposed merger with GCS will see a much more integrated service offer for patients with co-morbid physical and mental health issues. In CYPS we work collaboratively with social care and the third sector.

11. The organisation has clear plans to promote equality and diversity and has leadership that closely resembles the communities it serves. The research outlined in the NHS provider roadmap[42] demonstrates the scale and persistence of discrimination at a time when the evidence demonstrates the links between staff satisfaction and patient outcomes.

XXXXX

12. The organisation has effective strategies to recruit, retain and develop their staff, as well as managing and planning for predicted loss of staff to avoid over-reliance on temporary staff.

As part of the STP (in both Counties) the Trust is engaged in workforce planning including recruitment and retention strategies. Internally we have developed some innovation approaches such as paying bursaries for pre-registered nurse training and additional funding in respect of bank shifts to be worked are now in place. We have invested in the TNA programme in both Counties and looking at new roles to enhance the current workforce. We are working with the University of Gloucestershire to begin MH nurse training from September 2018. In addition we have in place a 'peripatetic' HCA workforce at 3 of our inpatient sites now which will significantly impact positively on our agency use and spend. We are holding workforces 'summits' initially focussed on recruitment and retention for nursing which will bring together key colleagues to discuss further developments to enhance our existing approaches.

13. In planning the future workforce, the organisation is mindful of the differing generational needs of the workforce. Clinical leaders ensure workforce plans

address how to support staff from a range of generations, through developing flexible approaches to recruitment, retention and career development

This is part of the overall STP workforce planning. We are using the 'Mind the Gap' research to influence our 'offer' to both newly qualified staff and flexible return and retire arrangements for other staff.

Expectation 3: Right Place (16 standards)

1. The organisation uses 'lean' working principles, such as the productive ward, as a way of eliminating waste.

The organisation has quality improvement at its heart and continues to embed the principles and methodologies of this within all that it does. In addition the Quality Service Improvement and Re-design (QSIR) national roll out and our previous patient safety collaborative work are in place. We are also part of the Carter Review for Mental Health and Community Trusts. In addition we have been working with NHSI on two 90 Day rapid improvement programmes.

2. The organisation designs pathways to optimise patient flow and improve outcomes and efficiency eg by reducing queueing.

Our extended bed management team is in place and works closely with our staff bank and e-rostering team. This will form one overall team from April 2018. A weekly bed management meeting takes place and a twice daily sit-rep now takes place. In IAPT services where a wait might occur this is being closely monitored through the Delivery Committee.

3. Systems are in place for managing and deploying staff across a range of care settings, ensuring flexible working to meet patient needs and making best use of available resources.

Matrons have continued their work to ensure they get the best efficiencies across their hospital sites. In addition the Trust has participating in two 90 day rapid improvement programmes which will impact on this regarding more efficient roster management and improvements in reviewing levels of observation. In addition our peripatetic team will be used flexibly across all wards on each site- this resource has made a significant impact of use of HCA agency spend. Overall inpatient nursing has saved around £1.1m on agency spend this financial year.

4. The organisation focuses on improving productivity, providing the appropriate care to patients, safely, effectively and with compassion, using the most appropriate staff.

We continue to participate in the Carter review for Mental Health and Community Trusts. This work will inform future practices and appropriately increase productivity. Our Governance structures monitor and challenge all aspects of patient safety and effectiveness. In addition we have a number of initiatives which support compassionate care. With the introduction of new roles this will enhance the current skill mix. Our Quality Impact Assessment Process ensures safety is not impacted on where savings are proposed.

5. The organisation supports staff to use their time to care in a meaningful way, providing direct or relevant care or care support. Reducing time wasted is a key priority.

The Trust has embarked on an 'Improving Care through Technology' programme of work which it has brought forward to enable all clinicians to have the technology they need to support their practice in a more efficient way. This includes the use of including digital dictation and mobile devices (phones, tablets and laptops). This will improve productively as staff will no longer need to return to a base to update records etc.

6. Systems for managing staff use responsive risk management processes, from frontline services through to board level, which clearly demonstrate how staffing risks are identified and managed.

Safe staffing levels are reported monthly to QCR and Governance bi-monthly and subsequently to Board as well as uploaded onto Unify. Actual fill rates are over 96% compliant against planned levels. Our escalation process is clear and there is a line of sight through to the Director of Quality where any issues result in potential increased risk or patient safety concerns. Each locality has a full risk register which is discussed at the monthly QCR subcommittee led by the executive clinicians and escalated to Governance Committee if appropriate. Workforce is one of the top 5 risks for the organisation and is continually discussed at executive and Board level. Much work has been done and continuing to be done to improve recruitment and retention- especially in professions where there is a national shortage such as mantle health nursing and psychiatrists.

7. Organisational processes ensure that local clinical leaders have a clear role in determining flexible approaches to staffing with a line of professional oversight, that staffing decisions are supported and understood by the wider organisation, and that they are implemented with fairness and equity for staff.

Clinical and professional leaders participate in the Senior Leadership Forum and the Clinical Directors sit alongside the Service Directors managing and leading their localities. Any concerns or issues can be escalated to the QCR subcommittee and through to Governance Committee.

8. Clinical capacity and skill mix are aligned to the needs of patients as they progress on individual pathways and to patterns of demand, thus making the best use of staffing resource and facilitating effective patient flow.

Clinical capacity and skill mix are reviewed team by team and by the Matrons within the hospital sites. This work will need a further review this year following publication of the MH and LD safe staffing toolkits. Where resource is not meeting demand such as IAPT services this has been discussed with commissioners and further investment made. We are currently piloting a caseload management capacity tool within LD community services.

9. Throughout the day, clinical and managerial leaders compare the actual staff available with planned and required staffing levels, and take appropriate action to ensure staff are available to meet patients' needs.

The staffing levels within inpatient settings are reviewed on a shift by shift basis by the nurse in charge of the shift and overseen by the Matron for the hospital site. Any change from planned levels will be discussed by the ward manger and the Matron. Consideration will be made as to the best appropriate action should acuity increase or the planned levels of staffing cannot be met. Our internal exception reporting will note any change from planned levels. In community teams the team manager will notify the service manager if additional resource is required.

10. Escalation policies and contingency plans are in place for when staffing capacity and capability fall short of what is needed for safe, effective and compassionate care, and staff are aware of the steps to take where capacity problems cannot be resolved.

We have an escalation policy and business continuity policy which are enacted if this becomes relevant. In addition our observation policy cross references to the escalation policy for completeness. We report on all planned against actual exceptions in the bi-monthly report to Governance Committee.

11. Meaningful application of effective e-rostering policies is evident, and the organisation uses available best practice from NHS Employers[46] and the Carter Review Rostering Good Practice Guidance (2016).

We have now implemented an e-rostering system (April 2017) and as part of the Carter review are using the improvement methodology to inform our practice alongside 22 other Trusts. Positive feedback from NHSI has been received in terms of our progress with e-rostering. We will also be mandated to collate CHPPD from April 2018.

12. The annual strategic staffing assessment gives boards a clear medium-term view of the likely temporary staffing requirements. It also ensures discussions take place with service leaders and temporary workforce suppliers to give best value for money in deploying this option. This includes an assessment to maximise flexibility of the existing workforce and use of bank staff (rather than agency), as reflected by NHS Improvement guidance.

The Trust currently has a monthly Temporary staffing Project Board and reports on safe staffing within nursing to the Governance Committee. The Board receives the 6 monthly updates.

13. The organisation is actively working to reduce significantly and, in time, eradicate the use of agency staff in line with NHS Improvement's nursing agency rules, supplementary guidance and timescales.

The monthly temporary staffing board continues to be in place chaired by the Director of Quality. Yearend spend on agency will be around £1.2m less than 2016/17. This is largely owing to significantly reduced spend on inpatient nursing agency. A review of the form and function of staff bank has taken place which has had a positive impact on reduction of agency spend- particularly in Herefordshire. In addition there is a peripatetic HCA nursing team in place at all inpatient sites (apart from LD). Although the overall control total has not been met the nursing agency control total has been achieved which is extremely positive. The Trust has taken part in two NHSI 90 Day improvement programmes which impact on this work.
During 2018/19 we are tendering for an agency to supply qualified nurses for at least 12 week periods and at a below price cap cost. This will significantly reduce spend and improve quality.

14. The organisation's workforce plan is based on the local Sustainability and Transformation Plan (STP), the place-based, multi-year plan built around the needs of the local population.

Several members of the Executive team continue to be integral partners of both STP's and the many associated work-streams. The Trust Director of OD chairs the STP workforce work-streams in Gloucestershire and works closely with the Director of Nursing and Quality.

15. The organisation works closely with commissioners and with Health Education England, and submits the workforce plans they develop as part of the STP, using the defined process, to inform supply and demand modelling.

The Trust works closely with both CCGs and HEE through the STP workforce work stream to map supply and demand. Additional work is being planned in terms of new skills needed to deliver the Five Year Forward View and 5 Year Forward View for MH and working with commissioners t secure funding where appropriate.

16. The organisation supports Health Education England by ensuring that high quality clinical placements are available within the organisation and across patient pathways, and actively seeks and acts on feedback from trainees/students,

The Trust continues to work with a number of HEI's and alongside HEE to ensure the placement experience within our Trust is the best it can be. We continue to receive positive feedback across professional groups. We are currently working with the University of Gloucestershire to develop and validate a BSc in MH nursing commencing September 2018.

Wards/Units staffing level and quality indicators **Appendix 2**

Information regarding Data	
Safer Staffing	For month of January 2018
Workforce & Training	Rolling 12 months
Quality Indicators	Cumulative in year totals

				Staffing																																
Bed Information				**Day**		**Night**		**Day**				**Night**									**Other Quality indicators**																
				Registered nurses	Care Staff	Registered nurses	Care Staff	Registered nurses		Care staff		Registered nurses		Care staff		Agency	Workforce		Training/Supervision																		
Wards	Current established beds	Ward average occupancy (month) % including leave	Ward average occupancy (month) % excluding leave	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Agency Rate% of all shifts	Turnover by WTE %	Sickness Absence	Appraisal Compliance %	Statutory and Mandatory Training %	Formal complaints	Medication incidents Total	Medication incidents resulting in harm	RT Incidents	MRSA Bacteraemia	Clostridium difficile infection (CDI)	Falls total	Falls *with harm	SIRIs	AWOLs of detained patients	AWOLs of detained patients * with harm	Prone Restraint	Supine Restraint	Total restraints * with harm	RAG Score: Green = 0 - 1 trigger Amber = 2 - 3 triggers Red = 4 or more triggers
Abbey Ward, WLH	18	109%	96%	81.2%	147.6%	91.9%	135.5%	1395	1132.5	930	1372.5	620	570	310	420	7.14	0	12.77	56	91.6	2	22	0	87	0	0	5	0	2	36	0	56	15	0	
Dean Ward, WLH	15	106%	96%	103.2%	114.0%	96.8%	158.1%	930	960	1395	1590	620	600	310	490	9.68	9.83	9.34	74	77.1	2	10	0	50	0	0	22	0	0	10	0	29	17	0	
Kingsholm Ward, WLH	15	101%	99%	100.8%	100.5%	98.4%	103.2%	930	937.5	1395	1402.5	620	610	310	320	4.2	11.5	17.44	72	81.6	0	11	0	22	0	0	3	0	0	12	0	16	7	0	
Priory Ward, WLH	18	100%	98%	84.4%	158.9%	98.4%	145.2%	1395	1177.5	930	1477.5	620	610	310	450	5.04	4.47	6.74	100	89.5	2	24	0	29	0	0	19	0	0	27	0	22	11	0	
Greyfriars, WLH	10	84%	84%	74.2%	126.9%	98.4%	122.6%	1395	1035	1395	1770	620	610	620	760	6.65	5.72	11.35	83	90.5	1	6	0	71	0	0	15	0	0	5	0	50	105	0	
Montpellier WLH	12	98%	92%	91.9%	102.2%	100.0%	101.6%	930	855	1395	1425	620	620	620	630	4	18.96	10.51	67	84	1	3	0	14	0	0	0	0	1	1	0	9	11	0	
Chestnut Ward, CLH	14	99%	97%	106.5%	102.6%	103.2%	98.4%	930	990	1162.5	1192.5	310	320	620	610	1.25	6.7	1.44	77	90.7	0	8	0	5	0	0	66	0	0	0	0	0	0	0	
Mulberry Ward, CLH	18	101%	95%	101.6%	121.0%	103.2%	100.0%	930	945	1395	1687.5	310	320	620	620	1.49	10.54	6.35	92	90	0	13	0	75	0	0	98	0	0	0	0	0	7	0	
Willow Ward, CLH	16	95%	93%	110.5%	99.0%	100.0%	106.5%	930	1027.5	2325	2302.5	310	310	930	990	1.84	10.12	4.16	85	89.2	0	10	0	20	0	0	173	2	0	4	0	0	16	0	
Berkeley House	6	100%	100%	129.0%	91.7%	151.6%	82.1%	930	1200	4500	4125	310	470	2790	2290	2.24	7.39	6.34	86	94.9	0	11	0	1	0	0	10	0	0	1	0	0	473*	16*	
Honeybourne	10	105%	92%	82.8%	112.2%	100.0%	100.0%	697.5	577.5	697.5	782.5	310	310	310	310	1.09	0	1.28	89	89.3	0	7	0	0	0	0	1	0	0	0	0	0	0	0	
Laurel House	13	100%	98%	67.7%	130.1%	100.0%	100.0%	697.5	472.5	697.5	907.5	310	310	310	310	0.41	4.02	6.15	100	93.4	0	13	0	0	0	0	3	0	0	0	0	0	0	0	
Oak House	10	78%	65%	100.0%	141.9%	103.2%	100.0%	713	713	356.5	506	356.5	368	356.5	356.5	3.34	13.6	0	60	94.1	0	6	0	0	0	0	3	0	0	1	0	0	0	0	
Mortimer Ward, SB	22	101%	94%	102.2%	232.3%	100.0%	219.4%	1069.5	1092.5	713	1656	713	713	713	1564	13.06	0	10.36	50	71.4	3	8	0	20	0	0	15	0	3	18	0	9	7	0	
Jenny Lind Ward, SB	8	96%	92%	96.8%	219.4%	103.2%	219.4%	713	690	356.5	782	356.5	368	356.5	782	13.84	0	13.99	58	88.2	0	6	0	6	0	0	28	1	0	0	0	1	1	0	
Cantilupe Ward, SB	12	99%	99%	104.1%	149.9%	50.0%	292.7%	713	742.5	1069.5	1603	713	356.5	496	1452	9.74	12.78	1.95	82	91.6	0	7	0	73	0	0	40	1	1	0	0	12	5	0	

Appendix 3 January 2017 – National safe staffing upload

Only complete sites your organisation is accountable for					Day				Night				Day		Night	
Hospital Site Details		Ward name	Main 2 Specialties on each ward		Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
Site code *The Site code is automatically populated when a Site name is selected	Hospital Site name		Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours				
RTQ02	WOTTON LAWN HOSPITAL	Dean	710 - ADULT MENTAL ILLNESS		930	960	1395	1590	620	600	310	490	103.2%	114.0%	96.8%	158.1%
RTQ02	WOTTON LAWN HOSPITAL	Abbey	710 - ADULT MENTAL ILLNESS		1395	1132.5	930	1372.5	620	570	310	420	81.2%	147.6%	91.9%	135.5%
RTQ02	WOTTON LAWN HOSPITAL	Priory	710 - ADULT MENTAL ILLNESS		1395	1177.5	930	1477.5	620	610	310	450	84.4%	158.9%	98.4%	145.2%
RTQ02	WOTTON LAWN HOSPITAL	Kingsholm	710 - ADULT MENTAL ILLNESS		930	937.5	1395	1402.5	620	610	310	320	100.8%	100.5%	98.4%	103.2%
RTQ02	WOTTON LAWN HOSPITAL	Montpelier	710 - ADULT MENTAL ILLNESS		930	855	1395	1425	620	620	620	630	91.9%	102.2%	100.0%	101.6%
RTQ02	WOTTON LAWN HOSPITAL	Greyfriars	710 - ADULT MENTAL ILLNESS		1395	1035	1395	1770	620	610	620	760	74.2%	126.9%	98.4%	122.6%
RTQ01	CHARLTON LANE HOSPITAL	Willow	715 - OLD AGE PSYCHIATRY		930	1027.5	2325	2302.5	310	310	930	990	110.5%	99.0%	100.0%	106.5%
RTQ01	CHARLTON LANE HOSPITAL	Chestnut	715 - OLD AGE PSYCHIATRY		930	990	1162.5	1192.5	310	320	620	610	106.5%	102.6%	103.2%	98.4%
RTQ01	CHARLTON LANE HOSPITAL	Mulberry	715 - OLD AGE PSYCHIATRY		930	945	1395	1687.5	310	320	620	620	101.6%	121.0%	103.2%	100.0%
RTQ11	LAUREL HOUSE CHELT	Laurel	710 - ADULT MENTAL ILLNESS		697.5	472.5	697.5	907.5	310	310	310	310	67.7%	130.1%	100.0%	100.0%
RTQ13	HONEYBOURE	Honeybourne	710 - ADULT MENTAL ILLNESS		697.5	577.5	697.5	782.5	310	310	310	310	82.8%	112.2%	100.0%	100.0%
RTQ54	BERKELEY HOUSE	Berkeley	700- LEARNING DISABILITY		930	1200	4500	4125	310	470	2790	2290	129.0%	91.7%	151.6%	82.1%
RTQHJ	STONEBOW UNIT	Mortimer	710 - ADULT MENTAL ILLNESS		1069.5	1092.5	713	1656	713	713	713	1564	102.2%	232.3%	100.0%	219.4%
RTQHJ	STONEBOW UNIT	Cantilupe	715 - OLD AGE PSYCHIATRY		713	742.5	1069.5	1603	713	356.5	496	1452	104.1%	149.9%	50.0%	292.7%
RTQHJ	STONEBOW UNIT	Jenny Lind	710 - ADULT MENTAL ILLNESS		713	690	356.5	782	356.5	368	356.5	782	96.8%	219.4%	103.2%	219.4%
RTQHM	OAK HOUSE	Oak House	710 - ADULT MENTAL ILLNESS		713	713	356.5	506	356.5	368	356.5	356.5	100.0%	141.9%	103.2%	100.0%

Agenda item 14 **Enclosure Paper I**

Report to: 2gether NHS Foundation Trust Board – 28th March 2018
Author: Colin Merker – Acting Chief Executive
Presented by: Colin Merker – Acting 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. An overview of engagement by Board members
2. A summary of headline news against Quality, Sustainability and Engagement criteria

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:		
Executive Team	Date	*March 2018*

Where in the Trust has this been discussed before?		
ACEO	Date	*March 2018*

What consultation has there been?		
N/A	Date	

Explanation of acronyms used:	

1. CONTEXT

1.0 Engagement

1.1 Internal Board Engagement

02.01.18 The Director of Quality met with the new Chair of 2gether NHS Foundation Trust

03.01.18 The Director of Quality attended a board visit at Cheltenham Crisis Team.

The Acting Chief Executive and Director of OD attended the Strategic Intent Leadership Group

The Director of Finance attended a monthly CIP review

04.01.18 The Director of OD attended the meeting for the recruitment of the Joint Chief Executive

05.01.18 The Director of OD attended Corporate Induction

The Director of Quality attended Criminal Justice Liaison Team for a Clinical Shift

08.01.18 The Executive Directors attended an Executive Development Committee

The Director of Engagement and Integration co-hosted a Team Talk at Weavers Croft

The Executive Director's conducted Team Talks at the various services

The Acting Chief Executive and Medical Director attended a Programme Management Executive meeting with Gloucester care Services colleagues

The Director of Finance attended a Research Proforma meeting

09.01.18 The Acting Chief executive participated in a meeting to Review IT Service Delivery Models

The Director of Finance attended a Board visit to the Hereford Recovery Teams

The Director of Finance attended an HR and Finance Meeting

10.01.18 The Acting Chief Executive attended the mental Health Legislation Scrutiny Committee meeting

The Acting Chief Executive attended a Social Care meeting

The Director of OD and Director of Finance attended an Estate Team engagement session

The Director of Finance attended a Finance Strategy meeting

11.01.18 The Director of OD attended a JNCC Pre-Meet

The Director of OD attended a Longlisting call for the recruitment of a Non Executive Director

The Acting Chief Executive attended a meeting regarding GRiP Capacity

The Director of Quality attended the 2gether Safeguarding Committee

The Director of Finance attended a Transformation (CIP) Project Board

12.01.18 The Acting Chief Executive conducted a Board Visit to IHOT Team at Pullman Place

The Medical Director took part in Specialty Doctor interviews

The Director of OD attended an ATOS Committee Meeting

15.1.18 The Executive Directors attended Executive Committee Business meeting

The Director of Engagement and Integration attended a Trustwide Quality Improvement Meeting

16.01.18 The Director of OD attended a Senior HR Team Meeting

The Acting Chief Executive, Director of OD, the Director of Engagement and Integration and the Director of Finance attended the Trust's Council of Governors meeting

The Director of Engagement and Integration hosted a Board Visit with the Cheltenham Recovery Team at Charlton Lane

17.01.18 The Acting Chief Executive and, the Director of OD and the Director of Engagement and Integration attended a Programme Management Executive meeting with Gloucester care Services colleagues

The Director of OD attended a People Committee

The Medical Director and Director of Finance took part in Consultant interviews

19.01.18 The Medical Director attended the Junior Doctors Forum

The Director of Quality chaired the Quality & Clinical Risk sub-Committee.

The Director of Engagement and Integration chaired a Triangle of Care Project Board meeting

22.01.18 The Executive Directors attended an Executive Committee Business meeting

The Acting Chief Executive, Director of Quality, The Director of Engagement and Integration attended the Trust's Leadership Forum at Bowden Hall

The Director of OD attended an HR Review meeting

23.01.18 The Director of OD attended a JNCC Management Pre-Meeting

24.01.18 The Director of Quality attended 2 patient safety visits at Wotton Lawn Hospital.

The Director of Quality chaired the Temporary Staffing Demand Project Board.

25.01.18 The Director of OD attended a Safety Health & Environment Committee

29.01.18 The Executive Directors attended an Executive Development Committee

	The Acting Chief Executive, Director of OD and The Medical Director attended the Programme Management Executive Meeting
	The Director of OD attended a Staff Cultural Diagnostic Survey meeting
30.01.18	The Executive Directors attended a Trust Board meeting
	The Acting Chief Executive attended an AToS meeting
31.01.18	The Director of Quality chaired the Smoking Cessation Project Board in Herefordshire.
01.02.18	The Director of Quality attended 2 patient safety visits at Wotton Lawn Hospital.
	The Director of Quality attended the NPAC meeting
	The Acting Chief Executive attended a Contracts update meeting
	The Director of Finance attended a Counter Fraud meeting
02.02.18	The Acting Chief Executive attended the Medical Staffing Committee
	The Director of Engagement and Integration held interviews for the Trust's Head of Research and Development post
05.02.18	The Director of Engagement and Integration co-hosted the Team Talk at Rikenel
06.02.18	The Director of Engagement and Integration took part in a focus group as part of the recruitment for a Non-Executive Director
	The Acting Chief Executive and the Director of OD participated in the recruitment of a Non-Executive Director
07.02.18	The Acting Chief Executive and the Director of Finance attended a Trust Board meeting
	The Director of OD and The Director of Finance attended the Audit Committee
	The Acting Chief Executive and the Director of OD participated in the recruitment of the Interim Director of Service Delivery
	The Director of Finance and the Director of Engagement and Integration attended the Trust's Development Committee
08.02.18	The Acting Chief Executive attended a meeting regarding AFC Child Psychology posts

The Acting Chief Executive attended an Executive visit to Berkeley House

The Director of OD attended a Board Visit at MHICT Team South

09.02.18 The Acting Chief Executive participated in the recruitment of a Programme Director

The Director of Engagement and Integration met with the Senior colleagues of her Directorate

The Director of OD attended the Clinical Excellence Awards Meeting

The Director of Quality attended the Child Protection Inter-Agency Training Level 3 at Dowtys Sports and Social Club

12.02.18 The Executive Directors attended the Executive Business Committee

The Acting Chief Executive, Director of OD and Director of Engagement and Integration attended a Programme Management Executive meeting with Gloucester care Services colleagues

13.02.18 The Director of Quality attended a Board Visit at Colliers Court

The Director of OD attended a Senior HR Team meeting

The Director of OD attended the Shortlistng teleconference for the recruitment of the Joint CEO

14.02.18 The Acting Chief Executive and the Director of Finance attended a CITS meeting

The Director of Engagement and Integration hosted a Patient Safety Visit with the Stroud Recovery Team

15.02.18 The Director of Engagement and Integration hosted a Board Visit with the Autistic Spectrum Condition Service in Cheltenham

The Director of OD attended an HR Team meeting

The Director of OD attended an Operational Plan meeting

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

The Director of Quality chaired the Quality & Clinical Risk sub-committee

19.02.18 The Executive Director's attended an Executive Development Committee

	The Director of Engagement and Integration welcomed new staff members at the Corporate Induction
	The Director of Finance attended an Urgent Care Modelling meeting
20.02.18	The Acting Chief Executive and the Director of Finance attended an Operational Plan refresh meeting 2018/19
	The Acting Chief Executive attended a Strategic Intent Leadership Group meeting
21.02.18	The Acting Chief Executive attended the Trust Delivery Committee
	The Acting Chief Executive conducted a board visit to the GRIP Team at Pullman Place
	The Director of Engagement and Integration, Medical Director, the Director of Finance and Director of OD took part in a focus group as part of the recruitment for the Joint Chief Executive Officer
22.02.18	The Medical Director took part in the CQC focus groups
23.02.18	The Medical Director took part in the CQC focus groups
	The Director of Engagement and Integration attended the Trust's Governance Committee
	The Director of Quality attended the Trust Governance Committee.
	The Director of Quality chaired the Temporary Staffing Demand Project Board.
26.02.18	Executive Directors attended the Executive Business Committee
	The Acting Chief Executive, Medical Director and Director of Integration and Engagement attended a Programme Management Executive meeting with Gloucester care Services colleagues
	The Director of Finance attended a Schedule 4 Finalisation meeting for Gloucestershire
27.02.18	The Executive Directors attended the Trust Board
28.02.18	The Acting Chief Executive attended an introductory meeting with the newly appointed Joint Chief Executive
28.02.18	The Medical Director undertook a board visit to Occupational Health at GRH
	The Director of OD attended a JNCC Pre meeting

The Director of OD attended a Patient Safety Visit to the AO Team at Leckhampton Lodge

The Director of Finance attended a Board Visit at Vocational Service/Better2Work and West CPI Team

1.2 Board Stakeholder Engagement

02.01.18 The Director of Quality and Director of OD attended a workforce meeting at Sanger House

03.01.18 The Acting Chief Executive attended an IRIS Project Board at Sanger House

The Acting Chief Executive attended an Community Dementia meeting at Sanger House

04.01.18 The Acting Chief Executive attended a STP Delivery Board meeting at Sanger House

The Director of OD attended an STP Gloucester Capability Thematic Group

The Acting Chief Executive attended a New Models of Care Board meeting

The Director of Finance attended the IT Partnership Review Board

05.01.18 The Acting Chief Executive meet with the Accountable Officer of Herefordshire Clinical Commissioning Group

The Acting Chief Executive attended a Dementia Partnership Board.

08.01.18 The Acting Chief Executive attended a One Place Programme Board with Gloucestershire Clinical Commissioning Group

The Acting Chief Executive, The Director of OD and the Director of Engagement and Integration attended a Programme Management Executive meeting at Edward Jenner Court

09.01.18 The Director of Engagement and Integration attend the Gloucestershire Health and Care Overview and Scrutiny Committee meeting at Shire Hall

The Director of Engagement and Integration met with the Chief Executive of Carers Gloucestershire

The Acting Chief Executive attended a Joint RSG/PDG Meeting

The Acting Chief Executive attended a Joining Up Your Information Project Board and Clinical Information Sharing Projects Group Meeting

The Acting Chief Executive attended an IAPT Service Performance and Forward Plans with Gloucestershire Clinical Commissioning Group

The Director of Quality attended the STP Clinical Reference Group in Worcester

10.01.18 The Director of Quality attended a walkaround with Hereford CCG at the Stonebow unit

The Director of Quality attended the Clinical Governance Working Group with Taurus Healthcare in Herefordshire

The Director of Finance attended Contract Board meeting with Gloucestershire Clinical Commissioning Group

11.01.18 The Acting Chief Executive and Director of Finance attended a meeting with Hereford Mind colleagues

The Director of Finance attended an STP Health Estates Meeting for Gloucestershire

12.01.18 The Director of Engagement and Integration met with colleagues from 2gether and Gloucestershire Constabulary to discuss Social Inclusion Work

15.01.18 The Acting Chief Executive attended a 'One Gloucestershire' service reconfiguration' meeting with Gloucestershire Clinical Commissioning Group

16.01.18 The Acting Chief Executive and the Director of Quality attended a STP Partners Visit to Dorset CCG

The Director of OD attended the SW Regional HRD Teleconference

The Director of Finance attended an Audit meeting with KPMG

18.01.18 The Acting Chief Executive attended a STP CEO Meeting

The Acting Chief Executive and the Director of Finance attended a Hereford Contract Negotiations meeting.

The Acting Chief Executive and the Director of Finance attended a 2gether/Gloucester CCG Contract Negotiation Meeting

The Director of Quality attended the Herefordshire Clinical Quality Reference Group

19.01.18 The Director of Engagement and Integration attended the Gloucestershire Health and Care Overview and Scrutiny Committee Work Planning meeting at Shire Hall

The Director of OD attended the Social Partnership Forum Board

23.01.18 The Director of Engagement and Integration chaired the Tackling Mental Health Stigma Group

The Director of Engagement and Integration attended the STP Clinical Reference Group meeting at Sanger House

The Director of Quality attended the STP Clinical Reference Group in Gloucestershire

24.01.18 The Medical Director held a relatives meeting following a serious incident review

The Director of OD attended a Gloucestershire HR and OD Workstream meeting

25.01.18 The Medical Director attended an inquest

The Director of Quality attended a Smokefree Event at Eastwood Park training centre

The Director of Engagement and Integration attended the Herefordshire Adults and Wellbeing Scrutiny Committee

26.01.18 The Acting Chief Executive attended a Local Resolution Meeting

29.01.18 The Director of Quality attended the GCC Improvement Planning Meeting at Shire Hall

31.01.18 The Acting Chief Executive attended a meeting with West Mercia Police

The Acting Chief Executive attended an Interface meeting at Shire Hall

The Director of OD attended a Tempre/Liaison Review meeting

01.02.18 The Acting Chief Executive attended a GP meeting regarding PC Nurse Pilot

The Director of Engagement and Integration attended an IPS Planning meeting at Sanger House

The Director of OD attended an STP Glos Capability Thematic Group

05.02.18 The Director of Engagement and Integration took part in a conference call for the Executive Management Group Meeting with the West of England Clinical Research Network

The Director of Engagement and Integration attended the Herefordshire Children and Young People Scrutiny Committee

The Acting Chief Executive attended a STP Delivery Board

The Acting Chief Executive attended the One Place Programme Board with Gloucester care Services colleagues

The Medical Director attended the Annual Educational Supervisors Update

06.02.18 The Acting Chief Executive attended an Assurance visit to OPCMHT

The Acting Chief executive attended a Herefordshire Corporate Peer Challenge meeting

The Director of Finance attended a One Gloucestershire Estate Group meeting

07.02.18 The Director of OD attended the STP MH Workforce meeting

09.02.18 The Acting Chief Executive attended a Mental Health Supported Housing meeting

12.02.18 The Acting Chief Executive attended GHNHSFT - Council of Governors Quality Group

The Executive Directors attended a Joint Working Workshop with GCS

The Director of Quality attended a community visit to the Nelson Trust with Lisa Bayliss-Pratt from Health Education England

13.02.18 The Director of Engagement and Integration held a teleconference with colleagues from Herefordshire Council to discuss Learning Disability Services

The Director of Finance attended a One Herefordshire Workshop

14.02.18 The Director of OD attended an STP MH Workforce

The Director of Finance attended a Contract Board meeting for Gloucestershire

The Director of Finance attended Contract Board meeting for Herefordshire

20.02.18 The Director of Quality attended the Gloucester Safeguarding Children's Board at Shire Hall

The Director of Engagement and Integration #liedentity Conference at Gloucester Rugby Club

The Director of Engagement and Integration met with colleagues from Cobalt

22.02.18 The Acting Chief Executive and the Director of Finance attended a Partnership Board Review Meeting

The Acting Chief Executive and the Director of Finance met with colleagues from Herefordshire Mind

27.02.18 The Medical Director attended the NHS England South Responsible Officer Network meeting

28.02.18 The Director of OD attended the STP MH Workforce

1.3 National Engagement

11.01.18 The Director of OD attended the SW Pan STP UEC Workforce Programme Board

18.01.18 The Director of OD attended the SW HRD Network meeting

31.01.18 The Director of Finance attended the NHSi Provider Finance Directors meeting

16.02.18 The Director of OD attended the SW Regional Social Partnership Forum

2. Sustainability – Headline News

2.1 Triangle of Care Quality/Engagement

The triangle of care project is drawing to a close. The final submission report for the Carers Trust was reviewed by Governance Committee on 23rd February and the report submitted after a few small changes were made. Feedback was received from the Carers Trust on the report and the Trust was invited to present their submission at the Regional (SW) Triangle of Care meeting on 16 March 2018 in Taunton. Confirmation was given following the meeting on 16 March that the Trust had been successful in its application and has been awarded 2 star accreditation of the Triangle of Care Membership Scheme. A celebration event has been planned for 19 April 2018, 12.30 in the Council Chamber, Shire Hall, Gloucestershire County Council.

Steps have been taken to ensure sustainability and reporting for the scheme moving forward. Lessons learned will be discussed at the final project board meeting on 27 March 2018 and will form part of the end of project report.

2.2 Gloucester City Hub Sustainability/Quality

Pullman Place is now fully operational with all teams having transferred to the refurbished building, and feedback from both service users and staff is very positive. As with any project such as this, some small works remain to be completed to resolve issues that have arisen following occupation and which were not foreseen during the design period. The vacated buildings have either been handed back to the landlords or sales agreed with prospective purchasers. The construction was completed on time and the teams moved in on programme. The project is forecast to be completed below the allocated capital expenditure budget.

The project has formally been closed by the Project Board and the on-going responsibility has been passed to the Gloucestershire Estates Board as part of their portfolio of buildings.

2.3 Social Care Project Quality

Good progress is being made on the changes to the delivery of the Trust's Mental Health Act Assessment and Social Care Services responsibilities. A revised "Hub and Spoke" structure for the completion of assessments by Approved Mental Health Professionals (AMHPs) has been agreed and funded by the Commissioners. Recruitment to the Hub has been successfully progressed with the AMHP Lead, Administration Assistant and four out of the five AMHP posts being filled. Once fully operational, the Hub will operate between 9am and 11pm Monday to Friday completing all of the referrals that are made for Mental Health Act assessments during this period. This change will remove the assessment responsibilities from social workers within our general Teams/Services freeing them to focus on the provision of social care to service users. A review of the social care structure will now commence to ensure that this service responsibility is being delivered as efficiently and effectively as possible.

2.4 Quarter 4 Staff Friends and Family Results (SFFT) Sustainability/Engagement/Quality

Just under 200 responses were received from staff, up from the 160 responses received for the last SFFT in Quarter 2. The key results are summarised below:

- 90.5% of staff would now recommend the Trust as place to receive care or treatment, an increase of 3.5% over last time. This is the Trust's best score since the introduction of the test.
- 77% of staff would now recommend the Trust as a place to work. This has risen from 73%, the last time and again is also the best score to date.
- Circa 2% of staff would be unlikely or extremely unlikely to recommend the Trust as a place to receive care or treatment.

2.5 Three Counties Medical School Update Sustainability/Quality

The Medical Director and Director of Organisational Development met with Professor John Cookson earlier in March to discuss the Trust's support for the development of the Three Counties Medical School by the University of Worcestershire. As expected the University's national bid for funded medical school places was unsuccessful in this current round. The five new medical schools which have been announced this month were all in a more advanced stage of preparation than others when the applications for perspective new schools was opened last year. It is very likely that there will be another round of applications invited within the next 18 months and both the Trust and the University look forward to working with each other and stakeholders to making the creation of the Three Counties Medical School a reality in the early 2020s. A new local Medical School has the potential in the longer term of significantly improving our medical staffing recruitment and reducing the related current risks.

2.6 Agenda for Change Pay Deal Sustainability/Engagement

You may have heard in last week's news that a deal has been confirmed with trades unions to end the recent pay restraint for Agenda for Change staff. This deal will now be put to a vote of trades unions' memberships. Unison, the Royal College of Nursing, and Unite have confirmed they will be encouraging their members to accept the deal.

Jeremy Hunt, the Secretary of State for Health and Social Care, confirmed in a ministerial statement last week that:

- 1.3 million workers on the NHS Agenda for Change contract will receive a pay rise worth at least 6.5 per cent, without changes to annual leave entitlements or unsocial hours payments
- The Treasury has committed to fully fund the deal with £4.2 billion extra for the NHS. £800 million was set aside in the Autumn Budget 2017 to fund the first year of the Agenda for Change pay deal. The Chancellor will also provide additional funding through the 2018 Autumn Budget and make available the £4.2 billion over three years needed to fund the deal.
- Pay will rise between 6% and 29% for NHS staff over three years, depending on their banding
- The minimum rate of pay in the NHS will be set at £17,460 from 1 April 2018
- The lowest earning staff will see basic pay rise by 15% over 3 years
- Changes to pay progression, and standards to link pay progression to the completion of an appraisal process will be introduced
- Terms and conditions have been amended to include:
    - a national framework on buying and selling leave
    - enhanced shared parental leave
    - child bereavement leave
- The key ask for providers is the commitment to work together to improve the health and wellbeing of NHS staff so as to improve levels of attendance in the NHS

- The deal does not include the medical workforce and the Government is currently saying that any above 1% pay award for doctors will have to be funded from within NHS existing funds.

A fully funded end to pay restraint is something that has been discussed for some time now, so this will be a welcomed proposal.

The deal will now go to the trades unions' membership for consideration.

2.7 National Agreement on Consultant Clinical Excellence Awards

Sustainability/Quality

NHS Employers, the Department of Health and Social Care (DHSC) and the British Medical Association (BMA) have this month reached a collective agreement on the future of local clinical excellence awards (LCEA) for consultants.

The agreement covers some interim changes to the current LCEA scheme ahead of continuing negotiations on wider contractual reform, including a fully revised LCEA scheme. The agreement also addresses some of the uncertainty around the contractual nature of LCEA which, as you may know were subject to a legal challenge from the BMA. As the result of this agreement, that action will now be withdrawn in accordance with the settlement agreed between the BMA and the DHSC. This agreement will provide the basis for a more consistent approach in line with current government policy on pay and reward.

The main outcome of the agreement will be the addition of a new schedule to the 2003 terms and conditions of service. The key points of the new schedule are that in the period from April 2018 – March 2021:

- all trusts must run annual awards rounds
- the investment ratio of new awards will be 0.3 per eligible consultant
- awards rounds must be conducted in line with current agreed policies, subject to any changes reached in agreement with our own local Local Negotiating Committee (LNC)
- existing LCEA (those granted before April 2018) will be retained and will remain pensionable and consolidated
- new CEA (those granted after April 2018) will be non-pensionable and non-consolidated
- where national awards are withdrawn, there will be a mechanism based on current scoring allowing reversion to a local level award

The move to a non-consolidated performance scheme will mean that trusts will be able to incentivise productivity improvements in return for making future awards contractual. In the longer term, the agreement will allow trusts to shape the performance pay scheme in a way that better meets their organisational needs and encourage the pay review body to support greater flexibility in linking pay to performance.

As NHS Employers progress with negotiations, there will be an opportunity nationally to establish a new scheme by April 2021. All parties agree that this should more closely reflect current, rather than previous, excellence in delivering an organisation's main aims and objectives of providing high-quality care and improved outcomes for patients.

Agenda item 15 **Enclosure Paper J**

Report to:	Board of Directors – 28 March 2018
Authors:	Nick Grubb - Assistant HR Director Neil Savage – Director of Organisational Development
Presented by:	Neil Savage – Director of Organisational Development

SUBJECT: **2017 NHS National Staff Survey**

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

EXECUTIVE SUMMARY

This report provides the Board of Directors with an overview and analysis of the 2017 NHS Annual Staff Survey which was sent to all staff in post on 1st September 2017.

NHS England published the national and local NHS 2017 Staff Survey results on the 6th of March 2018. Nationally 487,227 NHS staff members took part.

Our local response rate from staff was 45%, an improvement of 5% on the previous year. In terms of headcount, the number of respondents rose from 777 to 921.While this is a great improvement within the Trust, the rate remains lower than the national average for Mental Health and Learning Disability Trusts (26 organisations) of 52%.

The responses to the survey were grouped into 32 Key Findings. The Trust was shown to be better than average in 17 Key Findings (53%) and better than average or average in 27 (84%) of the 32 key findings. There were no statistically significant improvements in any of the categories. There was a statistically significant deterioration in two key findings detailed in the commentary of this report. .

Crucially, the score for overall staff engagement remained steady but the component parts that make up this result were all shown to be better than average. The Trust's score was 3.88. The national average was 3.79 from a maximum score of 5. Overall staff engagement within the wider NHS nationally has declined for the first time since 2014. This is not surprising given that public satisfaction with the NHS is now 57% -- 6% lower than last year. Similarly, some 43% of NHS providers are in deficit, with a £1,281 million provider deficit at the end of December 2017, £365 million above plan.

RECOMMENDATIONS

The Board of Directors is asked to:

- Note the report, the conclusions and recommendations going forwards
- Note a rating of significant assurance on staff experience with the Trust

Corporate Considerations	
Quality implications	The results are part of a range of feedback mechanisms that reflect how staff view the Trust, including the quality of the services it provides and of the Trust as an employer.
Resource implications:	The delivery of the action plan is managed within existing resources.
Equalities implications:	The Survey's lack of equalities monitoring across all protected characteristics reduces the usefulness of the evidence to support actions to reduce barriers and improve staff experience particularly regarding race.
Risk implications:	The results of the l Staff Survey are published nationally and locally. Lower results may impact upon the view of service users and carers and other stakeholders and the care the Trust provides. In addition poor results can impact upon the Trust's ability to demonstrate that we are an employer of choice when recruiting and Commissioners may choose not to commission services from a Trust that has poor Staff Survey results.

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:		
Neil Savage, Director of Organisational Development	Date	

Where in the Trust has this been discussed before?		
People Committee	Date	March 2018
Executive Committee		February 2018
Delivery Committee		March 2018
What consultation has there been?		
JNCC	Date	March 2018

Explanation of acronyms used:	MHLDT – Mental Health/Learning Disability Trusts QH – Quality Health ESR – Electronic Staff Record NHSE – NHS England

1. Introduction

The Trust participates in the NHS Annual Staff Survey, a requirement of the Department of Health. The Survey is carried out by our independent contractor Quality Health (QH). The Trust provided a full staff listing extracted from the Electronic Staff Record (ESR).

All staff who were in post on 1st September 2017 were invited to take part online. All responses are returned directly to QH who confidentially hold the data. The Trust does not know who responded to the survey.

2. Response to the Survey

The survey was responded to by 921 staff or 45%. This marks an increase from 777 (40%) responses in 2016. The 2017 Survey took place between September and December 2017.

3. Key Findings

For the 2017 survey, there are still 32 key Findings. The groupings are:

- Appraisals and Support for Development
- Equality and Diversity
- Errors and Incidents
- Health and Wellbeing
- Working Patterns
- Job Satisfaction
- Managers
- Patient Care and Experience
- Violence, Harassment and Bullying

As in previous years, there are two types of Key Finding:

- percentage scores, i.e. percentage of staff giving a particular response to one, or a series of, survey questions
- scale summary scores, calculated by converting staff responses to particular questions into scores. For each of these scale summary scores, the minimum score is always 1 and the maximum score is 5.

Each year the Trust's results are compared with a group of like/type trusts. The group consists of 26 Mental Health and Learning Disability Trusts in England.

The Survey was run online and a number of reminders were sent to staff from Quality Health to those who had not responded. Global email reminders were also issued to encourage staff to complete the survey.

To reassure colleagues that the Survey was completely confidential, QH's Statement of Confidentiality was published on ^{2}getherNet, the Trust's intranet.

The full Survey report provides not just the Key Findings but also the raw data from which the Key Findings are determined. Demographic information to view responses by profession, locality etc., is also included.

4. Headline Results

The first indicator shown in the report is that of overall staff engagement. The score is obtained from combining the responses to three of the Key Findings:

- *KF1 – Staff recommendation of the Trust as a place to work or receive treatment*
- *KF4 – Staff motivation at work*
- *KF7 – Staff ability to contribute towards improvements at work*

Although the score fell slightly, the component parts were all found to be better than average when compared against our comparator group of 26 mental health and learning disability trusts.

Table 1.

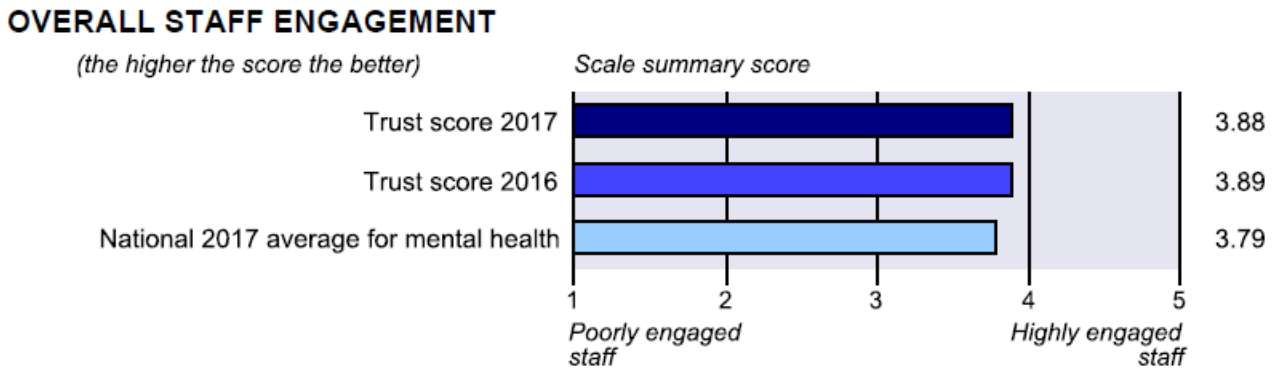


Table 1 highlights the statistically insignificant change to our overall score and that the trust remains significantly higher than our comparator group.

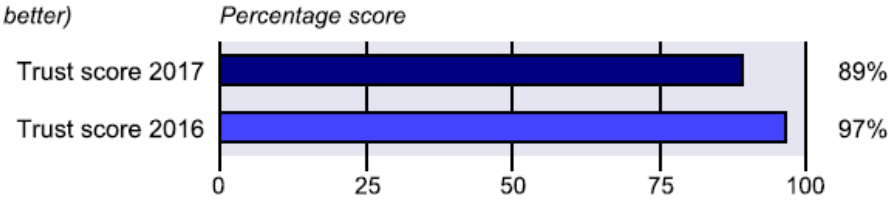
Overall, the 2017 results shows a minor and statistically insignificant change since 2016.

There were only two significant changes in the survey, both seen as a deterioration in the staff experience and these are shown in Table 2.

WHERE STAFF EXPERIENCE HAS DETERIORATED

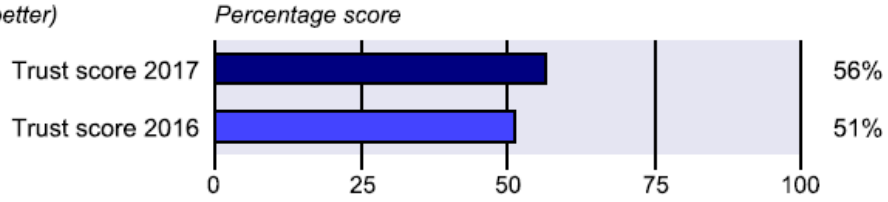
! KF29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month

(the higher the score the better)



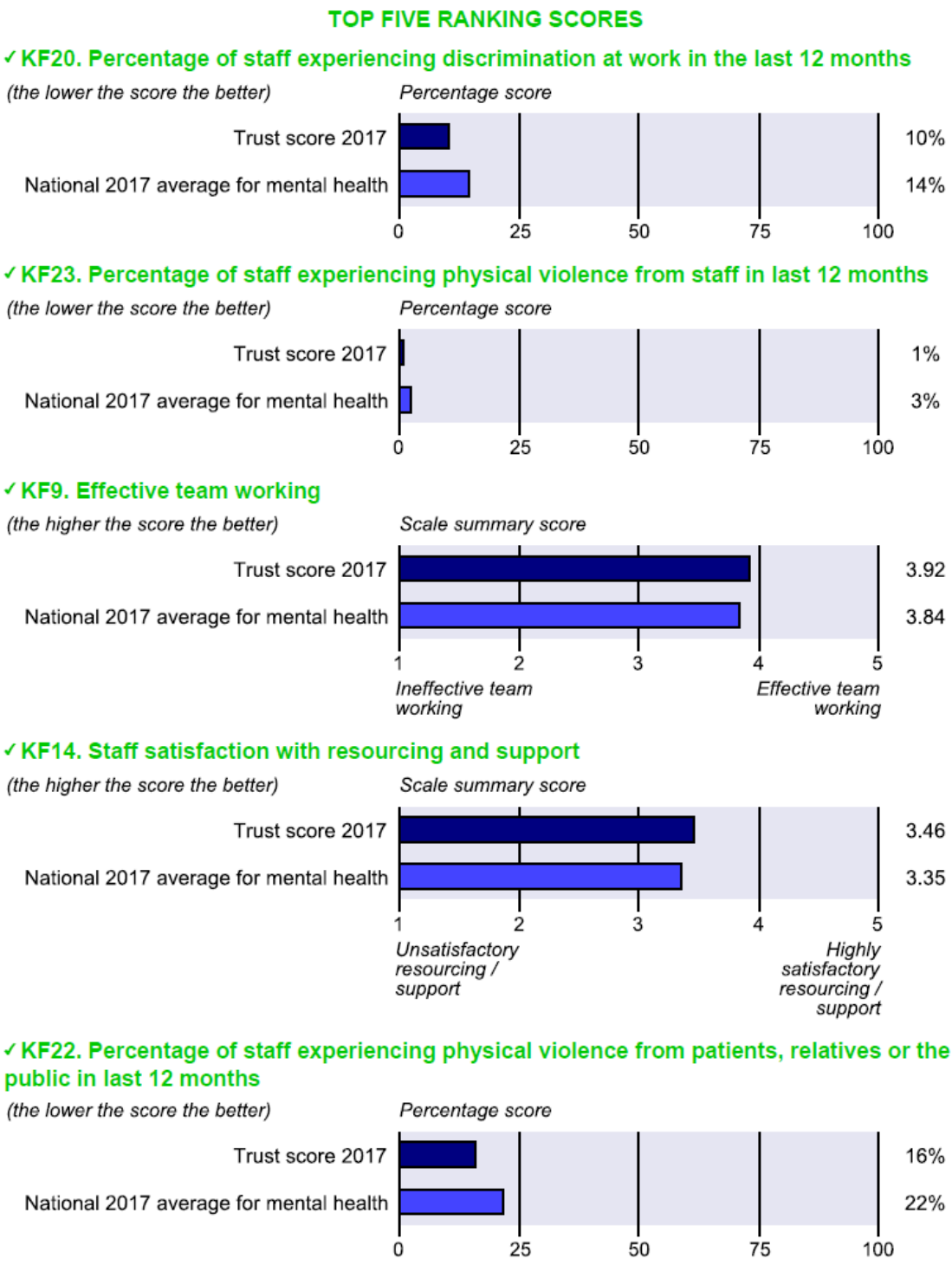
! KF18. Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves

(the lower the score the better)



The survey findings are grouped into the top and bottom 5 ranking scores. Our Trust compares most favourably with other MH/LD Trusts in the following 5 categories:

Table 3



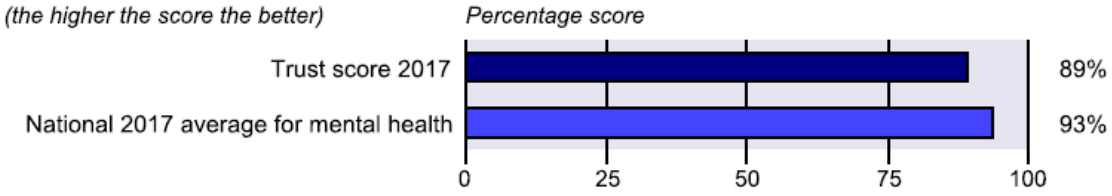
Once again the Survey reports that there have been staff who have experienced violence at work from other staff but there is no casework evidence supporting this.

The key findings where the Trust compared least favourably were:

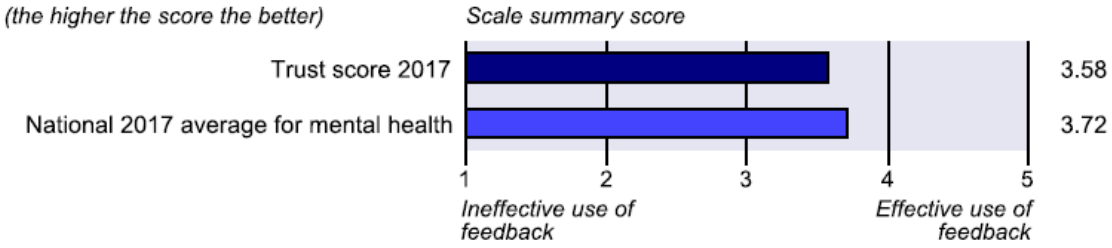
Table 4.

BOTTOM FIVE RANKING SCORES

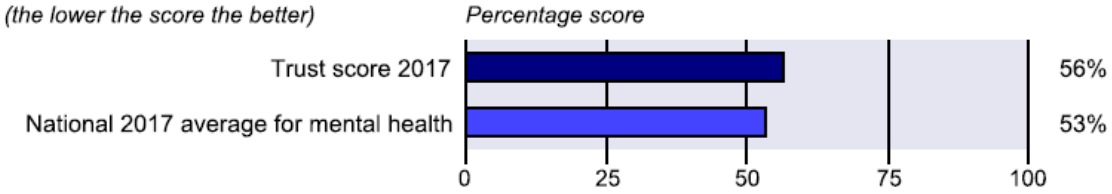
! KF29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month



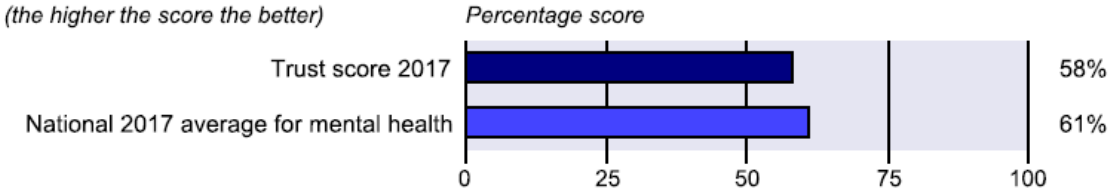
! KF32. Effective use of patient / service user feedback



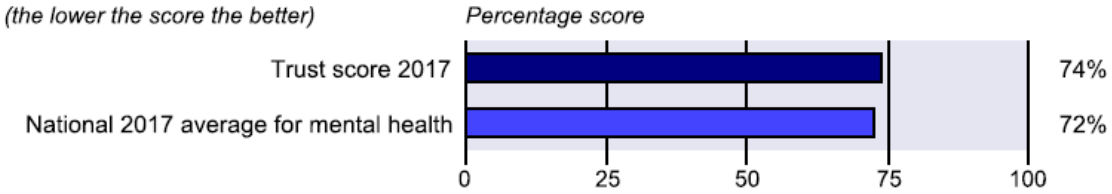
! KF18. Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves



! KF27. Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse



! KF16. Percentage of staff working extra hours



5. Key Findings

The Trust was better than average in 17 key Findings, average in 10 and worse than average in 5.

Although there were no statistically significant changes in all but two between Key Findings from 2016 and 2015, 16 of the 32 Key Findings showed some improvement, 13 worsened and 3 showed no change. It should be noted that the changes were usually a few percentage points either way. Briefly looking at each of the groupings;

5.1 Appraisals, support and development

The national average score for staff having an appraisal was 89%. The score for the Trust was 91%, up slightly on the previous year.

The quality of appraisals was marked as 3.19 from a possible score of 5, again better than previously but below the national average of 3.22.

The quality of non-mandatory training and development saw a very small improvement and was above the national average.

5.2 Equality and Diversity

Although well below the national average there was an increase in the percentage of people experiencing discrimination at work, rising from 8% to 2%.

89% of staff reported that the Trust provides equal opportunities for career progression, a slight increase on the previous year and better than the national average of 85%.

5.3 Errors and Incidents

The key findings in this category show that a higher percentage of staff have witnessed incidents but significantly less people have reported them although staff confidence in reporting unsafe practice has remained the same.

5.4 Health and wellbeing

The percentage of staff feeling unwell due to work related stress increased from 38% to 42% equal to the national average.

56% said they had attended work despite feeling unwell because of pressure from themselves, managers and colleagues, up from 51%.

There has been an increase in staff who think the organisation takes an interest in and action on their health and wellbeing and this is better than the national average.

5.5 Working patterns

58% of staff said they were satisfied with opportunities for flexible working patterns, down from 62% whilst 74% of the Trust works extra hours, no change from last year.

5.6 Job satisfaction

Once again there has been a slight improvement in the score received for recommending the Trust as a place to work or receive treatment and it is notably higher than the national average (KF1).

Staff motivation fell slightly but again, the Trust scores higher than the national average.

Less people felt able to contribute towards improvements at work but this remained above the national average and the minor downturn was rated as “No change” using the national methodology. More staff were satisfied with their level of responsibility and involvement.

Effective team working saw an improvement as did satisfaction with resourcing and support, both Key Findings being higher than the national average.

5.7 Managers

This category comprises of 3 Key Findings, all of which showed some improvement, including communications between staff and senior managers. This Key Finding has steadily improvement from a low point of 17% in 2012 to 35% in 2017, just one percentage point behind the national average, reflecting the persistent work that has gone into improving communications in recent years.

5.8 Patient care and experience

KF2. Staff satisfaction with the quality of work and care they are able to deliver remained in the average range when benchmarked nationally.

KF3. % agreeing that their role makes a difference to patients / service users remained in the above score (better than) average.

KF32, effective use of patient/service user feedback while unchanged from 2016 remains one of our bottom 5 ranked scores, with a below (worse than) average rating.

5.9 Violence, bullying and harassment

There was no change in the percentage of staff experiencing violence from patients (16%), relatives or the public but this remains significantly lower than the national average (22%).

However the percentage of staff experiencing bullying from other staff has fallen from 26% to 22% with more people reporting their experiences, perhaps a reflection of the work that has been put in to deal with this type of behaviour in recent years.

6. Workforce Race Equality Standard

The Workforce Race Equality Standard (WRES) was mandated in 2014. Four of the standard indicators are taken directly from the Staff Survey.

Table 5.

			Your Trust in 2017	Average (median) for mental health	Your Trust in 2016
KF25	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White	28%	32%	30%
		BME	36%	36%	30%
KF26	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White	21%	21%	25%
		BME	12%	26%	21%
KF21	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	White	90%	87%	89%
		BME	84%	77%	83%
Q17b	In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?	White	5%	6%	5%
		BME	7%	14%	6%

Table 5 shows that BME staff have experienced more inappropriate behaviour from patients, relatives or the public than white staff and the rating has generally reduced since last year.

There has been a significant improvement and reduction in the percentage of BME staff experiencing harassment, bullying or abuse from staff in the last 12 months, reducing from 21% in 2016 to 12% in 2017 against a national average of 26%.

A considerably higher percentage of white staff say they have experienced bullying behaviour from other staff than those from a BME background.

BME staff report less equality of opportunity than white colleagues and slightly more BME colleagues say they have experienced discrimination at work although this is significantly better than the national average.

A separate action plan will accompany the 2018 WRES submission.

7. Workforce Profile and Demographic Information

The full Survey report contains a profile of the workforce:

- 77% of respondents worked part time
- 28% (245 people) of respondents had worked for the Trust for over 15 years
- 39% of respondents were aged 51 and over (347 people)
- 74% of respondents were female which matches the overall profile of the Trust
- 93% of respondents were white, again matching the overall profile of the Trust
- 14% of respondents reported that they were disabled

There is a wealth of detail relating to staff groups, directorates, age groups etc. where the Key Findings are assigned to these different groups, enabling a picture to be built up of where there are high levels of satisfaction and where some action may be needed. The nature of each role should be considered when reviewing this information.

Some selected highlights include:

- 20% of medical staff had experienced discrimination at work, by far the highest level of any staff group
- 45% of additional clinical services staff were satisfied with opportunities for flexible working, the lowest level of satisfaction by far and way below that of Admin and clerical staff at 68%
- 92% of medical staff work extra hours whilst this applies to 43% of estates and ancillary staff
- 34% of Additional Clinical Services staff experienced physical violence from patients, relatives or the public, a considerably higher percentage than any other staff group
- 47% of registered nursing staff reported experiencing bullying, harassment or abuse from patients, relatives or the public with 39% of medical staff and 35% of additional clinical services. 43 % of staff from Countywide Services experienced this type of behaviour
- Staff aged between 31 and 40 were most likely to recommend the Trust as a place to work or receive treatment but those aged over 51felt the most motivated
- Staff aged between 16 and 30 experienced the highest level of violence from (23%) and bullying and abuse (34%) from patients, relatives or the public than any other age group
- Male staff reported the highest level of violence and abuse but more female staff reported it
- Once again there are reports of ‘staff on staff’ violence but there is no related casework
- 30% of disabled staff reported bullying from other staff compared to 19% of white staff
- 36% of BME staff experienced abuse from patients, relatives or the public compared with 28% of white staff
- 21% of white staff reported bullying from other staff compared with 12% of BME staff

8. Staff comments

At the end of the questionnaire, staff are invited to add any comments in a free text section. Over 160 separate comments were received, some of which were of a positive nature and others that expressed dissatisfaction and frustration with various aspects of their employment or their lives. The comments show a broad spectrum of views and experiences with some of the comments being very personal to the contributor with many others more general in nature.

The challenges faced by the NHS are reflected upon but a clear dissatisfaction with pay constraint is apparent. This reflects the national dissatisfaction. It is also clear that staff believe in the work they do with many being proud of the organisation but feel restricted by targets and the speed of change.

These comments will be carefully considered when formulating the action plan that will follow this survey. In the meantime, some points could be addressed in a ‘you said, we did’ format to address some of the more direct questions raised.

9. Local Comparisons

The following table presents a comparison of the other NHS Trusts in our area. 2gether compares very favourably in terms of Key Findings that were better than average and with overall staff engagement.

Trust	Response Rate	Overall Staff Engagement	Better than Average	Worse than Average	Average
2gether	44.73%	3.88	17	5	10
Glos. Care Services	44.17%	3.71	1	24	7
Glos. Hospitals Trust	47.41%	3.67	3	22	7
Wye Valley Trust	48.71%	3.74	4	18	10

Work is underway, as part of a cultural diagnostic, to compare the results of 2gether and Gloucestershire Care Services ahead of the proposed merger.

10. Recommendations

Following initial review and discussion of the findings, it is suggested that three priority areas are focussed on corporately over the coming year. These include:

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

It is recommended that each Locality also reviews their local ratings and agree two to three priority areas and actions to focus on in the year.

It is also recommended that the People Committee progresses this through the Working ²gether (W²) Thematic Group, with Staff Side involvement. Progress will be reported back through the usual Trust communication and governance routes.

11. Conclusions

The 2017 Staff Survey does not show any statistically significant improvements when compared with the previous year. However there are small improvements in some of the key findings and equally small deterioration in others. This presents a picture of an organisation maintaining its position with regards to staff experience against a backdrop nationally of a system-wide deterioration.

The Trust has been viewed as better than average or average in 27 (84%) of the 32 key findings when compared with the national average for mental health and learning disability trusts.

²gether compares very well in comparison with other trusts in the Gloucestershire and Herefordshire area.

As is always the case with the Staff Survey, the results are not contextualised – there is no indication for example of the type or level or discrimination that members of staff have experienced. With more staff attending work when they feel unwell because they had felt pressure from managers, colleagues or themselves may be the result of sickness absence procedure or the desire to not create a burden on others.

Staff engagement remains high and better than average with all three component parts being better than average.

Our best and highest ranked score was the percentage of staff experiencing discrimination at work (10%) compared to the national average of 14%.

Going forwards, the Trust will need to be mindful of the potential impacts on staff experience, both positive and negative, which may arise from the proposed merger work and other key decision-making opportunities later in the year.

Although there is still much to do, this is an encouraging report. Given the ratings and benchmarking, significant assurance is given on staff experience and the Trust's approach to staff engagement generally.

2017 National NHS staff survey

Brief summary of results from 2Gether NHS Foundation Trust

Table of Contents

1. Introduction to this report

This report presents the findings of the 2017 national NHS staff survey conducted in 2Gether NHS Foundation Trust.

In section 2 of this report, we present an overall indicator of staff engagement. Full details of how this indicator was created can be found in the document ***Making sense of your staff survey data***, which can be downloaded from www.nhsstaffsurveys.com.

In sections 3 and 4 of this report, the findings of the questionnaire have been summarised and presented in the form of 32 Key Findings.

These sections of the report have been structured thematically so that Key Findings are grouped appropriately. There are nine themes within this report:

- Appraisals & support for development
- Equality & diversity
- Errors & incidents
- Health and wellbeing
- Working patterns
- Job satisfaction
- Managers
- Patient care & experience
- Violence, harassment & bullying

Please note, two Key Findings have had their calculation changed and there have been minor changes to the benchmarking groups for social enterprises since last year. For more detail on these changes, please see the ***Making sense of your staff survey data*** document.

As in previous years, there are two types of Key Finding:

- percentage scores, i.e. percentage of staff giving a particular response to one, or a series of, survey questions

- scale summary scores, calculated by converting staff responses to particular questions into scores. For each of these scale summary scores, the minimum score is always 1 and the maximum score is 5

A longer and more detailed report of the 2017 survey results for 2Gether NHS Foundation Trust can be downloaded from: www.nhsstaffsurveys.com. This report provides detailed breakdowns of the Key Finding scores by directorate, occupational groups and demographic groups, and details of each question included in the core questionnaire.

Your Organisation

The scores presented below are un-weighted question level scores for questions Q21a, Q21b, Q21c and Q21d and the un-weighted score for Key Finding 1. The percentages for Q21a – Q21d are created by combining the responses for those who “Agree” and “Strongly Agree” compared to the total number of staff that responded to the question.

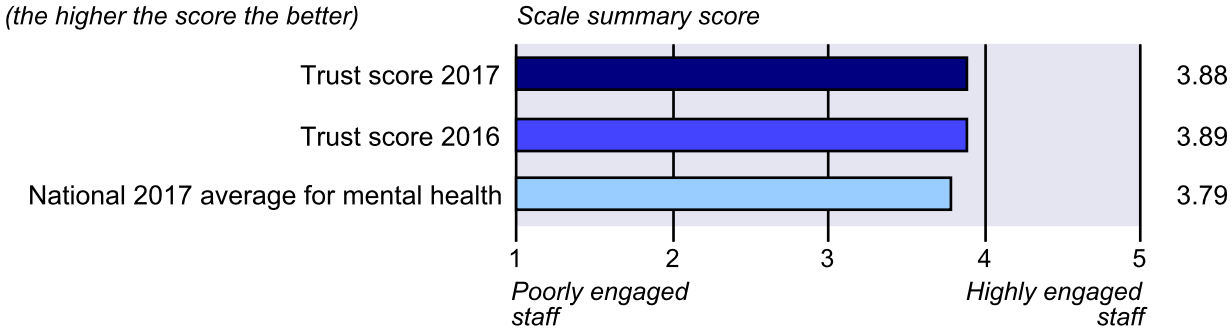
Q21a, Q21c and Q21d feed into Key Finding 1 “Staff recommendation of the organisation as a place to work or receive treatment”.

		Your Trust in 2017	Average (median) for mental health	Your Trust in 2016
Q21a	"Care of patients / service users is my organisation's top priority"	78%	73%	78%
Q21b	"My organisation acts on concerns raised by patients / service users"	77%	75%	78%
Q21c	"I would recommend my organisation as a place to work"	69%	57%	68%
Q21d	"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	75%	61%	73%
KF1.	Staff recommendation of the organisation as a place to work or receive treatment (Q21a, 21c-d)	3.88	3.67	3.85

2. Overall indicator of staff engagement for 2Gether NHS Foundation Trust

The figure below shows how 2Gether NHS Foundation Trust compares with other mental health / learning disability trusts on an overall indicator of staff engagement. Possible scores range from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and 5 indicating that staff are highly engaged. The trust's score of 3.88 was above (better than) average when compared with trusts of a similar type.

OVERALL STAFF ENGAGEMENT



This overall indicator of staff engagement has been calculated using the questions that make up Key Findings 1, 4 and 7. These Key Findings relate to the following aspects of staff engagement: staff members' perceived ability to contribute to improvements at work (Key Finding 7); their willingness to recommend the trust as a place to work or receive treatment (Key Finding 1); and the extent to which they feel motivated and engaged with their work (Key Finding 4).

The table below shows how 2Gether NHS Foundation Trust compares with other mental health / learning disability trusts on each of the sub-dimensions of staff engagement, and whether there has been a significant change since the 2016 survey.

	Change since 2016 survey	Ranking, compared with all mental health
OVERALL STAFF ENGAGEMENT	• No change	✓ Above (better than) average
KF1. Staff recommendation of the trust as a place to work or receive treatment *(the extent to which staff think care of patients/service users is the trust's top priority, would recommend their trust to others as a place to work, and would be happy with the standard of care provided by the trust if a friend or relative needed treatment.)*	• No change	✓ Above (better than) average
KF4. Staff motivation at work *(the extent to which they look forward to going to work, and are enthusiastic about and absorbed in their jobs.)*	• No change	✓ Above (better than) average
KF7. Staff ability to contribute towards improvements at work *(the extent to which staff are able to make suggestions to improve the work of their team, have frequent opportunities to show initiative in their role, and are able to make improvements at work.)*	• No change	✓ Above (better than) average

Full details of how the overall indicator of staff engagement was created can be found in the document ***Making sense of your staff survey data***.

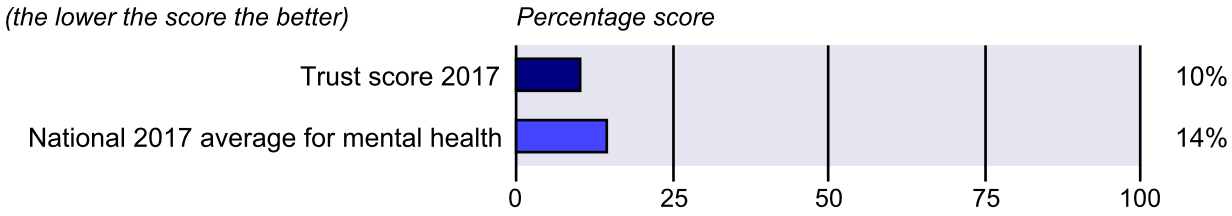
3. Summary of 2017 Key Findings for 2Gether NHS Foundation Trust

3.1 Top and Bottom Ranking Scores

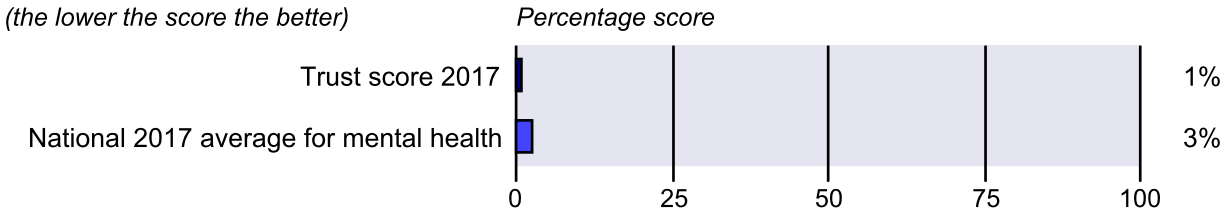
This page highlights the five Key Findings for which 2Gether NHS Foundation Trust compares most favourably with other mental health / learning disability trusts in England.

TOP FIVE RANKING SCORES

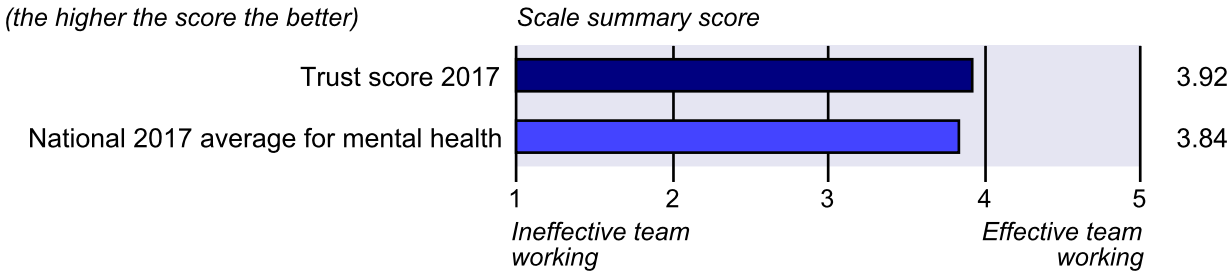
✓KF20. Percentage of staff experiencing discrimination at work in the last 12 months



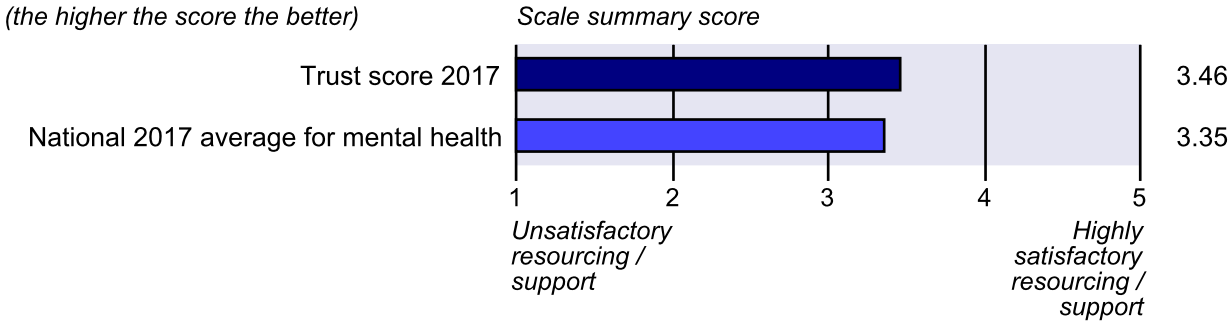
✓KF23. Percentage of staff experiencing physical violence from staff in last 12 months



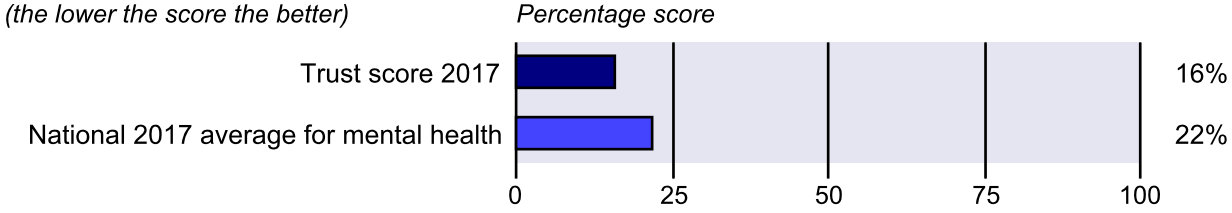
✓KF9. Effective team working



✓KF14. Staff satisfaction with resourcing and support



✓KF22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months



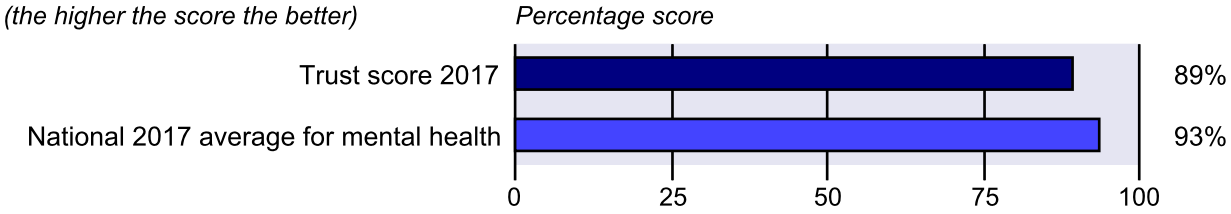
For each of the 32 Key Findings, the mental health / learning disability trusts in England were placed in order from 1 (the top ranking score) to 26 (the bottom ranking score). 2Gether NHS Foundation Trust's five highest ranking scores are presented here, i.e. those for which the trust's Key Finding score is ranked closest to 1. Further details about this can be found in the document ***Making sense of your staff survey data***.

This page highlights the five Key Findings for which 2Gether NHS Foundation Trust compares least favourably with other mental health / learning disability trusts in England. It is suggested that these areas might be seen as a starting point for local action to improve as an employer.

BOTTOM FIVE RANKING SCORES

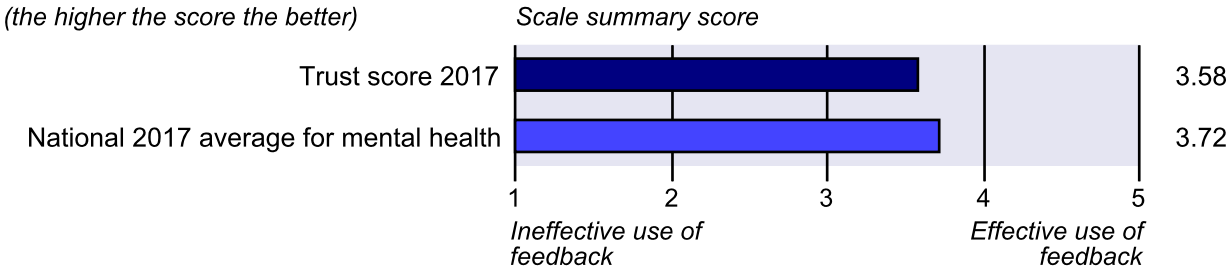
! KF29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month

(the higher the score the better)



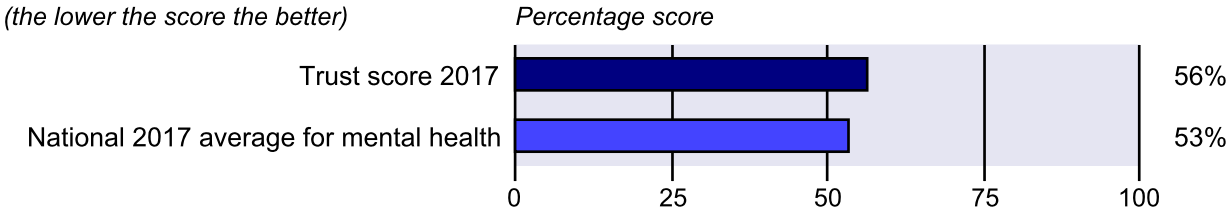
! KF32. Effective use of patient / service user feedback

(the higher the score the better)



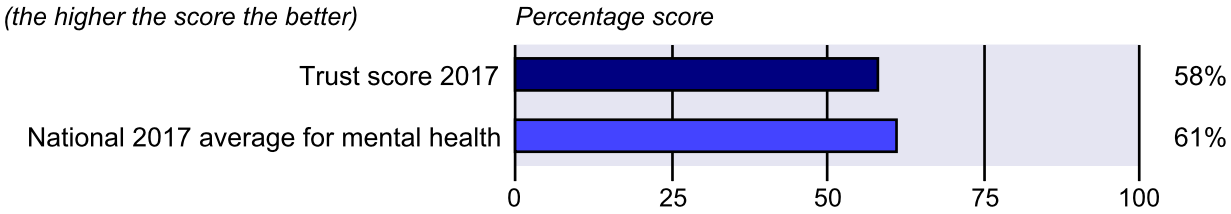
! KF18. Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves

(the lower the score the better)



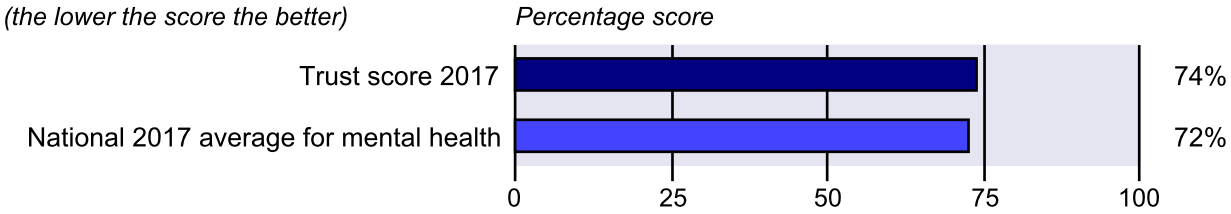
! KF27. Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse

(the higher the score the better)



! KF16. Percentage of staff working extra hours

(the lower the score the better)



For each of the 32 Key Findings, the mental health / learning disability trusts in England were placed in order from 1 (the top ranking score) to 26 (the bottom ranking score). 2Gether NHS Foundation Trust's five lowest ranking scores are presented here, i.e. those for which the trust's Key Finding score is ranked closest to 26. Further details about this can be found in the document ***Making sense of your staff survey data***.

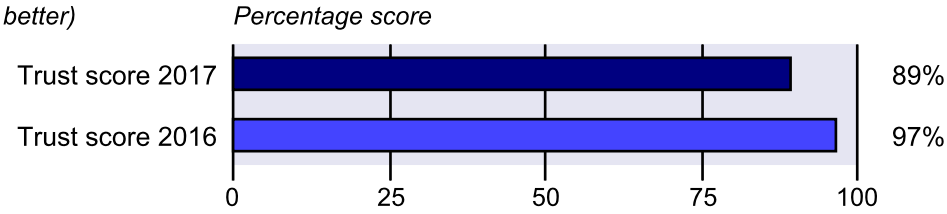
3.2 Largest Local Changes since the 2016 Survey

This page highlights the two Key Findings where staff experiences have deteriorated since the 2016 survey. It is suggested that these areas might be seen as a starting point for local action to improve as an employer.

WHERE STAFF EXPERIENCE HAS DETERIORATED

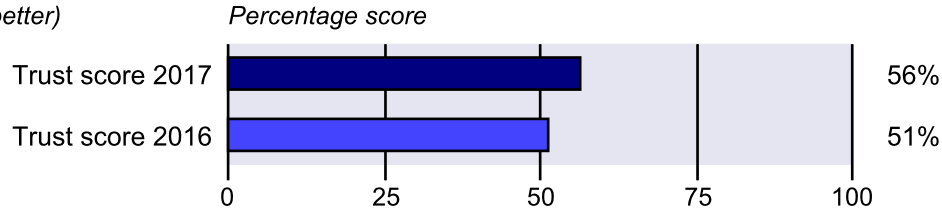
! KF29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month

(the higher the score the better)



! KF18. Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves

(the lower the score the better)



Because the Key Findings vary considerably in terms of subject matter and format (e.g. some are percentage scores, others are scale scores), a straightforward comparison of score changes is not the appropriate way to establish which Key Findings have deteriorated the most. Rather, the extent of 2016-2017 change for each Key Finding has been measured in relation to the national variation for that Key Finding. Further details about this can be found in the document ***Making sense of your staff survey data***.

3.3. Summary of all Key Findings for 2Gether NHS Foundation Trust

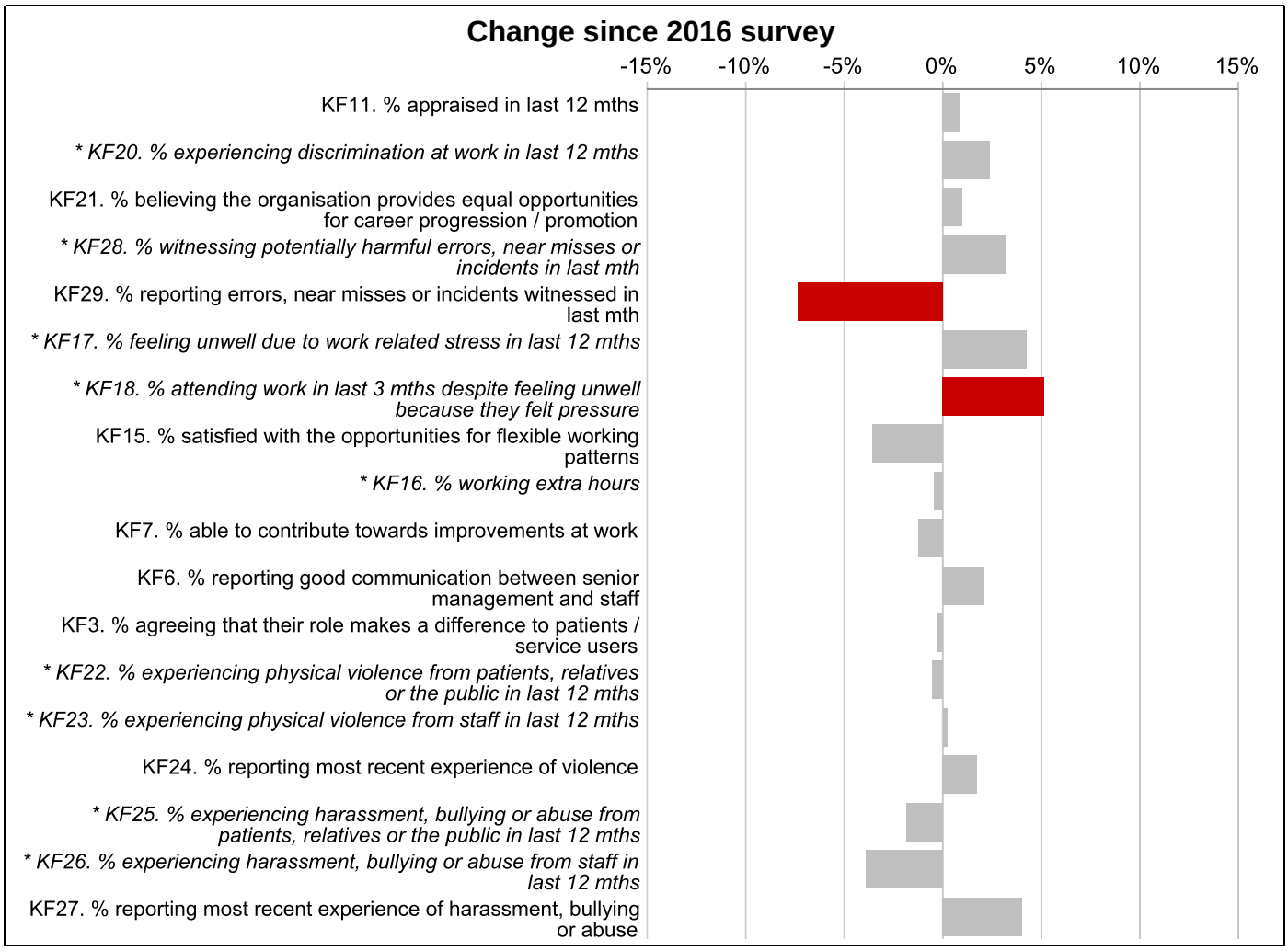
KEY

Green = Positive finding, e.g. there has been a statistically significant positive change in the Key Finding since the 2016 survey.

Red = Negative finding, e.g. there has been a statistically significant negative change in the Key Finding since the 2016 survey.

Grey = No change, e.g. there has been no statistically significant change in this Key Finding since the 2016 survey.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.



3.3. Summary of all Key Findings for 2Gether NHS Foundation Trust

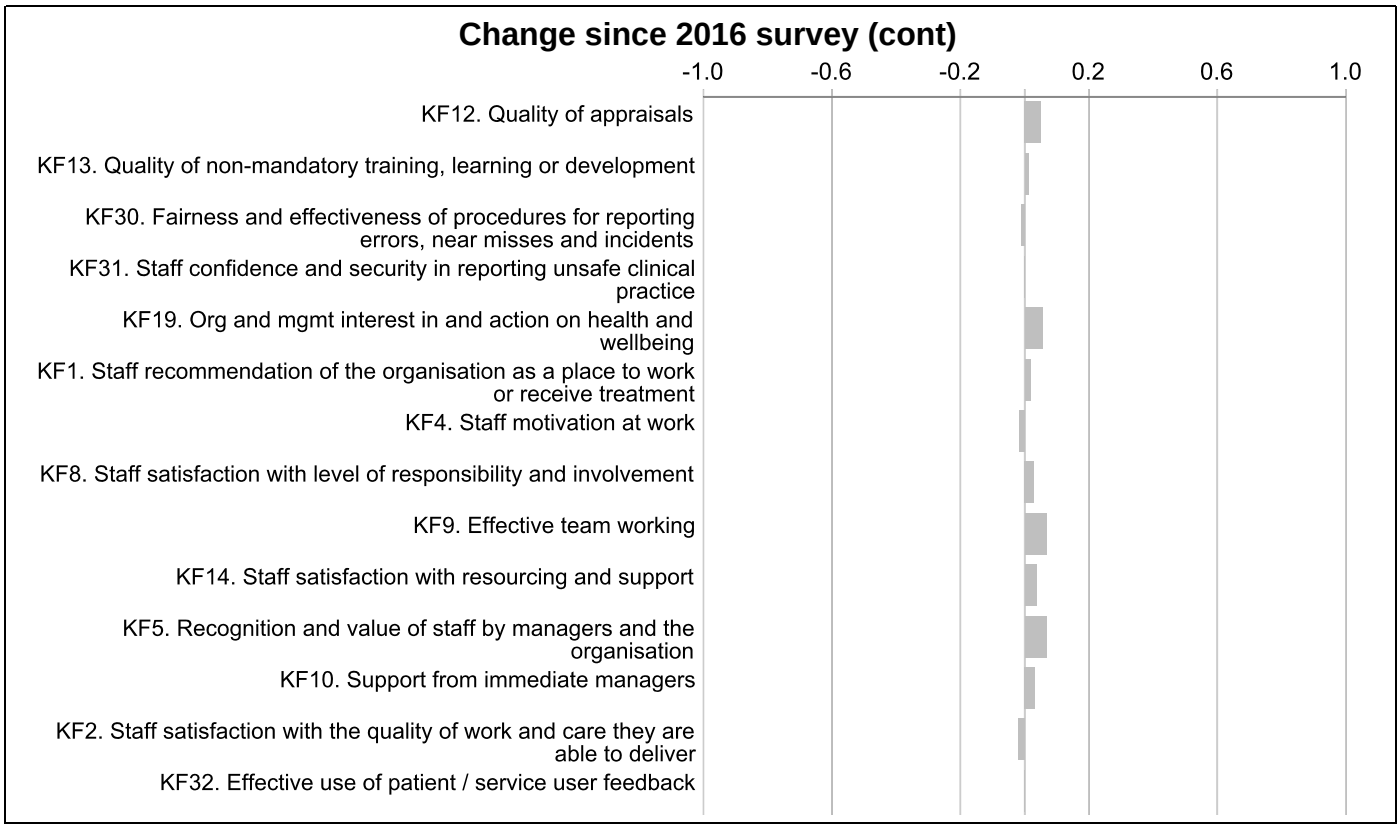
KEY

Green = Positive finding, e.g. there has been a statistically significant positive change in the Key Finding since the 2016 survey.

Red = Negative finding, e.g. there has been a statistically significant negative change in the Key Finding since the 2016 survey.

Grey = No change, e.g. there has been no statistically significant change in this Key Finding since the 2016 survey.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.



3.3. Summary of all Key Findings for 2Gether NHS Foundation Trust

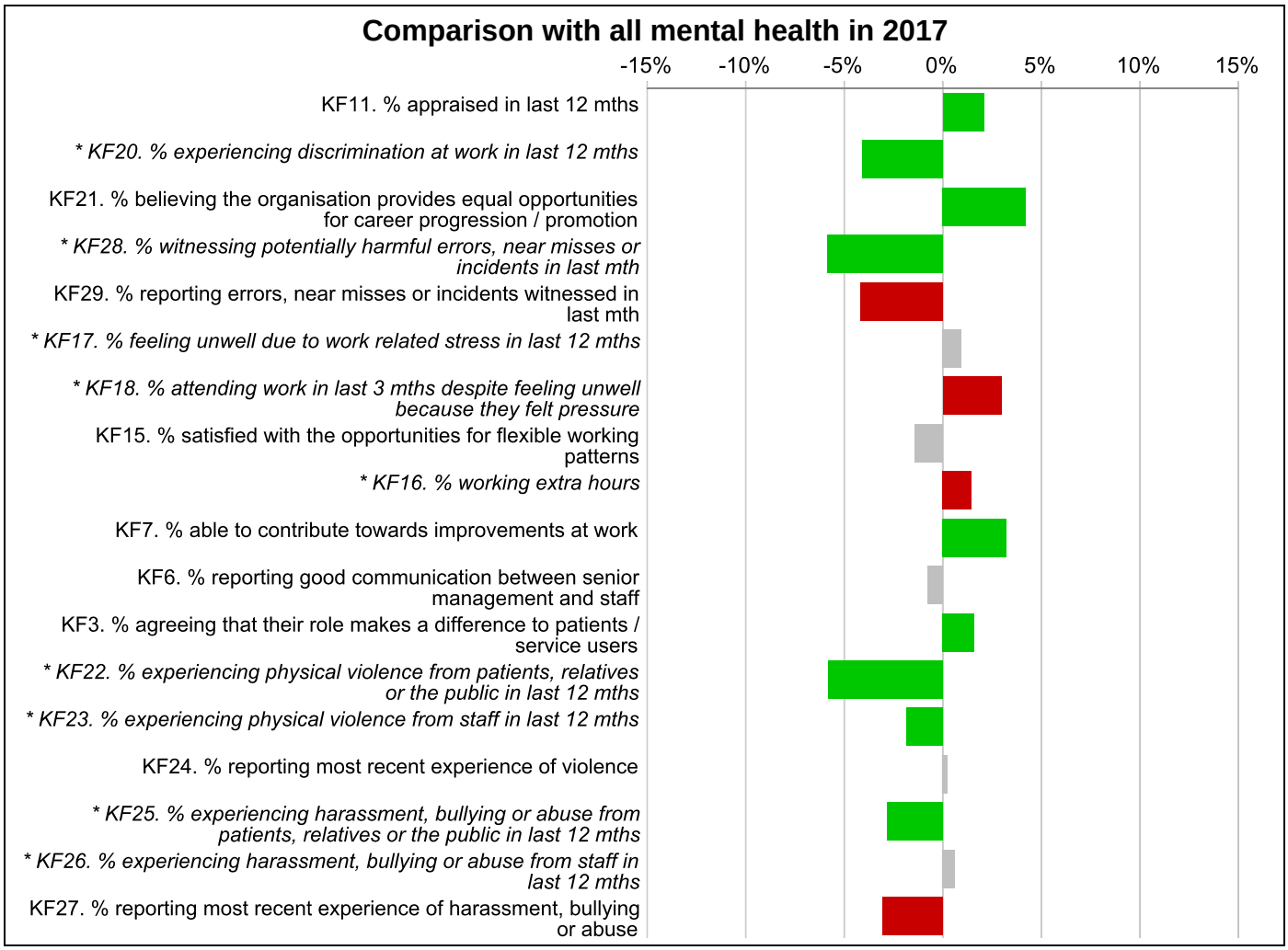
KEY

Green = Positive finding, e.g. better than average.

Red = Negative finding, i.e. worse than average.

Grey = Average.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.



3.3. Summary of all Key Findings for 2Gether NHS Foundation Trust

KEY

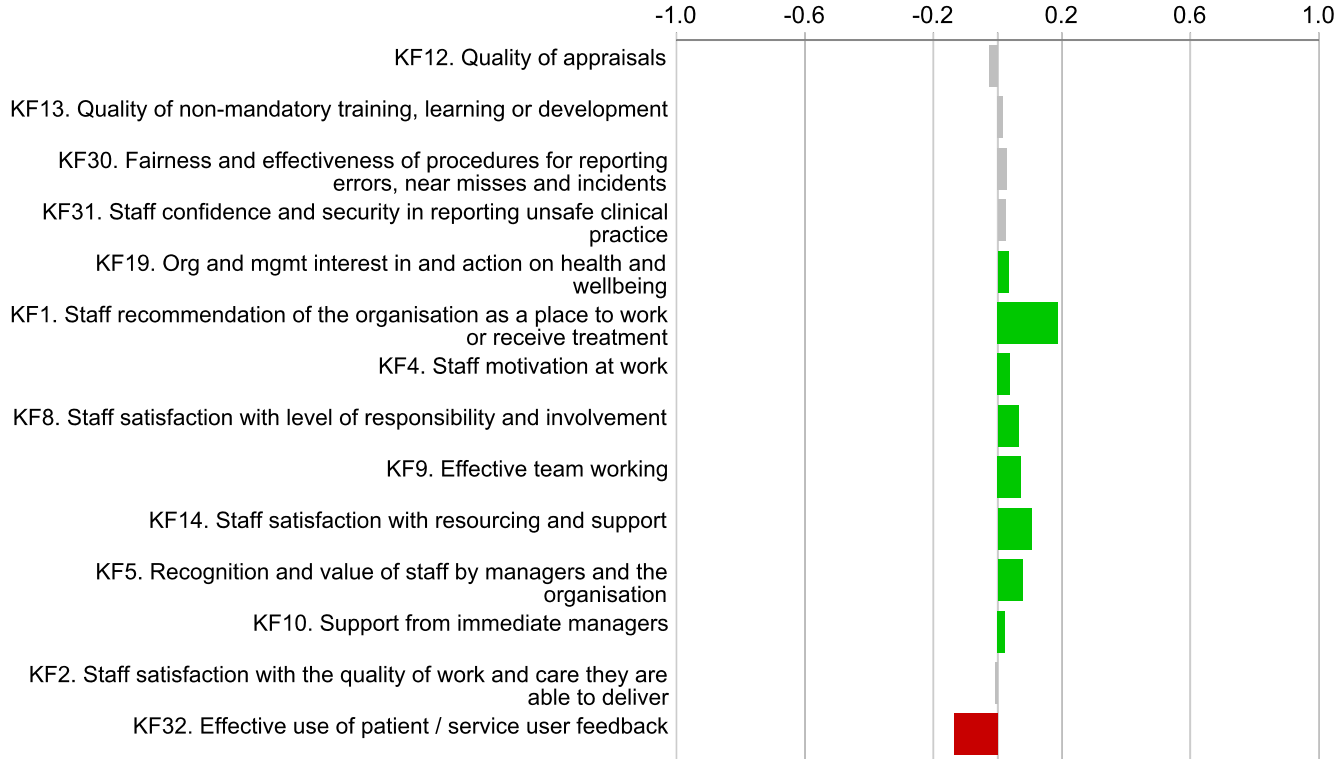
Green = Positive finding, e.g. better than average.

Red = Negative finding, i.e. worse than average.

Grey = Average.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.

Comparison with all mental health in 2017 (cont)



3.4. Summary of all Key Findings for 2Gether NHS Foundation Trust

KEY

✓ Green = Positive finding, e.g. better than average, better than 2016.

! Red = Negative finding, e.g. worse than average, worse than 2016.

'Change since 2016 survey' indicates whether there has been a statistically significant change in the Key Finding since the 2016 survey.

-- No comparison to the 2016 data is possible.

* For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.

	Change since 2016 survey	Ranking, compared with all mental health in 2017
Appraisals & support for development		
KF11. % appraised in last 12 mths	• No change	✓ Above (better than) average
KF12. Quality of appraisals	• No change	• Average
KF13. Quality of non-mandatory training, learning or development	• No change	• Average
Equality & diversity		
* *KF20. % experiencing discrimination at work in last 12 mths*	• No change	✓ Below (better than) average
KF21. % believing the organisation provides equal opportunities for career progression / promotion	• No change	✓ Above (better than) average
Errors & incidents		
* *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth*	• No change	✓ Below (better than) average
KF29. % reporting errors, near misses or incidents witnessed in last mth	! Decrease (worse than 16)	! Below (worse than) average
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	• No change	• Average
KF31. Staff confidence and security in reporting unsafe clinical practice	• No change	• Average
Health and wellbeing		
* *KF17. % feeling unwell due to work related stress in last 12 mths*	• No change	• Average
* *KF18. % attending work in last 3 mths despite feeling unwell because they felt pressure*	! Increase (worse than 16)	! Above (worse than) average
KF19. Org and mgmt interest in and action on health and wellbeing	• No change	✓ Above (better than) average
Working patterns		
KF15. % satisfied with the opportunities for flexible working patterns	• No change	• Average
* *KF16. % working extra hours*	• No change	! Above (worse than) average

3.4. Summary of all Key Findings for 2Gether NHS Foundation Trust (cont)

	Change since 2016 survey	Ranking, compared with all mental health in 2017
Job satisfaction		
KF1. Staff recommendation of the organisation as a place to work or receive treatment	• No change	✓ Above (better than) average
KF4. Staff motivation at work	• No change	✓ Above (better than) average
KF7. % able to contribute towards improvements at work	• No change	✓ Above (better than) average
KF8. Staff satisfaction with level of responsibility and involvement	• No change	✓ Above (better than) average
KF9. Effective team working	• No change	✓ Above (better than) average
KF14. Staff satisfaction with resourcing and support	• No change	✓ Above (better than) average
Managers		
KF5. Recognition and value of staff by managers and the organisation	• No change	✓ Above (better than) average
KF6. % reporting good communication between senior management and staff	• No change	• Average
KF10. Support from immediate managers	• No change	✓ Above (better than) average
Patient care & experience		
KF2. Staff satisfaction with the quality of work and care they are able to deliver	• No change	• Average
KF3. % agreeing that their role makes a difference to patients / service users	• No change	✓ Above (better than) average
KF32. Effective use of patient / service user feedback	• No change	! Below (worse than) average
Violence, harassment & bullying		
* *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths*	• No change	✓ Below (better than) average
* *KF23. % experiencing physical violence from staff in last 12 mths*	• No change	✓ Below (better than) average
KF24. % reporting most recent experience of violence	• No change	• Average
* *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	• No change	✓ Below (better than) average
* *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths*	• No change	• Average
KF27. % reporting most recent experience of harassment, bullying or abuse	• No change	! Below (worse than) average

4. Key Findings for 2Gether NHS Foundation Trust

2Gether NHS Foundation Trust had 921 staff take part in this survey. This is a response rate of 45%[1] which is below average for mental health / learning disability trusts in England (52%), and compares with a response rate of 40% in this trust in the 2016 survey.

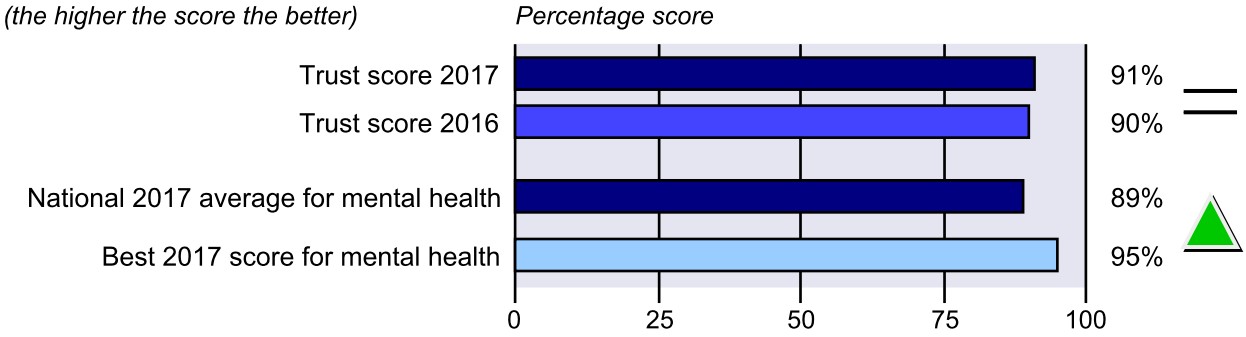
This section presents each of the 32 Key Findings, using data from the trust's 2017 survey, and compares these to other mental health / learning disability trusts in England and to the trust's performance in the 2016 survey. The findings are arranged under nine themes: appraisals and support for development, equality and diversity, errors and incidents, health and wellbeing, working patterns, job satisfaction, managers, patient care and experience , and violence, harassment and bullying.

Positive findings are indicated with a green arrow (e.g. where the trust is better than average, or where the score has improved since 2016). Negative findings are highlighted with a red arrow (e.g. where the trust's score is worse than average, or where the score is not as good as 2016). An equals sign indicates that there has been no change.

Appraisals & support for development

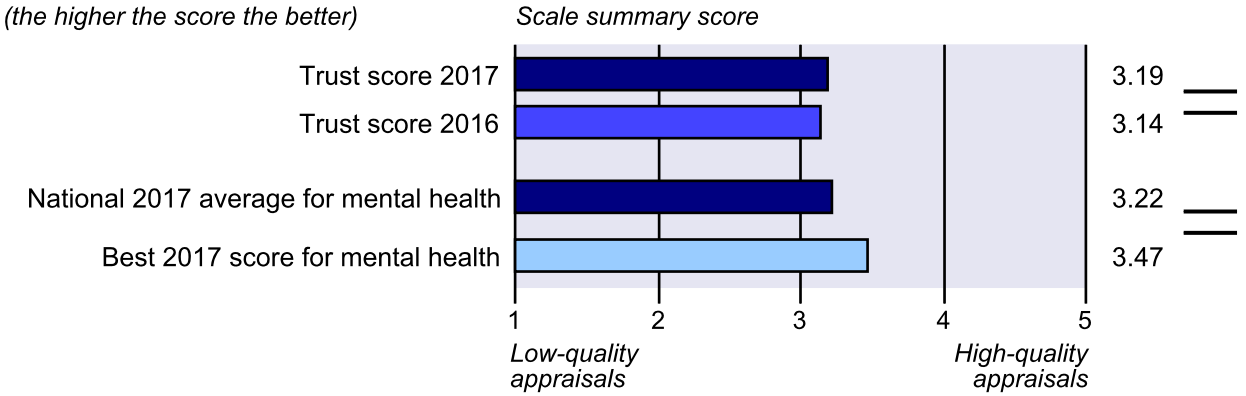
KEY FINDING 11. Percentage of staff appraised in last 12 months

(the higher the score the better)



KEY FINDING 12. Quality of appraisals

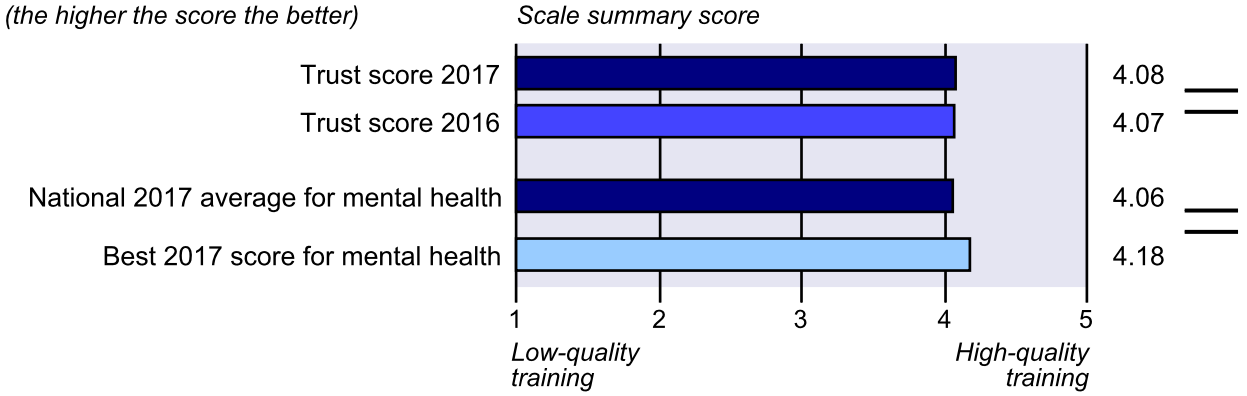
(the higher the score the better)



[1]Questionnaires were sent to all 2059 staff eligible to receive the survey. This includes only staff employed directly by the trust (i.e. excluding staff working for external contractors). It excludes bank staff unless they are also employed directly elsewhere in the trust. When calculating the response rate, questionnaires could only be counted if they were received with their ID number intact, by the closing date.

KEY FINDING 13. Quality of non-mandatory training, learning or development

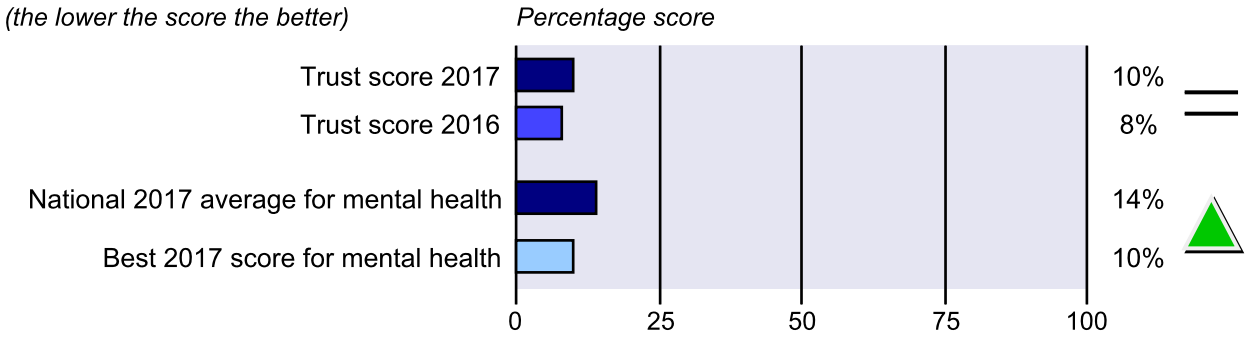
(the higher the score the better)



Equality & diversity

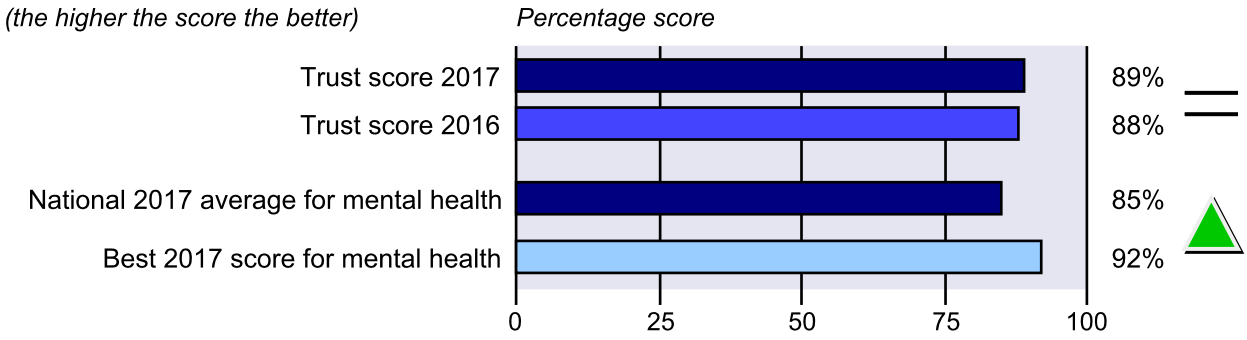
KEY FINDING 20. Percentage of staff experiencing discrimination at work in the last 12 months

(the lower the score the better)



KEY FINDING 21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion

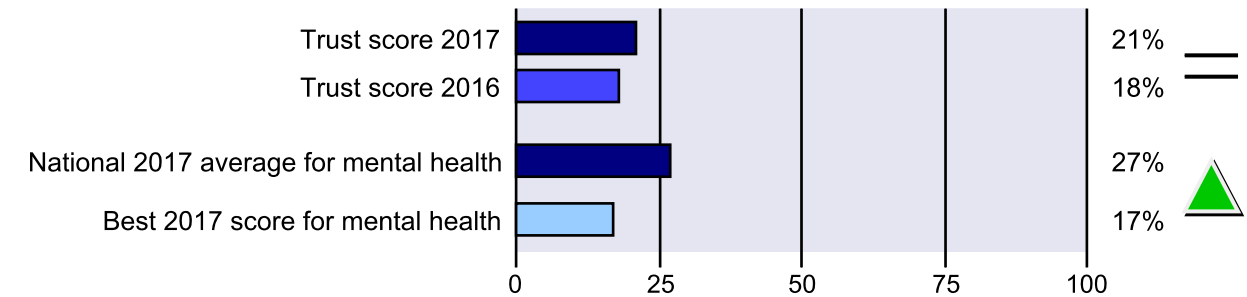
(the higher the score the better)



Errors & incidents

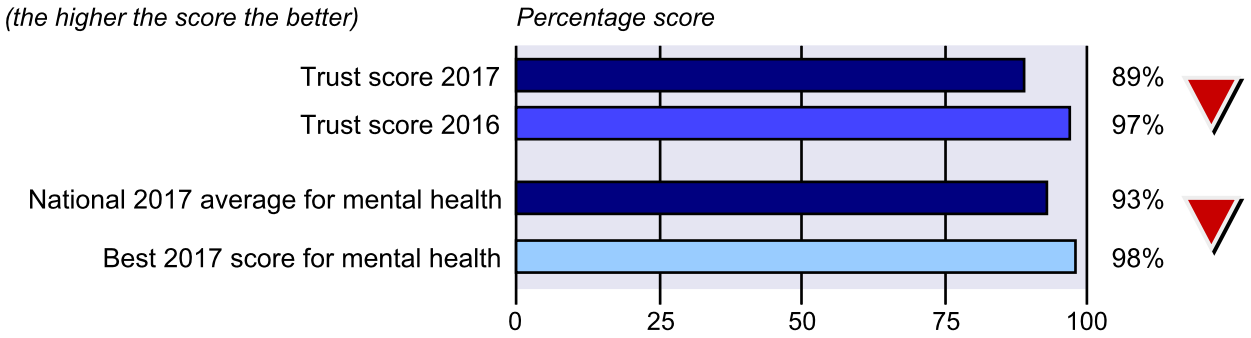
KEY FINDING 28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month

(the lower the score the better)



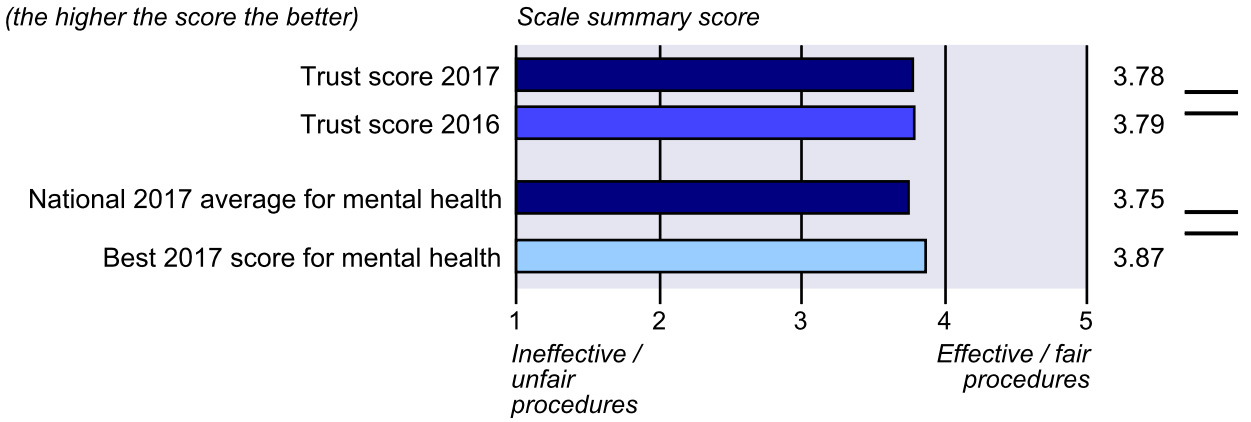
KEY FINDING 29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month

(the higher the score the better)



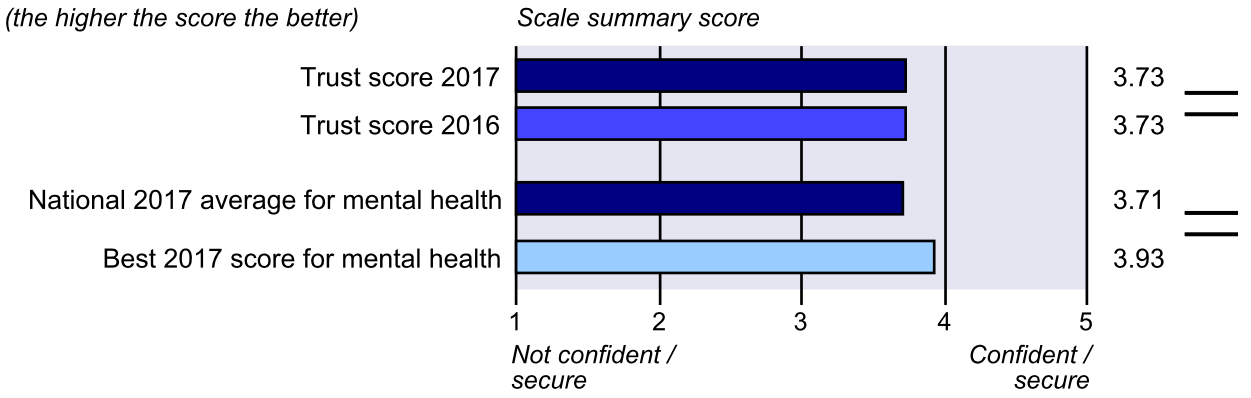
KEY FINDING 30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents

(the higher the score the better)



KEY FINDING 31. Staff confidence and security in reporting unsafe clinical practice

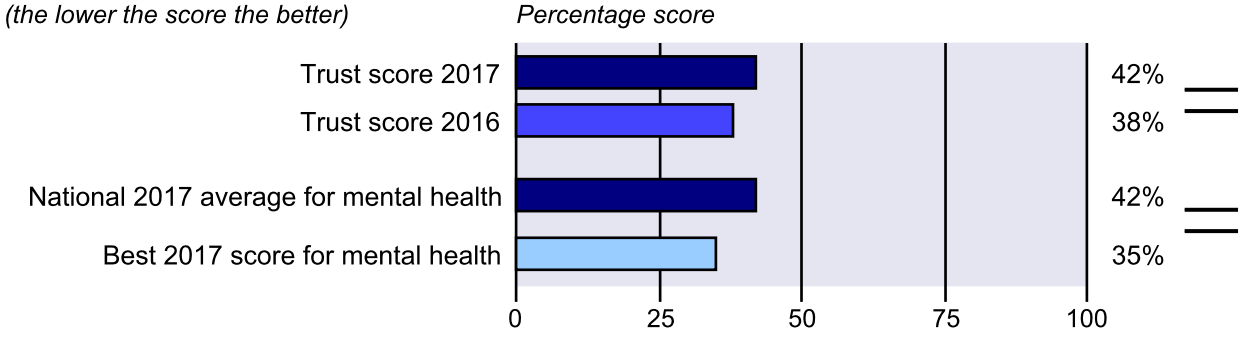
(the higher the score the better)



Health and wellbeing

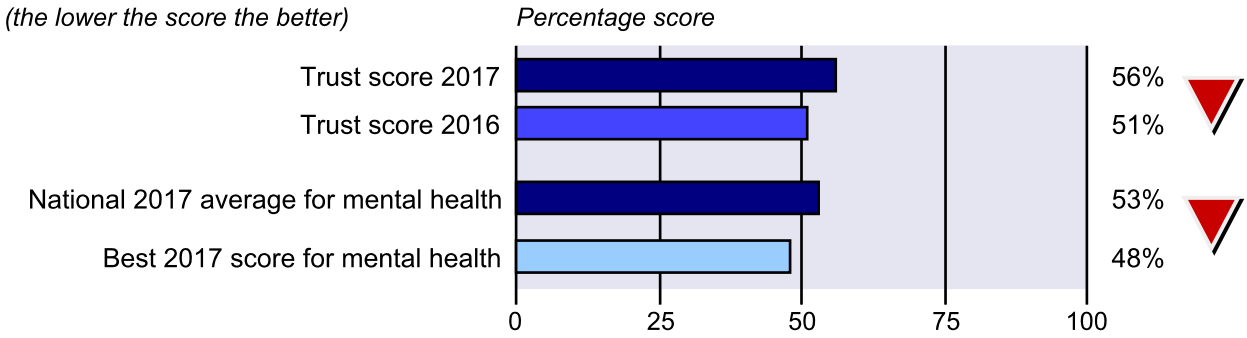
KEY FINDING 17. Percentage of staff feeling unwell due to work related stress in the last 12 months

(the lower the score the better)



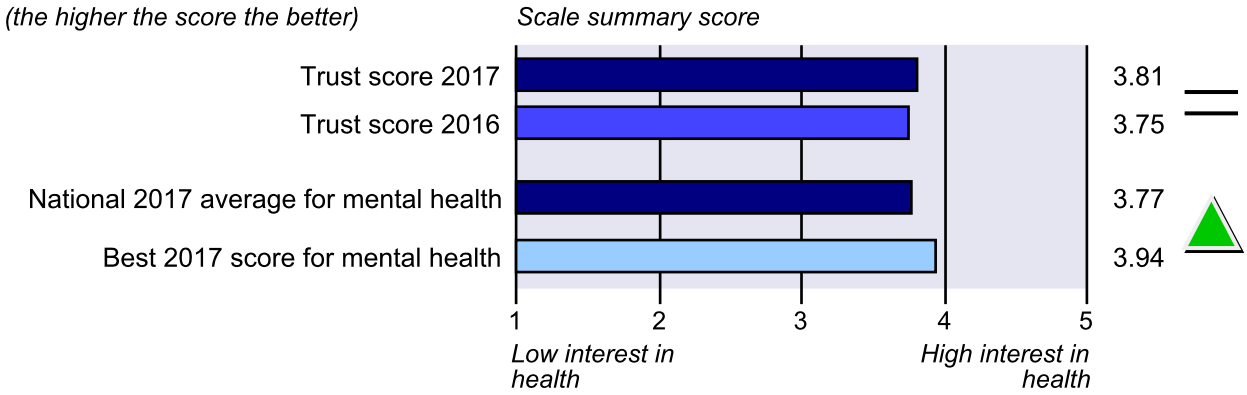
KEY FINDING 18. Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves

(the lower the score the better)



KEY FINDING 19. Organisation and management interest in and action on health and wellbeing

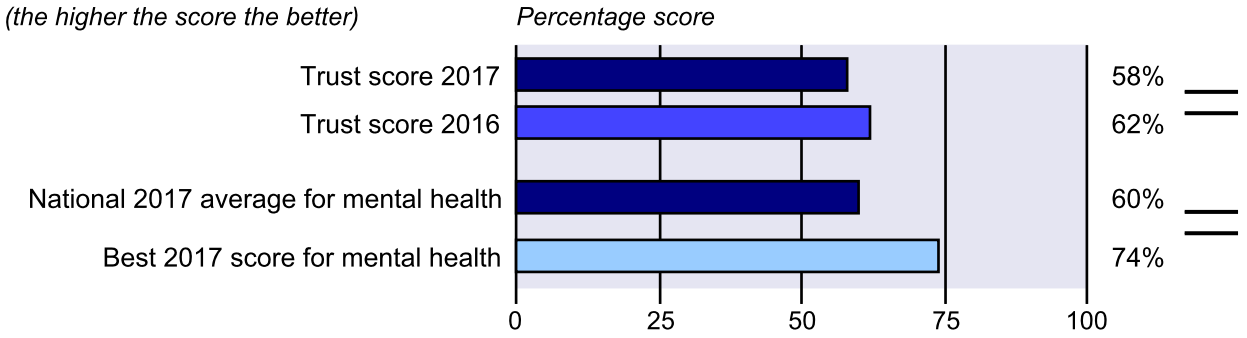
(the higher the score the better)



Working patterns

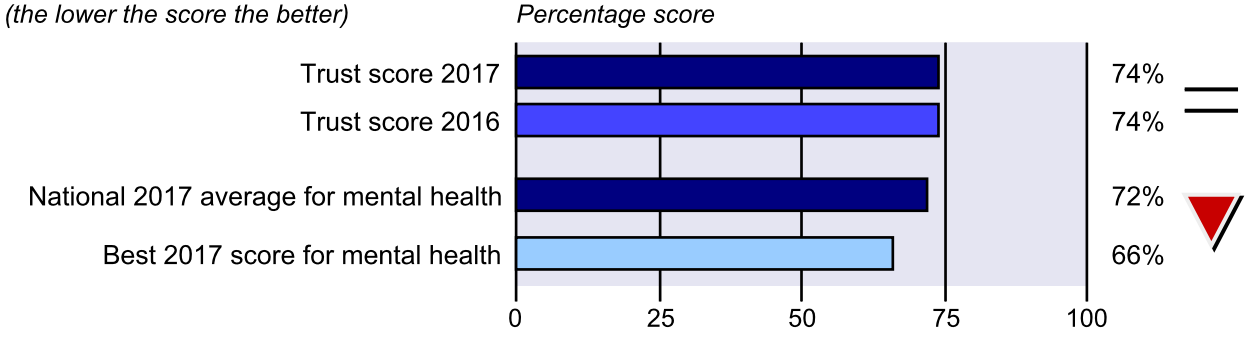
KEY FINDING 15. Percentage of staff satisfied with the opportunities for flexible working patterns

(the higher the score the better)



KEY FINDING 16. Percentage of staff working extra hours

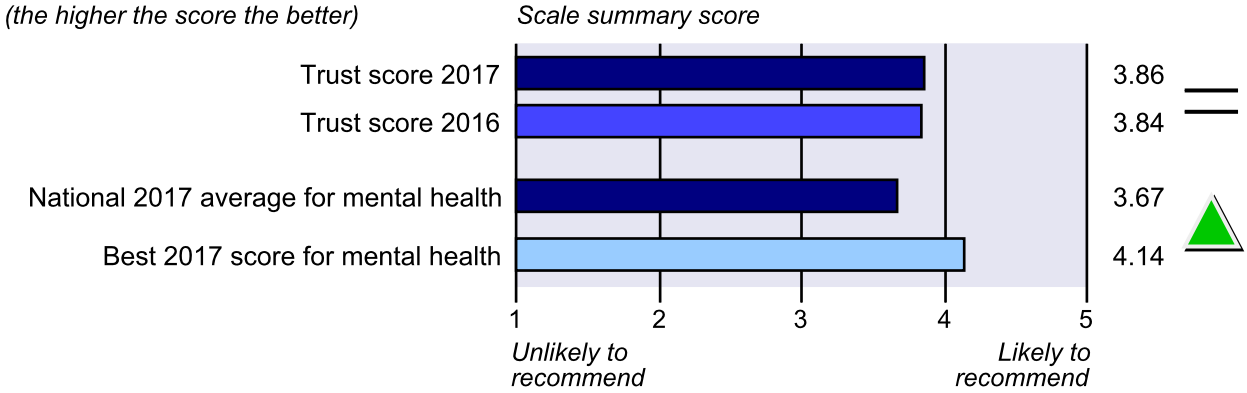
(the lower the score the better)



Job satisfaction

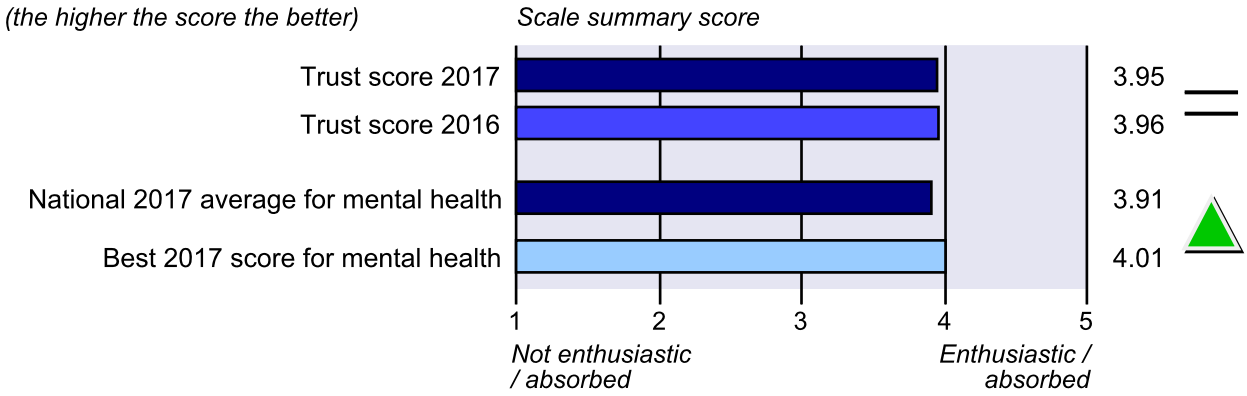
KEY FINDING 1. Staff recommendation of the organisation as a place to work or receive treatment

(the higher the score the better)



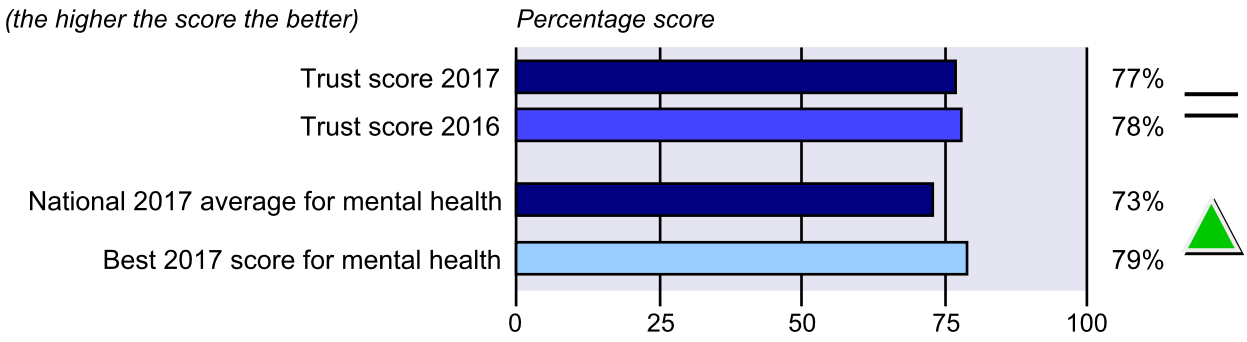
KEY FINDING 4. Staff motivation at work

(the higher the score the better)



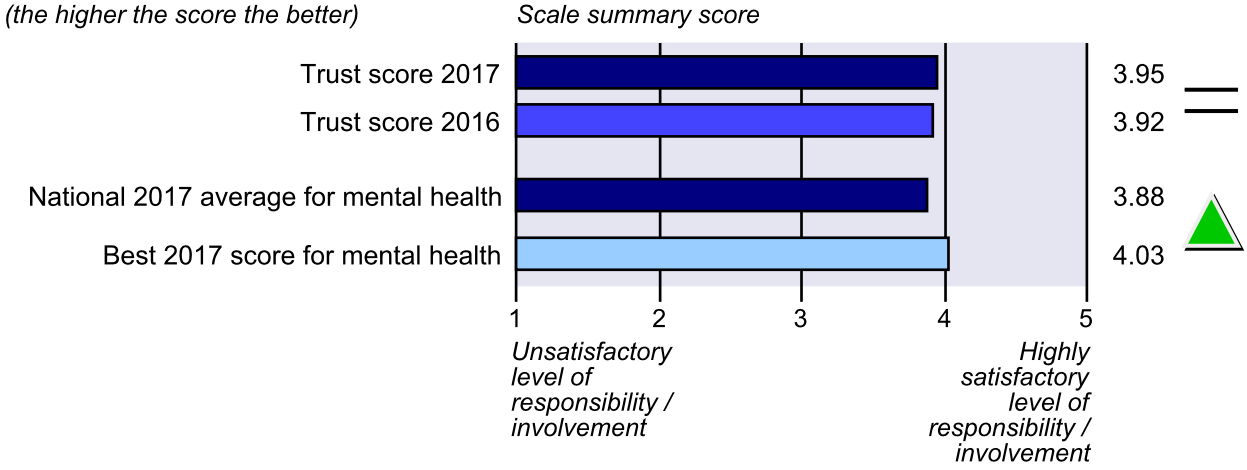
KEY FINDING 7. Percentage of staff able to contribute towards improvements at work

(the higher the score the better)



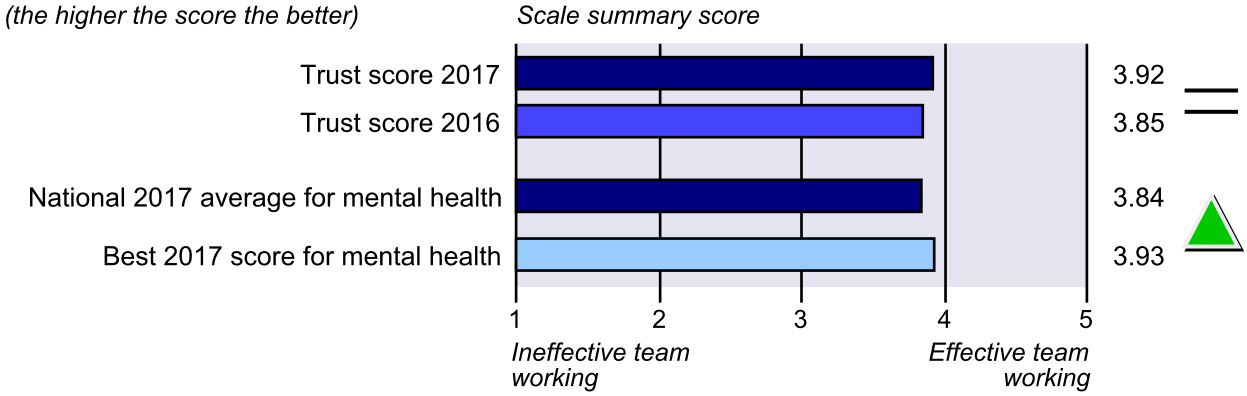
KEY FINDING 8. Staff satisfaction with level of responsibility and involvement

(the higher the score the better)



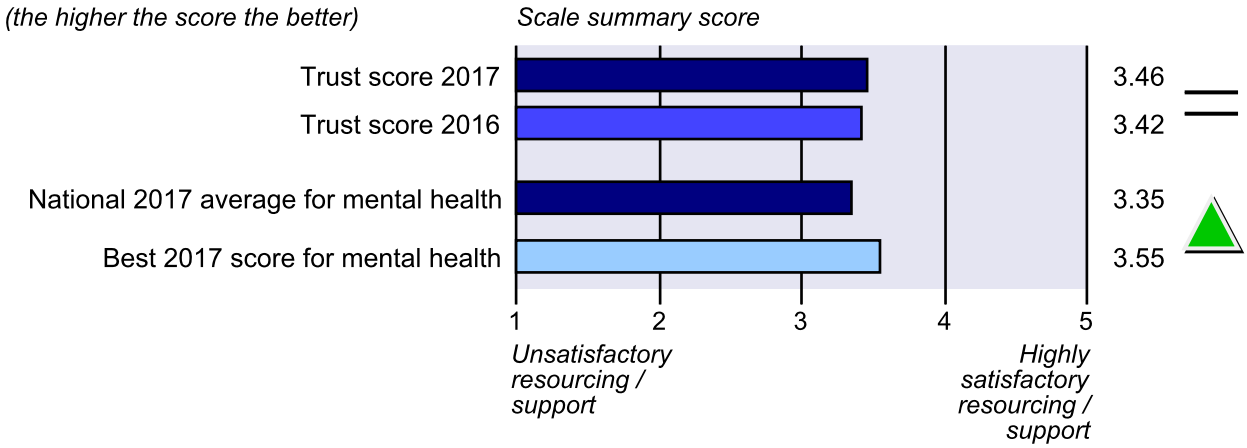
KEY FINDING 9. Effective team working

(the higher the score the better)



KEY FINDING 14. Staff satisfaction with resourcing and support

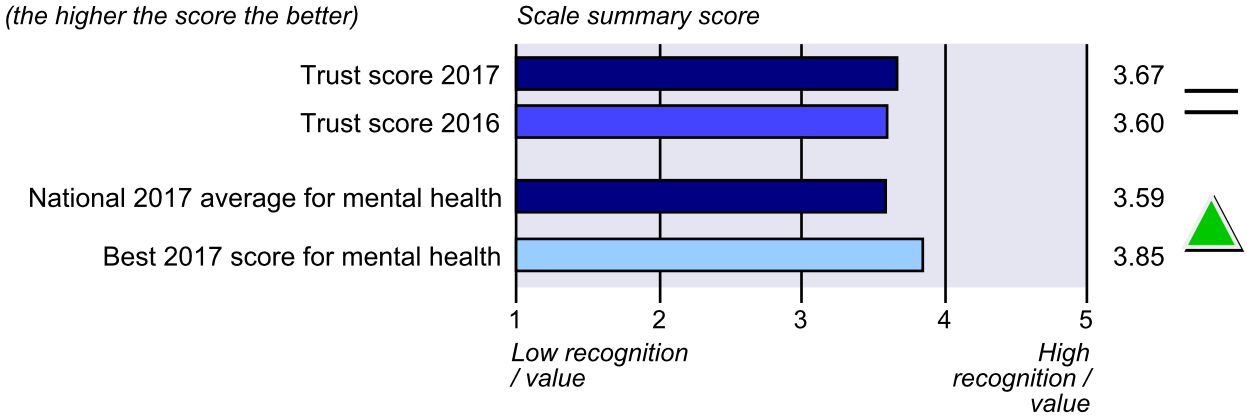
(the higher the score the better)



Managers

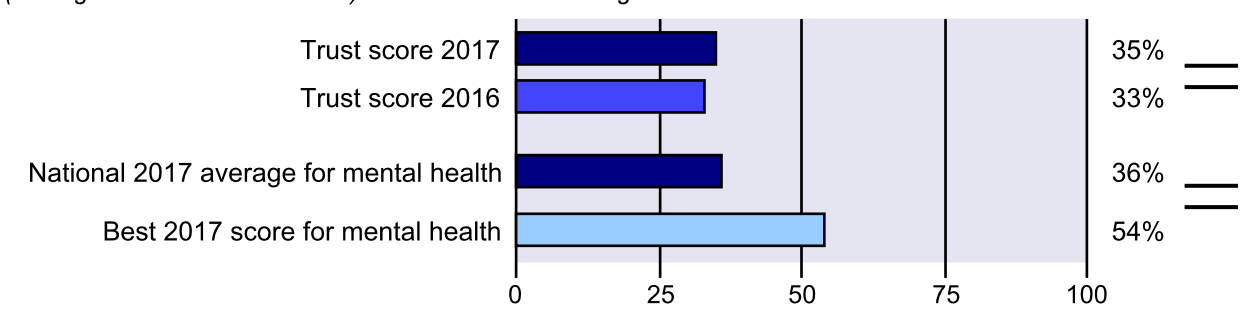
KEY FINDING 5. Recognition and value of staff by managers and the organisation

(the higher the score the better)



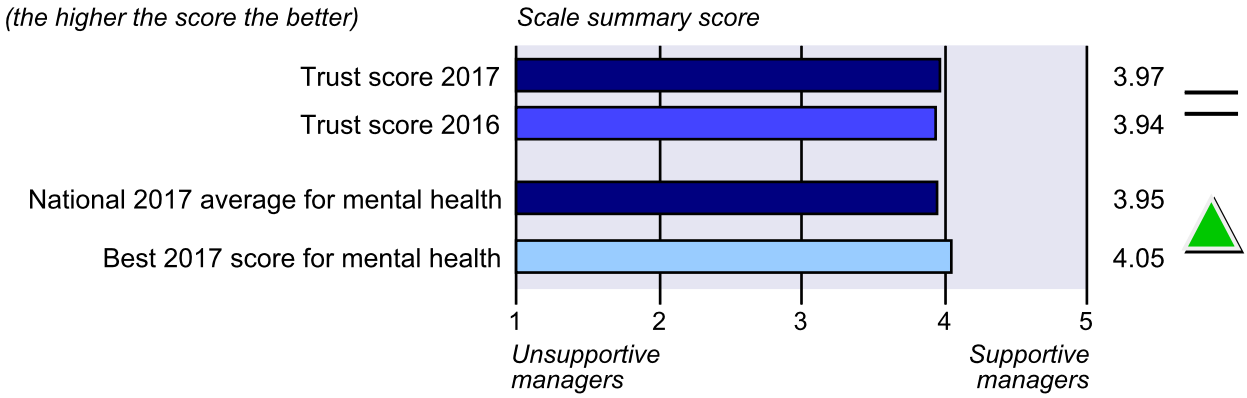
KEY FINDING 6. Percentage of staff reporting good communication between senior management and staff

(the higher the score the better)



KEY FINDING 10. Support from immediate managers

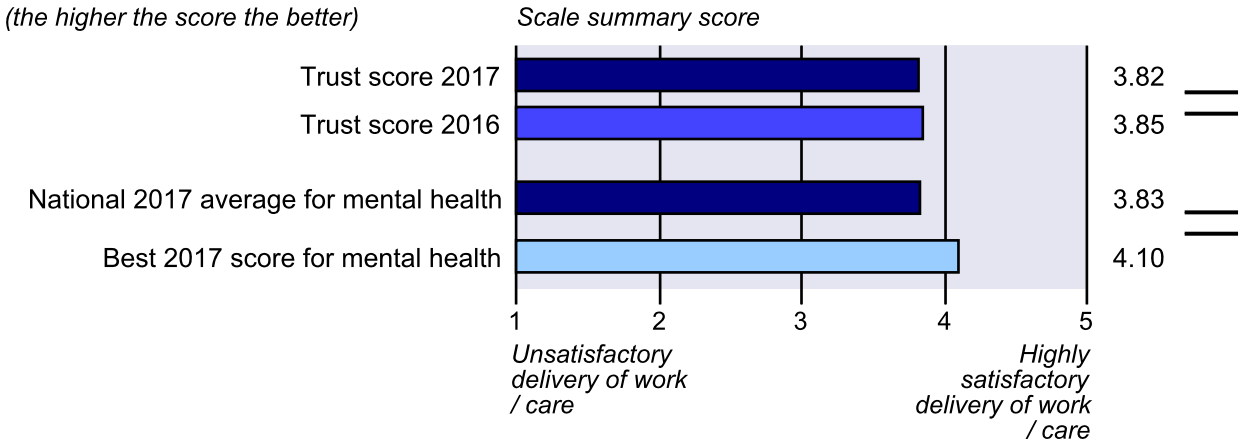
(the higher the score the better)



Patient care & experience

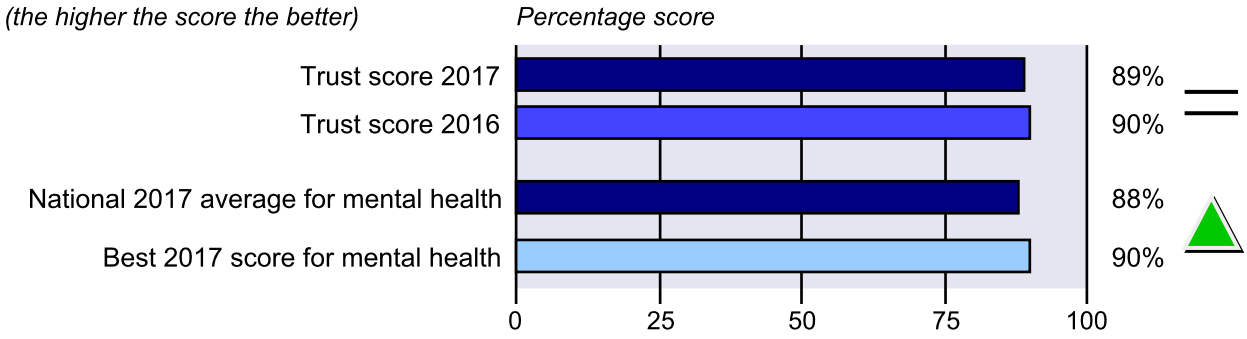
KEY FINDING 2. Staff satisfaction with the quality of work and care they are able to deliver

(the higher the score the better)



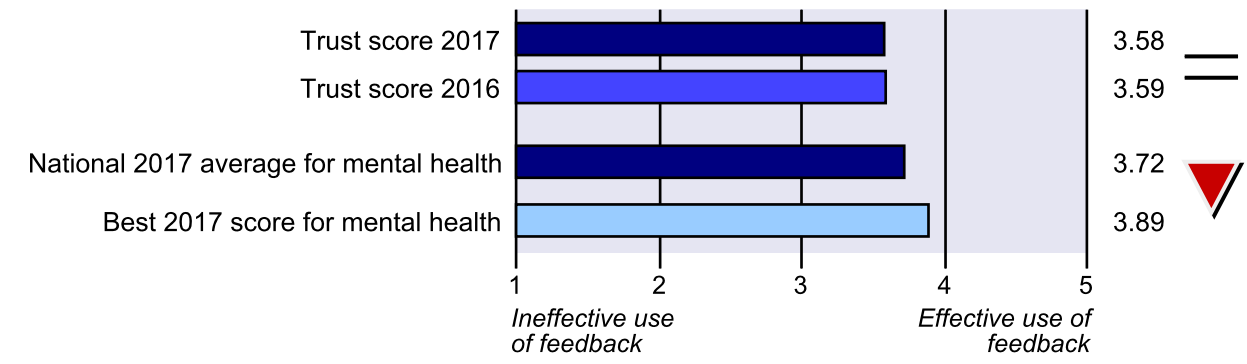
KEY FINDING 3. Percentage of staff agreeing that their role makes a difference to patients / service users

(the higher the score the better)



KEY FINDING 32. Effective use of patient / service user feedback

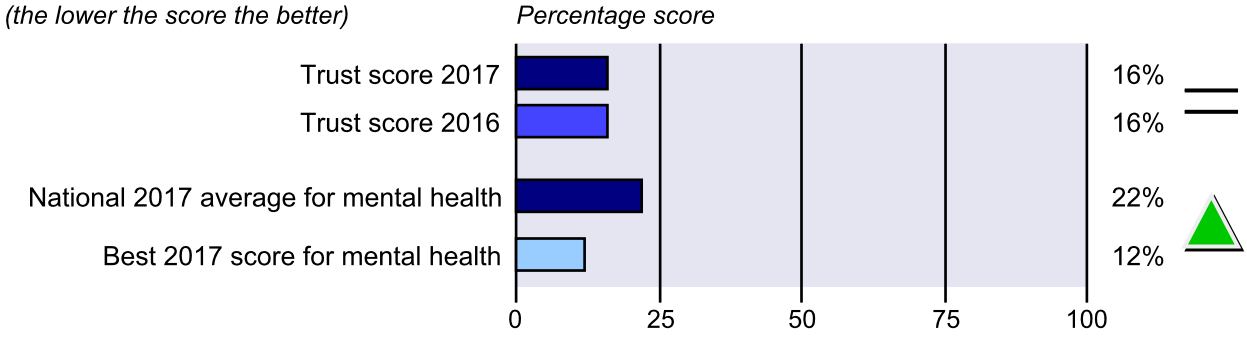
(the higher the score the better)



Violence, harassment & bullying

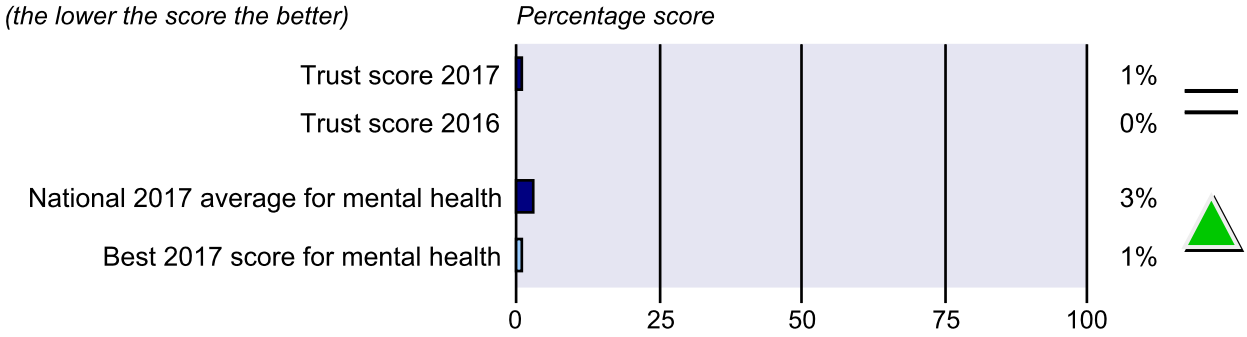
KEY FINDING 22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months

(the lower the score the better)



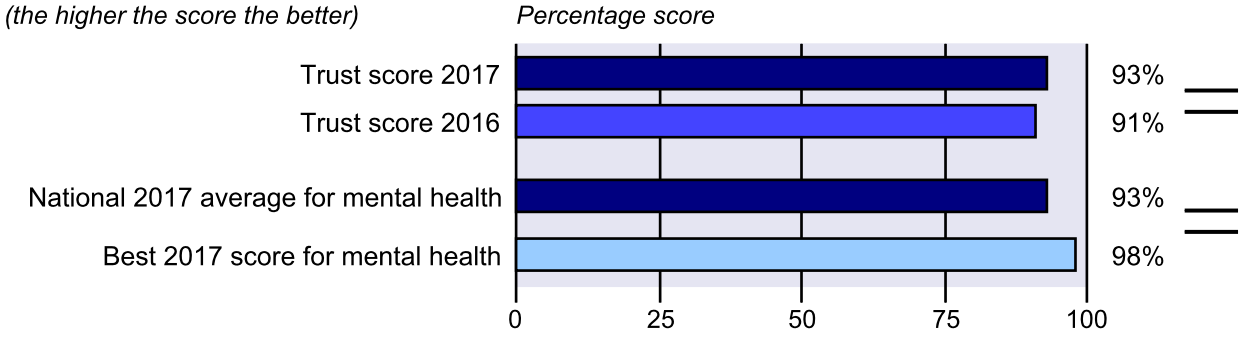
KEY FINDING 23. Percentage of staff experiencing physical violence from staff in last 12 months

(the lower the score the better)



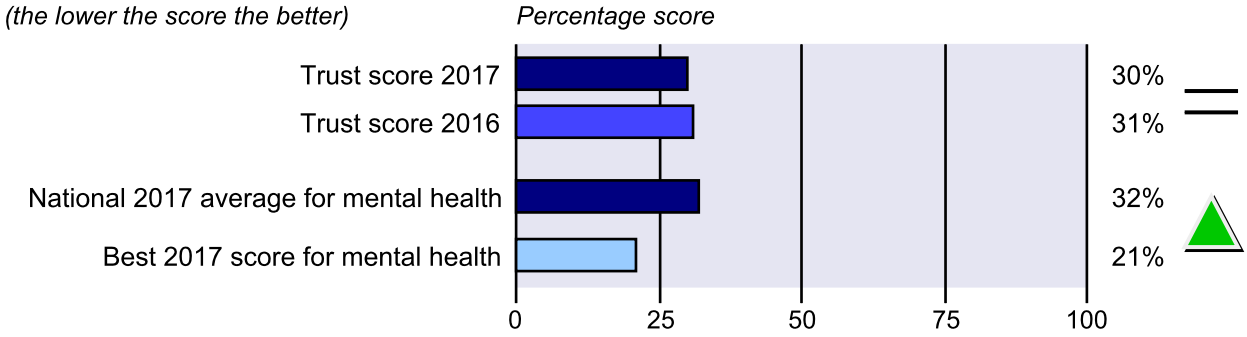
KEY FINDING 24. Percentage of staff / colleagues reporting most recent experience of violence

(the higher the score the better)



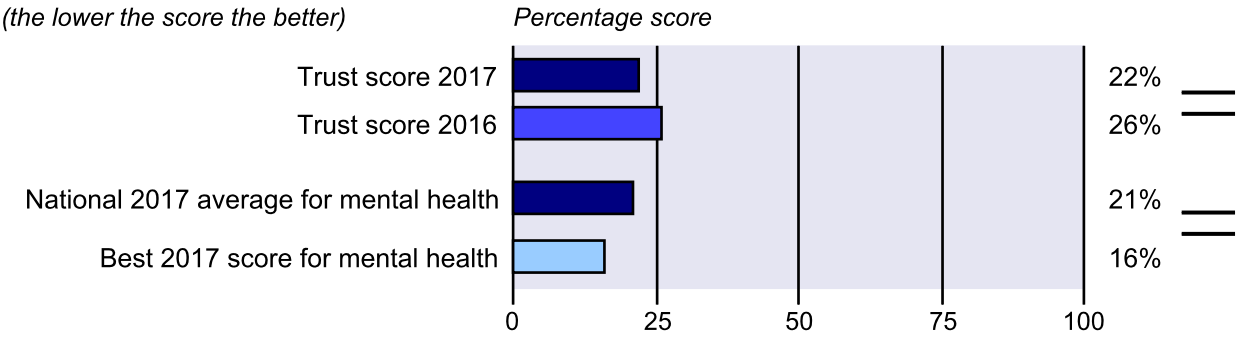
KEY FINDING 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

(the lower the score the better)



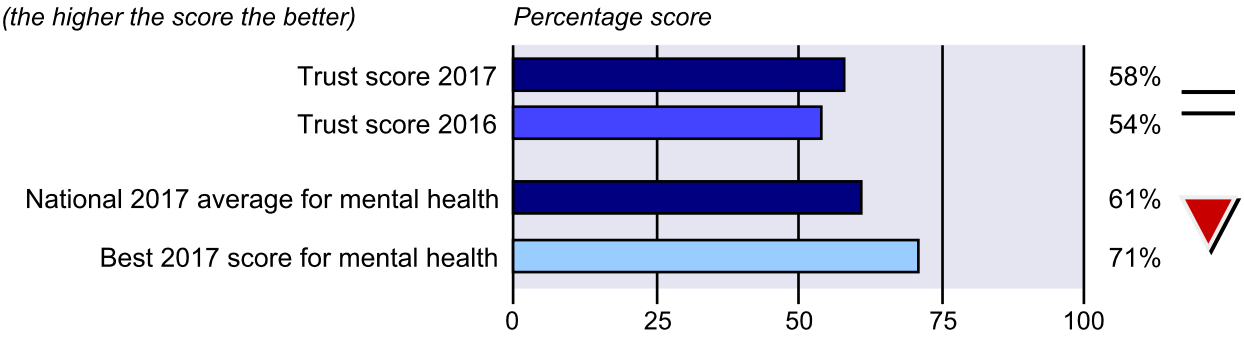
KEY FINDING 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

(the lower the score the better)



KEY FINDING 27. Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse

(the higher the score the better)



Agenda item 16 **Enclosure No** **Paper K**

Report to: 2gether NHS Foundation Trust Board 28th March 2018
Author: Stephen Andrews, Deputy Director of Finance
Presented by: Andrew Lee, Director of Finance and Commerce

SUBJECT: **Finance report for period ending 28th February 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 11 position is a surplus of £882k which is £100k above the planned surplus before impairments. The Trust had a revaluation of its asset base conducted which has resulted in a £1.033m impairment in October 2017. The Trust commissioned a second valuation based on an Alternative Site Valuation and this has resulted in a further impairment of £12.571m. Including the impairment the Trust's position at month 11 is a £12.723m deficit.
- The month 11 forecast outturn is an £953k surplus before the impairment, which is £70k above the Trust's control total. There is the potential for the Trust to receive incentive STF payments of £102k if we deliver this position which would take our surplus to £1.055m. Including the impairment the Trust's forecast outturn position is a £12.651m deficit.
- The Trust has an Oversight Framework segment of 2 and a Finance and Use of Resources metric of 2.
- Agency spend at the end of February is £3.886m. On a straight line basis the forecast for the year would be £4.239m, which would be a reduction of £1.252m on last year's expenditure level, but above the agency control total by £0.835m. It is estimated however that with the initiatives that have been introduced to reduce agency usage the year end forecast will be £4.189m (£10k lower than last month's forecast). The Trust saw agency costs fall in February due to reduced usage of medical agency staff.
- The Trust has undertaken an Alternative Site Modern Equivalent Asset (MEA) revaluation of its land and buildings and the draft report indicates the Trust should receive a significant recurring saving from this exercise. The Trust is working through the details of the report to assure itself of the accuracy and validity of the proposed revaluation but has included the anticipated impact in the financial position of a £2m reduction in depreciation and PDC. As a result the Trust has been able to remove a number of financial risks that could have caused the Trust to miss its financial control total.

- The Trust is progressing well with budget setting for next year and a separate paper will be presented to the Board this month. The Financial Control Total for 2018/19 has been reduced to an £834k surplus and was accepted by the Board at its February meeting.

RECOMMENDATIONS

It is recommended that the Board:

- note the month 11 position
- note the reasons for variances from budget
- note the risks and opportunities to delivery of the year end forecast

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	15th March 2018

Where in the Trust has this been discussed before?		
	Date	

What consultation has there been?		
	Date	

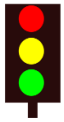
Explanation of acronyms used:	PDC – Public Dividend Capital STP – Sustainability and Transformation Partnerships

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**		
Year End I&E	Single Oversight Framework Segment	2.00	
Income	FOT vs FT Plan	102.2%	
Operating Expenditure	FOT vs FT Plan	104.2%	
Year end Cash position	£m	10	
PSPP	%age of invoices paid within 30 days	98.0%	90% paid in 10 days
Capital Income	Monthly vs FT Plan	73.6%	
Capital Expenditure	Monthly vs FT Plan	63.2%	£4,837k expenditure.

The parameters for the traffic light dashboard are detailed below:

INDICATOR	RED 	AMBER 	GREEN 
NHS Improvement FOT segment score	>3	2.5 - 3	<2.5
INCOME FOT vs FT Plan	<99%	99% - 100%	>100%
Expenditure FOT vs FT Plan	>100%	99% - 100%	<99%
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 Expenditure - Monthly vs FT Pla	>115% or <85%	110% - 115% or 85% to 90%	>90% to <110%

- The financial position of the Trust at month 11 is a surplus of £882k before impairments which is £100k above the plan (see appendices 1 & 8). Including the impairments the Trust has a year to date deficit of £12.723m.
- Income is £2,402k over recovered against budget and operational expenditure is £4,422k over spent, and non-operational items are £2,120k under 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	(4,877)	(4,469)	(4,514)	(45)	(4,952)	(75)
Stroud & S Cots Locality	(4,582)	(4,200)	(4,418)	(218)	(4,877)	(295)
Gloucester & Forest Locality	(4,227)	(3,862)	(3,822)	40	(4,183)	43
Social Care Management	(3,801)	(3,484)	(4,831)	(1,347)	(5,275)	(1,475)
Entry Level	(6,247)	(5,726)	(5,864)	(138)	(6,390)	(142)
Countywide	(31,383)	(28,780)	(29,084)	(304)	(31,755)	(372)
Children & Young People's Service	(6,488)	(5,946)	(5,742)	204	(6,292)	196
Herefordshire Services	(13,074)	(11,999)	(12,165)	(166)	(13,286)	(212)
Medical	(15,271)	(13,999)	(14,658)	(660)	(15,946)	(675)
Board	(1,641)	(1,504)	(1,978)	(474)	(2,149)	(508)
Internal Customer Services	(1,833)	(1,680)	(1,648)	32	(1,833)	0
Finance & Commerce	(6,212)	(5,704)	(6,069)	(364)	(6,572)	(360)
HR & Organisational Development	(3,110)	(2,851)	(2,987)	(136)	(3,327)	(217)
Quality & Performance	(2,870)	(2,634)	(2,784)	(151)	(3,086)	(216)
Engagement & Integration	(1,334)	(1,223)	(1,305)	(82)	(1,443)	(109)
Operations Directorate	(1,124)	(1,031)	(1,121)	(90)	(1,233)	(108)
Other (incl. provisional / savings / dep'r	(4,528)	(4,171)	(16,154)	(11,983)	(16,060)	(11,531)
Income	113,485	104,044	106,421	2,386	116,006	2,521
TOTAL	**883**	**782**	**(12,723)**	**(13,497)**	**(12,651)**	**(13,533)**

The key points are summarised below;

In month

- The Stroud and S. Cotswold locality over spend relates to Supporting People costs above the budget set which is matched by additional income
- The Social Care Management over spend relates to Community Care and is offset by additional income
- The Entry Level over spend relates to the IAPT service, agency staff and additional leadership and administration time
- Countywide is over spent due to Complex Care cost increases
- Herefordshire is over spent due to ward staffing costs but a proportion of this is due to specialling and will be offset by additional income
- The Medical over spend has been caused by agency expenditure - £1,881k in the year to date
- The Board over spend relates to Improving Patient Safety project and STP expenditure for which there is matching income
- Finance and Commerce is overspent due mainly to additional maintenance costs. This has risen in the month due to an increased number of unavoidable works. The Estates team continue to try and drive costs down and there is a rigorous process in place to review all requests
- Income is over recovered due to additional income for activity related Community Care work and additional development funds which weren't budgeted
- Other is over spent due to slippage against the savings programme and the impairment relating to the revaluation

Forecast

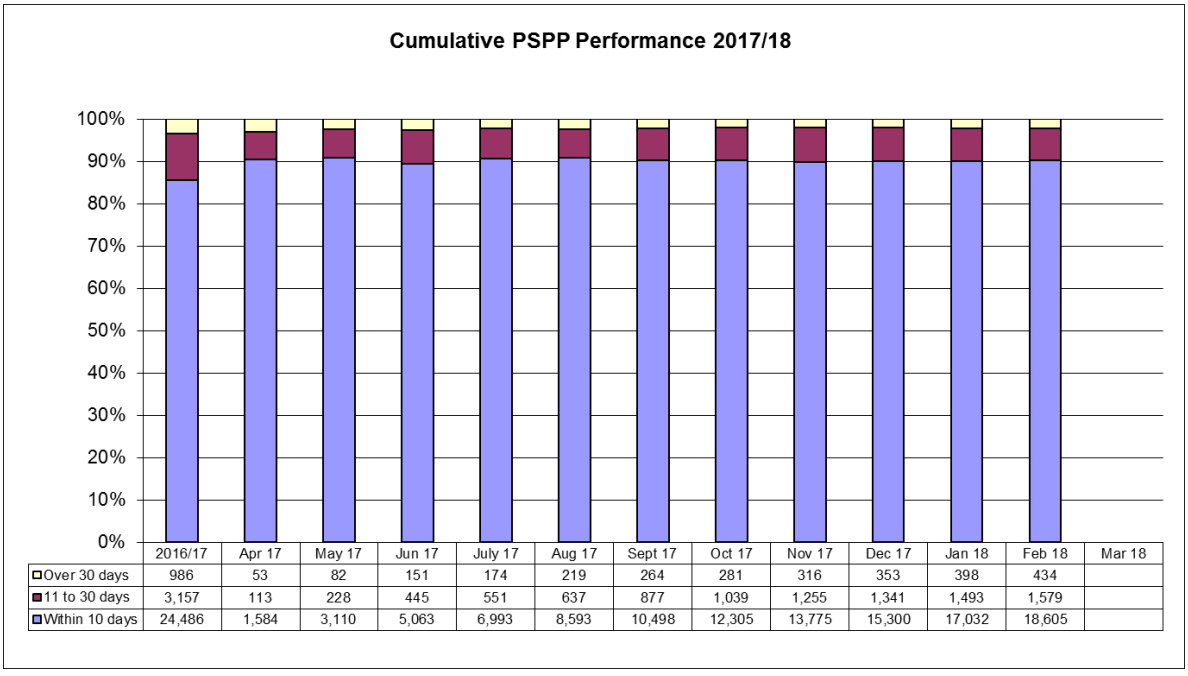
There are significant cost pressures within Directorates including

- Agency costs for Medical and Inpatients are still expected to be significant, even after the effect of actions being taken to reduce this usage
- The apprenticeship levy of £310k, against which there is currently little offset of training costs
- Despite some success in bringing placements back into county the forecast for Complex Care has increased to £788k over spend due to the effect of new recent high cost placements.
- The forecast for the use of agency staff in IAPT has been increased as further agency staff are required after December in order to meet national targets and cover vacancies.
- The forecast for Other has changed by £12.571m due to the impairment

These are offset by under spends in other areas and additional income expected.

PUBLIC SECTOR PAYMENT POLICY (PSPP)

The cumulative Public Sector Payment Policy (PSPP) performance for month 11 remains at 90% of invoices paid in 10 days and 98% paid in 30 days. The cumulative performance to date is depicted in the chart below and compared with last year's position. The Trust has maintained a strong cash position which enables it to continue to consistently pay suppliers promptly.



	2016/17	Apr 17	May 17	Jun 17	July 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
Over 30 days	986	53	82	151	174	219	264	281	316	353	398	434	
11 to 30 days	3,157	113	228	445	551	637	877	1,039	1,255	1,341	1,493	1,579	
Within 10 days	24,486	1,584	3,110	5,063	6,993	8,593	10,498	12,305	13,775	15,300	17,032	18,605	

	10 days		30 days	
	In month	**YTD**	**In month**	**YTD**
Number paid	1,594	18,605	1,668	20,184
Total Paid	1,695	20,618	1,695	20,618
%age performance	**94%**	**90%**	**98%**	**98%**
Value paid (£000)	6,071	64,271	6,307	68,714
Total value (£000)	6,513	70,145	6,513	70,145
%age performance	**93%**	**92%**	**97%**	**98%**

Agenda item 17 **PAPER L**

Report to: Trust Board, 28 March 2018
Author: John McIlveen, Trust Secretary
Presented by: Andrew Lee, Director of Finance & Commerce

SUBJECT: Arrangements for monitoring capital expenditure

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

Following changes to Committee portfolios last year, monitoring of capital expenditure (formerly undertaken by the Development Committee) is now a function of the Executive Committee, which provides assurance to the Board through Executive Committee summary reports. The Board also now receives a bespoke quarterly Capital Expenditure report alongside the usual Finance Report, of which capital expenditure is one element.

At the last Audit Committee, members discussed the current arrangements for monitoring capital expenditure, and agreed to raise the issue at their informal meeting with the Trust Chair with a view to considering mechanisms for increasing Non-Executive Director oversight of capital expenditure outside formal meetings of the Board. Suggestions for such a mechanism included a reversion of the capital monitoring function to the Development Committee, or having a NED chair the Capital Review Group. The matter has also been discussed at the Executive Committee and at the February Board, where it was agreed that the March Board would receive a proposal (there being no Development Committee in March) so that if agreed, new arrangements could commence from 1 April 2018.

This report sets out options for securing greater NED oversight of capital expenditure, and recommends that monitoring of capital expenditure reverts to the Development Committee. Revised terms of reference for the Development Committee are attached for discussion and agreement by the Board. In addition to seeing capital monitoring revert to the Committee, the list of officers in attendance has been amended to include the Assistant Director of Finance – Financial Accounts, who leads on capital expenditure.

Terms of reference for the Executive Committee are also being reviewed to take account of the transfer of responsibility for capital monitoring to the Development Committee. Executive Committee terms of reference will be presented to the Board for approval at the next meeting.

RECOMMENDATIONS

The Board is asked:

1. to agree that monitoring of capital expenditure transfers from the Executive Committee to the Development Committee with effect from 1 April 2018
2. to approve the revisions to the Development Committee's terms of reference.

Corporate Considerations	
Quality implications:	None other than those identified in this report
Resource implications:	None other than those identified in this report
Equalities implications:	None other than those identified in this report
Risk implications:	None other than those identified in this report

WHICH TRUST VALUESIVES DOES THIS PAPER PROGRESS OR CHALLENGE?			
Supporting clinical care		Skilled workforce	
Getting the basics right	P	Using better information	
Social inclusion		Financial efficiency	
Seeking involvement		Legislation	

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

Reviewed by:		
Andrew Lee	Date	07/03/2018

Where in the Trust has this been discussed before?		
Executive Committee	Date	5 March 2018

What consultation has there been?		
IG Committee Executive Committee	Date	16 January 2018 26 February 2018

Explanation of acronyms used:	

1 BACKGROUND

1.1 As part of a realignment of Committee roles and functions in 2016/17, responsibility for monitoring capital expenditure moved from the Development Committee to the Executive Committee. Alongside this change, the terms of reference of the Capital Review Group were strengthened to provide more robust management and timely approval of capital expenditure.

1.2 CRG's role is to recommend a starting point capital programme to the Executive Committee, which if agreed goes on to the Development Committee and Board. CRG is authorised to approve schemes up to a value of £50k provided that such approval does not take the overall programme value above the agreed level.

Approval of expenditure over and above the agreed programme value would require a new business case.

1.3 Minutes of the CRG's monthly meetings are received by the Executive Committee.

1.4 The February Audit Committee discussed capital expenditure monitoring, and agreed that increased oversight of capital spending by Non-Executive Directors, in addition to the scrutiny offered by the Board, would be helpful in providing robust assurance to the Board that capital programmes were being managed effectively.

1.5 This report sets out options for achieving that increased NED oversight.

2 OPTIONS

2.1 OPTION 1 - NED presence on the Capital Review Group: This option would see the Executive Committee retain responsibility for overseeing capital expenditure and providing onward assurance to the Board. However, that assurance would be augmented by having a NED as a member of, or possibly chairing, the CRG.

2.2 While this option would provide some direct oversight by NEDs of capital expenditure, it has a number of dis-benefits. There are no similar sub-Board Committee groups which have a NED member/chair, and having a NED in such a role on the CRG would blur the line between operational management and NED roles to some degree. There would also be an additional time commitment on NEDs which may be difficult to satisfy given existing commitments and current NED vacancies. NED oversight through this route would be unnecessary were oversight of capital expenditure to transfer from the Executive Committee to another Board Committee. This option is therefore not recommended.

2.3 OPTION 2 - Transfer of capital oversight to a Board Committee other than the Development Committee. This option would see a Committee other than the Development Committee assuming responsibility for the oversight of capital expenditure. This would have the advantage of enabling NEDs on the Committee to review capital spend and progress, and provide onward assurance to the Board. This arrangement would also remove the need for a NED to sit on the Capital Review Group.

2.4 A disadvantage of this option is that not all Committees may be suitable to assume this responsibility, due to incompatibility with existing portfolios, or because of the infrequency of some Committee meetings. The Committee which meets most frequently is the Delivery Committee, and while the Committee's schedule may make it suited to oversight of capital expenditure, the Committee already has a very busy workload which may mean that capital expenditure would sit better elsewhere. This option is not therefore recommended.

2.5 OPTION 3 - Transfer of capital oversight to the Development Committee. This option would see oversight of capital expenditure revert to the Development Committee, where it sat until February 2017. This would have the advantage of enabling NEDs on the Committee to review capital spend and progress, and provide onward assurance to the Board. This arrangement would also remove the need for a NED to sit on the Capital Review Group. The Development Committee's workload is not so heavy as to prevent it from resuming this responsibility. Under

this option the minutes of the CRG would be received by the Development Committee.

2.6 One disadvantage of this option is that the Development Committee currently meets bi-monthly, whereas the Executive Committee is able to provide monthly oversight of capital spend. However, given that the CRG will continue to monitor capital spend each month, and the Executive Committee will continue to receive monthly financial position reports which include capital expenditure, NED oversight every other month should be sufficient to provide robust assurance to the Board in relation to capital projects and timescales. The Committee's terms of reference allow it in any case to convene outside the normal schedule to consider any urgent business.

3 RECOMMENDATION

3.1 Option 3 (transfer of capital oversight to the Development Committee) is therefore recommended, and revised terms of reference for the Development Committee are attached for the Board's approval, should this recommendation be accepted. Changes to the terms of reference are shown in red text.

[2]GETHER NHS FOUNDATION TRUST

THE DEVELOPMENT COMMITTEE
TERMS OF REFERENCE

CONSTITUTION AND AUTHORITY

1. The Board hereby resolves to establish a committee of the Board to be known as the Development Committee. The Committee has no executive powers other than those delegated by these terms of reference. The Chair of the Committee will be a Non-Executive Director appointed by the Chair of the Trust.

Membership

2. Core Membership:

- 2 Non-executive Directors (Chair and Deputy Chair)
- Director of Engagement and Integration
- Director of Finance and Commerce

Ex officio Members

- Trust Chair
- Chief Executive

Core members will normally attend each meeting. Other members will attend on a more infrequent basis.

In attendance

3. In attendance:
- Trust Secretary/Assistant Trust Secretary
- Board Committee Secretary
- Assistant Director of Finance – Financial Accounts

Observers:
- Representatives of the Council of Governors

Quorum

4. Two members including at least one Non-Executive Director and one Executive Director

Substitutes

5. Provided the Chair or Trust Secretary is notified in advance, members of the Committee may nominate a suitably qualified substitute to attend the meeting in their absence (e.g. a Non-executive Director may nominate another Non-executive Director; Executive Directors may nominate another Executive Director or senior manager). Substitutes act on their own authority, may exercise any voting rights and count towards the quorum.

6. Any Board member may attend and speak at a meeting of the Committee. They will not count towards the quorum or vote unless acting as a substitute for a Committee member.

Frequency of Meetings

7. The Committee will normally meet bi-monthly but may convene outside this timeframe to consider urgent business.

Authority

8. The Committee is authorised by the Board to review and consider any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the committee. The committee is authorised by the Board to obtain outside legal or other independent advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

9. The committee may establish sub committees or working groups as required.

10. On behalf of the Board, the Committee is authorised to approve local policies, procedures and annual reports and plans that relate to its areas of responsibility.

Purpose

11. The Committee will seek 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.

DUTIES

12. The duties of the Committee are to hold the Executive to account on the following matters in order to be assured that:

a) Analysis takes place which means that service development decisions are informed by an understanding of local people's needs, trend and comparative information on how the organisation is performing (including in terms of service line costs) and market and stakeholder analysis.
b) A strategy is in place to ensure that service developments are informed by meaningful engagement with stakeholders and opinion formers within and beyond the organisation including patients, staff, governors, members, commissioners and regulators.
c) Enabling strategies are developed, reviewed and updated, which are aligned to organisational strategic priorities and reflect the national and local health and social care agenda. (Monitoring of delivery of milestones is via the Executive Committee).
d) A long term capital programme aligned to organisational strategic priorities and the agreed development of services is in place annually. ~~(Monitoring of capital plan implementation is via the Executive Committee)~~
e) Capital plans and programmes are implemented in a timely way and in line with agreed budgets and forecasts

f) Allocated corporate and strategic risks from the trust's risk register are monitored, and potential threats at strategic and operational levels are systematically identified, assessed and, as far as is reasonably practicable, mitigated.

13. The Committee will review and consider endorsement to the Trust Board of business cases that have been referred by the Executive Committee, within the delegated financial authority of the Development Committee as set out in Standing Financial Instructions. Exceptionally the Executive Committee may refer other business cases for review by the Development Committee.

14. Where the Executive Committee has set up task and finish groups to evaluate new ways of providing services, the Development Committee will receive assurance reports from those groups.

15. The Committee will seek assurance that the benefits of any item considered under its terms of reference have been effectively realised.

16. The Committee will provide onward assurance to the Board on all the above matters.

17. In delivering against its purpose, the Development Committee will receive relevant enabling strategies including those listed at Appendix A.

Reporting

18. The minutes of the Committee meetings shall be formally recorded and a report of the meeting submitted to the Board. The Chair of the Committee shall draw to the attention of the Board any issues raised in the Committee that require disclosure to the full Board, or require executive action.

19. The Committee will review its performance against its terms of reference and report the findings of its assessment to the Board at least once annually.

Other Matters

20. The Committee shall be supported administratively by the Trust Secretariat, whose duties in this respect will include:

- Agreement of agenda with Chair and attendees and collation/issue of papers
- Ensuring the minutes are taken and a record of matters arising kept and issues carried forward
- Advising the Committee on pertinent areas

APPENDIX A – ENABLING STRATEGIES RECEIVED BY THE DEVELOPMENT COMM ITTEE INCLUDE:

- Commercial and Partnerships
- Marketing
- Finance
- Engagement and Communication
- Research and Practice Development
- Allied Health Professions Practice Development

- Organisational Development
- Workforce
- Training
- Information Management and Technology
- Clinical Services

Agenda item 18 **Paper M**

Report to:	Board of Directors – 28 March 2018
Authors:	Nick Grubb, Assistant HR Director
	Neil Savage, Director of Organisational Development
Presented by:	Neil Savage, Director of Organisational Development
SUBJECT:	**Gender Pay Gap Reporting**

This Report is provided for:

Decision Endorsement **Assurance** **To Note**

EXECUTIVE SUMMARY

Gender Pay Gap legislation requires the Trust to publish annually a series of calculations that highlight the gender pay gap across the workforce. The information must be published on the Trust website and Gov.UK by 31 March 2018. An estimated 9,000 UK organisations are required to submit their data.

Aviva was one of the first big companies to report on gender pay. Aviva's median pay gap was 27.6% and their bonus gap stood at 40.5%. Goldman Sachs reported a median gender pay gap of 36.4% for hourly pay and a median bonus gap of 67.7%. Its mean average pay gap for hourly pay was 55.5%, and 72.2% for bonuses. Similarly, Easyjet reported that women's median hourly pay rates were 45.5% lower than men's. Women also earn 38.4% less at Virgin Money and 2.5% less per hour at Ladbrokes.

This report contains the required calculations, presenting the gender pay gap within ²gether NHS Foundation Trust against the six indicators. These are similar to many other NHS employers positions published to date and are summarised below:

- Mean average gender pay gap – Females earn 20% less than males
- Median average gender pay gap - Females earn 16% less than males
- Mean average bonus gender pay gap – Females are paid 15% less than males
- Median average bonus gender pay gap – Females are paid 41% less than males
  60% of males receive a bonus payment (Consultant Staff Clinical Excellence Awards) compared with 43% of females
- Proportion of males and females when divided into four groups ordered from lowest to highest pay - there are a higher proportion of females in all quartiles although the gap closes with progression toward the upper quartile

RECOMMENDATIONS

The Board of Directors is asked to note and debate this report and support the proposal that a working group be established to review the detailed data, compare with other NHS employers and advise on any proposed actions to close the gender pay gap.

Corporate Considerations	
Quality implications:	The Trust strives to provide equality for all staff, leading to increased levels of staff satisfaction and ultimately improved patient care.
Resource implications:	By failing to recognise and address issues of equality, staff turnover could increase and also increase the amount of casework by responding to claims of detrimental treatment.
Equalities implications:	The Equalities Act 2010 sets out the duties of the Trust and the Equality and Human Rights Commission give clear guidance which the Trust should endeavour to meet. This report is intended to progress the agenda to meet these duties and guidance and to ensure compliance.
Risk implications:	Failure to provide equality of opportunity may result in claims of discrimination and damage to the reputation to the Trust as a fair employer.

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

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:		
Neil Savage, Director of Organisational Development	Date	16.03.18

Where in the Trust has this been discussed before?		
N/A	Date	

What consultation has there been?		
	Date	

Explanation of acronyms used:	CEA – Clinical Excellence Awards

1. Context – what is gender pay gap reporting?

Recent legislation requires employers with more than 250 employees to publish annually a range of statutory calculations showing how large the pay gap is between their female and male employees. There are two sets of regulations, one mainly for private and voluntary sectors, effective from 5 April 2017. The second is mainly for public sector organisations, taking effect from 31 March 2017. Employers were given 12 months to publish their gender pay gaps.

The results must be published on the Trust's website and a government website (Gov.UK). These results must be accompanied by a written statement of confirmation from the Chief Executive or another appropriate person. Whilst employers may already be taking steps to improve gender pay equality, this process is intended to support and encourage action.

It should be noted that gender pay reporting is different to equal pay. The Trust operates equal pay systems (i.e. Agenda for Change, Medical and Dental, Hay-based job evaluation for Executive Directors). Equal pay deals with the differences in pay between men and women doing the same or similar jobs or jobs of equal value. It is unlawful to pay people unequally because of their gender.

The gender pay gap shows the difference in the average pay between all men and all women in the workforce. If the workforce has a high gender pay gap, this may indicate a number of issues to deal with, and the individual calculations may help to identify what those issues are.

NHS Agenda for Change terms and conditions of service contain the national pay and conditions of service for NHS staff other than very senior managers and medical staff.

The majority of ²gether NHS Foundation Trust staff work under the central NHS terms and conditions known as 'Agenda for Change'. These arrangements were introduced in 2004 with the express intention of avoiding pay inequalities. Agenda for Change covers more than 1 million people and harmonises their pay scales and career progression arrangements across traditionally separate pay groups. Staff are expected to move up the pay bands irrespective of gender. The Agenda for Change (AfC) Job Evaluation process enables jobs to be matched to national job profiles and allows Trusts to evaluate jobs locally to determine in which AfC pay band a post should sit.

Medical and Dental staff have different sets of Terms and Conditions, depending on their seniority. However, these too are set across a number of pay scales for basic pay, which have varying thresholds within them

2. Gender Pay Gap Indicators

Employers must publish the results of six calculations showing their:

1. Average gender pay gap as a mean average
2. Average gender pay gap as a median average
3. Average bonus gender pay gap as a mean average
4. Average bonus gender pay gap as a median average
5. Proportion of males receiving a bonus payment and proportion of females receiving a bonus payment
6. Proportion of males and females when divided into four groups ordered from lowest to highest pay.

It should be noted that only Consultant Medical Staff receive bonus payments within the Trust in the form of national or local Clinical Excellence Awards. Directors and Senior Managers do not receive any bonus or performance related pay.

3. Gender Pay Gap Analysis (31st March 2017 Snapshot)

Table 1 - 2gether NHS Foundation Trust headcount as at 31st March 2017 (exc. Staff bank)

Payband	Female	% make-up	Male	% make-up
Band 1	36	78%	10	22%
Band 2	80	86%	13	14%
Band 3	351	81%	82	19%
Band 4	175	88%	23	12%
Band 5	282	81%	67	19%
Band 6	367	78%	106	22%
Band 7	151	72%	58	28%
Band 8a	53	65%	28	35%
Band 8b	40	77%	12	23%
Band 8c	10	50%	10	50%
Band 8d to Band 9	5	50%	5	50%
Apprentice	1	100%		0%
Board Member	2	29%	5	71%
Medical	53	52%	48	48%
Student Practitioner	6	75%	2	25%
VSM	3	100%		0%
Grand Total	**1615**	**77%**	**469**	**23%**

Medical includes junior and senior staff.

Table 2 - 2gether NHS Foundation Trust Staff bank Headcount as at 31st March 2017

Payband	Female	% make-up	Male	% make-up
Band 1	2	50%	2	50%
Band 2	40	78%	11	22%
Band 3	104	73%	39	27%
Band 4	32	89%	4	11%
Band 5	51	88%	7	12%
Band 6	50	82%	11	18%
Band 7	10	77%	3	23%
Band 8a	6	86%	1	14%
Band 8b	4	80%	1	20%
Band 8d to Band 9	1	100%		0%
Medical	1	50%	1	50%
Student Practitione	6	75%	2	25%
Grand Total	**307**	**79%**	**82**	**21%**

Table 3 – Average gender pay gap as mean and median average

	Gender							
Pay Scheme	**Male**		**Female**		**£ difference between male and**		**% difference**	
	Mean	Median	Mean	Median	Mean	Median	Mean	Median
Agenda for Change	£15.66	£14.03	£14.58	£13.45	-£1.08	-£0.58	-7%	-4%
Medical and Dental	£42.57	£42.15	£33.34	£30.42	-£9.23	-£11.73	-22%	-28%
Trust Board	£66.19	£62.74	£46.95	£46.95	-£19.24	-£15.79	-29%	-25%
VSM Locally Agreed			£48.25	£46.95				

Table 4 – Average and Median Hourly Rates – all eligible staff and pay schemes

Gender	Avg. Hourly Rate	Median Hourly Rate
Male	£19.23	£16.54
Female	£15.22	£13.88
Difference	£4.01	£2.67
Pay Gap %	20.84%	16.12%

Table 5 – Number of employees – Q1=Low, Q4=High

Quartile	Female	Male	Female %	Male %
1	436.00	93.00	82.42	17.58
2	467.00	103.00	81.93	18.07
3	430.00	120.00	78.18	21.82
4	359.00	190.00	65.39	34.61

Table 6 – Average Bonus* Gender Pay Gap

	Male		**Female**		**£ diffierence**		**% difference**	
Pay Scheme	Mean	Median	Mean	Median	Mean	Median	Mean	Median
Medical and Dental	£13,013.82	£10,194.90	£11,052.56	£5,967.20	-£1,961.26	-£4,227.70	-15.07%	-41.47%

Table 7 – Proportion of males and females receiving a bonus* against the total eligible

Total of eligible medical staff (consultants)	Gender		% of total		Number of Staff receiving bonus		% of staff receiving bonus	
	Males	Females	Males	Females	Males	Females	Males	Females
50	35	15	70%	30%	21	7	60%	46%

*Clinical Excellence Awards – consultant medical staff only

4. Conclusions

As a Trust we very much welcome the introduction of gender pay gap reporting nationally across both the public and private sector. We are fully supportive of equality of opportunity within our workforce. However, we recognise that this data informs us that there is further work to be undertaken to achieve that equality of opportunity. We have females represented in many senior positions – our Chair of the Board is a woman and five of our Board Directors are female, albeit that only 2 Executive Directors are female.

We acknowledge that there could be greater representation in consultant and the senior clinical management roles. Similarly, there could be greater female representation in the bonus pay consultants receive through the Clinical Excellence Award national and local schemes. The current medical students and Junior Doctors are increasingly balanced with more females, and, in the longer term this should create an improved pipeline to more senior roles and Clinical Excellence Awards over time (bearing in mind that the Scheme may have been changed shortly following national consultation with the BMA).

Similarly, we would like to see greater numbers of men working in the less senior roles, both clinical and non-clinical.

We have best practice recruitment processes and our values of diversity and inclusion are deeply embedded into these, and all our workforce policies. We will continue to recruit on merit in a fair and transparent manner. We also have a suite of family friendly policies with a range of flexible working patterns which are constantly reviewed and updated.

We hope that, with time, changes in the gender uptake within medical schools, and by taking account of some of the issue highlighted in this report, the gender pay gap will reduce.

5. Summary of results and recommended actions

Indicator	Result	Action	Timeframe & Lead
Average gender pay gap as a mean average	Females earn less than males as a mean average although the gap is much less for Agenda for Change staff.	Working group to be established to further investigate findings and advise on proposed actions that may enable the gap to be closed.	End Q2 2017 / 18 – Neil Savage, Director of Organisational Development, supported by Assistant HR Director (Staff Experience)
Average gender pay gap as a median average	Females earn less than males as a median average although the gap is much less for Agenda for Change Staff.	Working group to be established to further investigate findings and advise on proposed actions that may enable the gap to be closed.	End Q2 2017 / 18 – Neil Savage, Director of Organisational Development, supported by Assistant HR Director (Staff Experience)
Average bonus gender pay gap as a mean average	Female CEA pay is less than male CEA pay	Review the Trust's CEA Scheme against equalities requirements and recommend actions for implementation prior to the next round planned for Q4 2018/19.	End Q3 2017 / 18 – Neil Savage, Director of Organisational Development, supported by Medical Director and Assistant HR Director (Staff Experience)
Average bonus gender pay gap as a median average	Female CEA pay is less than male CEA pay	Write to all female medical staff to encourage applications for CEA and offer support with submissions	End Q3 2017 / 18 – Neil Savage, Director of Organisational Development, supported by Medical Director.
Proportion of males receiving a bonus payment and proportion of females receiving a bonus payment	There is a significantly higher percentage of males receiving CEA pay than female.	Write to all female medical staff to encourage applications for CEA and offer support with submissions	End Q3 2017 / 18 – Neil Savage, Director of Organisational Development, supported by Medical Director.
Proportion of males and females when divided into four groups ordered from lowest to highest pay	There are a higher proportion of females in all quartiles although the gap reduces in each quartile. The gap closes significantly in the upper quartile.	Working group to be established to investigate data further and advise on findings that may relate to barriers to career progression.	End Q2 2017 / 18 – Neil Savage, Director of Organisational Development, supported by Assistant HR Director (Staff Experience)

All indicators		The Appointment and Terms of Service Committee (ATOS) to consider Gender Pay Gap data in any future Executive Director or VSM pay decisions	Immediate and on-going. Chair.

Agenda item 19 **Enclosure Paper N**

Report to: 2gether NHS Foundation Trust Board – 28th March 2018
Author: Colin Merker – Acting Chief Executive
Presented by: Colin Merker – Acting Chief Executive

SUBJECT: **JOINT STRATEGIC INTENT UPDATE**

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 is intended to provide members with a consolidated overview of the history relating to our agreed Strategic Intent to merge with Gloucestershire Care Services.

The paper provides a headline overview of the drivers supporting the proposal, and comments on the process to gaining formal fund approval to the merger.

Future papers will provide a brief update on progress, and keep the Board briefed on any matters that need specific Board comment.

RECOMMENDATIONS

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

Corporate Considerations	
Quality implications:	The merger offers significant potential to improve outcomes for people with combined needs, access to the healthcare system. The Board need to ensure that the process of the merger is well led, so that there is no impact on quality/ensuring business as usual during the Transition Stage.
Resource implications:	An indicative Resource Plan to support the Transaction, Transition and Transformation processes has been agreed by the Strategic Intent Leading Group, and has been included in both Trusts Financial Projections.
Equalities implications:	It is expected that the merger proposals will enable the new organisation to address a number of inequalities currently experienced by a number of vulnerable patient groups supported by both Trusts.
Risk implications:	The programme management team have prepared a risk register for the project which has been accepted by the Strategic Intent Leadership Group, who are providing assurance to the project on behalf of both Trusts.

WHICH TRUST STRATEGIC OBJECTIVE(S) DOES THIS PAPER PROGRESS OR CHALLENGE?	
Continuously Improving Quality	P
Increasing Engagement	
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		Can do	P
Valuing and respectful		Efficient	P

Reviewed by:		
Executive Team	Date	March 2018

Where in the Trust has this been discussed before?		
	Date	

What consultation has there been?		
N/A	Date	

Explanation of acronyms used:	

Introduction
As a Trust we have a strategic aim to grow so that we could sustain the services we provide.

In progressing this aim, we have considered growing as a specialist Mental Health provider, but recognised that Mental Health needs to be an integrated part of an overall health care system and opportunities for growing as a specialist service had stopped becoming available and could also lead to our services becoming too specialist and isolated if we were working over many Sustainability Transformation Partnerships/health care systems.

We know that Mental Health overlaps/touches people in Primary, Secondary and Acute physical health care. In working with colleagues in both Herefordshire and Gloucestershire, we have been able to identify real opportunities where we can do things differently in partnership with our wider system partners to get better outcomes for people with comorbid physical and mental health needs.

i.e. Acute Liaison services and Crisis Resolution Home Treatment underpinning the Emergency and Urgent Care System, supporting admission avoidance at the front door, flow through the hospital and pulling people out at the back door. Dementia Nurses working differently in primary care with GP's and Community Physical Health Services, ICT and fast response, to risk stratify people with dementia at risk of admission to reduce impact on urgent care and improved care and outcomes for the patient. Adult Mental Health Nurses working in Primary Care in the GP role seeing 10 – 30% of a practices presenting patients in any one day who can be streamed for Mental Health Support.

A review of people accessing our care/services within one of the localities of Gloucestershire, showed a 59% overlap with GCS's Community Services for Older People, 53% for Children and 40% for Adults.

It has been this platform that drives our ambition to merge, as we believe we can offer significantly different and improved services for people with comorbid conditions and by working differently with other clinical colleagues where currently organisational boundaries and/or conflicting priorities reduce us working together effectively.

Expectation from Merger

In merging, we expect to deliver a range of non clinical benefits from managing Corporate back office services in a different way and in reducing the two Boards. These financial efficiencies would not be available to the system otherwise and will be used to drive further benefits from within the services the new organisation will deliver, rather than just be absorbed as efficiency savings by the system or us a new Trust.

Clinicians in both Trusts see these opportunities and are supportive of the merger.

The merger will simplify service and strategic delivery and planning within the health communities, as there will be one less organisation to co-ordinate and align priorities with.

It is supportive of our proposals to move towards being an integrated care system (ICS) within Gloucestershire and Herefordshire and will give mental health a stronger voice as part of larger integrated mental health and physical healthcare services

Foundation trust the new organisation will be. The merged organisation will also ensure that the mental health specialisms and less visible parts of the mental health system at a health community level, i.e. inpatient services, recovery services, etc, are maintained appropriately in the health economies strategic planning and development discussions.

At the current time, we have formally agreed as two organisations that we will merge through 2gether acquiring GCS. This is supported by NHSi in its regulator role for both Trusts i.e. NHSi and NHS TDA. It is supported by our health and social care community partners in both Herefordshire and Gloucestershire although we recognise that it will not impact in Herefordshire as much as it will in Gloucestershire in the initial instance i.e. Community physical health care services in Herefordshire are currently sitting within the acute provider, Wye Valley Trust, who want to retain them as they feel vertical integration gives them a better opportunity to manage the Herefordshire system pressures/challenges. We have to respect this and look for opportunities to use the Gloucestershire experience to influence Herefordshire and vice versa.

The Process to Merger

As part of us agreeing to merger as the way forward, we have formally agreed with NHSi and as two Trusts, to appoint a Joint Chair and Joint Chief Executive to progress the integration of the two organisations. These are now appointed.

Our task at the current time is to get on and deliver the Strategic Case (SC) required to be submitted and approved by NHSi over the next 4 to 6 months, subject to resource availability, so that we do not impact upon business as usual and have the capacity to deliver the demands of the merger, our health system STP plans and our own priorities.

We have now got a plan for resourcing the programme and should start to accelerate our efforts although the SC stage which will take 4 months minimum.

Following SC approval, we will progress to the development of a Business Case(BC) stage which will take circa 10 months. Following this stage, final approvals will take circa a further 2 months, so our target date to become a fully merged organisation is likely to be September 2019, however we may be able to reduce this by up to 2 months, if our SC demonstrates a strong financial case and long term financial model that is supported by NHSi. NHSi have said they are strongly supportive of our proposals, but as are proposals are not based on addressing known system deficits/problems, their support will be arm's length as they have to prioritise the use of their resources.

Challenges and Way Forward

Our key challenge in delivering the merger proposals, will be ensuring that the programme is appropriately resourced. We have a fully worked up project plan and project support plan, supported by a financial plan to fund the resources required. This plan has been built into both GCS's and our financial plans for 2018/19 and 2019/20, and we are now putting the staffing/project resources in place to drive the project.

It is critical that we maintain the clinical ownership, engagement and enthusiasm we currently have for our proposals as we progress our transaction, as the timescales are not as short as we would like. We are starting a coordinated programme of clinical workshops in April which will bring clinicians together on an ongoing basis throughout our programme so that they can drive the service Transformation proposals which will make this merger a success. Our programme of clinical engagement will involve our wider system partners as many of our transformation opportunities will involve working with others outside of our core services.

At the current time we are focussed on progressing and getting approval to a successful Strategic Case as that will enable us to accelerate “integration” between the two organisations with increased confidence and let staff in our two organisations and wider health care system see that the merger is happening, it is being well led, they are influencing its direction and much can be achieved before final formal authorisation to the new organisation.

2gether Making life better

2gether NHS Foundation Trust

PAPER O1

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Audit Committee

DATE OF COMMITTEE MEETING: 7 February 2018

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

INTERNAL AUDIT PROGRESS REPORT
The Committee received an update on progress against the Internal Audit Plan. Four final reports were received by the Committee at this meeting. Remaining reviews were on target for completion by the end of the financial year. The Committee reviewed the recommendations tracker and noted the good progress in timely closure of actions and recommendations.

Estates
This review produced an overall rating of medium risk, having been classified as low risk in the previous audit. There were 2 medium level findings relating to inaccurate data and out of date variance commentary for smaller capital schemes being reported to Capital Review Group for discussion, and benefits analysis in relation to capital projects. Three low risk findings related to CRG papers being submitted late or tabled on the day, to limited attendance at these meetings by Service Directors, and to the use and scrutiny of Estates KPIs since the change to Committee portfolios early in 2017. The Committee noted that more commentary detail would be added in respect of small schemes for future CRG meetings, and that video conferencing was being examined as a way of increasing participation by Service Directors. In respect of reporting of KPIs, the Committee noted that the matter of capital reporting would be discussed at the Executive Committee on 12 February. In respect of the analysis of benefits realisation, the Committee noted that these reviews were done, and would be included in future reports.

Data Quality
This review produced an overall classification of medium risk, the same as the previous audit. There were 2 medium risk findings, relating to Care Programme Approach reviews not being conducted in line with the agreed process, and reported values for new social care packages not being in line data reported elsewhere. Two low risk findings related to timelines for CPA reviews, and the lack of a clear local policy for completing new social care packages reviews. The Committee noted that reporting issues were regularly picked up by the Governance Committee which found that reviews were done but often data would be recorded in the wrong place on RiO. In respect of reported values, the Audit Committee noted that no definitions for these indicators had yet been agreed by commissioners; this was being discussed as part of contract negotiations.

Human Resources Bank and Agency Staff
This review produced an overall classification of medium risk, an improvement on the previous audit. There were 3 medium findings, relating to agency shifts not being booked in accordance with policy, agency staff checklists not being retained, and induction checklists not being completed before the first shift. Two low level findings related to performance monitoring of temporary staff, and one instance of reasons for overriding the qualification requirement not being recorded. The Committee noted that the staff bank office was now open longer, and that all temporary staffing is processed through that office, with Executive Directors signing off on any Thornbury shifts, which had reduced considerably in recent months. In respect of induction, the Committee noted that for the sake of continuity, wards tried to use the same temporary staff wherever possible, meaning that an induction was not always necessary. The Governance Committee was due to receive a report on the issue at its next meeting.

Core Financial Systems
This review produced a low risk rating overall, the same as in previous reviews, with 1 medium risk finding relating to authorisation by 2gether to run the payroll. There were 3 low risk findings relating to timely review and sign off of the monthly balance sheet, authorisation of credit notes, and timely communication of additions to the Fixed Asset Register. The Committee noted that the current process for payroll was in accordance with the Service Level Agreement with Financial Shared Services, and which holds FSS accountable. The Committee noted that were 2gether to sign off the payroll, then FSS could not be held accountable for any errors.

EXTERNAL AUDIT REPORT
The Committee received the plan for the 2017/18 audit, and noted the scope and areas of focus for the audit. The audit would consider a number of significant risks including fraud risk from income recognition, accounting for property valuations, and management override of controls. The Committee noted that these were generic risks considered as part of the audit process, and did not imply any specific risk in relation to 2gether.

COUNTER FRAUD
The Committee received and noted the draft counter fraud progress report for the period April 2017 to January 2018 and associated Work Plan, and noted the proactive report which had included a Counter Fraud survey conducted during January. The survey had received a good response, with 90% of respondents saying they were aware of the Counter Fraud service. Counter Fraud continued to attend each corporate induction session, and had incorporated the Trust's Conflicts of Interest policy into their presentation. The Committee noted the significant assurance offered by the report.

OTHER ITEMS
The Audit Committee also:

- Received a summary of all 2gether waivers over £25,000 for orders raised during Q3 2017/18. The report included reasons for waiving the tender process are as set out in Standing Financial Instructions. The Committee asked that reasons should be expanded in the next version.
- In the light of an item regarding Pullman Place, discussed capital expenditure reporting and the mechanisms for ensuring that Non-Executive Directors and the Board were sighted and assured in relation to the progress of the capital programme. The Committee noted that since the changes to Committee portfolios in 2017, when oversight of the capital programme moved from the Development Committee to the Executive Committee, Finance reports to the Board were the only route for such oversight by NEDs. The Committee noted that a planned review of these new Committee arrangements had not yet taken place, and the Audit Committee Chair agreed to discuss the issue of oversight of the capital programme, and the wider issue of Committee portfolios, during a forthcoming NEDs/Chair meeting.
- Reviewed the risk register and noted the top 5 risks which had been identified by the Executive Committee as part of its regular review
- Received an assurance report regarding preparations for new data protection rules coming into force in May 2018
- Noted special payments totaling £4.8k
- Agreed that the Trust should prepare its annual accounts on a 'Going Concern' basis
- Reviewed the Assurance Map

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: 7 February 2018

2gether Making life better

2gether NHS Foundation Trust

PAPER O2

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Development Committee

DATE OF COMMITTEE MEETING: 7 February 2018

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

QUALITY STRATEGY

The Committee received an updated draft of the Quality Strategy, covering the period 2017-2019, and noted that this had been reviewed by the Executive Committee which had felt that the messages contained within the strategy were clear and that measurable objectives were clearly set out. The Development Committee noted that the strategy would be received by the March Board for formal approval. The Development Committee endorsed the strategy for circulation to staff in draft, subject to the correction of a number of typographical errors.

COMMERCIAL AND PARTNERSHIPS STRATEGY

The Committee received the Commercial and Partnerships Strategy, and noted that two existing strategies had been combined as part of a scheduled review in order to create this single document. The strategy would need a further refresh in 12-18 months as the proposed merger with Gloucestershire Care Services came to fruition.

Drivers for this current refresh include changes in commissioning of patient care, a continued drive to work within a shared STP framework with key partners, increased opportunities to work in partnership, reducing care budgets and drivers to make increasing savings whilst continuing to deliver the same or better patient care. The strategy reflected an increased focus from NHS England on identifying and developing home-grown ideas and commercial opportunities. The strategy proposed creating an Innovation and Learning Group within 2gether to identify such opportunities; this would probably be a quarterly or bi-monthly meeting, but terms of reference had not yet been formalised. The Committee noted that while there would remain some focus on commercial development, this would probably be of a smaller scale than previously envisaged while the merger with GSC was progressing. The intention would be to be aware of any commercial opportunities so as to keep options open, as some smaller initiatives might help to achieve Cost Improvement Plan savings. Service Line Reporting, once fully implemented, would help to cost out some commercial proposals more accurately.

The Committee welcomed the strategy, and asked that an explanatory paragraph be added to the report when it was presented to the Board to set out how the Trust was seeking to align its commercial approach with that of GCS, and how 2gether's focus on commercial development would be kept at a realistic and manageable level while the merger process was ongoing.

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.

DRAFT FINANCIAL PLAN 2018/19

The Committee received the draft Financial Plan for 2018/19, and noted that it addressed a number of cost pressures and put some flexibility back into the balance sheet, although no national planning guidance had yet been issued to the NHS. The plan set out the Trust's anticipated income for the coming year, on the basis of good progress in discussions with commissioners. The Trust expected contracts to have been signed by 31 March, and it was hoped they will include a significant element of funding to support demographic and non-demographic growth that the Trust had anticipated it would receive when it developed its financial plans. Some of this funding will support new developments but

the remainder will be used to cover existing areas of expenditure where costs have risen over the past few years. The maximum level of risk is predominantly around the non-demographic funding and whilst this could be as much as £1.07m it is expected that the majority of this will be funded.

As part of the national planning framework the Trust has been given a financial control total to meet of an £883k surplus in the next financial year. This includes confirmed Sustainability and Transformation Funding (STF) of £642k providing the Trust meets all of its key targets, including meeting the financial control total. The Trust has set budgets that will deliver an £883k surplus in 2018/19, then similar surpluses in each of the subsequent four years with STF assumed of £642k in each year. This position translates to a Finance and Use of Resources score of 1 and supports the Trust being in segment 2 or better under the new Single Oversight Framework from NHS Improvement.

The Trust anticipates it will meet its financial control total and deliver significant recurring savings due largely to a revaluation of the Trust's land and buildings assets. This, along with anticipated demographic funding being negotiated through 2018/19 contract discussions, had given the Trust a reasonable financial platform for 2018/19 and allows it to set budgets that meet its financial target, address a number of cost pressures that arose in 2017/18 and set appropriate reserves to strengthen the Trust's financial position. These factors have also enabled the Trust to set a balanced recurrent budgetary position for 2018/19. The savings target for 2018/19 is currently set at £2.45m, which includes non-recurring savings of £0.650m. This equates to an efficiency savings target that is 2.2% of the Trust's turnover. The Trust has identified savings schemes that fully cover the £2.45m target. Capital expenditure is planned to be £4.9m in 2018/19. The main focus of the programme will be starting to undertake improvements to inpatient facilities in Herefordshire, developments in Learning Disability services in Gloucestershire and the further development of IT services across all areas of the Trust.

The Committee noted that a significant number of financial challenges remain for the Trust in the coming year that could undermine its financial plans. These include delivery of the recurring savings target, achievement of the agency spend target and maintenance of sound financial control to remain in a good financial position to focus on the delivery of high quality healthcare.

SERVICE PLANNING 2018/19

The Committee received the draft Service Plan for 2018/19, and noted that apart from all corporate areas being included in the plan, there were no significant changes this year. The plan was aligned in large part to strategic priorities, although the Committee felt that there was not a complete alignment. SMART objectives for each service and team were included, and feedback on the content would be sought from Governors. The Committee queried 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 asked whether Governors could 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.

RESEARCH DEVELOPMENTS

The Committee received an update on research activity, and an initiative to inform service users about research opportunities that may be relevant to them. The proposal was for one of presumed consent to be informed about relevant research opportunities, and the Committee noted that this approach was in line with national policy which sought to increase participation in research studies, and was also be in line with data protection rules. The Committee noted that the proposal would be considered at a future Board meeting, and suggested that it would be beneficial for the Board to receive periodic research updates in future.

ACTIONS REQUIRED BY THE BOARD

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

SUMMARY PREPARED BY: Jonathan Vickers ROLE: Committee Chair
DATE: 7 February 2018

PAPER O3

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Delivery Committee

DATE OF COMMITTEE MEETING: 21 February 2018

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

DATA QUALITY PRESENTATION

The intelligent use of information was key to the delivery of safe, effective, efficient and economical mental health services. The Committee noted that Data Quality was a risk on the Trust Risk Register and reliable information could only be produced if good quality data was captured at source when collecting and transcribing data items. Recording of information in the incorrect place was one issue which was noted and more could be done to triangulate information across the Trust. Progress was being made on the Patient tracking list.

It was important to support the development of individuals, processes and systems to minimise the risk of data errors and work was being undertaken to ensure that data input was as simple as possible for users. The Committee noted that whilst there was a high level of data quality within the Trust, work continued to improve Information Technology (IT) literacy, to improve operational analytical skills, to expand performance culture at all levels, to embed operational ownership of data and to develop a user friendly Business Intelligence Tool.

LOCALITY EXCEPTION REPORTS

The Committee received the Locality exception reports from Gloucestershire Localities, Countywide, CYPS/CAMHS and Herefordshire and noted the current financial and workforce data.

A sickness absence focussed report was being produced by the countywide locality which would drill down and look at levels of acuity, environmental factors and incident reporting to see whether any trends could be identified. This report would be presented back to the Delivery Committee.

PERFORMANCE DASHBOARD

This month's report set out the performance of the Trust for the period to the end of January 2018. Of the 178 performance indicators, 88 were reportable in January with 75 being compliant and 13 non-compliant at the end of the reporting period.

The Committee was asked to note that Gloucestershire CCG Contractual Indicators (Schedule 4) had been finalised with Commissioners and 23 new indicators were now being reported, including 3 indicators around eating disorders. The Trust's overall percentage compliance with KPIs had decreased due to this inclusion. These indicators had been agreed very late on in the contract year and it was noted that 2gether had raised this as a concern with commissioners. Assurance was received however, that there was no financial or quality impact relating to these new indicators and their non-compliance at this time.

ACCOMMODATION SERVICES REPORT

The Committee received a report on the current situation with availability of accommodation in the county for service users. Availability of accommodation within Gloucestershire was mainly within the inner city Gloucester and town centre Cheltenham areas. This reduced choice and the ability for service users to return to familiar or chosen locations. The effects of living in an unfamiliar location with limited ability to maintain social networks was likely to impact on the well-being and recovery for a number of service users.

Opportunities to expand the portfolio of accommodation were limited, mainly due to house prices and the ability of providers to secure appropriate property for such purposes. The Accommodation Service continued to explore ways to reduce the reliance on GL1 based accommodation and work was taking place with commissioners and other agencies. A recent meeting with commissioners had identified a significant change in national thinking in relation to supported accommodation and a document was shared which proposed a significant change to short and long term accommodation provision and it was anticipated that service users would be able to secure appropriate accommodation.

DEMAND MANAGEMENT FOCUSSED REPORTS

The Committee received a number of reports which provided an understanding of Capacity and Demand Management within Trust services. Information had been analysed and the implications for services going forward was provided.

Going forward, the Delivery Committee would receive a 30 minute, specific service focussed presentation on a bi-monthly basis. John Campbell, Interim Director of Service Delivery would discuss and agree a reporting schedule of services with the Service Directors, and update the Committee at the next meeting in March.

MAJOR INCIDENT PLAN

The Delivery Committee had agreed an extension to the Major Incident Plan review process due to the introduction of two new policies and a change in planning/response methodology being implemented. Escalating Incident Frameworks (EIF) had been developed to replace the Trust's Major Incident Plan for each geographical county to take account of the slight differences in services, commissioning arrangements and relationships with multi agency organisations. The frameworks provided for a more operational approach with reporting templates, aide memoires, checklists and procedures being adopted for individuals and teams to coordinate and manage the response to more complex incidents.

The frameworks provided for a scaling up or scaling down of an emergency response based on the incident; type, complexity and/or duration. Local, service based Emergency Response Guides were being rolled out to support individuals and teams to respond to incidents locally before more formal command and control arrangements were put in place. These would form part of the Trust's overall capability for responding to incidents regardless of scale or duration. The implementation plan set out tasks and timings for the transition to the new Frameworks from the 20 April 2018.

The Committee was significantly assured about the capabilities the Trust had in place to respond to a major incident. The progress made in improving the Trust's Major Incident capabilities and the implementation schedule for introducing the new documentation and training were noted. The Committee expressed their thanks to colleagues for the huge amount of work carried out to produce this plan, noting that visits to teams and services had been carried out during its development to ensure that staff felt engaged and "owned" the plan.

HR INDICATORS REPORT

The Committee received an update on Quarter 3 performance against the Trusts Workforce Key Performance Indicators (KPI). The report detailed compliance for statutory and mandatory training, appraisal and sickness absence. It also reported on the current position regarding workforce turnover.

Training compliance had remained steady throughout the last 12-month period. The average compliance for Q3 2017/18 was 88%; 8% better than the same period in 2016/17. Managers and staff continued to work to embed, enhance and develop Learn2gether and the quality of training data continued to improve. The Committee was assured that the Trust had the ability to meet its target of 85% for the remainder of the financial year.

Appraisal compliance had decreased slightly over the last quarter of 2017/18 at 81% against a target of 85%. However, figures had improved after the Christmas period and compliance was now at 85%.

Managers and staff had been working hard to reduce sickness absence and this had seen a reduction allowing the Trust target to be met in some areas. A small benchmarking exercise had been conducted and revealed that the Trust sickness absence percentage was 4.59% against a national figure of 4.00% in September 2017. The Trust also continued to monitor turnover and for quarter 3 this was 8.57% which compared well across the NHS.

IAPT SERVICE IMPROVEMENT PLAN

The Committee received an overview of the key issues relating to the progress made within IAPT Services for Gloucestershire and Herefordshire, including updates on all aspects of the IAPT recovery plans.

In January Gloucestershire Commissioners agreed an additional £250k to increase staffing capacity levels and to support introduction of digital options. The digital platforms would be in place for March and it was anticipated that it would help achieve back log and would provide another option for patients. Herefordshire Commissioners had acknowledged the pressures on the service and the need for increasing staffing capacity but no funding was available in 2017/18. However, the service in Hereford had a small non-recurrent underspend due to staffing vacancies and this funding was to be utilised to introduce Step 2 digital provision.

The waiting list backlog clearance was achieved in line with the initially agreed recovery plans. A further backlog was being managed as waiting time targets were now not being met. Access rates in Gloucestershire and Herefordshire were below the performance threshold set out in the improvement plan trajectory for January 2018. This related largely to the availability of staff. Recovery rates for January 2018 were at 46% for both Counties. It was anticipated that with the changes made to the care pathway the improvement and stability in recovery rates would continue.

OTHER ITEMS

The Delivery Committee also received and discussed:

- The Perinatal MH report for Quarter 3 which detailed progress to date with training, staffing and developments, noting that all key milestones had been met including activity.
- A review of the Delivery Committee owned risks was carried out.
- A presentation on e-Rostering was received and it was noted that all in-patient units were now using the system. E-rostering was already impacting positively on agency usage, and a further report would be presented back to the Committee in May.
- The Committee noted a number of HR policies and procedures that had been reviewed and agreed in line with Trust policy
- The Committee noted the significant assurance provided by the National Patient survey results and endorsed the action plan to further develop practice.

ACTIONS REQUIRED BY THE BOARD

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

SUMMARY PREPARED BY: Maria Bond **ROLE: Chair**

DATE: 20 March 2018

PAPER O4

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Governance Committee

DATE OF COMMITTEE MEETING: 23 February 2018

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

PATIENT SAFETY AND SERIOUS INCIDENT REPORT

There had been 2 new serious incidents (SIs) reported during January 2018. 1 SI was reported for Gloucestershire and 1 in Herefordshire. No Never Events had occurred within Trust services. The SI rate per 1000 caseload for January 2018 was 0.08. The trend of reported suspected suicides was demonstrating a marginal increase across the last 4 years.

The Committee noted the Open Actions Report which demonstrated overdue actions only from the 2016/17 and 2017/18 SI Action Plans at the request of the Committee. Good progress had been made on the closure of actions. For the 2016/17 action plan there was only 1 amber action outstanding which was approaching completion.

A 50% reduction in the reporting of slips, trips and falls at Charlton Lane Hospital in Q3 was noted. This was positive news. Further work would be carried out to look at whether this reduction was due to a change in the patient population or whether it had come from areas of good practice, and to see if there was any learning that could be shared elsewhere in the Trust.

An increasing trend in reporting of detained absconders was noted. There was no harm associated with these incidents; however, more work was needed to understand this and to investigate any themes or underlying reasons.

SAFE STAFFING LEVELS REPORT AND USE OF TEMPORARY STAFFING

The Committee received the Safe Staffing data for November and December 2017 and for January 2018. Current projections suggested that the Trust would not achieve the NHSI agency control total but following a number of actions would save around £1.4m compared with 2016/17. In particular inpatient nursing agency had reduced substantially and was now on target to achieve the control total.

The impact of sickness absence on ward staffing was discussed and it was noted that the Delivery Committee had requested a detailed analysis of sickness absence to be presented to the Committee, looking at levels of absence, trends and any patterns of absence with increased acuity of patients or the number of serious incidents. This report would also be shared with the Governance Committee for information.

SERVICE EXPERIENCE REPORT

The Committee received the Service Experience Report which provided a high level overview of feedback received from service users and carers in Quarter 3 2017/18.

The Trust continued to seek feedback about service experience from multiple sources on a continuous basis and colleagues across the Trust were working to develop practice around complaint themes and the Countywide Locality were piloting a system to monitor complaints and look at whether improvements were happening and learning was being embedded. It was agreed that it would be helpful for the Committee to receive a presentation on the pilot work taking place at a future Committee meeting and the Committee was pleased to note the approach being taken.

TRIANGLE OF CARE SUBMISSION

The Trust joined the Triangle of Care Accreditation programme in 2015. The Trust has completed a formal self-assessment process and is due to present a report to the Carers Trust and regional group.

The Committee received significant assurance from the report that practice development activity continued to ensure that Carers and family members were involved wherever possible. The report offered assurance around the implementation of Triangle of Care and the Committee endorsed the report for submission to the Carers Trust. The Committee expressed their thanks to colleagues for all of the work involved.

COMPLAINTS PROCESS

The Trust has reviewed 4 complex formal complaints, two of which have been externally reviewed and had follow up recommendation reports from either the PHSO and CQC. The four cases reviewed spanned a period of over four years, during this time period the Trust received and investigated in excess of 500 formal complaints in total. The Committee requested that independent assurance that learning had been identified and implemented should be provided. This was felt to be good practice and it was important to be able to offer the Committee and the Trust the assurance that when things do not go right, we do have the processes in place to listen and to learn from the feedback.

COMPLAINTS AND CONCERNS POLICY

The Committee received and endorsed an updated Policy on Handling and Resolving Complaints and Concerns. The review process had involved a review of learning from challenges in the complaint handling process, feedback from complainants, colleagues and Experts by Experience, recommendations received from the Parliamentary and Health Service Ombudsman, incorporation of national best practice guidance and legislative updates. It was noted that the Policy would be reviewed again once the CQC review had been finalised.

OTHER ITEMS

The Committee also received and discussed:

- The Committee received the first issue of the Aggregated Learning infographic, in line with the agreed evolving new process. This had been discussed at Locality Management Boards and Locality Governance Committees, as well as being circulated out to all teams for discussion at team meetings and was well received.
- The Committee received the draft outline of the 2018/19 clinical audit programme, which included all audits carried forward from the 2017/18 audit programme together with all NICE, contractual audits, CQUIN audits and those that require re audit from the 2017/18 audit programme. Delegated approval of the final clinical audit programme was given to the QCR Sub-Committee.
- The Committee received and endorsed the recommended changes to the Listening to Patient Stories at Board Meetings protocol, and noted that an Easy Read version was being developed.
- The Quarter 3 Quality report was received which demonstrated the progress made towards achieving targets, objectives and initiatives identified in the Annual Quality Report.
- The Committee received a report summarising CQC feedback on a complaint investigation from 2016/17. Although the CQC did not disagree with the findings of the Trust's investigation, areas of the handling of the complaint were found to be "unsatisfactory". It was noted that the case had not been closed by the CQC as yet as closure was pending receipt of the Trust's completed findings from reinvestigation of the areas identified. The Committee received full assurance that the Trust would comply with the recommendation made by the CQC and significant assurance that the Trust would not make these errors going forward. However, the Committee received only limited assurance that the individual concerned would be satisfied with the Trust's response to the CQC recommendations.
- The Committee noted the Governance Policies and Procedures that had been signed off, in line with Trust policy over the past month.

ACTIONS REQUIRED BY THE BOARD

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

SUMMARY PREPARED BY: Nikki Richardson **ROLE: Chair**

DATE: 20 March 2018

2gether Making life better

2gether NHS Foundation Trust

PAPER O5

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Mental Health Legislation Scrutiny Committee

DATE OF COMMITTEE MEETING: 14 March 2018

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

REVIEW OF (CQC) INPATIENTS MONITORING VISITS

For the period 1 Dec 17 to 19 Feb 18, there had been no CQC visits. From the start of this financial year to 19 Feb18. there had been eleven CQC annual monitoring visits. Key themes included:

- Section 17 Leave (completeness of forms, risk assessments, review of outcomes)
- Capacity to consent to treatment
- Personalisation of Care plans
- Medicines management (including temperatures and storage and completion of T2 T3 forms).

The Committee received a separate Aggregated Learning paper which had been compiled to outline current issues and lessons to be learnt from a range of sources. 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.

REVIEW OF ISSUES ARISING AT MHA REVIEWS

Two MHA Managers Hearing issue forms had been received between 30 Dec17 and 21 Feb 18. The system around advocacy was improving, advocates were now checking what CTOs were scheduled and were checking if advocacy was required. Fewer issues were being raised by MHA Managers. The Committee was significantly assured that processes and structures were in place to manage and monitor MHA Manager issues.

KEY PERFORMANCE INDICATORS

The Committee received the KPI report for the period Oct - Dec17 and the seven preceding quarters. The Committee was significantly assured of compliance with the MHA and Code of Practice.

The Committee noted the comparison between national data in MHA; the rise in the use of the MHA to detain people in England (CQC January 2018) and 2gether data. The Committee asked if there were any opportunities to compare 2gether's KPIs with other Trusts. The Trust's Health Records Manager had met with colleagues in other organisations to look at future benchmarking opportunities and how this might work. The Trust did compare Gloucestershire and Herefordshire figures and it was agreed that consideration would be given to adding a dataset to the National Benchmarking Set.

CQC REPORT JANUARY 2018 – MHA ACT

The Committee received the CQC's report which noted that between 2005/06 and 2015/16, the reported number of uses of the MHA had increased by 40%. It was unfortunately well established that people from BME groups were more likely to be detained than other groups. In Oct17, the government announced an independent review of the MHA. During 2017, eight NHS trusts, two independent mental health service providers and 23 local authorities were visited. The sites included parts of the country where rates had fallen or remained the same over the previous three years, as well as areas where there had been an increase. Gloucestershire was represented positively in the report for some of the services provided and it was agreed that a further update on the CQC MHA Report would be received at a future meeting.

MHA POLICIES

MHA Information Policy

Sections 132 & 132A of the MHA required that the Hospital Managers ensured that all detained/CTO patients and, if applicable, their nearest relatives, were provided with information about their detention or

CTO. The Committee endorsed the revised policy setting out how the Trust provided the information and monitored its provision.

Allocation of Responsible Clinician (RC)
All patients detained in hospital under the MHA must have an RC, who had overall responsibility for the patient's case and who made key decisions, such as granting Section 17 leave and discharge. The Committee endorsed the revised Allocation of RCs Policy.

Receipt and Scrutiny
An audit of the administrative scrutiny of applications by approved mental health professionals (AMHPs) was carried out for the period Oct 17- Mar 18. The Committee noted that no errors were identified and were significantly assured by the results of this audit.

Audit of the Timing of Hearings
RCs could renew hospital detentions and extend CTOs by completing the appropriate form within two months of the expiry date. Hospital Managers must review all renewals/extensions. An audit of 110 MHA Managers' hearings had indicated that 61% took place either before expiry or within 14 days after the expiry date (the timescale set out in the Trust's *MHA Managers' Policy)*.

The Committee considered options for increasing compliance with Trust policy timescales and discussed the 14 day expiry date for holding the hearings. Other Trusts worked to a 3-4 week timescale and the Committee noted that the Trust would have much higher compliance if the deadline was extended. It was agreed that this issue would be discussed at the next MHA Managers Forum.

AMHP COVER AND THE EMERGENCY DUTY TEAM

The Committee received an update on the local and national challenges around AMHP availability and the ability to deliver 24/7 services. Work was being undertaken to mitigate these risks including training of new AMHPs and secondments. Agency spend had been agreed until the end of March, to be reviewed monthly after that; recurrent funding of £500k from Gloucestershire County Council had also been confirmed with further investment for the 24/7 AMHP Service.

REVIEW OF THE TERMS OF REFERENCE

The Committee endorsed changes to the TOR which more accurately reflected the work of Mental Health professionals across the local health and social care system. It was agreed that approval of the terms of reference would be appended to the Committee Summary to be taken to Board.

OTHER ITEMS

Other items received and discussed by the Committee included:

- The Committee received the 2017/18 draft MHLS Committee Annual Report. The Committee agreed that the report provided significant assurance on the controls in place for ensuring that the Trust monitored and sustained compliance with the MHA, Mental Capacity Act, Human Rights Act and where necessary took action to address non-conformities.
- An update on the Trust's compliance with the Human Rights Act was received and the Committee noted the mechanisms in place for monitoring performance in relation to the specific provisions of the MHA and new Code of Practice, Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DOLs). It was agreed that these mechanisms very largely covered our obligations in respect of Human Rights and Equality legislation.

ACTIONS REQUIRED BY THE BOARD

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

SUMMARY PREPARED BY: Quinton Quayle ROLE: Committee Chair

DATE: 22 March 2018

[2]GETHER NHS FOUNDATION TRUST

THE MENTAL HEALTH LEGISLATION SCRUTINY COMMITTEE

TERMS OF REFERENCE

Constitution

1. The Board hereby resolves to establish a committee of the Board to be known as the Mental Health Legislation Scrutiny Committee. The Committee has no executive powers other than those delegated by these terms of reference. The Chair of the Committee will be a Non-Executive Director appointed by the Chair of the Trust.

Membership

- Two Non-Executive Directors
- Director of Service Delivery
- Director of Organisational Development (Executive lead for Human Rights)

Ex-officio Member

- Trust Chair
- Chief Executive

In Attendance

- Two section 12 approved doctors (One from Gloucestershire and one from Herefordshire)
- Deputy Director of Nursing
- Two senior operational in-patient nurses (One from Gloucestershire and one from Herefordshire).
- Head of Profession for Social Care and key associates
- Head of Health Records/MHA Practice Policy Lead
- MHA Administrator/Health Records Manager
- Trust Secretary
- MCA/DOLS Organisational Lead ([2]gether)
- Senior Operations Lead
- Community Services Manager(s)
- EDT Rep
- AMHP Rep
- Glos CCG Rep
- Chair of the IAMG
- Board Committee Secretary

Observers:

- Herefordshire Council representative
- Gloucestershire County Council representative
- 2 representatives of the Council of Governors

Substitutes

2. Members of the Committee may nominate a suitably qualified substitute to attend the meeting in their absence (e.g. a Non-Executive Director may nominate another Non-Executive Director; Executive Directors may nominate another Executive Director or senior manager). Substitutes act on their own authority, may exercise any voting rights and count towards the quorum.

   Any board member may attend and speak at the meeting. They will not count towards the quorum or vote unless acting as a substitute for a committee member.

Quorum

3. Two members, including at least one Non-Executive Director and one Executive Director.

Frequency of Meetings

4. The Committee will meet not fewer than four times annually.

Authority

5. The Committee is authorised by the Board to review and consider any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the committee. The committee is authorised by the Board to obtain outside legal or other independent advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

6. On behalf of the Board, the Committee is authorised to approve local policies, procedures and annual reports and plans that relate to its areas of responsibility.

Purpose

7. The purpose of the Mental Health Legislation Scrutiny Committee is to hold the Executive to account and provide assurance to the Trust Board that the Trust establishes, monitors and maintains appropriate integrated systems, processes and reporting arrangements to ensure continued compliance with the Mental Health Act, Mental Capacity Act and Human Rights Acts and associated codes of practice.

Duties of the Committee

8. The duties of the Committee are as follows:

   a. To seek assurance that the Trust complies with the Mental Health and Human Rights Acts and any associated codes of practice in relation to patients detained under the MHA or subject to supervised community treatment.

   b. To seek assurance that the Trust complies with the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS) requirements and monitor their interface with the Mental Health Act and Human Rights Act.

c. To seek assurance there is a robust performance and compliance framework and effective arrangements for the ongoing review and monitoring of statistical information on MHA activity.

~~c.~~d. To receive integrated performance and benchmarking information on Mental Health Act activity

~~d.~~e. To seek assurance that all Trust staff acting on the Hospital Managers' behalf under the Scheme of Delegation are competent to undertake their delegated tasks and to monitor their performance.

~~e.~~f. To seek assurance that appropriate arrangements are in place and are operating satisfactorily for the completion and review of relevant legal documentation relating to the compulsory admission and detention of patients and automatic referrals to the Mental Health Review Tribunal.

~~f.~~g. To seek assurance that procedures are in place and operating satisfactorily to inform detained patients and their nearest relatives about the applicable provisions of the Mental Health Act and of their rights.

~~g.~~h. To review and ratify policies and procedures relating to the Mental Health Act and Mental Capacity Act. Policies relevant to this Committee are:

- MHA Information Policy
- Receipt and Scrutiny of Documents Policy
- Allocation of RCs Policy
- SCT – Concerns of Relatives Policy
- Scheme of Delegation
- Renewal of Detention
- MHA Managers' Policy.

~~h.~~i. To consider through exception reports and other appropriate updates, any matters referred from the Mental Health Act Managers' Forum to ensure that appropriate action is taken.

j. To review issues raised through Care Quality Commission visits and Annual Reports and to receive reports on any recommendations and action plans resulting from them.

~~i.~~k. To review incidents designated as 'Serious Incidents' in respect of the Trust's actions under the Mental Health Act or Mental Capacity Act, and ensure that learning is identified and disseminated appropriately throughout the Trust and to partner organisations, where appropriate

~~j.~~l. To review issues arising from Managers' Hearings, ensuring that any lessons learned are identified and disseminated throughout the Trust and to partner organisations where appropriate

~~k.~~m. To seek assurance that appropriate training programmes are in place for

- Trust staff, and
- MHA Managers.

~~l.~~n. To receive reports from the Interagency Monitoring Group (Gloucestershire) and the Mental Health Act Multi-agency Group (Herefordshire) regarding any issues associated with either the Mental Health Act or the Mental Capacity Act.

o. Receive reports from the Mental Capacity Act Governance Group (Gloucestershire) regarding issues associated with the Mental Capacity Act.

~~m.~~p. Receive reports from the Mental Health Operational Group on matters within that group's terms of reference

~~n.~~g. Through monitoring of allocated corporate and strategic risks from the trust's risk register, seek assurance that potential threats at strategic and operational levels are systematically identified, assessed and, as far as is reasonably practicable, mitigated.

r. To raise issues for action and review by the Executive Committee, ~~or~~ other Board Committee, group or partner organisation as appropriate.

b) To produce an annual assurance report on relevant matters for Directors of Adult Social Care

~~o.~~a.

~~p.~~b. To produce an Annual Report for the Trust Board.

Reporting

8. The minutes of the Mental Health Legislation Scrutiny Committee meetings shall be formally recorded. The Chair of the Committee will draw to the attention of the Board any issues that require disclosure to the full Board or require executive action.

Other Matters

9. The Committee shall be supported administratively by the Trust Secretariat, whose duties in this respect will include:

- agreement of agenda with Chair and attendees and collation of papers;
- Issuing papers at least 5 working days in advance of each Committee meeting, with late papers being issued at the Chair's discretion
- ensuring the minutes are taken and a record of matters arising kept and issues carried forward;
- advising the Committee on pertinent areas.

10. The Trust Secretariat will produce an annual plan for the Committee which will outline the business to be discussed at each meeting.

11 Members of the Committee will aim to achieve at least 75% attendance.

Agenda item 21 **Enclosure Paper P**

Report to: Trust Board, 28 March 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**

1. PURPOSE, ASSURANCE AND RECOMENDATION

This report sets out the key activities of the Trust Chair and Non-Executive Directors for the period 25th January – 21st March 2018.

The report offers full assurance that regular, targeted and purposeful engagement is being undertaken by the Chair and Non-Executive Directors aiming to support the strategic goals of the Trust.

This report is for information only and the Board is invited to note the report.

2. CHAIR'S KEY ACTIVITIES

- Chairing two Trust Board meetings
- Chairing two Appointment and Terms of Services Committee meetings
- Chairing a Nomination and Remuneration Committee
- Participating in the Trust's CQC Well Led Inspection and Interview
- Attending a Governor Induction session at Rikenel
- Attending a meeting with the Lead Governor and Deputy Chair
- Chairing two Strategic Intent Leadership Group meeting
- Meeting with the Chair of Herefordshire Clinical Commissioning Group
- Attending a teleconference call with the STP Chairs for Herefordshire and Worcestershire
- Participating in a telephone call with the Herefordshire STP Lead
- Attending a One Herefordshire Workshop
- Attending a meeting of Gloucestershire Health and Wellbeing Board

- Participating in an interview regarding the County Council's Public Health and Prevention Peer Review
- Participating in the recruitment process for the appointment of the Joint Chief Executive
- Meeting with a Non Executive Director and Deputy Chair
- Preparing for and conducting a Non Executive Director appraisal
- Participating in the recruitment of a Non-Executive Director
- Chairing a meeting with Non-Executive Directors
- Participating in a preparation meeting for the annual ROSCA ceremony
- Attending a Board Visit with Director of Quality at Wotton Lawn
- Visiting Abbey Ward and Therapy Team at Wotton Lawn
- Participating in a visit to Colliers Court in the Forest of Dean as part of induction
- Visiting Berkeley House Learning Disability In-patient services
- Visiting Oak House facility as part of induction
- Attending Team Talk at Charlton Lane
- Meeting with the Head of Communications and participating in a 'video' blog for the Trust's forthcoming Team Talk

- Additional regular background activities include:
    - attending and planning for smaller ad hoc or informal meetings
    - dealing with letters and e-mails
    - reading many background papers and other documents.

3. NON-EXECUTIVE DIRECTORS' ACTIVITIES

Jonathan Vickers

Since his last report Jonathan has;

- prepared for and attended two ATOS committee meetings
- held discussions with NED colleagues on trust matters
- held discussions with Executive Director colleagues on Development Committee and other matters
- prepared for and attended a meeting of the Audit Committee
- prepared for and chaired a meeting of the Development Committee
- prepared for and attended a SILG meeting
- participated in a discussion group for the CEO recruitment process
- prepared for and attended a Board meeting

Nikki Richardson (Deputy Trust Chair)

Since her last report Nikki has;

<u>February</u>

- Prepared for and attended Trust Board meeting
- Attended a serious incident review
- Attended a Time to Talk Carers event in Herefordshire
- Panel member for NED interviews
- Prepared for and attended Audit Committee
- Attended extraordinary Board meeting
- Meeting with Chair and interim CEO re complaint
- Panel member for Interim Director of Service Delivery interview
- Panel member for Project Director interviews
- Meeting with Director of Finance at GCS
- Attended GHNHSFT Governors Quality Meeting

- Panel member for CEO shortlisting
- Attended NED meeting
- Shadowed Criminal Justice Liaison Team at Compass House
- Telephone call with prospective NED
- Telephone conversations re complaint
- Meeting with Acting CEO re complaint
- Panel member for CEO interviews
- Prepared for and attended ATOS Committee
- Prepared for and attended Board meeting
- Prepared for and attended Strategic Intent Leadership Group
- Attended meeting with Chair and Lead Governor
- Prepared for and Chaired Governance Committee
- Prepared for and attended Council of Governors
- Prepared for and Chaired Board meeting
- Attended Board Development session

March

- Covered for the Chair during period of annual leave
- Prepared for and attended Health & Care Scrutiny Committee
- Meeting with Acting CEO re complaint
- Reviewed complaint correspondence
- Prepared for and Chaired Council of Governors meeting
- Completed annual appraisals for NED colleagues
- Meeting with CEO
- Prepared for and attended MHLS Committee
- Meeting with CEO designate
- Prepared for and attended Strategic Intent Leadership Group
- Meeting to discuss complaints issues
- Telephone call with Director of Quality re CQC Well Led Review
- Panel Member for NED interviews
- Correspondence with complainant
- Prepared for and attended CQC interview re Governance
- Prepared for and attended CQC interview re MHLS
- Meeting with Trust Governor re complaint

Marcia Gallagher

Since her last report Marcia has;

February

- Attended the Time to Talk Carers event in Hereford
- Held meeting with Trust Counter Fraud manager and Director of Finance
- Booked call with Director of Finance in preparation for the Audit Committee
- Chaired the Audit Committee
- Participated in a focus group as part of the recruitment process for a potential NED appointment
- Prepared for and attended the Development Committee
- Attended a Non-Executive meeting with the Chair
- Booked call with the Director of Finance re the Finance Report
- Prepared for and attended the Board meeting and Development session.

March

- Prepared for and attended the March Council of Governors meeting
- Prepared for and chaired an interview panel for two Consultant appointments

- Undertook a Board visit with the Director of Quality to Pullman Place to meet with the AOT and Recovery teams
- Booked call with Director of Finance as part of CQC interview preparation
- CQC interview as part of Audit and Risk Chair role
- Prepared for and attended the Charitable Funds Committee
- Met with Director of Finance to discuss March Board paper and 2018/19 Budgets
- Prepared for and attended the March Board meeting
- Prepared for and attended the Delivery Committee

Duncan Sutherland
Since his last report Duncan has;

- Prepared for and attended two board meetings
- Had a meeting with the Trust Chair
- Prepared for and attended the Audit Committee
- Attended an informal meeting with the Chair and Non-Executives
- Prepared for and attended the Development Committee
- Attended an extraordinary Board meeting
- Prepared for and met with Chair for Appraisal
- Prepared for and Chaired a meeting of the Charitable Funds Committee and New Highways

Quinton Quayle
Since his last report, Quinton has:

- Had a meeting with the Chair and Vice Chair
- Prepared for and attended two board meetings
- Prepared for and attended two meetings of the Appointments and Terms of Service Committee
- Prepared for and attended a meeting of the Audit Committee
- Attended an informal meeting with the Chair and Non-Executives
- Had a one-to-one meeting with the Acting Chief Executive
- Prepared for and chaired a meeting of the Mental Health Legislation Scrutiny Committee
- Prepared for and attended a meeting of the Delivery Committee

Maria Bond
Since her last report, Maria has:
<u>February</u>

- Prepared for and attended an Audit Committee
- Prepared for and attended a Board meeting
- Carried out a NED Audit of complaints process and write-up report
- Attended a NED meeting with Chair
- Met with deputy CEO prior to Delivery Committee
- Prepared for and Chaired Delivery Committee
- Dialled in to an ATOS and Board meeting
- Prepared for and attended a Governance Committee
- Acted as a MHAM for Appeal hearing at Charlton Lane

<u>March</u>

- Attended a board visit to eating disorder team at Brownhill Centre, Cheltenham
- Judged the bake-off competition at Charlton Lane Hospital
- Attended a NED interview discussion group
- Read through clinical awards applications and returned scoring.

- Attended a Clinical Awards meeting
- Prepared for and met with Chair for Appraisal
- Prepared for and attended a Board meeting
- Met with deputy CEO prior to delivery committee
- Prepared for and Chaired Delivery Committee

4. OTHER MATTERS TO REPORT

Strategic Intent Update

Appointment of Joint Chief Executive Officer
I am delighted to formally announce that Paul Roberts has been appointed to the role of Joint Chief Executive following an extensive national search and rigorous selection process, which included discussions with service users, partners and representatives from both Trusts, in addition to a formal interview.

Paul has been a Chief Executive for over twenty years and spent more than five years in Wales leading a large Health Board responsible for community, mental health and learning disability services as well as for four acute hospitals. Prior to that he spent fourteen years in Plymouth as Chief Executive of the community and mental health services, and then the acute teaching hospital NHS Trust.

An Oxford University graduate, he has also held a variety of national roles across the NHS, including being a trustee of the NHS Confederation, vice-chair of the Association of UK University Hospitals and a member of the Independent Reconfiguration Panel.

He will take up his position on Monday 16 April and lead the development of a business case to take forward the Strategic Intent plans announced last September.

Governance Arrangements
2gether NHS Foundation Trust and Gloucestershire Care Services NHS Trust have established a Strategic Intent Leadership Group (a group of Executives and Non-Executives from both Trusts) which is meeting on a monthly basis.

The Strategic Intent Leadership Group is responsible to the respective Boards of 2gether NHS Foundation Trust and Gloucestershire Care Services NHS Trust for the overall direction and management of the programme of work required to progress the Joint Strategic Intent agreed by both Trusts.

It will be responsible for overseeing the work of the Joint Strategic Intent Programme Management Executive Group which will be responsible for the delivery of the Strategic Outline Case (SOC) and, subject to the required milestones and approvals being achieved, will oversee the development of the Business Case and associated regulatory approval processes.

The Strategic Intent Leadership Group is supported by the Programme Management Executive Group which has been working to put in place the foundations to support progression of the Strategic Intent.

Work is ongoing to progress Engagement events to ensure clinicians and the people we serve remain at the heart of our plans. Regular briefings to update colleagues on the Strategic Intent activity has continued and a Joint Board Seminar event is planned for April.

Paper Q

[2]GETHER NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS MEETING
TUESDAY 16 JANUARY 2018
BUSINESS CONTINUITY ROOM, RIKENEL, GLOUCESTER

PRESENT:

Ingrid Barker	Rob Blagden	Jenny Bartlett
Vic Godding	Katie Clark	Stephen McDonnell
Mervyn Dawe	Said Hansdot	Bren McInerney
Ann Elias	Cherry Newton	Euan McPherson
Hazel Braund	Mike Scott	Jan Furniaux
Faisal Khan		

IN ATTENDANCE: Maria Bond, Non-Executive Director
Marcia Gallagher, Non-Executive Director
Anna Hilditch, Assistant Trust Secretary
John McIlveen, Trust Secretary
Jane Melton, Director of Engagement and Integration
Kate Nelmes, Head of Communications
Quinton Quayle, Non-Executive Director
Nikki Richardson, Non-Executive Director
Neil Savage, Director of Organisational Development
Jonathan Vickers, Non-Executive Director

1. WELCOMES AND APOLOGIES

1.1 Apologies for the meeting had been received from Jo Smith, Jennifer Thomson, Lawrence Fielder, Xin Zhao, Hilary Bowen, Svetlin Vrabtchev and Kate Atkinson. Colin Merker, Acting Chief Executive was also unable to attend the meeting.

2. DECLARATION OF INTERESTS

2.1 There were no new declarations of interest. All Governors had received a new DOI form and were asked to complete this and return it to Anna Hilditch.

2.2 Looking forward at the agenda for the meeting, Bren McInerney advised that he was a member of the CQC Experts by Experience group. The Chief Executive's report would be providing an update on the forthcoming CQC inspection so Bren said that he wanted to declare this interest in advance.

3. COUNCIL OF GOVERNOR MINUTES

3.1 The minutes of the Council meeting held on 9 November 2017 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.

4.2 It was noted that an "Engagement Guide" for Governors had been produced and this had been included in the papers for the November Council meeting. However, it was agreed that a copy of this guide would be emailed out to all Governors as it offered some helpful suggestions on how to increase engagement with members.

ACTION: Governor Engagement Guide to be emailed out to all Governors for information

4.3 Mervyn Dawe asked whether it would be possible for the Governors to receive a report or presentation at a future meeting on Health and Safety and how this was managed within the Trust. Neil Savage said that he would be happy to produce something for Governors and it was agreed that this item would be added to the work plan.

ACTION: Governors to receive a presentation at a future Council meeting on Health and Safety Management within 2gether

4.4 The Council received and noted the Meeting Evaluation feedback from the last meeting in November.

5. CHIEF EXECUTIVE'S REPORT

5.1 The Council noted the Chief Executive's report which was intended to draw Governors' attention to key areas for awareness, information or for exploring further if of sufficient interest. This report provided the Council of Governors with an update in relation to a number of issues since the last Council meeting in November 2017.

5.2 Neil Savage presented this report to the Council in Colin Merker's absence. Governors were aware that Shaun Clee has been unwell recently and during this extended period of ill health, Colin Merker, as the Deputy CEO, has taken on the role of Acting Chief Executive, to ensure we maintain strong leadership within the Trust senior team. Colin himself was due to retire in late January 2018 after more than 40 years in the NHS, but he has very helpfully agreed to stay on to provide senior leadership for as long as necessary and will work with us until Shaun's health position becomes clear and the longer term appointment to the Joint Chief Executive post and an appropriate induction and handover can be made. Hazel Braund said that the Governors appreciated the support by the Senior Team during the current period of absence; however, she said that they needed some assurance around the proposed back fill arrangements as this was a huge pressure on Colin. Neil Savage advised that the Trust was in the process of appointing an interim Director of Service Delivery on a 12 month fixed term contract. It was hoped that the interviews for this post would take place ASAP, with the view of having someone in post within 2 weeks.

Finance Update

5.3 At the end of October (month 7) we had a surplus of £430k in line with our planned surplus before impairments. The month 7 forecast outturn remains for an £884k surplus before impairment, in line with our agreed control total. We completed a mid-year review of our financial position in October. Revenue

budgets, capital expenditure, savings schemes, cash, balance sheet provisions and potential risks and opportunities have all been reviewed. The actions identified in the review are being implemented and we remain on track to meet our agreed financial control total. However, there remain a significant number of risks within our financial position which we remain mindful of as they will require strong leadership and support to successfully deliver.

5.4 The Governors noted that agency spend at the end of October was £2.626m. On a straight line basis the forecast for the year would be £4.501m, which would be a reduction of £0.991m on last year's expenditure level, but above the agency control total by £1.097m. The Council were advised however, that with a number of initiatives currently being implemented it was anticipated that we would be able to reduce agency usage further in year and our year end forecast was for a spend of £4.084m. The Governors were asked to note that a lot of focus had been placed on the reduction of agency staffing expenditure over the past few years but it was important to note that the reduction of agency usage was also key to improving quality of care, not just financial.

Joint Working with Gloucestershire Care Services

5.5 Work is continuing with Gloucestershire Care Services NHS Trust on the proposal to bring our two organisations together. Ingrid Barker, Joint Chair across both Trusts took up her post formally from 1st January 2018. The interviews for the joint Chief Executive post have now been rearranged to take place on 21st February 2018.

5.6 We have set up a new joint group between the two Trusts to progress the planning and progress of our joint strategic proposal to 'merge'. This group is called the Strategic Intent Leadership Group (SILG). The Group is chaired by Ingrid Barker and includes Non-Executive and Executive Director representation from both Trusts. We have also agreed that a joint Programme Executive Management Group (PEMG) will sit below the SILG to deliver the detailed work programme required to achieve a successful merger. Both of these groups are beginning in January 2018 and a Project Director is currently being appointed to coordinate our joint work overall.

5.7 Bren McInerney asked how the Trust was going to share the plans with the wider community and whether a communications plan was in place to keep people informed of developments. He said that he was not yet assured that this was in place. Neil Savage thanked Bren for raising this as the importance of communicating the plans with staff, stakeholders and the public was key. He advised that the Communications Team at 2gether and GCS were working together to produce a comprehensive communications plan and there was a communications work stream as part of the joint working group. However, he noted that this process had only just started but gave assurance that the Engagement and Communications Plan was on the agenda for the next Joint Working Group which was due to take place the following day.

5.8 Stephen McDonnell asked whether there were likely to be any staff redundancies as part of the proposed merger. Neil Savage said that at this time no redundancies were being planned for. He said that there would be a number of redeployment opportunities available and staff would be offered opportunities

to work differently. All of the work taking place to look at this was in line with the STP workforce plan.

5.9 Mike Scott asked for clarification around the next steps for the appointment of a Joint CEO. The Council noted that the planned interviews on 19 January had been postponed. Neil Savage informed the Council that a new date for the interviews had now been confirmed as 21 February. It was agreed that the new date would be emailed out to all Governors inviting participation in the discussion groups.

ACTION: New date for the joint CEO interviews would be emailed out to all Governors inviting participation in the discussion groups.

Crisis Resolution Service (MHARS)

5.10 The Council noted that the contract for the 'Mental Health Matters' helpline has been finalised and the new service has been operational from November 2017. This service provides support to people who would normally access our Crisis teams but for which their needs do not require an acute response. Callers can be escalated to our Crisis Team for an urgent response if required.

5.11 Our S136 Triage service 'Mental Health Nurse in a Police Car' has increased its operational periods to 4 days per week from 2pm until midnight, Tuesday through to Friday. This service development appears to offer the opportunity to significantly reduce S136 detentions. The pilot will be reviewed in conjunction with the police during February 2018, before formalising a decision around future service provision and operational times.

5.12 Cherry Newton and Euan McPherson both asked whether the S136 Triage service was being rolled out in Herefordshire, or whether this was a Gloucestershire only pilot. Hazel Braund, nominated Governor for Herefordshire CCG said that this was only being piloted in Gloucestershire for the time being; however, it was currently being reviewed by Herefordshire CCG. A request was made that items included within the Chief Executive's report, and other reports for the Council make clear whether developments related to both Gloucestershire and Herefordshire, only just one county. This was agreed as a sensible and helpful action.

ACTION: Future CEO Report to the Council to make clear whether developments in services relate to both Gloucestershire and Herefordshire, or just one county

5.13 Mervyn Dawe noted that the S136 Triage service was currently a 4 day a week service; however, this was a 7 day a week problem. Neil Savage agreed and noted that the service was being reviewed. The development did offer the opportunity to significantly reduce the number of S136 detentions and had been seen as a very beneficial service, but there was still a long way to go.

Smoking Cessation

5.14 On Monday 8th January the Trust started the implementation of smoking cessation in Herefordshire. Implementation planning meetings have been taking

place and staff/service user/carer events have been held across Herefordshire. Signs and banners are being prepared to promote this initiative at our Herefordshire sites. It has now been six months since we started our smokefree journey in Gloucestershire, and to find out how staff feel about the introduction of our smokefree policy, a survey has been launched via our intranet. The findings of the survey will assist in the further implementation of smoking cessation in Gloucestershire and Herefordshire.

5.15 Jenny Bartlett said that she had seen a number of negative comments and message threads on social media in Herefordshire about the planned implementation and she queried whether the correct messages had been sent out by the Trust to manage this. Kate Nelmes said that she was aware of the comments that had been posted and she had responded to these online on the Herefordshire Times website. It was a very difficult subject; however, Kate advised that more information and the key facts and frequently asked questions had been updated to help people's understanding of what was happening.

5.16 Bren McInerney said that it was good to see the Trust leading on this work and he acknowledged the huge effort of staff in implementing smokefree across the Trust.

Believe in Gloucester Award

5.17 The Governors were informed that The Pied Piper Room for Children and Families at Wotton Lawn Hospital won the 'Best Community Project' category in the Believe in Gloucester awards 2017. The award was accepted by Nick Broady, Chair of the Pied Piper Appeal, which part-funded the room which was officially opened by HRH the Countess of Wessex earlier this year.

Congratulations to Andy

5.18 Andy Webb, 2gether's Criminal Justice Liaison Team Manager has been awarded a Commander's Commendation by Gloucestershire Police. The Commendation was awarded by Superintendent Tony Godwin of the Criminal Justice Department in 'recognition of excellence'.

5.19 The Council of Governors congratulated both the team at Wotton Lawn and Andy Webb for their achievements. It was agreed that a letter would be sent to the relevant people from the Trust Chair, on behalf of the Council.

ACTION: It was agreed that a letter would be sent from the Trust Chair, on behalf of the Council congratulating both the team at Wotton Lawn and Andy Webb for their achievements

CQC Inspection

5.20 Neil Savage provided an update to the Council on the Trust's forthcoming CQC revalidation visit which would take place during February and March of this year. He said that a lot of preparation was already underway and action plans in place where necessary.

5.21 Mike Scott asked whether there would be any Governor involvement in the inspection process and if so, what this would be. Neil Savage said that it was difficult to predict what/who the CQC may ask to speak to during their visit; however, at the request of the Governors Neil agreed to see whether there was a mechanism for asking the CQC in advance if they would wish to see the Governors and to be proactive about managing this engagement once the final dates for the inspection were known. Governors acknowledged that this may not be possible but advance notice of any proposed engagement would be extremely welcome.

ACTION: Neil Savage to see whether there was a mechanism for asking the CQC in advance if they would wish to see the Governors and to be proactive about managing this engagement once the final dates for the inspection were known

6. CQC NATIONAL PATIENT SURVEY RESULTS 2017

6.1 Enabling people to have positive experiences of NHS services which meet their needs and expectations is a key national strategic goal and an underpinning core value of 2gether NHS Foundation Trust. This report outlined the Care Quality Commission's published results of the data analysis of the 2017 survey sample of people who use 2gether's services. The CQC makes comparison with all other English mental health Trust results of the same survey. The Council was asked to note that Quality Health had carried out the survey and the sample of participants was drawn randomly from Herefordshire and Gloucestershire using a prescribed national formula. The full results were published on 15th November 2017 on the CQC website.

6.2 Jane Melton informed the Council that three mental health Trusts in England were classed as 'better than expected' across the entire survey and ²gether was named as one of these 3 Trusts. These results represent a further improvement when compared with our results from last years' service user feedback in the same survey. ²gether is categorised as performing 'better' than the majority of other mental health Trusts in 5 of the 10 domains and as performing 'about the same' as the majority of other mental health Trusts in the remaining 5 domains. ²gether is not categorised as performing 'worse' than the majority of other mental health Trusts for any of the domains or any of the specific questions.

6.3 The Council noted that these were excellent results; however, the Trust would never be complacent and an action plan to address those areas for development would be undertaken during January. The key areas of focus for development would include:

- Supporting people at times of crisis
- Involving people in planning and reviewing their care
- Involving family members or someone close, as much as the person would like
- Giving people information about getting support from people with experience of the same mental health needs as them
- Helping people with their physical health needs and to take part in an activity locally
- Providing help and advice for finding support with finances, benefits and employment

6.4 Cherry Newton noted that this was a combined report and asked whether it was possible to breakdown the results into Gloucestershire and Herefordshire, to see whether there were any areas for improvement that might be hidden by the combined result. Jane Melton said that it would be possible to provide an overall profile for each county and agreed to look at producing this.

ACTION: Jane Melton to provide an overall profile of the National Patient Survey results for each county.

6.5 Euan McPherson said that he thought this was an excellent report. There had been a good response rate to the survey and great results and he congratulated the Trust on this achievement.

6.6 Bren McInerney referred to the response rate and he asked whether there was anything more that the Trust could do to increase the number of responses, both to these surveys and in more general terms around people raising concerns. Jane Melton said that a lot of work was taking place to address the issue of people not feeling able to comment on Trust services and the triangulated work was demonstrated in the quarterly Service Experience report received by the Board. Bren added that there were a number of "amber" indicators within the survey report and he asked that thought be given to what needed to happen to move these to "green" next year.

6.7 Mervyn Dawe agreed that this was an excellent result for the Trust and suggested that a summary be included in the next Membership newsletter.

ACTION: Summary of the results from the National Patient Survey to be included in the next Membership newsletter

7. CHILDREN AND YOUNG PEOPLE'S SERVICES - PRESENTATION

7.1 The Council welcomed Sarah Batten (Service Director) and Dr Rosemary Richards (Clinical Director) to the meeting who gave an overview of CYPS/CAMHS services in Gloucestershire and Herefordshire. A copy of this presentation would be circulated to all Governors for reference.

ACTION: Copy of the CYPS/CAMHS Presentation to be circulated to Governors

7.2 One of the key issues highlighted in the presentation was the continuing problem with the provision of Tier 4 Inpatient CAMHS beds. The Council noted that this was a national issue, with these services commissioned by NHS England; however, 2gether would keep this on its agenda locally. The current practice of admitting under 18 year olds to adult units was not suitable; however, this did occur when the clinical need arose and 2gether ensured that all of the necessary safeguards were in place to manage such admissions. Sarah Batten reported that patient's experience of the quality of care received at Wotton Lawn was very good, but this did not take away from the admissions being unsuitable. Thorough reviews of all under 18 admissions were carried out.

7.3 The Council of Governors were directed to the new CYPS website which had been developed and was now live. Sarah Batten said that the service was very proud of the website and suggested that Governors go in and take a look. The new website had been developed with the Communications Team and strong engagement with the young people that use 2gether's services.

7.4 Mike Scott asked whether consideration had been given to commissioning a CAMHS inpatient unit in Gloucestershire. Dr Richards said that thought had been given to this but the current number and profile of patients requiring inpatient admission within the county would not make a good mix for a single unit, with many requiring specialist care.

7.5 Mervyn Dawe said that he felt passionately about services for Children and Young People, noting that proper investment in early life meant that there would be less problems developing in later life. He said that he was very keen to find out more about the service and asked whether it would be possible to organise a Governor visit to CYPS. Sarah Batten said that she would be very happy to host a visit for Governors and it was agreed that Anna Hilditch would liaise with the team to organise this.

ACTION: Anna Hilditch to liaise with CYPS to arrange a visit to services for Governors

7.6 Bren McInerney asked about the transition date for moving from CYPS into adult services. Sarah Batten said that the transition pathway commenced when the young person was 17.5 which would enable a 6 month transition to take place. CYPS would work closely with the young person to ensure a successful transition. Dr Richards added however, that if the young person was planning to go away to university then there were occasions that they would stay with CYP services until they moved and work would take place with the university to ensure that the young person was successfully transitioned directly to adult services in the appropriate location.

7.7 Bren McInerney said that he was pleased to see the excellent amount of engagement that took place with CYP which was evident from the presentation. He said that he would like to see the changes that had taken place in direct response from the young people's comments, such as changes in lighting and decoration. This would give helpful additional assurance.

7.8 Euan McPherson said that the collaboration between Gloucestershire and Herefordshire services was excellent and welcomed the bringing together of the two teams under one management structure. He asked whether there were any hotspots or tricky areas that arose in terms of transitioning young people into adult services. Dr Richards said that those young people on the autistic spectrum were often more difficult to transition.

7.9 The Council thanked Sarah and Rosemary for their presentation.

8. QUALITY REPORT INDICATORS AND AUDIT

Quality Report – Quarter 2 Progress Report

8.1 Gordon Benson, Assistant Director of Governance and Compliance was in attendance to present this report which gave the Council of Governors a review of progress with the Quality Report priorities for 2017/18 and an opportunity to agree the indicators for external audit purposes.

8.2 The Quarter 2 report showed the progress made towards achieving targets, objectives and initiatives identified in the Annual Quality Report. Overall, there were 3 targets which were not currently being met: Personalised discharge care planning, Numbers of service users being involved in their care and Reduction in the use of prone restraint. There was also limited assurance that target 3.1 – Reduction in the proportion of patients in touch with services who die by suspected suicide when compared with data from previous years would be met.

8.3 The Governors noted that these targets continued to receive considerable focus through operational management systems, wider work streams such as the Patient Safety Improvement Programme, and sub-committees such as the Positive & Safe Sub-Committee. There had been sustained improvements across most User Experience targets and joint CPA reviews for service users who make the transition from children's to adult services. The Council was also asked to note that an Easy Read section was now routinely included within the Quality Report which was welcomed.

8.4 Rob Blagden noted that there were 3 red targets; however, the Trust's performance against all of the quality measures had actually improved in terms of percentages from last year which was important to be aware of.

Quality Report 2017/18 Audit Process

8.5 The Council was informed that NHS Improvement guidance was currently unavailable for the external assurance report which will be provided by KPMG; however, it is unlikely there will be significant changes in the Quality Report assurance requirements. Therefore, in keeping with previous guidance we are working on the assumption that one locally chosen Governor indicator will still be required in addition to two mandated indicators. On this basis the Council was presented with the potential options for auditing under the set domain headings of effectiveness, user experience and safety.

8.6 On review of the indicators, the Council asked that the following mandated indicator be reviewed; "100% enhanced Care Programme Approach (CPA) patients receive follow-up contact within seven days of discharge from hospital". Governors asked whether this audit could also cover follow up within 48 hours of discharge which was a Trust stretch target. The Governors agreed that their locally selected indicator for auditing this year would be "To improve personalised discharge care planning in Adult inpatient wards and Older People's wards." Gordon Benson agreed to pass these recommendations on to the Trust's external auditors. He added that the purpose of the audits was to ensure that the Trust had the necessary

processes in place for capturing data and therefore accurately reporting the data.

2018/19 Quality Report Development

8.7 Gordon Benson advised that the Trust was currently considering quality priorities for inclusion in the 2018/19 Quality Report, working with colleagues within the organisation and externally. Governors were invited to provide suggestions for potential indicators, to be submitted to the Assistant Director of Governance & Compliance no later than 31 January 2018.

9. MEMBERSHIP ACTIVITY REPORT

9.1 The Council received and noted the Membership Report which provided a brief update to inform the Council of Governors about information for members, Governor Engagement Events and information about membership (year to date).

9.2 The Trust's newly formed Membership Advisory Group has met twice – once during July and once during September 2017. A meeting planned for December was postponed due to the unavailability of group members due to other commitments. Currently the group is comprised of three Governors, two members of Trust staff and two public members. The next meeting is planned to take place in Herefordshire to attract representation from Herefordshire, as this has not yet been achieved.

9.3 Bren McInerney said that he would like to join the Membership Advisory Group as he took a real interest in promoting and engaging with the Trust's membership. He also encouraged other Governors to get more involved.

9.4 The Governors noted that as of 31 December 2017, the Trust had 301 more public members than we had at the end of 2016/17. Membership now stood at 5656 Public members and 2130 Staff members.

10. FEEDBACK FROM GOVERNOR OBSERVATION AT BOARD COMMITTEES

10.1 A number of Board and Board Committee meetings had taken place since the Council of Governors last met in November 2017 and Governors had been present in an observation capacity at these meetings.

- Mike Scott had attended the Board meeting which took place in November in Herefordshire
- Euan McPherson attended the Development Committee meeting on 13 December. He reported that this meeting had been excellently chaired and there was good engagement between the Executive and Non-Executive members of the Committee.
- Cherry Newton had observed the MH Legislation Scrutiny Committee meeting in January
- Vic Godding had attended the Governance Committee in December.

10.2 Mike Scott advised that the Governors had valued being invited to attend the Board Committees and a request was made that future Board Committee meeting dates and Governor nominees for each of these be included on the Council of Governor agendas by way of keeping them clearly on the radar.

ACTION: Future Board Committee meeting dates and Governor nominees for each of these to be included on the Council of Governor agendas

11. GOVERNOR ACTIVITY

11.1 Cherry Newton was supporting a Carers event being held to coincide with Time to Talk Day (February 1) in Herefordshire. Two fellow Governors had also expressed an interest in participating in this event.

11.2 Bren McInerney and Said Hansdot would be meeting to discuss a future engagement event to be held in the Barton and Tredworth area of Gloucester.

11.3 Bren McInerney advised that he was proposing to attend and speak at the Tewkesbury Borough Council's Scrutiny Committee, to tell them about the role of the Governor and to explore with them what support they could offer him in representing the Tewkesbury constituency. Bren said that he would be speaking with the Trust Secretary after today's meeting to discuss this opportunity further.

12. ANY OTHER BUSINESS

12.1 There was no other business.

13. DATE OF NEXT MEETINGS

Council of Governor Meetings

Business Continuity Room, Trust HQ, Rikenel		
Date	**Governor Pre-meeting**	**Council Meeting**
2018		
Thursday 8 March	1.30 – 2.30pm	3.00 – 5.00pm
Tuesday 8 May	4.00 – 5.00pm	5.30 – 7.30pm
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		
Tuesday 30 January	10.00 – 1.00pm	Business Continuity Room, Rikenel
Wednesday 28 March	10.00 – 1.00pm	Business Continuity Room, Rikenel
Thursday 31 May	10.00 – 1.00pm	Hereford
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
16 January 2018			
4.2	Governor Engagement Guide to be emailed out to all Governors for information	Anna Hilditch	**Complete** Emailed on 23 January
4.3	Governors to receive a presentation at a future Council meeting on Health and Safety Management within 2gether	Neil Savage	This has been scheduled to take place at the July 2018 Council meeting
5.9	New date for the joint CEO interviews would be emailed out to all Governors inviting participation in the discussion groups.	Anna Hilditch	**Complete** Emails sent by Lead Governor and attendance confirmed by AH on 31 January
5.12	Future CEO Report to the Council to make clear whether developments in services relate to both Gloucestershire and Herefordshire, or just one county	Colin Merker	Future reports to Council will be reviewed in advance to ensure that this information is included
5.19	It was agreed that a letter would be sent from the Trust Chair, on behalf of the Council congratulating both the team at Wotton Lawn and Andy Webb for their achievements	Ingrid Barker	**Complete**
5.21	Neil Savage to see whether there was a mechanism for asking the CQC in advance if they would wish to see the Governors and to be proactive about managing this engagement once the final dates for the inspection were known	Neil Savage	**Complete** 2 sessions arranged for the Governors to meet with the CQC as part of the inspection process
6.4	Jane Melton to provide an overall profile of the National Patient Survey results for each county	Jane Melton	
6.7	Summary of the results from the National Patient Survey to be included in the next Membership newsletter	Kate Nelmes	Next Newsletter scheduled for April 2018 and an item has been prepared for inclusion in this.
7.1	Copy of the CYPS/CAMHS Presentation to be circulated to Governors	Anna Hilditch	**Complete** Emailed on 23 January
7.5	Anna Hilditch to liaise with CYPS to arrange a visit to services for Governors	Anna Hilditch	**Ongoing** CYPS have discussed this at a team meeting and a date is being sought during May/June
10.2	Board Committee meeting dates to be included on the Council of Governor agendas	Anna Hilditch	This will be included on all future Council of Governor meeting agendas