2gether
Making life better

2gether
NHS Foundation Trust

BOARD MEETING

THURSDAY 31 MAY 2018
AT 10.00AM

THE MAIN HALL, THE KINDLE CENTRE
HEREFORD

Our Core Values

Seeing from a service user perspective
Excelling and improving
Responsive
Valuing and respectful
Inclusive, open and honest
Can do
Efficient, effective, economic and equitable

²GETHER NHS FOUNDATION TRUST
BOARD MEETING
THURSDAY 31 MAY 2018 AT 10.00AM
THE KINDLE CENTRE, HEREFORD

AGENDA

10.00	1	**Apologies** Maria Bond, Dominique Thompson, Amjad Uppal, John Campbell	
	2	**Declaration of Members Interests**	
10.05	3	**Minutes of the Board Meeting held on 28 March 2018**	**PAPER A**
	4	**Action Points and Matters Arising**	
	5	**Questions from the Public**	
IMPROVING QUALITY			
10.10	6	**Patient Story Presentation**	**VERBAL**
10.40	7	**Performance Dashboard Report and IAPT Update**	**PAPER B**
10.45	8	**Quality Report 2017/18**	**PAPER C**
10.55	9	**Learning Disabilities Mortality Review National Report**	**PAPER D**
11.05	10	**Learning from Deaths – Quarter 4**	**PAPER E**
11.15	11	**Non-Executive Director Audit of Complaints – Quarter 4**	**PAPER F**
11.25	12	**Complaints Annual Report 2017/18**	**PAPER G**
11.35	13	**CQC Inspection Update**	**VERBAL**
BREAK – 11.45AM			
IMPROVING ENGAGEMENT			
11.55	14	**Chief Executive's Report**	**PAPER H**
12.05	15	**Annual Membership Report 2017/18**	**PAPER I**
12.15	16	**Research Update**	**PAPER J**
IMPROVING SUSTAINABILITY			
12.25	16	**Summary Financial Report**	**PAPER K**
12.30	17	**Provider License Declarations**	**PAPER L**
12.40	18	**Mental Health Legislation Scrutiny Committee Annual Report**	**PAPER M**
12.45	19	**Board Committee Summaries** • Charitable Funds Committee – 27 March • Audit Committee – 4 April and 25 May (v) • Development Committee – 18 April • Delivery Committee – 29 March, 25 April and 23 May (v) • Governance Committee – 27 April	 **PAPER N1** **PAPER N2** **PAPER N3** **PAPER N4** **PAPER N5**
INFORMATION SHARING (TO NOTE ONLY)			
12.55	20 21 22	**Chair's Report** **Council of Governor Minutes – March 2018** **Use of the Trust Seal – Quarter 4**	**PAPER O** **PAPER P** **PAPER Q**
1.00	23	**Any Other Business**	
	24	**Date of Next Meeting** Thursday 26 July 2018 at Trust HQ, Rikenel, Gloucester	

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
28 MARCH 2018

PRESENT

Ingrid Barker, Trust Chair
Maria Bond, Non-Executive Director
John Campbell, Director of Service Delivery
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
Duncan Sutherland, Non-Executive Director
Dr Amjad Uppal, Medical Director

IN ATTENDANCE

Luke Allinson, CQC
Clare Angel, Liaison
Kate Atkinson, 2g Trust Governor
Robert Graves, Gloucestershire Hospitals NHSFT
Anna Hilditch, 2g Assistant Trust Secretary
Bren McInerney, Member of the Public
Kate Nelmes, 2g Head of Communications
Ruby Punchard, 2g NHS Management Trainee
2 x Members of the Public

1. WELCOMES, APOLOGIES AND INTRODUCTIONS

1.1 Apologies were received from Jonathan Vickers.

1.2 The Board welcomed John Campbell to his first Board meeting as Director of Service Delivery.

2. DECLARATIONS OF INTERESTS

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

3. MINUTES OF THE PREVIOUS BOARD MEETINGS

30 January 2018

3.1 The minutes of the meeting held on 30 January were agreed as a correct record, subject to a minor typo at 11.8 to include the word “not”.

22 February 2018

3.2 The minutes of the extraordinary Board meeting held on 22 February were agreed as a correct record. This meeting had taken place to approve the appointment of a new Joint Chief Executive.

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 received a question in advance of the meeting from Bren McInerney. The question related to the NHS Constitution and how many times 2gether had cited this in its strategic work over the last 12 months. The Acting Chief Executive provided Bren and fellow Board members with a written response to this question, and also provided a verbal response. Bren McInerney thanked the Acting Chief Executive for the response and the spirit in which it was provided. *(The question and the full response is included as Appendix A to these minutes).*

5.2 A member of the public agreed about the importance of the NHS Constitution, and how this was embedded.

6. PATIENT EXPERIENCE PRESENTATION

6.1 The Board welcomed a member of the public to the meeting who had been invited to read out an impact statement relating to her experience of mental health services provided by 2gether.

6.2 The member of the public tabled a list of the key areas that she wished the Trust to investigate further. The Board agreed that this was a helpful document to receive as it would ensure that attention was focused on mutually agreed areas of concern.

6.3 Ingrid Barker thanked the member of the public for attending the meeting and for speaking about her experiences. An opportunity to come back and speak in more detail at the confidential Board meeting later in the day was extended to the member of the public.

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 January 201 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 178 performance indicators, 88 were reportable in January with 75 being compliant and 13 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 the majority of the non-compliant indicators.

7.3 The Board noted that the Gloucestershire CCG Contractual Indicators (Schedule 4) had now been finalised with Commissioners and 23 new indicators had been added to the dashboard. This late addition of indicators had impacted on the Trust's compliance rate which in January had decreased to 85%. However, the Acting Chief Executive advised that performance in February had improved and services were working very hard and action plans continued to be scrutinised and monitored to ensure levels of compliance. The Board agreed that this late addition was very unhelpful. The Director of Finance informed the Board that the Trust had safeguards and agreements in place going forward to ensure that this would not happen again without mutual agreement between 2gether and commissioners.

7.4 Duncan Sutherland asked about the IAPT targets and recovery plan and queried how close the Trust was to achieving these targets. The Acting Chief Executive said that the Trust had

received new investment from commissioners for IAPT services which would help in increasing compliance. It was agreed that a more detailed report on IAPT would be provided alongside the performance dashboard at the May meeting for information.

ACTION: A more detailed report on IAPT would be provided alongside the performance dashboard at the May meeting

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

8. SERVICE EXPERIENCE REPORT – QUARTER 3

8.1 The Board received the Service Experience Report which provided a high level overview of feedback received from service users and carers in Quarter 3 2017/18. Learning from people's experiences was the key purpose of this paper, which provided assurance that service experience information had been reviewed, scrutinised for themes, and considered for both service-specific and general learning across the organisation.

8.2 The Board received significant assurance that the organisation had listened to, heard and understood Service User and carer experience of Trust services. This assurance was offered from information gathered across all domains of feedback. There was significant assurance that service users valued 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 Trust services. However, there was limited assurance that people were participating in the local survey of quality in sufficient numbers.

8.3 The Board received significant assurance that services were consistently reporting details of compliments they received and full assurance that complaints were acknowledged in the required timescale. However, the Director of E&I reported that there was only limited assurance that complaints were being dealt with by the initially agreed timescale and this had fallen to 67%. Significant assurance was given that all complainants received regular updates on any potential delays in the response being provided.

8.4 The Trust continued to seek feedback about service experience from multiple sources on a continuous basis and this report had been discussed at Locality Governance Committees. 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.

8.5 Quinton Quayle made reference to the table looking at overarching closed complaint themes. It was noted that 18 complaints had been received regarding Staff behaviour, and only 2 of these complaints had been upheld. He asked whether there was learning to be taken on board from this as the complaints related mostly to communication problems. The Director of E&I said that Communication continued 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.

8.6 The Board noted the Service Experience Report, and received additional assurance that the report and its content had been scrutinised in detail at the Governance Committee.

9. QUALITY REPORT – QUARTER 3

9.1 The Director of Quality reported that this was the third review of the Quality Report priorities for 2017/18. The report showed the progress being made towards achieving targets, objectives and initiatives identified in the Annual Quality Report.

9.2 The Board noted that the following 3 targets were not currently being met:
1.2 – Personalised discharge care planning
2.1 – Numbers of service users being involved in their care
3.3 – Reduction in the use of prone restraint.

There was also limited assurance that target 3.1 – Reduction in the numbers of reported deaths by suspected suicide would be met by year end.

9.3 There continued to be a sustained focus on unmet targets, particularly in discharge care planning as completion of the necessary documentation was within the gift of staff to accomplish. This target had 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 would be included in the final report at year end. The Director of Quality advised that the use of prone restraint was monitored at the Positive and Safe sub-committee. The Trust was not currently achieving the target, however, assurance was received that some excellent work was being carried out within the Trust to manage this.

9.4 The Board noted the progress made to date and the actions in place to improve/sustain performance where possible. The Board also agreed that the Quarter 3 Quality Report update should be shared with partner organisations, commissioners and governors.

10. QUALITY STRATEGY 2018-2020

10.1 The Quality Strategy 2018 – 2020 had been developed through extensive engagement with colleagues. The strategic vision presented was aligned with the transformation and sustainability agenda and was structured to 'Gain and maintain outstanding quality services for and with Service Users and Carers through assuring safety, optimum treatment outcomes and best service experience'.

10.2 The Director of Quality informed the Board that this had been developed as a visual strategy and continual quality improvement methodology flowed through it.

10.3 The Director of E&I said that she had re-read the strategy with the theme of learning in mind and she was happy that this had been incorporated.

10.4 The Board noted that the strategy had been presented to both the Development Committee and the Executive Committee at different stages of its production. It was agreed that this was an excellent, clear and concise document and those involved in its development were congratulated.

11. LEARNING FROM DEATHS – QUARTER 2 & 3

11.1 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.

11.2 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.

11.3 From Quarter 3 2017, the Trust Board receives a quarterly dashboard report at a public meeting, which includes:

- 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.

11.4 From June 2018, the Trust will publish an annual overview of this information, 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.

11.5 This report included data 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 remained open (52.2%) and require a Mortality Review. 294 of those (98.9%) await a table-top review and 3 (0.7%) require additional discussion at MoReC (a Care Record Review).

11.6 The Board noted that this was still "work in progress" and was asked to recognise that this was at an early stage and that processes in partner organisations, and in primary care were less developed to date. A work-stream was being developed by the Strategic Transformation Partnership to look at how we can get a better understanding of multi-agency working around this.

12. NON-EXECUTIVE DIRECTOR AUDIT OF COMPLAINTS

12.1 The Board received the Non-Executive Director Audit of Complaints that was conducted by Maria Bond. This audit covered three complaints that had been closed between 1 October and 31 December 2017 (Quarter 3 2017/18).

12.2 Maria Bond said that she had found carrying out the audit an excellent learning experience and that 2gether had an excellent system in place for managing complaints and the importance of taking on board the learning from complaints was also demonstrated.

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

12.4 Nikki Richardson made reference to the earlier public question around the NHS Constitution and suggested that the template for carrying out the NED audits be reviewed to take on board key references from the NHS Constitution. The Director of E&I agreed that this would be helpful and agreed to take this forward as an action with the Service Experience Team.

ACTION: Reference to the NHS Constitution to be incorporated into the NED Audit of Complaints audit template

12.5 The Board noted the content of this report and the assurances provided. Maria Bond added her thanks to the Service Experience Team for their assistance in carrying out the audit.

13. SAFE STAFFING 6 MONTHLY REPORT

13.1 The Board received the six monthly safe staffing report, produced in line with the revised safe staffing guidance issued by the National Quality Board (NQB) in July 2016. This 6 monthly update outlined:

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

13.2 National reporting with regards to fill rates continued 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. 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.

13.3 This report also included an initial quality dashboard for the inpatient wards which is a requirement of the NQB guidance – ensuring triangulation of both staffing; workforce indicators and patient experience. This indicated that some wards had higher rates of sickness and turnover, and the Director of Quality would be working with the Director of OD to explore this further.

14. CHIEF EXECUTIVE'S REPORT

14.1 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.

14.2 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.

14.3 The Triangle of Care project is drawing to a close. The final submission report for the Carers Trust was reviewed by the Governance Committee on 23rd February. 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.

14.4 The Board noted that the Gloucester Hub at Pullman Place was now fully operational with all teams having transferred to the refurbished building, and feedback from both service users and staff was very positive. The vacated buildings have either been handed back to the landlords or sales agreed with prospective purchasers. The construction of the Hub was completed on time and the teams moved in on programme. The project is forecast to be completed below the allocated capital expenditure budget. Those members of the Board that had visited the new unit agreed that it was an excellent building and they had been very impressed. The Board asked that their thanks and congratulations be passed on to Andy Telford and his team.

ACTION: Thanks and congratulations to be passed on to Andy Telford and his team for their work in developing the Gloucester Hub at Pullman Court

14.5 The Acting Chief Executive also provided an update in his report on:

- Social Care Project / AMHPs
- Agenda for Change Pay Deal
- Friends and Family test results
- Three Counties Medical School
- National Agreement on Consultant Clinical Excellence Awards

14.6 In addition to the items within the written report, the Acting Chief Executive said that he stood humbled at the professionalism and commitment of Trust staff in both Herefordshire and Gloucestershire who went well beyond the extra mile to ensure services continued to operate safely and service users were supported safely across the period of recent adverse weather. He said that this was another example of why we should all be proud of 2gether staff for the tireless and unselfish commitment they make.

14.7 The Board noted the Chief Executive's report.

15. NATIONAL STAFF SURVEY RESULTS 2017

15.1 This report provided an overview and analysis of the 2017 NHS Annual Staff Survey which was sent to all staff in post on 1st September 2017. The Board noted that NHS England had published the national and local NHS 2017 Staff Survey results on the 6 March 2018. Nationally 487,227 NHS staff members took part.

15.2 It was reported that the local response rate from staff was 45%, an improvement of 5% on the previous year and an increase from 777 responses to 921. While this was a good improvement within the Trust, the rate remained lower than the national average of 52% for Mental Health and Learning Disability Trusts. The Director of OD said that 2gether wanted to continue to improve its response rate, but added that all staff now had the opportunity to respond to the survey, not just a sample which was a positive development.

15.3 The Board noted that 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. This was a strong performance putting 2gether in the top quartile.

15.4 The score for overall staff engagement remained steady but the component parts that made up this result were all shown to be better than average. The Trust's score was 3.88 out of 5 against a national average of 3.79. Overall staff engagement across the NHS had declined for the first time since 2014.

15.5 The Board was significantly assured on staff experience within the Trust. It was agreed that improving staff health and well-being, improving reporting of incidents, making more effective use of patient and service user feedback would be the three priority areas to be focused on over the coming year. Each Locality would review their local ratings and agree two to three priority areas and actions to focus on in the year. The People Committee would progress this work through the Working [2]gether (W[2]) Thematic Group, with Staff Side involvement. Progress would be reported back through the usual Trust communication and governance routes.

16. SUMMARY FINANCIAL REPORT

16.1 The Board received the Finance Report that provided information up to the end of February 2018. The month 11 position was a surplus of £882k which was £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 resulted in a further impairment of £12.571m. Including the impairment the Trust's position at month 11 was a £12.723m deficit. The month 11 forecast outturn was a £953k surplus before the impairment, which is £70k above the Trust's control total. There was 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 before impairments.

16.2 The Trust has an Oversight Framework segment of 2 and a Finance and Use of Resources metric of 2.

16.3 Agency spend at the end of February was £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.

16.4 The Trust has undertaken an Alternative Site Modern Equivalent Asset (MEA) revaluation of its land and buildings and the 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 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.

16.5 The Trust is progressing well with budget setting for next year. The Financial Control Total for 2018/19 has been reduced to an £834k surplus and was accepted by the Board at its February meeting.

16.6 The Director of Finance drew the Board's attention to the cumulative Public Sector Payment Policy (PSPP) performance, noting that month 11 remained at 90% of invoices paid in 10 days and 95% paid in 30 days. The Trust has a strong cash position which enables it to continue to consistently pay suppliers promptly.

16.7 The Board agreed that it would be important to produce some communication for staff and Governors around the financial position. The £12.723m deficit in the balance sheet would not impact on the Trust's financial control total and a detailed explanation of what this was and how it worked was thought to be very helpful.

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

16.8 The Board noted the month 11 financial position. The Director of Finance informed the Board that the Trust's surplus position, before impairments, had not happened by chance and had only been possible due to a lot of hard work from Trust services.

17. CAPITAL EXPENDITURE REPORTING

17.1 Following changes to Committee portfolios, monitoring of capital expenditure (formerly undertaken by the Development Committee) was 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.

17.2 However, 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.

17.3 This report set out options for securing greater NED oversight of capital expenditure, and recommended that monitoring of capital expenditure revert to the Development Committee. Revised terms of reference for the Development Committee were attached for discussion and agreement by the Board. In addition to seeing capital monitoring revert to the Committee, the list of officers in attendance at the Committee had been amended to include the Assistant Director of Finance – Financial Accounts, who leads on capital expenditure.

17.4 The Board approved the recommendation to revert the reporting of capital expenditure to the Development Committee, and approved the revised terms of reference which reflected this change.

18. GENDER PAY GAP REPORTING

18.1 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.

18.2 This report contained the required calculations, presenting the gender pay gap within [2]gether against the six indicators. These were similar to many other NHS employers positions published to date, as follows:

- 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

18.3 The Director of OD said that it was important to be clear that this report related to the Gender Pay Gap, and not Equal Pay which was very different. He noted that the NHS tended to perform better in relation to pay systems due to nationally agreed conditions such as Agenda for Change.

18.4 The Board noted this report and supported 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. The Board also agreed that an annual report on the Gender Pay Gap should be received.

ACTION: Annual Gender Pay Gap report to be scheduled annually for March

19. JOINT STRATEGIC INTENT UPDATE

19.1 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. Paul Roberts had been appointed as the Joint Chief Executive and would commence in post during April.

19.2 The 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 2gether's financial plans for 2018/19 and 2019/20, and we are now putting the staffing/project resources in place to drive the project.

19.3 The Acting Chief Executive said that it was 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.

19.4 At the current time we are focused 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.

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

20. BOARD COMMITTEE REPORTS - AUDIT COMMITTEE

20.1 Marcia Gallagher presented the summary report from the Audit Committee meeting held on 7 February. This report and the assurances provided were noted.

21. BOARD COMMITTEE REPORTS – DEVELOPMENT COMMITTEE

21.1 The Board received the summary report from the Development Committee meeting held on 7 February. This report and the assurances provided were noted.

22. BOARD COMMITTEE REPORTS – DELIVERY COMMITTEE

22.1 Maria Bond presented the summary report from the Delivery Committee meeting held on 21 February. This report and the assurances provided were noted.

23. BOARD COMMITTEE REPORTS – GOVERNANCE COMMITTEE

23.1 Nikki Richardson presented the summary report from the Governance Committee meeting that had taken place on 23 February. This report and the assurances provided were noted.

23.2 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 Governance Committee therefore 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.

24. BOARD COMMITTEE REPORTS – MH LEGISLATION SCRUTINY COMMITTEE

24.1 Quinton Quayle presented the summary report from the MH Legislation Scrutiny Committee meeting held on 14 March. This report and the assurances provided were noted.

24.2 The Committee had endorsed changes to its terms of reference which more accurately reflected the work of Mental Health professionals across the local health and social care system. The revised terms of reference were presented to and subsequently approved by the Board.

25. BOARD COMMITTEE REPORTS – CHARITABLE FUNDS COMMITTEE

25.1 Duncan Sutherland provided a verbal report from the Charitable Funds Committee meeting held on 27 March. A written summary from this meeting would be provided at the May Board meeting.

26. INFORMATION SHARING REPORTS

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

- Chair's Report
- Council of Governors Minutes – January 2018

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

27. ANY OTHER BUSINESS

27.1 There was no other business.

28. DATE OF THE NEXT MEETING

28.1 The next Board meeting would take place on Thursday 31 May 2018 at The Kindle Centre, Hereford.

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

BOARD MEETING
ACTION POINTS

Date of Mtg	Item ref	Action	Lead	Date due	Status/Progress
28 Mar 2018	7.4	A more detailed report on IAPT would be provided alongside the performance dashboard at the May meeting	John Campbell	May	
	12.4	Reference to the NHS Constitution to be incorporated into the NED Audit of Complaints audit template	Jane Melton	June	The NED Audit template will be reviewed for use by the Q1 2018/19 audit
	14.4	Thanks and congratulations to be passed on to Andy Telford and his team for their work in developing the Gloucester Hub at Pullman Court	Colin Merker	May	**Complete**
	16.7	Director of Finance to develop easy read communication around the Trust's year-end financial position that could be shared with staff, Governors and stakeholders	Andrew Lee	May	**Complete** To be agreed at Audit Committee on 25 May and information can then be shared as appropriate
	18.4	Annual Gender Pay Gap report to be scheduled annually for the March Board	Trust Secretariat		**Complete**

RESPONSE TO QUESTION ASKED AT MARCH 2018 PUBLIC BOARD MEETING

Question

How many times has 2gether NHS Foundation Trust cited the NHS Constitution in its strategic work over the last 12 months? If so, in what context has this been cited?

Response

Whilst it has not been possible to establish how many times we have cited the NHS Constitution in our strategic work over the last 12 months, the following provides an overview of how and in what context it has been cited.

The NHS Constitution establishes the principles and values of the NHS in England, and, as such, is the bedrock of everything we do. The Constitution is reflected in almost every element of the Trust's work, including the high quality services we give fair and effective access to, our policies and procedures, and the right to complain or raise concerns and have those concerns and complaints responded to and acted upon. Our Code of Governance (which is published annually in our Annual Report) confirms that we have adopted our own governance framework, which requires Governors, Directors and staff to have regard for recognised standards of conduct, including the overarching objectives and principles of the NHS, the seven Nolan Principles, the NHS Constitution and the NHS Foundation Trust Code of Governance.

Some specific examples of how we promote and share the values of the constitution include:

- A dedicated page on our Trust website: https://www.2gether.nhs.uk/nhs-constitution/
- A link to the NHS Constitution handbook from our website: https://www.2gether.nhs.uk/files/NHS_constitution_handbook_acc.pdf
- Our staff charter, which is built upon and specifically references the NHS Constitution: https://www.2gether.nhs.uk/wp-content/uploads/staff-charter.pdf
- Our Carers Charter, which is built upon the principles of the NHS Constitution: https://www.2gether.nhs.uk/files/Carers_Charter_2011.pdf
- Our Service User Promise (Charter) is also built upon the principles of the NHS Constitution: and on our website here: https://www.2gether.nhs.uk/nhs-constitution/ (bottom of the page)
- Our Core Values, built upon the principles of the Constitution, can be found here: https://www.2gether.nhs.uk/about-us/
- Our Service Experience reports, published both within and outside the Trust, state that 'listening to 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), a key component of the Trust's core values.'

If you look in our 2016/17 annual report you will also see that in our Director of HR and OD's biography it says:

She has responsibility for ensuring colleagues have the knowledge and skills to lead our services into the future, that our culture reflects Trust values and the NHS Constitution and, last but not least, that the health and wellbeing of staff is assured.

We will be looking at how we ensure that the NHS Constitution is visible to everyone who works for us and is seen as key as our vision and values as an organisation. Whilst our staff induction programme introduction by the Chief Executive covers the principles of the NHS Constitution, we are revising our slides to make clearer reference and we will be reviewing how it may as a standard be referenced in our job descriptions and/or person specifications.

Agenda item 7 **PAPER B**

Report to:	2gether Trust Board – 31 May 2018
Author:	Chris Woon, Head of Information Management and Clinical Systems
Presented by:	Colin Merker, Deputy Chief Executive

SUBJECT: **Performance Dashboard Report for the contract year 2017-18**

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

EXECUTIVE SUMMARY:

Overview

This outturn report sets out the performance of the Trust for the full 2017/18 contract period against our NHSI, Department of Health, Herefordshire and Gloucestershire CCG Contractual and CQUIN key performance indicators.

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

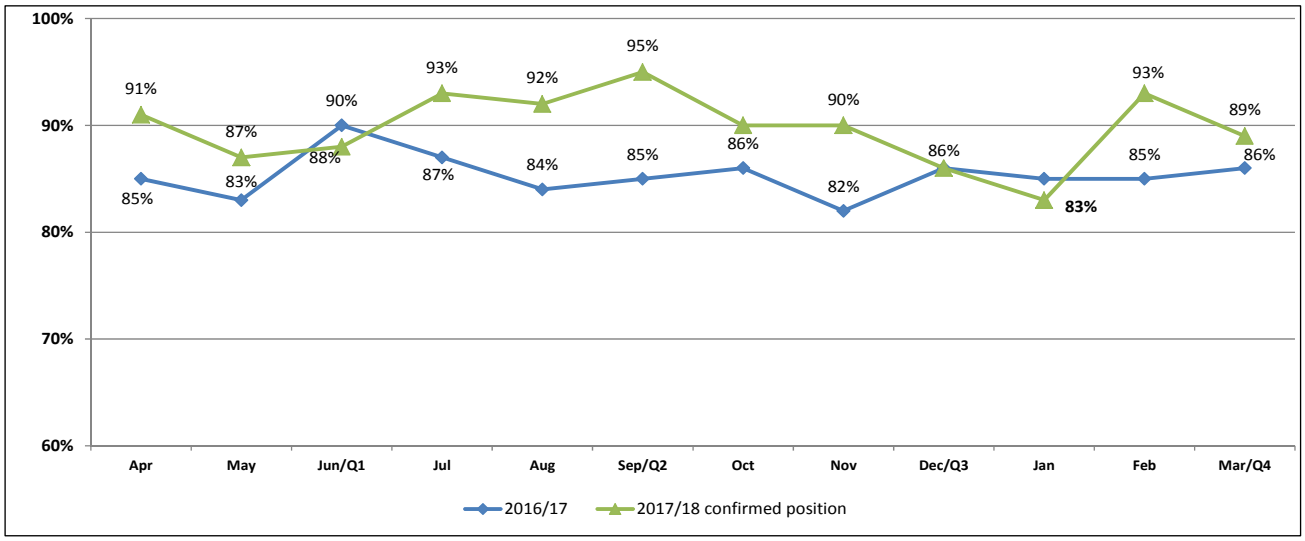
The key performance indicators that were compliant at the end of 2016/17 but non-compliant at the end of 2017/18 are:

- 3.07: Reduction in the number of reported suicides in the community and inpatient units.
- 3.27: CYPS: Level 2 and 3: Referral to treatment within 8 weeks
- 3.28: CYPS: Level 2 and 3: Referral to treatment within 10 weeks

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

Indicators Reported in 2017/18 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	9	8	1	11	1	0
Gloucestershire CCG Contract	76	46	37	9	20	7	23
Social Care	15	13	12	1	8	2	0
Herefordshire CCG Contract	22	16	13	3	19	6	0
CQUINS	25	25	25	0	0	0	0
Overall	179	139	123	16	12	17	23

The following graph shows our percentage compliance by month and the previous year's compliance for comparison



Summary Exception Reporting

The following 16 key performance thresholds were not met cumulatively for the Trust for 2017/18:

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

Department of Health Requirements

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

Gloucestershire CCG Contract Measures

- 3.07 – Reduction in the number of reported suicides in the community and inpatient units
- 3.19 – IAPT: Access rate
- 3.27 – CYPS: Level 2 and 3: Referral to treatment within 8 weeks
- 3.28 – CYPS: Level 2 and 3: Referral to treatment within 10 weeks
- 3.38 – Transition of CYPS to Adult Mental Health Care within 4 weeks
- 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: Wait time for assessments will be 4 weeks

Gloucestershire Social Care Requirements

- 4.03 – Ensure that reviews of new packages takes place within 12 weeks of commencement

Herefordshire CCG Contract Measures

- 5.08 – IAPT: Recovery rate
- 5.09 – IAPT maintain 15% of patients entering the service against prevalence
- 5.17 – CYP Eating Disorders: Urgent referral to NICE treatment within 1 week

There are currently 4 measures labelled as Not Yet Available

- 3.32: Number on the caseload during the year finding paid employment or self-employment
- 3.33: Number of people retaining employment at 3/6/9/12 + months
- 3.34: Number of people supported to retain employment at 3/6/9/12 + months
- 3.36: GP practices will have an individual annual (MH) ICT service review meeting

Where non-compliance has highlighted issues within a service, Service Directors have taken the lead to address issues and indicators have been “red flagged” to show where further analysis and work has been undertaken to fully scope data quality and performance issues.

Section 2 of this report provides a detailed commentary on indicators which did not meet the required performance threshold level during the final month of the year and also cumulatively for the 2017-18 reporting period.

RECOMMENDATIONS

The Board is asked to:

- Note the Performance Dashboard Report for the full 2017-18 contract period.
- Accept the report as a significant level of assurance that our contract and regulatory performance measures are being met or that appropriate action plans are in place to address areas requiring improvement.
- Be assured that there is ongoing work to review all of the indicators not meeting the required performance threshold. This includes a review of the measurement and data quality processes as well as clinical delivery and clinical practice issues.

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

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

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

Reviewed by:		
John Campbell	Date	May 2018

Where in the Trust has this been discussed before?		
Delivery Committee	Date	23 May 2018

What consultation has there been?		
Not applicable.	Date	

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

1. CONTEXT

This report sets out the performance Dashboard for the Trust for the complete 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 the completion of the 2017-18 period. 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
	Jan	Feb	Mar	
Total Measures	14	14	14	14
	3	2	1	2
	10	11	12	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):

1.10: 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
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
As above

Changes to Previously Reported Figures

None

Early Warnings / Notes

None

NHS Improvement Requirements

ID	Performance Measure (PM)		2016/17Outturn	January-2018	February-2018	March-2018	(Apr to Mar) Cumulative Compliance
1							
1.01	Number of MRSA Bacteraemias	PM	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
		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%
		Gloucestershire	98%	98%	100%	98%	99%
		Herefordshire	99%	100%	97%	96%	99%
		Combined Actual	98%	99%	99%	98%	99%
1.04	Care Programme Approach - formal review within12 months	PM	95%	95%	95%	95%	95%
		Gloucestershire	99%	98%	98%	98%	98%
		Herefordshire	99%	98%	99%	96%	98%
		Combined Actual	99%	98%	98%	98%	98%
1.05	Nationally reported - Delayed Discharges (Including Non Health)	PM	7.5%	7.5%	7.5%	7.5%	7.5%
		Gloucestershire	1.6%	3.5%	3.4%	3.3%	3.2%
		Herefordshire	2.2%	3.1%	5.5%	2.3%	2.4%
		Combined Actual	1.8%	3.4%	4.0%	3.0%	3.0%
1.05b	- Delayed Discharges - Outliers	PM					
		Gloucestershire		9.9%	9.6%	7.8%	10.1%
		Herefordshire		9.3%	9.7%	8.7%	12.5%
		Combined Actual		9.8%	9.6%	8.1%	10.7%
1.06	Admissions to Adult inpatient services had access to Crisis Resolution Home Treatment Teams	PM	95%	95%	95%	95%	95%
		Gloucestershire	99%	100%	96%	97%	99%
		Herefordshire	100%	100%	100%	100%	100%
		Combined Actual	99%	100%	98%	98%	99%
1.07	New psychosis (EI) cases as per contract	PM	72	60	66	72	72
		Gloucestershire	67	65	71	80	80
		PM	24	20	22	24	24
		Herefordshire	20	28	31	31	31
		PM	96	80	88	96	96
		Combined Actual	87	93	102	111	111
1.08	New psychosis (EI) cases treated within 2 weeks of referral	PM	50%	50%	50%	50%	50%
		Gloucestershire	72%	50%	67%	56%	71%
		Herefordshire	70%	0%	67%	N/A	68%
		Combined Actual	71%	33%	67%	56%	70%

NHS Improvement Requirements

ID	Performance Measure (PM)		2016/17Outturn	January-2018	February-2018	March-2018	(Apr to Mar) Cumulative Compliance
1.09	IAPT - Waiting times: Referral to Treatment within 6 weeks (based on discharges)	PM	75%	75%	75%	75%	75%
		Gloucestershire	35%	75%	74%	80%	69%
		Herefordshire	49%	59%	69%	57%	59%
		Combined Actual	38%	73%	73%	76%	67%
1.10	IAPT - Waiting times: Referral to Treatment within 18 weeks (based on discharges)	PM	95%	95%	95%	95%	95%
		Gloucestershire	86%	91%	88%	89%	88%
		Herefordshire	85%	68%	73%	69%	75%
		Combined Actual	86%	88%	85%	85%	85%
1.11	**MENTAL HEALTH SERVICES DATA SET PART 1 DATA COMPLETENESS: OVERALL**	PM	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%
		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%
		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%
		Gloucestershire	99.9%	100.0%	100.0%	100.0%	99.9%
		Herefordshire	99.9%	100.0%	100.0%	100.0%	99.9%
		Combined Actual	99.9%	100.0%	100.0%	100.0%	99.9%
1.11d	Mental Health Services Data Set Part 1 Data completeness: Organisation code of commissioner	PM	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%
		Gloucestershire	99.8%	99.7%	99.8%	99.8%	99.8%
		Herefordshire	99.8%	99.9%	99.9%	99.8%	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%
		Gloucestershire	99.4%	99.7%	99.6%	99.6%	99.6%
		Herefordshire	99.7%	99.7%	99.9%	99.9%	99.7%
		Combined Actual	99.5%	99.7%	99.7%	99.7%	99.7%

NHS Improvement Requirements

ID	Performance Measure (PM)		2016/17Outturn	January-2018	February-2018	March-2018	(Apr to Mar) Cumulative Compliance
1.12	**MENTAL HEALTH SERVICES DATA SET PART 2 DATA COMPLETENESS : OVERALL**	PM	50%	50%	50%	50%	50%
		Gloucestershire	95.7%	94.4%	94.2%	94.2%	94.7%
		Herefordshire	92.5%	89.5%	90.0%	89.9%	90.9%
		Combined Actual	95.1%	93.5%	93.4%	93.5%	94.1%
1.12a	Mental Health Services Data Set Part 2 Data completeness: CPA Employment status last 12 months	PM	50%	50%	50%	50%	50%
		Gloucestershire	90.0%	89.0%	88.7%	88.8%	89.4%
		Herefordshire	89.2%	84.5%	85.2%	84.9%	86.4%
		Combined Actual	89.9%	88.2%	88.1%	88.1%	88.9%
1.12b	Mental Health Services Data Set Part 2 Data completeness: CPA Accommodation Status in last 12 months	PM	50%	50%	50%	50%	50%
		Gloucestershire	97.3%	96.1%	95.8%	96.0%	96.6%
		Herefordshire	89.6%	85.3%	85.6%	85.3%	87.1%
		Combined Actual	95.9%	94.2%	94.1%	94.1%	94.9%
1.12c	Mental Health Services Data Set Part 2 Data completeness: CPA HoNOS assessment in last 12 months	PM	50%	50%	50%	50%	50%
		Gloucestershire	99.6%	98.0%	97.9%	97.9%	98.2%
		Herefordshire	98.5%	98.8%	99.2%	99.6%	99.2%
		Combined Actual	99.4%	98.1%	98.2%	98.2%	98.4%
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
		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
	Jan	Feb	Mar	
Total Measures	27	27	27	27
	1	0	1	1
	24	25	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 were 2 admissions to under 18 adult wards in March, 1 in Gloucestershire and 1 in Herefordshire.

In Gloucestershire a 16 year old was admitted to Dean Ward, Wotton Lawn following an assessment at A&E. The young person had suicidal intent and plan expressed and was unable to return home. Accommodation was sought and the patient was discharged 10 days later to a social care address.

In Herefordshire a 17 year old in a Residential Care Home was admitted to Stonebow after an MHA review when section 2 was applied. There were significant management issues at the Care Home which escalated into attempts to harm self and voicing desire to end life.
Referral was made for a Tier 4 bed and after continuous review Section 2 was removed with recommendation that the young person be discharged back to into care of the Care Home. The young person was discharged after 23 days.

Cumulative Performance Thresholds Not being Met

2.21: No children under 18 admitted to adult inpatient wards
During 2017/18 there were 11 under 18s admitted to adult inpatient wards, 6 in Gloucestershire and 5 in Herefordshire.

Now that the year has closed an internal review of the under 18 admissions in 2017/18 (11) will be undertaken and the lessons learned will be shared with partner organisations.

Changes to Previously Reported Figures

None

Early Warnings

None

DOH Never Events

ID	Performance Measure (PM)		2016/17Outturn	January-2018	February-2018	March-2018	(Apr to Mar) Cumulative Compliance
2							
2.01	Wrongly prepared high risk injectable medications	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.02	Maladministration of potassium containing solutions	PM	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
		Actual	0	0	0	0	0
2.04	Intravenous administration of epidural medication	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.05	Maladministration of insulin	PM	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
		Actual	0	0	0	0	0
2.07	Opioid overdose in opioid naive patient	PM	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
		Actual	0	0	0	0	0
2.09	Suicide using non collapsible rails	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.10	Falls from unrestricted windows	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.11	Entrapment in bedrails	PM	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
		Actual	0	0	0	0	0
2.13	Wrong gas administered	PM	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
		Actual	0	0	0	0	0
2.15	Air embolism	PM	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
		Actual	0	0	0	0	0
2.17	Mis-identification of patients	PM	0	0	0	0	0
		Actual	0	0	0	0	0

DOH Requirements

ID	Performance Measure (PM)		2016/17Outturn	January-2018	February-2018	March-2018	(Apr to Mar) Cumulative Compliance
2.18	Mixed Sex Accommodation - Sleeping Accommodation Breaches	PM	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
		Gloucestershire	10	0	0	1	6
		Herefordshire	8	1	0	1	5
		Combined	18	1	0	2	11
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	January-2018	February-2018	March-2018	(Apr to Mar) Cumulative Compliance
2.24	Serious Incident Reporting (SI)	Glos	35	2	3	1	33
		Hereford	8	1	0	2	18
2.25	All SIs reported within 2 working days of identification	PM	100%	100%	100%	100%	100%
		Gloucestershire	100%	100%	100%	100%	100%
		Herefordshire	100%	100%	N/A	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%
		Gloucestershire	91%	100%	100%	100%	100%
		Herefordshire	78%	100%	N/A	100%	100%
2.27	SI Report Levels 1 & 2 to CCG within 60 working days	PM	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%
		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	0	3	2	5
		Herefordshire	1	1	0	1	2

DASHBOARD CATEGORY – GLOUCESTERSHIRE CCG CONTRACTUAL REQUIREMENTS

Gloucestershire Contract				
	In month Compliance			Cumulative Compliance
	Jan	Feb	Mar	
Total Measures	76	76	76	76
	7	4	9	9
	17	24	29	37
NYA	11	11	26	21
NYR	39	34	7	2
UR	0	0	0	0
N/A	2	3	5	7

Performance Thresholds not being achieved in Month

3.07: Reduction in the number of reported suicides in the community and inpatient units
At the end of 2017/18 the number of reported suspected suicides was 28, 2 more than at the end of last year. We know that we are seeing more and more service users on our caseload year on year so we also measure suicide rate per 1000 service users on caseload for a more complete measure. The median value of this rate is 0.09 and remains unchanged since 2015/16.

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. An improved level of investment has been agreed with GCCG to meet the 19% access target by quarter 4 2018/19.

3.27: CYPS: Level 2 & 3 –Referral to treatment within 8 weeks and

3.28: CYPS: Level 2 & 3 –Referral to treatment within 10 weeks

Gloucestershire CYPS service performance in the 2017/18 Q3 and Q4 period fell short of meeting the 80% threshold for the 8 week Referral to Treatment (RTT) and the 95% threshold for the 10 week RTT wait time targets for the first time in the last three years.

There are multiple factors behind the drop in the RTT performance for the CYP service during this period. The service has experienced an increase in accepted referrals for level 2 and 3 service provision and as a result the service are undertaking demand and capacity analysis across the range of clinical care pathways in order to understand better how the service can effectively manage this increase in accepted referrals. This work will be completed within the next month and the outcomes will be discussed with service commissioners.

The service have also identified and reported to our commissioners the average length of treatment / contact for CYP treated within our service has increased, indicating that we are managing an increase in complex cases which is impacting on the service throughput. Finally, the staffing capacity levels in the Q2 and Q3 period fell below our planned staffing establishment, however 5 Whole Time Equivalent (WTE) vacancies have been recruited to within in the last few months and these new staff are currently working through the service induction process before they become fully clinically productive. It is anticipated the new staff will be fully productive by the end of Q2 in 2018/19, and this will have a positive impact on our capacity to meet demand.

It is important to acknowledge that whilst the service is experiencing challenges meeting the local RTT target thresholds, we remain one of the highest performers nationally for CYPS RTT. The national RTT target for CYPS is 18 weeks and NHS national benchmarking project confirmed in 2017 the Gloucestershire CYPS service as having some of the best performance levels in England for rapid service access and low waiting times.

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

A joint meeting between Recovery and CYPS Services has been held.
The cases were clinically reviewed and it has been confirmed that all relevant clinical steps have been taken in the required time; however it was felt that correcting recording on RiO would be too complex.
Going forward, the transition policy and processes are to be reviewed to ensure that recording becomes simpler and timelier.

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

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

Cumulative Performance Thresholds Not being Met

3.07: Reduction in the number of reported suicides in the community and inpatient units
As above

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

3.27: CYPS: Level 2 & 3 –Referral to treatment within 8 weeks and
3.28: CYPS: Level 2 & 3 –Referral to treatment within 10 weeks
As above

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

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
As above

3.53: Adolescent Eating Disorders: Routine referral to Non-NICE treatment within 4 weeks
As for 3.50 and 3.52 above

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

Changes to Previously Reported Figure

The following indicators that have previously been reported as Not Yet Available can now be reported on and are compliant:

- 3.08: To reduce the number of detained patients absconding from inpatient units
- 3.10: Minimum of 5% increase in the uptake of flu vaccination (on 15/16)
- 3.23: To demonstrate improvements in staff experience following national and local surveys
- 3.35: Vocational Services: Fidelity to the IPS model

The following indicator that has previously been reported as Not Yet Available can now be reported on and is non- compliant:

- 3.07: Reduction in the number of reported suicides in the community and inpatient units

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2016/17 outturn	January-2018	February-2018	March-2018	(Apr to Mar) Cumulative Compliance
	B. NATIONAL QUALITY REQUIREMENT						
3.01	Zero tolerance MRSA	PM	0	0	0	0	0
		Unavoidable	1	0	0	0	0
3.02	Minimise rates of Clostridium difficile	PM	0	0	0	0	0
		Unavoidable	1	0	0	0	0
3.03	Duty of candour	PM	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%
		Actual	99%	100%	100%	100%	100%
3.05	Completion of Mental Health Services Data Set ethnicity coding for all detained and informal Service Users	PM	90%	90%	90%	90%	90%
		Actual	99%	97%	100%	98%	99%
3.06	Completion of IAPT Minimum Data Set outcome data for all appropriate Service Users	PM	90%	90%	90%	90%	90%
		Actual	99%	100%	99%	100%	99%
	C. Local Quality Requirements						
	Domain 1: Preventing People dying prematurely						
3.07	Increased focus on suicide prevention and reduction in the number of reported suicides in the community and inpatient units	PM	Report			Report	Annual
		Actual	Complete			28	28
3.08	To reduce the numbers of detained patients absconding from inpatient units where leave has not been granted	PM	< 144			< 36	< 144
		Actual	96			26	122
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			Report	Annual
		Actual	Compliant			NA	NA
3.10	Minimum of 5% increase in uptake of flu vaccination (15/16 55.3%)	PM	>55.3%			Annual	Annual
		Actual	77.2%			76%	76%
	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%
		Actual	93%	93%	94%	95%	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%
		Actual	99%	100%	100%	100%	100%

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2016/17 outturn	January-2018	February-2018	March-2018	(Apr to Mar) Cumulative Compliance
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%
		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%
		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%
		Actual	95%			97%	97%
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%
		Actual	95%	94%	92%	93%	93%
3.17	AKI (previous CQUIN 1516) 95% of pts to have EWS score within 12 hours	PM	95%			95%	95%
		Actual	99%			96%	98%
	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%
		Actual	47%	46%	51%	45%	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%
		Actual	8.20%	1.20%	0.96%	1.11%	13.32%
3.20	IAPT reliable improvement rate: Access to psychological therapies for adults should be improved	PM	50%	50%	50%	50%	50%
		Actual	73%	68%	70%	64%	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%
		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
		Actual	Compliant			93%	93%
	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			Report	Annual
		Actual	Compliant			Compliant	Compliant
	CYPS						
3.24	Number of children that received support within 24 hours of referral, for crisis home treatment (CYPS)	PM	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%
		Actual	99%	99%	98%	98%	99%

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2016/17 outturn	January-2018	February-2018	March-2018	(Apr to Mar) Cumulative Compliance
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%
		Actual	99%			97%	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%
		Actual	89%			40%	78%
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%
		Actual	96%			51%	86%
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%
		Actual	94%	85%	91%	89%	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%
		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%
		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%			NYA	NYA
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%			NYA	NYA
3.34	The number of people supported to retain employment at 3/6/9/12+ months	PM	50%			50%	50%
		Actual	88%			NYA	NYA
3.35	Fidelity to the IPS model	PM	Report			90%	90%
		Actual	Compliant			100%	100%

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2016/17 outturn	January-2018	February-2018	March-2018	(Apr to Mar) Cumulative Compliance
	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			Report	Report
		Actual	NYA			NYA	NYA
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
		Actual	Compliant			82%	82%
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%
		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%
		Actual	NYR				NYR
3.40	MHARS wait time to assessment (4 hours)	PM	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			100%		100%
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			Report		Report
		Actual			Compliant		Compliant
3.43	LD: People with learning disabilities and their families report high levels of satisfaction with specialist learning disability services	PM			75%		75%
		Actual			Compliant		Compliant
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			100%		100%
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			80%		80%
3.46	Gloucestershire Sanctuary (Alexandra Road Wellbeing House) dataset available for Commissioners	PM		Report	Report	Report	Report
		Actual		Compliant	Compliant	Compliant	Compliant
3.47	IAPT DNA rate	PM		<16%	<16%	<16%	<16%
		Actual		12%	14%	13%	13%

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2016/17 outturn	January-2018	February-2018	March-2018	(Apr to Mar) Cumulative Compliance
3.48	CPI: Referral to Assessment within 4 weeks	PM		85%	85%	85%	85%
		Actual		94%	100%	100%	91%
3.49	CPI: Assessment to Treatment within 16 weeks	PM		85%	85%	85%	85%
		Actual		100%	100%	100%	99%
3.50	Adolescent Eating Disorders - Urgent referral to NICE treatment start within 1 week	PM		95%	95%	95%	95%
		Actual		0%	50%	67%	64%
3.51	Adolescent Eating Disorders - Urgent referral to non-NICE treatment start within 1 week	PM		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%
		Actual		33%	75%	33%	29%
3.53	Adolescent Eating Disorders - Routine referral to non-NICE treatment start within 4 weeks	PM		95%	95%	95%	95%
		Actual		0%	N/A	N/A	9%
3.54	Number of children in crisis urgently referred that receive support within 24 hours of referral by CYPS	PM				95%	95%
		Actual				100%	100%
3.55	MHARS Wait time to Assessment: Triage wait time 1 hour	PM		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%
		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%
		Actual		64%	81%	88%	75%
3.58	Patients with Dementia have weight assessments on admission	PM				85%	85%
		Actual				NYA	NYA
3.59	Patients with Dementia have weight assessments at weekly intervals	PM				85%	85%
		Actual				NYA	NYA
3.60	Patients with Dementia have weight assessments near discharge	PM				85%	85%
		Actual				NYA	NYA
3.61	Patients with Dementia have delirium screening on admission	PM				85%	85%
		Actual				NYA	NYA
3.62	Patients with Dementia have delirium screening at weekly intervals	PM				85%	85%
		Actual				NYA	NYA
3.63	Patients with Dementia have delirium screening near discharge	PM				85%	85%
		Actual				NYA	NYA

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2016/17 outturn	January-2018	February-2018	March-2018	(Apr to Mar) Cumulative Compliance
3.64	Eating Disorders - Wait time for adult assessments will be 4 weeks	PM		95%	95%	95%	95%
		Actual		28%	43%	41%	36%
3.65	Eating Disorders - Wait time for adult psychological interventions will be 16 weeks	PM		95%	95%	95%	95%
		Actual		NYA	NYA	NYA	NYA
3.66	Perinatal: Urgent Referral to Assessment within 6 hours - During working hours (unless otherwise negotiated with referrer or patient) in conjunction with Crisis Team	PM				85%	85%
		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%
		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%
		Actual				NYA	NYA
3.69	Perinatal: Preconception advice - Referral to assessment within 6 weeks	PM				50%	50%
		Actual				NYA	NYA
3.70	Perinatal: Preconception advice - Referral to assessment within 8 weeks	PM				95%	95%
		Actual				NYA	NYA
3.71	Perinatal: Routine referral to assessment within 2 weeks	PM				50%	50%
		Actual				NYA	NYA
3.72	Perinatal: Routine referral to assessment within 6 weeks	PM				95%	95%
		Actual				NYA	NYA
3.73	Perinatal: Number of women asked if they have a carer	PM				80%	80%
		Actual				82%	82%
3.74	Perinatal: Number of women with a carer offered carer's assessment	PM				90%	90%
		Actual				90%	90%
3.75	Perinatal: Women and families views inform the development of the service via a service user forum	PM				Report	Report
		Actual				NYA	NYA
3.76	Perinatal: All to have a Perinatal Care Plan and reviewed within 3 months	PM				95%	95%
		Actual				NYA	NYA
3.77	Perinatal: Reduction in number of episodes of Crisis	PM				Report	Report
		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.

Department of Health

2.21: No children under 18 admitted to adult inpatient wards
A 16 year old was admitted to Dean Ward, Wotton Lawn following an assessment at A&E. The young person had suicidal intent and plan expressed and was unable to return home. Accommodation was sought and the patient was discharged 10 days later to a social care address.

Changes to Previously Reported Figures

None

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

ID	Performance Measure (PM)		2016/17Outturn	January-2018	February-2018	March-2018	(Apr to Mar) Cumulative Compliance
NHSI 1.01	Number of MRSA Bacteraemias avoidable	PM	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
		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%
		Actual	98%	98%	100%	98%	99%
NHSI 1.05	Delayed Discharges (Including Non Health)	PM	7.5%	7.5%	7.5%	7.5%	7.5%
		Actual	1.6%	3.5%	3.4%	3.3%	3.2%
NHSI 1.06	Admissions to Adult inpatient services had access to Crisis Resolution Home Treatment Teams	PM	95%	95%	95%	95%	95%
		Actual	99%	100%	96%	97%	99%
NHSI 1.08	New psychosis (EI) cases treated within 2 weeks of referral	PM	50%	50%	50%	50%	50%
		Actual	72%	50%	67%	56%	71%
NHSI 1.09	IAPT - Waiting times: Referral to Treatment within 6 weeks (based on discharges)	PM	75%	75%	75%	75%	75%
		Actual	35%	75%	74%	80%	69%
NHSI 1.10	IAPT - Waiting times: Referral to Treatment within 18 weeks (based on discharges)	PM	95%	95%	95%	95%	95%
		Actual	86%	91%	88%	89%	88%
DoH 2.18	Mixed Sex Accommodation Breach	PM	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
		Actual	10	0	0	1	6
DoH 2.25	All SIs reported within 2 working days of identification	PM	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%	100%	N/A	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%
		Actual	100%	NYR	NYR	NYR	100%

DASHBOARD CATEGORY – GLOUCESTERSHIRE SOCIAL CARE

Gloucestershire Social Care				
	In month Compliance			Cumulative Compliance
	Jan	Feb	Mar	
Total Measures	15	15	15	15
	1	0	0	1
	12	13	13	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
None

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 have been addressed and performance is reported as 100% compliant each month since December 2017.

Changes to Previously Reported Figures
None

Early Warnings/Notes
None

Gloucestershire Social Care

ID	Performance Measure		2016/17 outturn	January-2018	February-2018	March-2018	(Apr to Mar) Cumulative Compliance
4.01	The percentage of people who have a Cluster recorded on their record	PM	90%	95%	95%	95%	95%
		Actual	96%	98%	98%	98%	98%
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%
		Actual	95%	92%	98%	95%	97%
4.03	Ensure that reviews of new packages take place within 12 weeks of commencement	PM	95%	80%	80%	80%	80%
		Actual	22%	100%	100%	100%	74%
4.04	Current placements aged 18-64 to residential and nursing care homes per 100,000 population	PM	13	13	13	13	13
		Actual	12.90	9.86	9.61	9.36	9.44
4.05	Current placements aged 65+ to residential and nursing care homes per 100,000 population	PM	22	22	22	22	22
		Actual	16.55	17.90	18.76	18.67	16.54
4.06	% of WA & OP service users on caseload asked if they have a carer	PM	100%	80%	80%	80%	80%
			86%	88%	88%	88%	88%
4.07	% of WA & OP service users on the caseload who have a carer, who have been offered a carer's assessment	PM	100%	90%	90%	90%	90%
		Actual	75%	93%	92%	91%	91%
4.08a	% of WA & OP service users/carers on caseload who accepted a carers assessment	PM	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
		Actual	244	520	517	521	521
4.09	% of eligible service users with Personal budgets	PM	80%	80%	80%	80%	80%
		Actual	100%	95%	95%	95%	95%

Gloucestershire Social Care

ID	Performance Measure		2016/17 outturn	January-2018	February-2018	March-2018	(Apr to Mar) Cumulative Compliance
4.10	% of eligible service users with Personal Budget receiving Direct Payments (ASCOF 1C pt2)	PM	15%	15%	15%	15%	15%
		Actual	18%	18%	19%	18%	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%
		Actual	89%	87%	87%	87%	87%
4.12	Adults not subject to CPA in contact with secondary mental health service in settled accommodation	PM	90%	90%	90%	90%	90%
		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%
		Actual	16%	18%	18%	18%	18%
4.14	Adults not subject to CPA receiving secondary mental health service in employment	PM	20%	20%	20%	20%	20%
		Actual	24%	23%	22%	21%	21%

DASHBOARD CATEGORY – HEREFORDSHIRE CCG CONTRACTUAL REQUIREMENTS

Herefordshire Contract				
	In month Compliance			Cumulative Compliance
	Jan	Feb	Mar	
Total Measures	22	22	22	22
🔴	3	1	2	3
🟢	12	14	12	13
NYA	0	0	0	0
NYR	0	0	0	0
UR	0	0	0	0
N/A	7	7	8	6

Performance Thresholds not being achieved in Month

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

5.09: 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. Trajectory plans and an associated investment envelope have been agreed with Herefordshire CCG in order to meet the 19% access target by quarter 4 2018/19. A service improvement development plan is being produced.

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.

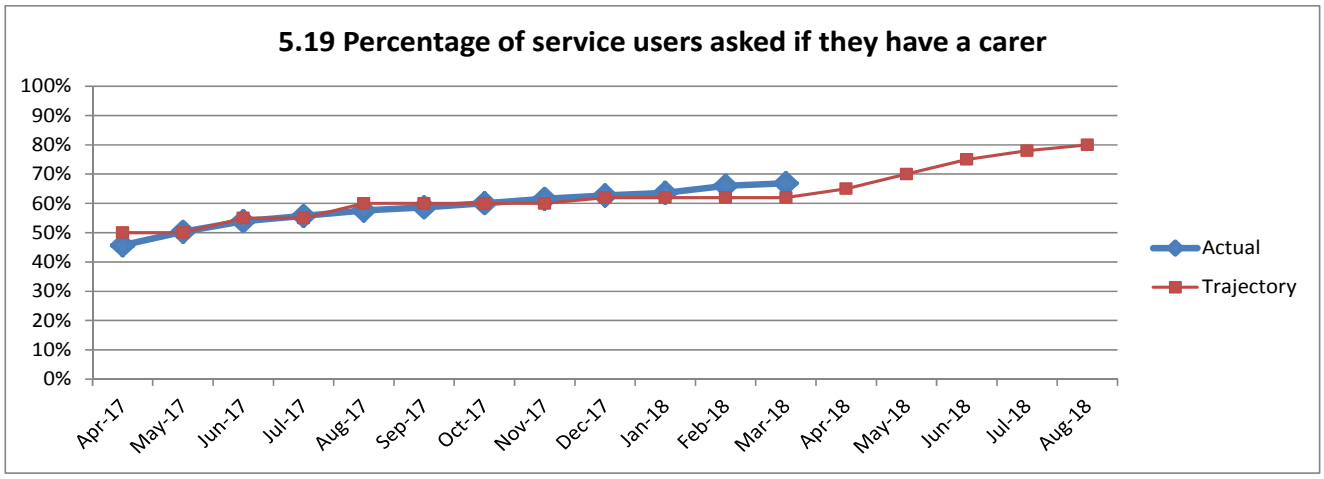
Changes to Previously Reported Figures

None

Early Warnings / Notes

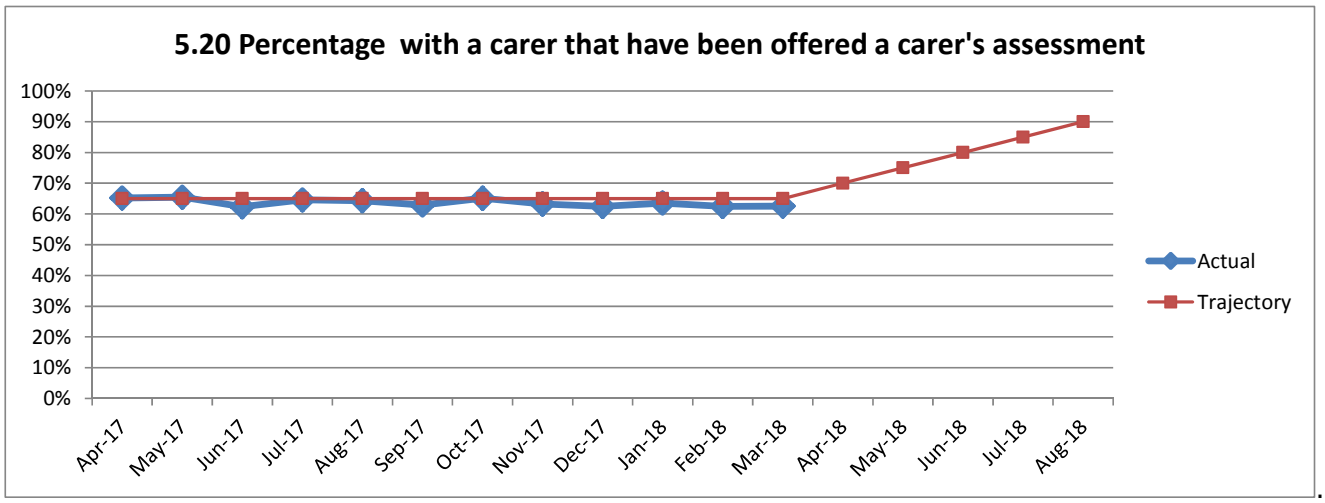
5.19: Percentage of service users asked if they have a carer

The following chart monitors progress against a trajectory to reach 80% by August 2018.



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 August 2018.



Herefordshire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2016/17 Outturn	January-2018	February-2018	March-2018	(Apr to Mar) Cumulative Compliance
5.01	Duty of Candour	Plan	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%
		Actual	99%	100%	100%	100%	100%
5.03	Completion of Mental Health Services Data Set ethnicity coding for all service users	Plan	90%	90%	90%	90%	90%
		Actual	100%	100%	100%	100%	100%
5.04	Completion of IAPT Minimum Data Set outcome data for all appropriate service users	Plan	90%	90%	90%	90%	90%
		Actual	99%	100%	100%	100%	100%
5.05	Zero tolerance MRSA	Plan	0	0	0	0	0
		Unavoidable	0	0	0	0	0
5.06	Minimise rates of Clostridium difficile	Plan	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%
		Actual	99%	93%	97%	97%	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%
		Actual	43%	46%	54%	47%	49%
5.09	IAPT Roll-out (Access Rate) - IAPT maintain 15% of patient entering the service against prevalence	Plan	2178	1,815	1,997	2,178	2,178
		Actual	1,191	1,647	1,820	1,978	1,978

Herefordshire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2016/17 Outturn	January-2018	February-2018	March-2018	(Apr to Mar) Cumulative Compliance
5.10a	Dementia Service - number of new patients aged 65 years and over receiving an assessment	Plan	540	45	45	45	540
		Actual	572	68	66	57	667
5.10b	Dementia Service - total number of new patients receiving an assessment	Plan					
		Actual	610	71	68	64	711
5.11	Patients are to be discharged from local rehab within 2 years of admission (Oak House). Based on patients on w ard at end of month.	Plan	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%
		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%
		Actual	88%	82%	95%	100%	89%
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%
		Actual	98%	97%	96%	100%	96%

Herefordshire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2016/17 Outturn	January-2018	February-2018	March-2018	(Apr to Mar) Cumulative Compliance
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%
		Actual		100%	100%	NA	96%
5.16	CYP Eating Disorders: Treatment waiting time for routine referrals within 4 weeks - non-NICE treatments	Plan		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%
		Actual		NA	NA	NA	80%
5.18	CYP Eating Disorders: Treatment waiting time for urgent referrals within 1 week - non-NICE treatments	Plan		95%	95%	95%	95%
		Actual		N/A	N/A	N/A	N/A

Herefordshire Carers Information

ID	Performance Measure		2016/17 Outturn	January-2018	February-2018	March-2018	(Apr to Mar) Cumulative Compliance
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%	64%	66%	67%	67%
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%	64%	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%	32%	29%	28%	28%

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

A 17 year old in a Residential Care Home was admitted to Stonebow after an MHA review when section 2 was applied. There were significant management issues at the Care Home which escalated into attempts to harm self and voicing desire to end life.
Referral was made for a Tier 4 bed and after continuous review Section 2 was removed with recommendation that the young person be discharged back to into care of the Care Home. The young person was discharged after 23 days.

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

ID	Performance Measure (PM)		2016/17Outturn	January-2018	February-2018	March-2018	(Apr to Mar) Cumulative Compliance
NHSI 1.01	Number of MRSA Bacteraemias avoidable	PM	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
		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%
		Actual	99%	100%	97%	96%	99%
NHSI 1.04	Care Programme Approach - formal review within12 months	PM	95%	95%	95%	95%	95%
		Actual	99%	98%	99%	96%	98%
NHSI 1.05	Delayed Discharges (Including Non Health)	PM	7.5%	7.5%	7.5%	7.5%	7.5%
		Actual	2.2%	3.1%	5.5%	2.3%	2.4%
NHSI 1.08	New psychosis (EI) cases treated within 2 weeks of referral	PM	50%	50%	50%	50%	50%
		Actual	70%	0%	67%	N/A	68%
NHSI 1.09	IAPT - Waiting times: Referral to Treatment within 6 weeks (based on discharges)	PM	75%	75%	75%	75%	75%
		Actual	49%	59%	69%	57%	59%
NHSI 1.10	IAPT - Waiting times: Referral to Treatment within 18 weeks (based on discharges)	PM	95%	95%	95%	95%	95%
		Actual	85%	68%	73%	69%	75%
DoH 2.18	Mixed Sex Accommodation Breach	PM	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
		Actual	8	1	0	1	5

DASHBOARD CATEGORY – GLOUCESTERSHIRE CQUINS

Gloucestershire CQUINS				
	In month Compliance			Cumulative Compliance
	Jan	Feb	Mar	
Total Measures	12	12	12	12
	0	0	0	0
	0	0	12	12
NYA	0	0	0	0
NYR	12	12	0	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

7.01a: Improvement of health and wellbeing of NHS Staff

Previously reported as non-compliant

As the data submitted for the staff survey is not directly comparable (the cohort of staff included in the 2015 return was a sample of staff and the latest staff survey was targeted at all staff), negotiations have taken place with Commissioners and this CQUIN is now agreed as compliant.

Early Warnings
None

Gloucestershire CQUINS

ID	Performance Measure (PM)		2016/17Outturn	January-2018	February-2018	March-2018	(Apr to Mar) Cumulative Compliance
	CQUIN 1						
7.01a	Improvement of health and wellbeing of NHS Staff	PM				Report	Qtr 4
		Actual				Compliant	Compliant
7.01b	Healthy food for NHS staff, visitors and patients	PM				Report	Qtr 4
		Actual				Compliant	Compliant
7.01c	Improving the update of flu vaccinations for frontline clinical staff	PM				Report	Qtr 4
		Actual				Compliant	Compliant
	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 4
		Actual				Compliant	Compliant
7.02b	Improving Physical healthcare to reduce premature mortality in people with SMI: Collaboration with primary care clinicians	PM				Report	Qtr 4
		Actual				Compliant	Compliant
	CQUIN 3						
7.03	Improving services for people with mental health needs who present to A&E	PM				Report	Qtr 4
		Actual				Compliant	Compliant
	CQUIN 4						
7.04	Transition from Young People's Service to Adult Mental Health Services	PM	Qtr 4			Report	Qtr 4
		Actual	Compliant			Compliant	Compliant
	CQUIN 5						
7.05a	Preventing ill health by risky behaviours - alcohol and tobacco: Tobacco screening	PM				Report	Qtr 4
		Actual				Compliant	Compliant
7.05b	Preventing ill health by risky behaviours - alcohol and tobacco: Tobacco brief advice	PM				Report	Qtr 4
		Actual				Compliant	Compliant
7.05c	Preventing ill health by risky behaviours - alcohol and tobacco: Tobacco referral and medication	PM				Report	Qtr 4
		Actual				Compliant	Compliant
7.05d	Preventing ill health by risky behaviours - alcohol and tobacco: Alcohol screening	PM				Report	Qtr 4
		Actual				Compliant	Compliant
7.05e	Preventing ill health by risky behaviours - alcohol and tobacco: Alcohol brief advice or referral	PM				Report	Qtr 4
		Actual				Compliant	Compliant

DASHBOARD CATEGORY – LOW SECURE CQUINS

Low Secure CQUINS				
	In month Compliance			Cumulative Compliance
	Jan	Feb	Mar	
Total Measures	1	1	1	1
	0	0	0	0
	0	0	1	1
NYA	0	0	0	0
NYR	1	1	0	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	January-2018	February-2018	March-2018	(Apr to Mar) Cumulative Compliance
	CQUIN 1						
8.01	Reducing the length of stay in specialised MH services	PM	Qtr 4			Report	Qtr 4
		Actual	Compliant			Compliant	Compliant

DASHBOARD CATEGORY – HEREFORDSHIRE CQUINS

Herefordshire CQUINS				
	In month Compliance			Cumulative Compliance
	Jan	Feb	Mar	
Total Measures	12	12	12	12
	0	0	0	0
	0	0	12	12
NYA	0	0	0	0
NYR	12	12	0	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

Herefordshire CQUINS

ID	Performance Measure (PM)		2016/17Outturn	January-2018	February-2018	March-2018	(Apr to Mar) Cumulative Compliance
7							
	CQUIN 1						
9.01a	Improvement of health and wellbeing of NHS Staff	PM	Qtr 4			Report	Qtr 4
		Actual	Compliant			Compliant	Compliant
9.01b	Healthy food for NHS Staff, Visitors and Patients	PM	Qtr 4			Report	Qtr 4
		Actual	Compliant			Compliant	Compliant
9.01c	Improving the uptake of Flu vaccinations for Front Line Clinical Staff	PM	Qtr 4			Report	Qtr 4
		Actual	Compliant			Compliant	Compliant
	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	Qtr 4
		Actual	Compliant			Compliant	Compliant
9.02b	Improving Physical healthcare to reduce premature mortality in people with SMI: Collaborating with primary care clinicians	PM				Report	Qtr 4
		Actual				Compliant	Compliant
	CQUIN 3						
9.03	Improving services for people with mental health needs who present to A&E	PM				Report	Qtr 4
		Actual				Compliant	Compliant
	CQUIN 4						
9.04	Transition from Young People's Service to Adult Mental Health Services	PM				Report	Qtr 4
		Actual				Compliant	Compliant
	CQUIN 5						
9.05a	Tobacco screening	PM				Report	Qtr 4
		Actual				Compliant	Compliant
9.05b	Tobacco brief advice	PM				Report	Qtr 4
		Actual				Compliant	Compliant
9.05c	Tobacco referral and medication offer	PM				Report	Qtr 4
		Actual				Compliant	Compliant
9.05d	Alcohol screening	PM				Report	Qtr 4
		Actual				Compliant	Compliant
9.05e	Alcohol brief advice or referral	PM				Report	Qtr 4
		Actual				Compliant	Compliant

Agenda Item 7 **Enclosure Paper B2**

Report to: Trust Board 31st May 2018
Author: Jan Furniaux Service Director, Gloucestershire Localities
Presented by: Jan Furniaux Service Director, Gloucestershire Localities

SUBJECT: **IAPT Services: 2017/18 Performance Report & 2018/19 Forward Plan**

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

This paper provides the Board with a summary report covering our 2017/18 performance against the IAPT service improvement plans objectives and sets out our forward plan targets for delivery in 2018/19.

Whilst significant improvements have been achieved there have been real challenges in maintaining our performance with access rates in line with our plan trajectories and the achievement of national waiting time standards on a consistent basis throughout the year due to lower than planned staffing capacity levels in our services in both localities.

The Trust has agreed 2018/19 contracts with Gloucestershire and Herefordshire CCG's and both include additional investment for IAPT services with plan trajectories to achieve 19% access rate by Q4 in 2018/19.

The successful implementation of the service improvement plans for 18/19 requires a significant increase in IAPT workforce and this remains an ongoing challenge for the service going forward to recruit to the plan staffing establishment.

The achievement of our plans in this year will bring our IAPT service performance into line with the national trajectory set out in the NHSE Mental Health Five Year Forward View (FYFV) for achieving a 25% access target by 2021.

The 2018/19 plan includes the delivery of digital IAPT services which have recently been introduced into the care pathway in both our localities providing both low and high intensity interventions. The introduction of digital services improves patient choice in service provision on offer and will significantly contribute towards meeting access targets and waiting standards.

The 2019/20 and 2020/21 plans are less detailed and subject to review during 2018/19 (particularly in relation to the digital options which may deliver more or less than the 3% planned in 2018/19). It

is anticipated that a significant proportion of the IAPT Access growth to 2021 will come from developing shared care pathways with long term condition services.

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

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

RECOMMENDATIONS

The Board is asked to;

To note the content of the performance report for 2017/18.

To note content of forward plan for 2018/19 and the outline planning for 2019/20 and 2020/21

To note that successful delivery of the forward plan presents a medium to high risk to the Trust.

Corporate Considerations	
Quality implications	Not meeting the waiting time targets presents a treatment quality risk to service users
Resource implications:	Recruitment challenges / successes and pathway revisions may impact on access rates and waiting times.
Equalities implications:	Meeting the access and recovery targets will provide a more timely and equitable service for service users.
Risk implications:	Not meeting the targets presents a service quality risk to service users, a reputational risk and a risk to the Trust.

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

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

Reviewed by:		
N/A	Date	

Where in the Trust has this been discussed before?		
Content discussed at Delivery Committee	Date	April / May 2018

What consultation has there been?		
NA	Date	

Explanation of acronyms used:	IAPT Improving Access to Psychological Therapies HI – High Intensity LI –Low Intensity RTT – Referral to Treatment IST – Intensive Support Team PWP – Psychological Wellbeing Practitioner LTC - Long term condition DNA – Did not attend WTE – Whole time equivalent HEE – Health Education England CCG – Clinical commissioning group FYFV - Mental Health Five Year Forward View

1. Introduction / Context

This paper provides the Board with a summary report covering our 2017/18 performance against the IAPT service improvement plan targets and sets out our forward plan for delivery in 2018/19, 2019/20 and 2020/21.

Following the IST review in 2016, significant improvements have been made by the service throughout the last year in response to the review findings. The issues identified by the IST were as follows;

- Clinical model did not meet the national standards,
- Insufficient capacity to meet the national standards
- Low staff productivity
- High DNA rates
- Lack of recorded diagnosis

The Clinical Model now reflects good practice and meets national standards. The clinical staffing productivity is now averaging the national standard level of 18 – 20 hours clinical work p.w. for each WTE therapist, and DNA rates for our service have been reduced to below the national average at 12% of booked appointments across the year. The data quality reporting including the recording of patient specific diagnosis has since improved to one of the highest ranking services nationally in 2017/18.

The delivery of the Improvement plan overall has been successful and this has led to securing improvements in reduced waiting times for referral to treatment and maintaining improved recovery rates reported for patients who access our services in both Gloucestershire and Herefordshire.

However, whilst these significant improvements have been achieved there have been real challenges in maintaining our performance with access rates in line with our plan trajectories

and the achievement of national waiting time standards on a consistent basis throughout the year due to lower than planned staffing capacity levels in our services in both localities.

2. Performance to date against Plan Trajectories and National Standards

2.1 Access Rate targets.

The Access rate is based on the number of people entering treatment as a percentage of the total estimated number people with anxiety and depression within our populations. We aimed to achieve 15% Access in April 2018, moving to 19% by Q4 in 2018/19.

Access in terms of patient numbers are detailed below:

Herefordshire – 14,520 (15% = 2178 / 19% = 2759)
Gloucestershire – 68,653 (15% = 10,298 / 19% = 13044)

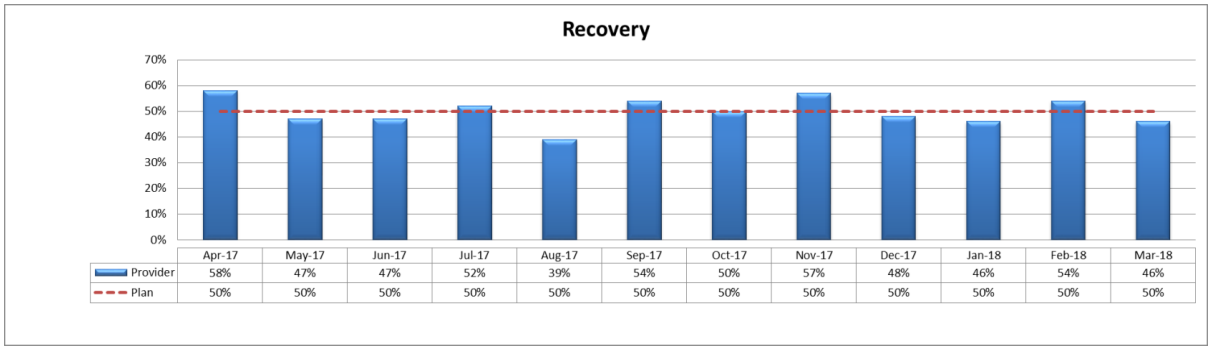
In both Herefordshire and Gloucestershire the agreed Access rate trajectories for our service improvement plan in 2017/18 were below the national trajectories set at 16.8%.

In April 2018 we achieved the Access recovery plan target of 15% in Gloucestershire (15.29%) and in Herefordshire we achieved just below the target of 15% (14.13%).

2.2 Recovery rate – 50% is the national standard and this is measured on the number of people who are moving to recovery (of those who have completed treatment) during the reporting period. The Recovery rate performance is measured on a quarterly aggregated basis by NHSE. The Improvement Plan agreed target was set to achieve within a range between 45%- 55% in each month.

2.2.1 Herefordshire – the overall performance throughout the year is shown in the table below. The levels in each month throughout the year were within the 45 – 55% target range set out in our Improvement Plan.

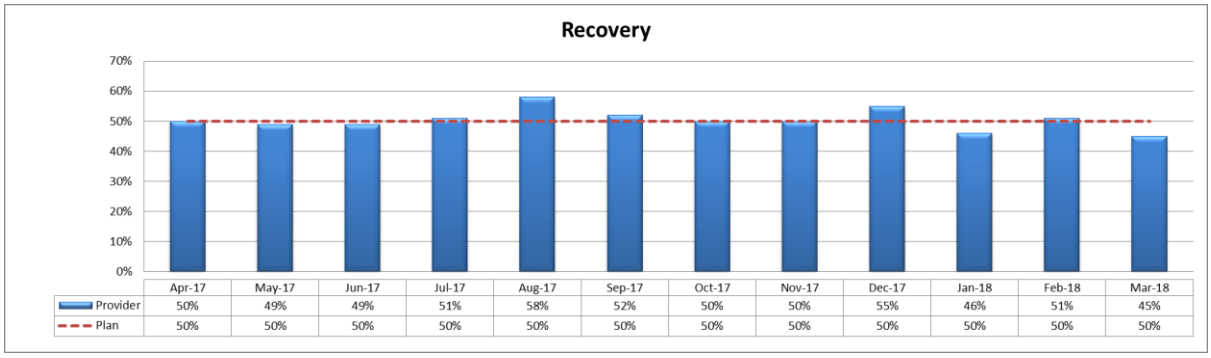
In April 2018, the recovery rate was 49.51%.



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Provider	58%	47%	47%	52%	39%	54%	50%	57%	48%	46%	54%	46%
Plan	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%

2.2.2 Gloucestershire – the performance on our Recovery Rate improved and stabilised towards end of 2016/17 and this has been maintained throughout 2017/18 with performance levels within the target range of 45 – 55% set within plan. The Trust recovery rates for 2018/18 were above the national averages.

In April 2018 the recovery rate was 52.46%.



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Provider	50%	49%	49%	51%	58%	52%	50%	50%	55%	46%	51%	45%
Plan	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%

2.3 Waiting Times - Referral to Treatment (RTT) (Finished Treatment)

The 6 and 18 week RTT target thresholds are measured from the point of referral to entering treatment and counted each month at the point when people finish treatment or discharged from service. This key performance indicator going forward into 2018/19 will be positively impacted from changes to the recording methodology for assessment / treatment appointments. The first assessment / treatment appointment is now classified as entering treatment. This change will take time to work through into our RTT performance when all patients who entered treatment before the recording changes were introduced are discharged and leave the service.

The 6 week RTT has 75% threshold target and 18 week RTT has a 95% threshold target. . With these recording changes now introduced we anticipate that we will achieve both 6 and 18 weeks RTT targets by the end of Q1 in 2018/19.

3. Staffing Capacity and Access – Actual vs Planned (the forward plan for 18/19)

The plan for 2018/19 includes the provision of digital health step 2 interventions which we have modelled a 3% activity towards the total access rate in both localities'. The step 3 digital option is available in Gloucestershire only at this time as part of the step 3 waiting list initiative. We intend to review the efficacy of this provision before considering implementing in Herefordshire as part of the pathway. The digital health options we have introduced as follows;

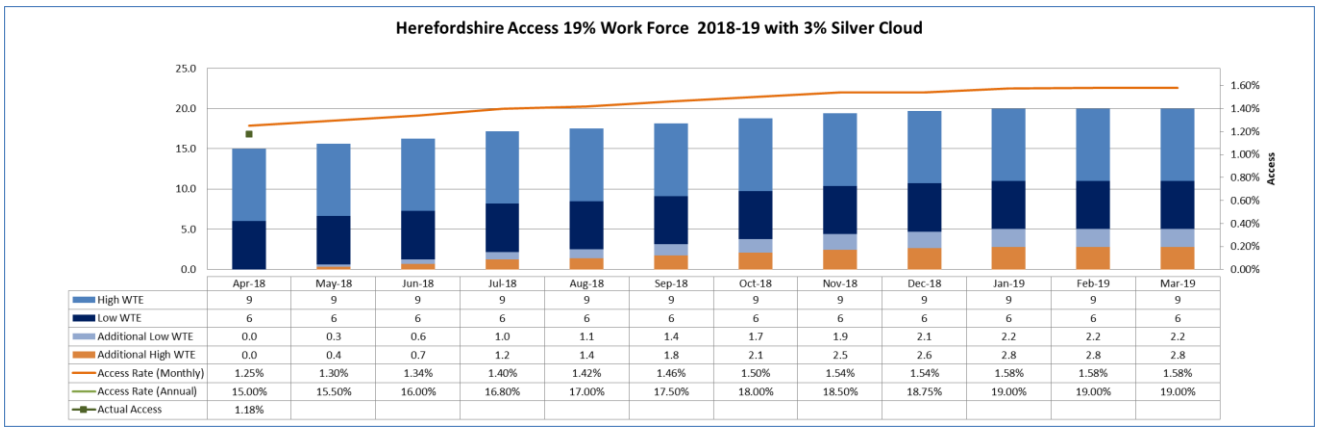
Silvercloud (www.silvercloudhealth.com) is a Step 2 low intensity treatment option, offered to patients currently on the Step 2 wait list and all patients who are assessed as requiring low intensity treatment. This provides asynchronous support to patients online- following an assessment by a therapist, patients have access to a range of interactive tools and activities.

IESO (www.iesohealth.com) is a Step 3 high intensity treatment option, specifically aimed at patients currently on the Step 3 wait list – all patients currently on the waiting list will be offered online therapy with a Therapist employed directly by IESO as an alternative to continuing to wait for traditional treatment .

The plans for achieving a 19% Access rate by Q4 in 2018/19 will bring the Trust IAPT service performance into line with the national plan trajectory. The charts below illustrate:

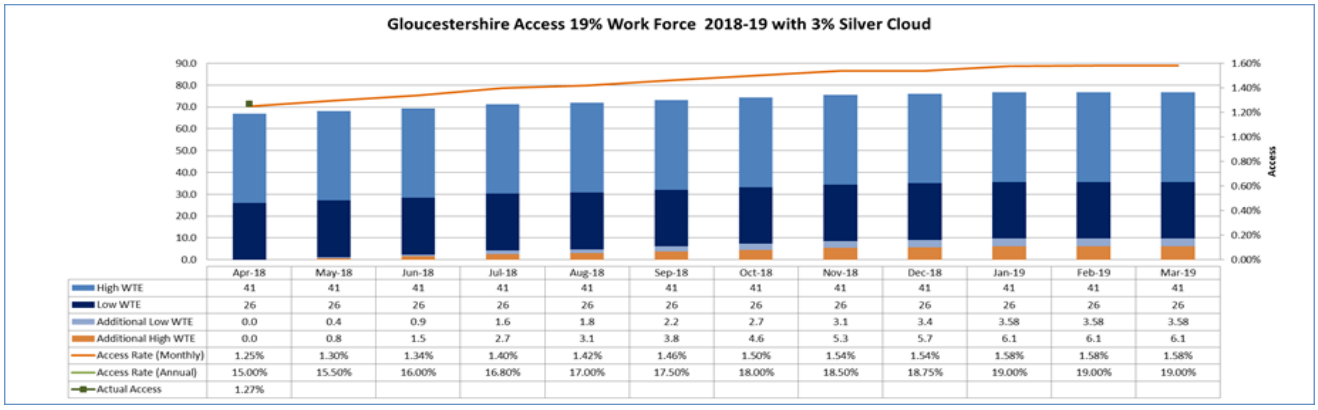
- Access achieved in Month 1 and the incremental increase planned to meet 19% by Q4 March 2019
- Staffing capacity available in Month 1staffing capacity required as we reach Q4 March 2019.

3.2. Herefordshire



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
High WTE	9	9	9	9	9	9	9	9	9	9	9	9
Low WTE	6	6	6	6	6	6	6	6	6	6	6	6
Additional Low WTE	0.0	0.3	0.6	1.0	1.1	1.4	1.7	1.9	2.1	2.2	2.2	2.2
Additional High WTE	0.0	0.4	0.7	1.2	1.4	1.8	2.1	2.5	2.6	2.8	2.8	2.8
Access Rate (Monthly)	1.25%	1.30%	1.34%	1.40%	1.42%	1.46%	1.50%	1.54%	1.54%	1.58%	1.58%	1.58%
Access Rate (Annual)	15.00%	15.50%	16.00%	16.80%	17.00%	17.50%	18.00%	18.50%	18.75%	19.00%	19.00%	19.00%
Actual Access	1.18%											

3.3 Gloucestershire



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
High WTE	41	41	41	41	41	41	41	41	41	41	41	41
Low WTE	26	26	26	26	26	26	26	26	26	26	26	26
Additional Low WTE	0.0	0.4	0.9	1.6	1.8	2.2	2.7	3.1	3.4	3.58	3.58	3.58
Additional High WTE	0.0	0.8	1.5	2.7	3.1	3.8	4.6	5.3	5.7	6.1	6.1	6.1
Access Rate (Monthly)	1.25%	1.30%	1.34%	1.40%	1.42%	1.46%	1.50%	1.54%	1.54%	1.58%	1.58%	1.58%
Access Rate (Annual)	15.00%	15.50%	16.00%	16.80%	17.00%	17.50%	18.00%	18.50%	18.75%	19.00%	19.00%	19.00%
Actual Access	1.27%											

It remains challenging at this stage to model the impact against our Access rate from the recent introduction of digital provision as there are a number of variables including the level of take up and dropout rates we will need to understand better going forward before we can accurately predict within our modelling assumptions the impact on performance.

We believe that the achievement of our plan trajectory whilst we increase our staffing capacity (during Q1 and Q2) is medium to high risk. We are developing Service Development Improvement Plans for both Counties which will set out detailed modelling, action and contingency plans to mitigate the risks further. These plans will be fully drafted by the end of May 2018.

4. The ‘in stage’ waiting list challenge

The change in recording methodology and the reclassification of assessment appointments to assessment / treatment appointments materially impacts on the RTT performance

measure and moves the majority of the waiting list to in stage waiting for a second treatment appointment.

The waiting list pressures are similar and in proportionate scale within both localities and are predominantly for step 3 interventions, with Herefordshire having no step 2 waiting list backlog.

The Trust secured £250k non recurrent funding from Gloucestershire CCG towards the end of 2017/18 for additional capacity towards in stage waiting list backlog clearance. This funding has been carried over into 2018/19 to fund digital step 3 provision and the recruitment of additional HI agency staff to further support clearing the step 3 waits in Gloucestershire locality. We have quantified the level of resource needed to clear the backlog in stage wait and have secured an additional £300k non recurrent funding in 2018/19.

The proposal to Herefordshire CCG for £295k recurrent funding for 2018/19 needed to achieve the 19% Access rate has now been confirmed and we anticipate that the non-recurrent slippage from this investment plan alongside the recent introduction of digital provision will be a sufficient level of capacity to clear backlog in stage waiting list and achieve our forward Access trajectory.

5. Recruitment and Retention

The IAPT Project Team at this time of writing this report is developing a set of initiatives to support IAPT Workforce Recruitment and Retention. This will be presented to the Trust Executive in due course for decisions which are required to support the ongoing delivery of the service and to achieve targets and national standards over the next three year period.

This incorporates a range of initiatives alongside the continued use of Agency staff whilst we recruit our permanent establishment, these include;

- Proposal to over recruit as the service has consistently seen turnover rates of above the Trust 10% average (PWPs 20%, HI's 15%)
- A review of current recruitment pathways to improve timescales
- To increase the number of training places via traditional HEE routes
- Explore procurement of bespoke training routes with other qualified training providers/establishments
- Targeting non-graduates and utilising Apprenticeship Levy
- A recruitment initiative in Northern Ireland which trains psychological therapy students to graduate level but does not currently provide an IAPT service.

It is difficult at this stage to model the impact against our Access rate from the recent introduction of digital provision. There are a number of variables including the level of take up, dropout and recovery rates which we will need to understand fully going forward before we can accurately predict the impact within our modelling assumptions..

It is clear that the achievement of our plan trajectory for the Q1 period whilst we increase our staffing capacity is medium to high risk.

6. Forward planning for 19/20 and 20/21

The Five Year Forward View for Mental Health details a commitment to increasing access to psychological therapies. This means that IAPT services nationally will move from seeing around 15% of all people with anxiety and depression each year to 25%.

It is anticipated that a significant proportion of the IAPT Access growth to 2021 will come from developing shared care pathways with long term condition services. Two thirds of people with a common mental health problem also have a long term physical health problem (LTC's), greatly increasing the cost of their care by an average of 45% more than those without a mental health problem. By integrating IAPT services with physical health services the NHS can provide better support to this group of people and achieve better outcomes.

During 2018/19, we will work with Commissioners to agree investment and Access trajectories for 19/20 and 20/21. Within the current IAPT programme we are already developing our workforce to improve the quality of psychological care to people with LTC's by accessing the National IAPT LTC training programme.

We are making links with key stakeholders locally to identify priority areas for LTC pathway development that include diabetes; cardiac care and respiratory conditions. We are raising the profile of IAPT in physical health settings to increase access into core IAPT Services. We will continue to explore opportunities to add value to existing physical health interventions.

7. Recommendations

The Board is asked to;

- Note the reported performance against Improvement Plan for 2017/18.
- Note the detailed forward plan trajectory for 2018/19
- Note the developing plans for 2019/20 and 2020/21
- Note the risk rating of medium to high

Agenda item 8 **Enclosure** **Paper C**

Report to: 2gether NHS Foundation Trust Board – 31 May 2018
Author: Gordon Benson, Assistant Director of Governance & Compliance
Presented by: Marie Crofts, Director of Quality

SUBJECT: **Quality Report for 2017-18**

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

2017-18 Quality Report

- The annual Quality Report summarises the progress made in achieving targets, objectives and initiatives identified, and has been collated following an extensive review of all associated information received from a variety of sources throughout the year.

- The priorities for improvement during 2018-19 have been agreed in consultation with both internal and external stakeholders. These priorities were categorised under the three key dimensions of effectiveness; user experience and safety. Any priorities in which the target was not met during 2017-18 have been rolled over.

- The Council of Governors at its January 2018 meeting chose one of the local indicators for our external auditor to audit as part of the external audit process of the Quality Report.

- The draft Quality Report has been shared with commissioners in Herefordshire and Gloucestershire, and also both Healthwatch organisations and the Health and Community Care Overview and Scrutiny Committees (HCOSCs) in the two counties, in order for them to provide formal feedback which is published as part of the final report.

- The Committee should note the requirement that External Assurance on the Quality Report (provided by KPMG) must provide a limited assurance report on the content of Quality Reports produced by Foundation Trusts. In providing this assurance, KPMG have reviewed the draft report for consistency with the following:
  1. Papers relating to the Quality Report reported to the Board over the year;
  2. Feedback from commissioners;
  3. Feedback from governors;
  4. Feedback from Healthwatch organisations;
  5. The trust‟ complaints report published under regulation 18 of the Local Authority,

Social Services and NHS Complaints (England) Regulations 2009;
6. Feedback from other named stakeholder(s) involved in the sign off of the Quality Report;
7. Latest national and local patient survey;
8. Latest national and local staff survey;
9. The Head of Internal Audit "annual opinion over the trust" control environment; and
10. Care Quality Commission data.

KMPG have also tested the following mandated indicators in line with the updated NHSI guidance:

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

   And the local indicator as requested by Trust Governors

3. *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.*

KPMG have issued an unqualified audit opinion which will be received by the Audit Committee on 25 May 2018.

- The Audit Committee will formally ratify the Quality Report on 25 May 2018 as mandated.

- The Quality Report must be included as part of the Trust Annual Report and be submitted to NHSI by the end of May.

RECOMMENDATIONS

The Board is asked to:

1. Note that the Audit Committee will approve the Quality Report on 25 May 2018.
2. Approve the Quality Report for submission to NHSI and wider publication.

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 Quality & Performance	Date	24 May 2018

Where in the Trust has this been discussed before?		
Governance Committee	Date	Quarterly
Council of Governors		Quarterly
Trust Board		Quarterly

What consultation has there been?		
Ongoing liaison with internal & external stakeholders, in particular commissioners, Healthwatch organisations & HCOSCs	Date	Quarterly

Explanation of acronyms used:	**HCOSC** = Health and Care Overview and Scrutiny Committee

1. CONTEXT

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 NHSI (incorporating the Department of Health Guidance for Quality Accounts) and the Quality Report checked for consistency against the defined regulations.

The Board is required to approve the areas for quality improvement in the forthcoming year following the period of consultation with stakeholders, and to approve the content of the Quality Report in its entirety.

2gether
Making life better

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NHS Foundation Trust

Quality Report 2017/18

CONTENTS

Part 1: Statement on Quality from the Chief Executive

Introduction

I am privileged on behalf of [2]gether NHS Foundation Trust to present our annual Quality Report for 2017/18. Continuous Quality Improvement is one of our three strategic priorities, and at the heart of everything we do.

In this report, you will read about the quality standards we have set ourselves, those set by our commissioners or nationally mandated, and how we monitor our performance. This report also outlines our main quality achievements of 2017/18 and our priorities for the coming year.

Our main quality initiatives this year included:

- measures focused on improving the physical health of our service users;
- improving the health and wellbeing of our staff, including increasing the uptake of flu vaccinations;
- closer working with GPs and also with our acute hospitals on supporting people who attend A&E with mental health needs;
- improved transitions for children and young people moving into adult services;
- risk reduction (including seven day follow ups after discharge for patients on CPA, reducing patient safety incidents and reducing the use of prone restraint); and
- improving the experiences of people who use our services.

We have achieved many of our targets, with particularly strong progress in supporting our service users with their physical health, providing information on who to contact in a crisis and reducing the number of service users who went absent without leave. We are particularly proud of our move to becoming Smokefree across both Herefordshire and Gloucestershire. Smoking is the biggest reason for the shortened life expectancy of people with serious mental health issues and supporting people to quit has a huge impact on their physical health and mental wellbeing. We were also proud to be in the top three mental health trusts for the number of frontline colleagues vaccinated against flu, and of being among the top three mental health providers nationally in the CQC's community mental health survey for 2017.

We have not, however, achieved every target - for a variety of reasons. These priorities will continue to be the focus of our attention in 2018/19. We have developed a new Quality Strategy for 2018 to 2020, which sets out our guiding principle of ensuring we deliver high quality, effective services which improve the lives of our service users and their families.

Our main priorities, as outlined in that strategy, will be:

- 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 patients who become absent without leave do not come to serious harm;
- Ensuring the people who use our services, and their carers, will report feeling involved in their care;
- Improving the physical health of patients with a serious mental illness on Care Programme Approach;
- Ensuring services are informed by and involved in research and evaluation;
- Making every contact count with approaches which prevent illness, promote health and encourage self-management; and
- Involving service users, family members and carers, and improving service user survey results.

Underpinning all of this will be creating a culture of openness and transparency with compassionate leaders so that continuous quality improvement is embedded at all levels of the organisation. We will also continue our focus of working with stakeholders and partners to create a whole system approach to improving quality across services.

We have recently (February/March 2018) had a comprehensive inspection conducted by the Care Quality Commission. The outcome of that inspection is not available at the time of writing. Therefore, our last comprehensive inspection in 2015 continues to inform many of our quality initiatives. Our overall outcome was 'good', however there were some areas for further development and we have taken steps to address the vast majority of the areas the CQC asked us to work on.

The content of this report has been reviewed by the people who pay for our services (our commissioners), the Health and Care Scrutiny Committees of our local authorities and Healthwatch. Their views on this report are included on page 56. The report is also subject to review by our external auditor.

In preparing our Quality Report, we have used 'best endeavours' to ensure that the information presented is accurate and provides a fair reflection of our performance during the year. The Trust is not responsible, and does not have direct control for all of the systems from which the information is derived and collated. The provision of information by third parties introduces the possibility that there is some degree of error in our performance, although we have taken all reasonable steps to verify and validate such information.

As Chief Executive, I confirm that to the best of my knowledge the information within this document is accurate.

Paul Roberts
Chief Executive

Part 2.1: Looking ahead to 2018/19

Quality Priorities for Improvement 2018/19

This section of the report looks ahead to our priorities for quality improvement in 2018/19. We have developed our quality priorities under the three key dimensions of **effectiveness, user experience and safety** and these have been approved by the Trust Board following discussions with our key stakeholders.

Following feedback from service users, carers and staff, our Governors and commissioners as well as Herefordshire and Gloucestershire Healthwatch, we have identified **7** goals and **11** associated targets for 2017/18. These targets will be measured and monitored through reporting to the Trust Governance Committee with the period of time varying from monthly, quarterly or annually dependent upon what we measure, and the frequency of data collection.

How we prioritised our quality improvement initiatives

The quality improvements in each area were chosen by considering the requirements and recommendations from the following sources:

Documents and organisations:

- [2]gether 2018/19 Business Plan;
- [2]gether Quality Strategy;
- NHS England: Five Year Forward View:
- NHS England: Implementing the Five Year Forward View for Mental Health. Updated July 2017;
- Care Quality Commission (via CQC Comprehensive Inspection at our sites in October 2015);
- NHS Outcomes Framework;
- Department of Health, with specific reference to 'No health, without mental health' (2011) and 'Mental health: priorities for change (January 2014);
- Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing. Department of Health 2015;
- NHS England: Commissioning for Quality & Innovation (CQUIN) Guidance for 2017-2019. November 2016;
- NHS Improvement. Single Oversight Framework November 2017;
- National Institute for Health & Care Excellence publications including their quality standards;
- Preventing suicide in England: Third annual report on the cross-government outcomes strategy to save lives. Department of Health 2016;
- National Confidential Inquiry into Suicide & Homicide by People with Mental Illness: Annual Report 2017;
- Gloucestershire Sustainability Transformation Plan (STP);
- Herefordshire & Worcestershire STP.

The feedback and contributions have come from:

- Healthwatch Gloucestershire;
- Healthwatch Herefordshire;
- Gloucestershire Health and Care Overview and Scrutiny Committee (HCOSC) and Council colleagues;
- Herefordshire Overview and Scrutiny Committee and Council colleagues;
- Gloucestershire Clinical Commissioning Group;
- Herefordshire Clinical Commissioning Group;
- Internal assurance and audit reports;
- NHS South of England Mental Health Patient Safety Improvement Programme;
- Trust Governors;
- Trust clinicians and managers.

Effectiveness

Goal	Target	Drivers
Improving the physical health care for people with serious mental illness.	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.	To support NHS England's commitment to reduce the 15-20 year premature mortality in people with psychosis and improve their safety through improved assessment, treatment and communication between clinicians. We wish to continue to improve the physical health for those people in contact with our services. There is historical data available for year on year comparison.
Ensure that people are discharged from hospital with personalised care plans.	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.	As we did not achieve this in 2017/19 we wish to ensure effective discharge from our inpatient services and enhance communication with both service users and primary care services. There is historical data available for year on year comparison.
Improve transition processes for child and young people who move into adult mental health services.	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. If a joint review does not take place, the reason must be recorded	As we did not achieve this in 2016/17 and 2017/18 we wish to continue to support this as a key quality priority during 2018/19 to further improve our transition processes. There is historical data available for year on year comparison.

User Experience

Goal	Target	Drivers
Improving the experience of service user in key areas. This will be measured though defined survey questions for both people in the community and inpatients.	2.1 Were you involved as much as you wanted to be in agreeing the care you receive? > 84% **Target :** To achieve a response 'Yes' for more than **84%** of the people surveyed.	Questions 2.2 – 2.4 are areas relating to patient experience where we wish to improve following the 2017 Care Quality Commission (CQC) national community mental health survey results.
	2.2 Have you had help and advice to find support to meet your physical health needs if you have needed it? > 71% **Target :** To achieve a response 'Yes' for more than **71%** of the people surveyed.	
	2.3 Do you know who to contact out of office hours if you have a crisis? >64% **Target :** To achieve a response of 'Yes' for more than **64%** of the people surveyed.	
	2.4 Has someone given you advice about taking part in activities that are important to you? > 73% **Target :** To achieve a response of 'Yes' for more than **73%** of the people surveyed.	

Safety

Goal	Target	Drivers
Minimise the risk of suicide of people who use our services.	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.	Gloucestershire Suicide Prevention Strategy and Action Plan Preventing suicide in England: Third annual report on the cross-government outcomes strategy to save lives. We have historical data available for year on year comparison. We did not achieve this in 2017/18.
Ensure the safety of people detained under the Mental Health Act.	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)	NHS South of England Patient Safety Improvement Programme It is a high risk area with historical data available for year on year comparison. We have historical data available for year on year comparison.
Minimise the risk of harm to service users within our inpatient services when we need to use physical interventions	3.3 To increase the use of supine restraint as an alternative to prone restraint. There will be a greater percentage of supine restraints compared to prone.	Positive and safe: reducing the need for restrictive interventions. April 2014 We wish to continue to support this as a key quality priority during 2018/19 to minimise risk of harm. This is a variation on our previous indicator. There is historical data available for year on year comparison.
	3.4 To ensure that 100% of service users within Berkeley House have a bespoke restrictive intervention care plan tailored to their individual need. This aims to reduce the use of restrictive practices and will include Primary & secondary prevention strategies.	Positive and safe: reducing the need for restrictive interventions. April 2014 We wish to support this as a new key quality priority during 2018/19 to minimise risk of harm.

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

Review of Services

The purpose of this section of the report is to ensure we have considered the quality of care across all our services which we undertake through comprehensive reports on all services to the Governance Committee (a sub-committee of the Board).

During 2017/2018, the 2gether NHS Foundation Trust provided and/or sub-contracted the following NHS services:

Gloucestershire
Our services are delivered through multidisciplinary and specialist teams. They are:

- One stop teams providing care to adults with mental health problems and those with a learning disability;
- Intermediate Care Mental Health Services (Primary Mental Health Services & Improving Access to Psychological Therapies);
- Specialist services including Early Intervention, Mental Health Acute Response Service, Crisis Resolution and Home Treatment, Assertive Outreach, Managing Memory, Children and Young People Services; Eating Disorders, Intensive Health Outcome Team and the Learning Disability Intensive Support Service;
- Inpatient care.

Herefordshire
We provide a comprehensive range of integrated mental health and social care services across the county. Our services include:

- Providing care to adults with mental health problems in Primary Care Mental Health Teams, Recovery Teams and Older People's Teams;
- Children and Adolescent Mental Health care;
- Specialist services including Early Intervention, Assertive Outreach and Crisis Resolution and Home Treatment;
- Inpatient care;
- Community Learning Disability Services;
- Improving Access to Psychological Therapies.

The 2gether NHS Foundation Trust has reviewed all the data available to them on the quality of care in all of these relevant health services.

The income generated by the NHS services reviewed in 2017/18 represents 92.3% of the total income generated from the provision of NHS services by the 2gether NHS Foundation Trust for 2017/18.

Participation in Clinical Audits and National Confidential Enquiries

During 2017/18 one national clinical audit and four national confidential enquiries covered NHS services that 2gether NHS Foundation Trust provides.

During that period**,** 2gether NHS Foundation Trust participated in 100% national clinical audits and 100% of confidential enquiries of the national clinical audits and national confidential enquiries which we were eligible to participate in.

The national clinical audits and national confidential enquiries that 2gether NHS Foundation Trust was eligible and participated in during 2017/18 are as follows:

National Clinical Audits

Clinical Audits	Participated Yes/No	Reason for no participation
National Clinical Audit of Psychosis (NCAP)	Yes	N/A

National Confidential Enquiries

National Confidential Enquiries	Participated Yes/No	Reason for no participation
Confidential Enquiry into Maternal and Child Health	Yes	N/A
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness	Yes	N/A
Sudden Unexplained Death Study	Yes	N/A

The national clinical audits and national confidential enquiries that [2]gether NHS Foundation Trust participated in, and for which data collection was completed during 2017/2018 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Topic	Trust Participation		National Participation	
	Teams	Submissions	Teams	Submissions
National Clinical Audit of Psychosis (NCAP)	All adult Community Mental Health Teams	Random sample of 100 service users	Information not available*	Information not available*

*This information has not been provided by the Royal College of Psychiatrists

The report of this national clinical audit is not yet available and [2]gether NHS Foundation Trust intends to take action to continue to improve the quality of healthcare provided based upon the information provided.

Participation in National Confidential Enquiries

Confidential Enquiries	% cases submitted	
	[2]gether	National Average
Confidential Enquiry into Maternal and Child Health	Information not published	Information Unavailable
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness	100%	98%
National Confidential Enquiry into Patient Outcome & Death – Young Peoples Mental Health	9	Information Unavailable
Sudden Unexplained Death Study	Information unavailable	Information unavailable

Local Clinical Audit Activity

Within our services there is a high level of clinical participation in local clinical audits, demonstrating our commitment to quality across the organisation. All clinically led local audits are reported to the Quality & Clinical Risk Committee in summary form to ensure that actions are taken forward and learning is shared widely. The table below shows the status of the audit plan at the end of the year. During this process we internally identified a significant number of recommendations to further improve our practice as part of our commitment to continuous improvement.

Clinical Audits	2016/17 audit programme	2017/18 audit programme
Total number of audits on the audit programme	168	158
Audits completed (at year end)	95	70
Audits that are progressing and will carry forward	31	40
Audits taken off the programme for specific reasons	42	48

The reports of 70 local clinical audits were reviewed by the provider in 2017/18 and [2]gether NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- Building on the review of key clinical policies ***Assessment and Care Management CPA*** and ***Assessing and Managing Clinical Risk and Safety***, the Trust has continued to implement and embed these principles into policies and practice. Most notably there has been a review of the electronic clinical record to ensure that this is in keeping with clinical activity and to ensure that this continues to reflect service user's needs. There have been a number of audits carried out throughout the year to provide assurance and actions plans were developed to support improvements in compliance throughout the year. This action continues from last year and will remain an ongoing focus moving forward;

- The Trust has continued to review and develop its training programme to all staff (clinical and non-clinical) in line with the learning that is established from the clinical audit programme. This has, and will continue, to drive the constant review and evaluation of training modules and their contents. This action also continues from last year.

Specific examples of change in practice that have resulted from clinical audits are:

- There is an expectation that young people under the age of 18 should not be on a general adult mental health unit and that they should be admitted to a specialist provider appropriate to their age and needs. However, specialist provision for children and young people (CYP) nationally does not currently meet the needs of the growing number of young people who require high support and admissions to adult units are sometimes necessary. All CYP admissions to [2]gether NHS Foundation Trust adult inpatient units are managed under the Trusts 'Young people in Inpatient settings policy against which the Trust audits such admissions. This is the first audit of this kind which resulted in a 93% compliance rate. Although this is a good outcome actions were identified to ensure that compliance increases to 100%. These actions include the need to develop it's own internal training for Level 3 Child Protection (Safeguarding training) which will help ensure that the course is more accessible for staff and will work toward improving compliance in the future. A pathway for admission from CYPS to the adult inpatient units needs to be developed to ensure that admissions are managed robustly and in keeping with the needs of CYP.

- The audit was undertaken to determine if the Trust was compliant with NICE Guidance Quality Statement 6: Covert Medicines Administration (published 25.3.15) and POPAM 16 Covert Administration Instructions. Overall compliance was 84%, which was below the required standard but represented a significant increase in compliance on the previous audit. As a result of completion of this audit a number of recommendations were made which included the need to ensure that

relatives and carers are involved in the Best Interests decision to proceed with covert administration. This will be achieved by raising awareness with the staff on older person's wards and our learning disability service inpatient unit where most of the covert administration is undertaken. In addition to this the policy which requires Speech and Language Therapy (SALT) review will be considered and audit questions regarding this will be adjusted in readiness for the next audit.

Participation in Clinical Research

Research Activity in ^{2}gether in 2017-18

The number of patients receiving relevant health services provided or subcontracted by ^{2}gether NHS Foundation Trust in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee **380**.

This participation was from across **24** different studies. This level of recruitment is slightly higher than the previous year's total of **352** participants (again from 24 studies), and reflects a fairly stable portfolio in 2017/18 compared to previous years' instability.

In 2017/18, the Trust registered and approved **24** studies. Of these studies, **19** were based in mental health services and **2** in dementia services. The remaining studies were made up from **2** "generic and cross-cutting themes" studies (often academic studies involving staff participants) and **1** based in primary care. Of the total number of studies **10** were Academic/Student projects, **8** were Non-Commercial Portfolio studies, **2** were Commercially Sponsored Portfolio Studies and **4** were Non-commercial, Non-Portfolio studies.

Growing ^{2}gether Research

Our research team continues to perform well in a national key performance indicator of recruiting to time and target for open research studies, as well as supporting a number of activities that help to grow research across the counties of Gloucestershire and Herefordshire. We continue to seek new ways to expand our service, and the Trust will be exploring opportunities to work more closely with Gloucestershire Care Services NHS Trust where the proposed merger of our respective organizations which could provide a potential opportunity for enhanced multi-disciplinary working and creating new opportunities for service users to be involved in research studies.

In August 2016 we held an official opening for the Fritchie Centre, Cheltenham; a new development for the organisation to expand our research activity to include commercial and academic research for clinical trials involving medicines. The Research Centre is the team base for both our Research Team and our Managing Memory Service, and we are working towards an integrated service where researchers work collaboratively with clinicians, offering research opportunities to service users and carers.

Alongside our research centre, our partnership with Cobalt Health continues. We have been collaborating to carry out research with people who experience Alzheimer's disease and dementia. The pioneering programme, between our Trust and the Cheltenham-based charity aims to ensure that research into the illness is undertaken in Gloucestershire and Herefordshire. The research results will contribute towards improving standards of care and treatment locally, and also to the wider research environment nationally and internationally. This year Cobalt has funded Research Nurse posts based at the Fritchie Centre, to exclusively support the development and opening of clinical trials for dementia.

2017/18 saw the opening of 2 Commercially-sponsored NIHR Portfolio Research Projects and the Trust is planning to expand on this in 2018/19 by exploring more opportunities for working with commercial partners to fully exploit the potential of the Fritchie Centre.

We continued to seek new ways to expand our service, and this year received funding from the Clinical Research Network West Midlands to fund a Research Nurse post for Herefordshire in 2017/18 enabling a wider reach for research activity and opportunities for clinical research in the county.

[2]gether plans to submit bids to the Clinical Research Networks for additional Contingency and Development funding wherever possible to further support the research team in developing the local portfolio and to improve the local study review processes.

Seeking new research opportunities

The availability of research through the National Institute of Health Research (NIHR) and local portfolios fluctuates regularly as studies close and new ones take their place. This can mean that the opportunities to open studies in [2]gether can vary over time and this is often one of the biggest challenges to maintaining a varied and productive local portfolio of studies.

The [2]gether Annual Plan for 2018/19 recognises this potential barrier to recruitment and a lower recruitment target for the coming year is predicted. However, the local team will continue to work closely with our Clinical Research Networks (West of England and West Midland) to scan the portfolio and submit Expressions of Interest for potential new studies.

In 2018/19 2gether is planning to realign its Research Governance Processes, providing more of them internally to allow for faster and more efficient review and approval of new studies.

Research [2]gether strategy

Our Research [2]gether Strategy 2016 – 2020 enters its third year and continues to work towards our vision to be a 'world class centre of practice-based research and development to help make life better'.

A new Head of Research has been appointed going into the new reporting year and they will be supporting the Research Team to develop the local portfolio as well as promoting the delivery of the 2gether Research Strategy.

Research Studies

A list of [2]gether studies recruiting in 2017/18 can be seen in table 1 overleaf.

Short Name	Managing Specialty	Status	Opening Date	Closure Date	Participants
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness	Mental Health	Open, With Recruitment	01/04/1997	31/03/2018	15
AD GENETICS - Detecting Susceptibility Genes for Late-Onset Alzheimer's disease	Dementias and Neurodegeneration	Open, With Recruitment	01/05/2001	01/02/2020	52
Molecular Genetic Investigation	Mental Health	Open, With Recruitment	01/04/2006	31/12/2019	2
DPIM - bipolar disorder (DNA Polymorphisms in Mental Health)	Mental Health	Suspended	01/10/2010	31/12/2017	15
DPIM - schizophrenia (DNA Polymorphisms in Mental Health)	Mental Health	Suspended	01/10/2010	31/12/2017	2
The RADAR trial - Reducing pathology in Alzheimer's Disease through Angiotensin TaRgetting – The RADAR Trial	Dementias and Neurodegeneration	Open, With Recruitment	01/04/2014	28/02/2018	8
VALID WPs 3/4: Pilot trial and RCT of COTiD-UK	Dementias and Neurodegeneration	Closed to Recruitment, In Follow Up	24/09/2014	04/07/2017	42
PPiP2 - Prevalence of neuronal cell surface antibodies in patients with psychotic illness	Mental Health	Open, With Recruitment	01/01/2015	30/08/2020	6
The Adult Autism Spectrum Cohort - UK	Mental Health	Open, With Recruitment	08/01/2015	01/09/2019	12
The effectiveness of perinatal mental health services	Mental Health	Closed to Recruitment, No Follow Up	10/02/2015	06/03/2018	3
Quality and Effectiveness of Supported Tenancies (QuEST) WP4	Mental Health	Closed to Recruitment, No Follow Up	01/05/2015	30/09/2017	2
Evaluation of Memory Assessment Services: Main Study (phase 2) v1	Dementias and Neurodegeneration	Closed to Recruitment, No Follow Up	12/10/2015	31/08/2017	6
Dementia Carers Instrument Development:DECIDE Psychometric evaluation	Dementias and Neurodegeneration	Closed to Recruitment, No Follow Up	05/01/2016	25/01/2018	31
Psychological Adjustment in Progressive Multiple Sclerosis	Neurological Disorders	Closed to Recruitment, No Follow Up	12/01/2016	31/07/2017	1
Caregiver obligations, preparedness and willingness to care	Dementias and Neurodegeneration	Closed to Recruitment, No Follow Up	26/02/2016	27/03/2018	11
REACT Trial - An online randomised controlled trial to evaluate the clinical and cost effectiveness of a peer supported self-management intervention for relatives of people with psychosis or bipolar disorder: Relatives Education And Coping Toolkit	Mental Health	Closed to Recruitment, In Follow Up	22/04/2016	30/09/2017	10
Voices Impact Scale (VIS): Evaluation	Mental Health	Open, With Recruitment	01/11/2016	31/07/2018	5
An anonymous survey of mindfulness, self-compassion, wellbeing and mental health.	Mental Health	Open, With Recruitment	10/02/2017	31/03/2018	80
Investigation of wellbeing interventions in NHS staff	Mental Health	Open, With Recruitment	20/02/2017	31/05/2018	8
Tackling chronic depression (TACK) Phase 1	Mental Health	Open, With Recruitment	23/05/2017	31/03/2019	15
everyBody Plus: Web-based self-help programme for BN, BED and OSFED	Mental Health	Open, With Recruitment	27/06/2017	31/01/2019	2
TRIANGLE: A novel patient and carer intervention for Anorexia Nervosa	Mental Health	Open, With Recruitment	30/06/2017	01/03/2019	4
Patient preferences for psychological help	Mental Health	Open, With Recruitment	03/10/2017	31/07/2018	8
FAM-Survey - Family involvement preferences in inpatient mental health treatment: Survey of recently admitted patients	Mental Health	Open, With Recruitment	24/11/2017	24/04/2018	40

Table 1

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

A proportion of [2]gether NHS Foundation Trust's income in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between [2]gether 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 2017/18 is £2,282,000 of which £2,282,000 was achieved

In 2016/17, the total potential value of the income conditional on reaching the targets within the CQUINs was £2,219,300 of which £2,219,300 was achieved.

2018/19 CQUIN Goals

CQUIN goals for 2018/19 reflect the nationally agreed two year scheme at the beginning of 2017/18 and are intended to deliver clinical quality improvements and drive transformational change in line with the Five Year Forward View and NHS Mandate. These include:

National CQUINs applicable to Gloucestershire and Herefordshire mental health services

- CQUIN 1 – NHS Staff Health and Wellbeing;
- CQUIN 2 - Improving physical healthcare to reduce premature mortality in people with serious mental illness (PSMI);
- CQUIN 3 – Improving Services for people with mental health needs who present to A & E;
- CQUIN 4 – Transitions out of Children and Young People's Mental Health Services;
- CQUIN 5 – Preventing ill health by risky behaviors – alcohol and tobacco.

Low Secure Services

- Reduction in Length of stay.

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 2017/18 or the previous year 2016/17.

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

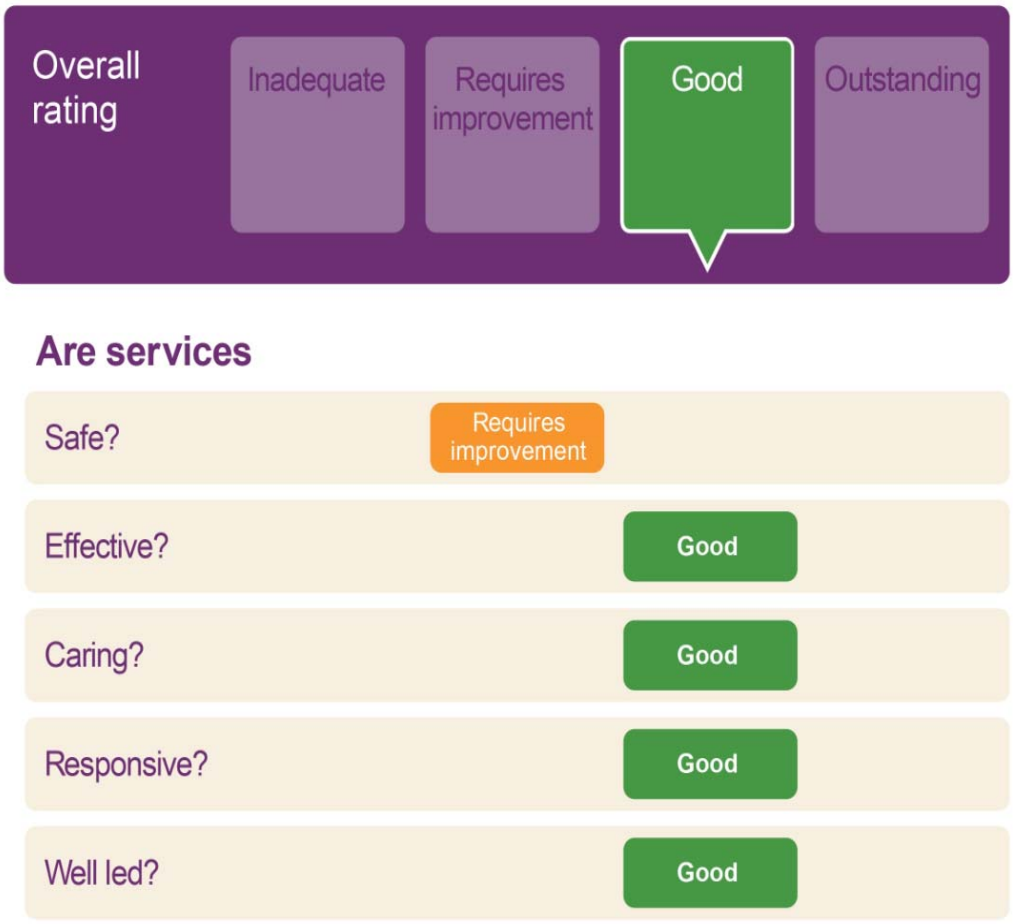
CQC Inspections of our services

The CQC undertook the following inspections during the reporting period:

1. Unannounced inspection of community based mental health services for older people
2. Unannounced inspection of wards for older people with mental health problems
3. Unannounced inspection of wards for people with learning disabilities or autism
4. Unannounced inspection of specialist community mental health services for children and young people
5. Well Led Review

At the time of writing the CQC report regarding these reviews has not been published so ratings remain as at the time of the comprehensive inspection in 2015. An action plan will be developed in response to recommendations.

The Care Quality Commission 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 took part in an unannounced CQC inspection during Quarter 4 2017/18 and a Well Led review on 21 - 22 March 2018. The report has not yet been published.

Quality of Data

Statement on relevance of Data Quality and actions to improve Data Quality

Good quality data underpins the effective provision of care and treatment and is essential to enabling improvements in care. [2]gether NHS Foundation Trust submitted records during 2017/18 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data (Month 9 data is reported below, as this was the only available information at the date of publication).

- The patient's valid NHS number was: **99.8%** for admitted patient care (**99.4%** national); and **99.9**% for outpatient care (**99.5**% national);

- The patient's valid General Practitioner Registration Code was: **100%** for admitted patient care (**99.9%** national); and **100%** for outpatient care (**99.8%** national).

[2]gether NHS Foundation Trust has taken the following action to improve data quality building on its existing clinical data quality arrangements:

- During 2017/18 the Trust has continued to progress data quality improvement. Based on the work undertaken in previous years to provide automated reports, we have continued the early warning reports for Senior Managers so they are alerted to any identified gaps;

- "Masterclasses" have continued to take place across all areas of the Trust. These have focused on educating staff how to use the Assessment and Care Management clinical audit dashboard which ensures the right data is entered, at the right time. This method enables effective management of data quality through awareness, training and support and moves away from the labor intensive data quality management through list generation;

- "Team Sites" a platform that brings many data sources together into one place, has been rolled out to all teams inpatient and community which enables staff to manage their individual and team data quality more effectively;

- "Patient Tracking List" this tool provides an overview of all clients within the service detailing current care pathways, waiting times from the referral to treatment and then waiting times between appointments. Following the successfully Implementation of the Improving Access to Psychological Therapies Patient Tracking List (PTL) we have recently created a PTL for all other services.

- 'Deep Dives' have continued throughout 2017/18 and will continue throughout coming years, reviewing all aspects of service performance and data quality focusing on Service Specific Reporting" and "Demand and Capacity".

Information Governance

[2]gether NHS Foundation Trust Information Governance Assessment Report overall score for 2017/18 was **85%** and was graded green. The Trust scored 85% in 2016/17.

The Toolkit has been the focus of regular review throughout the year by the Information Governance and Health Records Committee, and the Information Governance Advisory Committee. In this year's assessment of **45** key indicators:

- **26** key indicators were at level **3**;
- **19** key indicators were at level **2**;

The Toolkit has been the subject of an audit by the Trust's Internal Auditor, which produced a classification of low risk.

The Trust's efforts will remain focussed on maintaining the current level of compliance during 2018/19 and ensuring that the relevant evidence is up to date and reflective of best practice as currently understood, and that good information governance is promoted and embedded in the Trust through the work of the Information Governance and Health Records Committee, the IG Advisory Committee and Trust managers and staff.

Clinical Coding

[2]gether NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2017/2018 by the Audit Commission.

Learning from Deaths

During 1 April 2017 – 31 March 2018 795 patients of [2]gether NHS Foundation Trust died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

211 in the first quarter;
185 in the second quarter;
230 in the third quarter;
169 in the fourth quarter.

By 31 March 2017, 53 care record reviews and 24 investigations have been carried out in relation to 795 of the deaths included above. In 1 case a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

37 in the first quarter;
23 in the second quarter;
16 in the third quarter;
1 in the fourth quarter.

1 death representing 0.13% of the 795[1] patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided [2]gether NHS Foundation Trust to the patient. In relation to each quarter, this consisted of:

0 representing 0% for the first quarter;
1 representing 0.5% for the second quarter;
0 representing 0% for the third quarter;
0 representing 0% for the fourth quarter.

These numbers have been estimated using the root cause analysis methodology.

[1] Of the 795 deaths reported in 2017/18, 54.7% were open solely to the Acetylcholinesterase Inhibitors (ACI) Monitoring Caseload of the older people's dementia care teams. Additional administration support has been sourced to address this, and there is ongoing dialogue with both Primary Care and CCGs regarding which provider is best placed to undertake these reviews, as whilst the trust is currently completing these, contact with this patient cohort is limited and opportunities for learning marginal.

The trust identified that:

1. Further bespoke risk management training and how this relates to patient observations must be provided.
2. Documentation regarding observations needed amending to ensure that the location of a patient is recorded and by whom.
3. Greater clarity to staff must be provided regarding what actions to take when a patient cannot be located according to the Observation & Engagement Policy, particularly in regard to informal patients.
4. Reviews of garden areas including trees and branches must be undertaken to ensure that all ligatures are identified and mitigated against.
5. Staff personal alarm systems must cover garden areas.
6. Training on alarm systems is provided to junior doctors at induction.
7. A clinical audit of the implementation of the Observation Policy must be undertaken.

In response to the above learning points the trust has:

1. Updated and rolled out revised risk management training.
2. Improved the observation charts and updated the Observation & Engagement Policy.
3. Completed a review of garden areas and addressed the identified risks.
4. Updated personal alarm systems and provided training to junior doctors.
5. Undertaken a clinical audit of the Observation & Engagement Policy.

The trust believes that by implementing the above actions, patient safety and quality of care has improved.

0 case record reviews and 2 investigations completed after 31 March 2017 related to deaths which took place before the start of the reporting period.

0 representing 0% of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the root cause analysis methodology.

0 representing 0% of the patient deaths during 2016/17 are judged to be more likely than not to have been due to problems in the care provided to the patient. ”

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 4 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 2014	NHS Staff Survey 2015	NHS Staff Survey 2016	NHS Staff Survey 2017
[2]gether NHS Foundation Trust Score	3.61	3.75	3.84	3.86
National Median Score	3.57	3.63	3.62	3.67
Lowest Trust Score	3.01	3.11	3.20	3.26
Highest Trust Score	4.15	4.04	3.96	4.14

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

- For the second year running, all staff in post were invited to take part in the survey. Previously the survey had only been sent to a random sample of staff. The overall response rate in the most recent survey was **45%** (improved from 40% the previous year). This equated with **921** staff taking the time to contribute their views (up from 777 the previous year). The 2017 survey has arguably provided the richest and most accurate picture of the staff views in the Trust to date.

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

Taking steps to

- Improve Staff Health and Well-being;
- Improve Reporting of Incidents;
- Make more effective use of patient and service user feedback.

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 October 2016 – 31 March 2017				1 April 2017 – 30 September 2017			
	Number	Rate*	Severe	Death	Number	Rate*	Severe	Death
[2]gether NHS Foundation Trust	2,474	72.05	2	17	2,585	73.19	2	20
National	157,141	-	538	1233	167,477	-	532	1212
Lowest Trust	68	11.17	0	0	68	16	0	0
Highest Trust	6,447	88.21	72	100	6,447	126.47	89	83

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

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

- Establishing a Datix User Group to improve the processes in place for the timely review, approval of, response to and learning from 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.

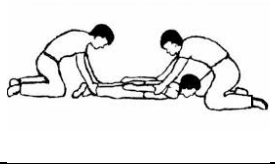
The table below provides a summary of our progress against these individual priorities. Each are subsequently explained in more detail throughout Part 3.

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**	**Not achieved**
User Experience			
2.1	Were you involved as much as you wanted to be in agreeing what care you will receive? **> 92%**	**83%**	**87%**
2.2	Do you know who to contact out of office hours if you have a crisis? **>74%**	**74%**	**84%**
2.3	Has someone given you advice about taking part in activities that are important to you? **> 69%**	**69%**	**88%**
2.4	Have you had help and advice to find support to meet your physical health needs if you needed it? **> 76%**	**76%**	**88%**
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.	**-**	**Not 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**	**229**

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. We have not met the target. We are doing lots of work to get better at this.	↓
Care (CPA) Review 	Not all people moving from children's to adult services had a care review. We have not met the target. We are doing lots of work to get better at this.	↓
Care Plans 	87% 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 	84% 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 	88% of people said they had advice about taking part in activities. This is more than the target (69%). We met the target.	↑
Physical Health 	88% of people said they had advice about their physical health This is more than the target (76%). We met the target.	↑

Suicide 	There were more suicides compared to this time last year. We have not met the target. We are doing lots of work to get better at this.	
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 four, the results of the audit undertaken in quarter three were published. This was 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. We are pleased to report that the audit showed the following rates of compliance:

- **Inpatients 95%**
- **Community Mental Health Services 90%**
- **Early Intervention Community Teams 92%**

These results show that the CQUIN targets have been successfully met, and that the process of completing the LESTER tool screening, along with sharing the information is continuing to embed within practice in community and inpatient settings.

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 serious mental illness, and the screening and recording of results is built into statutory and mandatory training programmes. An e-learning programme is being developed to ensure all staff have access to training, and face to face training sessions will also continue to be held.

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

Following the successful launch of the 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. In January 2018 we held a “Reducing Smoking in Mental Health” event. This was well attended by Trusts within the South-West and the day focussed on reducing harm from smoking in mental health services and how different teams are implementing the smoke free challenge across the South West.

Within quarter four, a new ECG machine was purchased for the Gloucestershire community recovery units. Having a machine located within the units provides patients who need screening access on site, rather than having to wait for an appointment at the local hospital.

A “Physical Health” study day for Trust staff has been successfully launched; it covers a broad range of physical healthcare topics and will reinforce the importance of screening for, and improving patients’ physical health. Feedback from the sessions has been overwhelmingly positive and more dates are planned for 2018/19.

The Trust has been approached to be involved with the project launch of “Equally Well” which is a new national collaborative to support the physical health of people with a mental illness. It aims to bring together health and care providers, commissioners, professional bodies, service user and carer organisations, charities and many more, working nationally or locally, to form a collaborative in the UK to bring about equal physical health for people with a mental illness.

We have met 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)	Year End Compliance (2017/18)
Overall Average Compliance	**69%**	**72%**	**73%**
Chestnut Ward	84%	85%	**83%**
Mulberry Ward	75%	79%	**73%**
Willow Ward	59%	71%	**69%**
Abbey Ward	72%	75%	**78%**
Dean Ward	79%	73%	**73%**
Greyfriars PICU	50%	62%	**64%**
Kingsholm Ward	75%	72%	**72%**
Priory Ward	80%	80%	**80%**
Montpellier Unit	50%	57%	**64%**
Honeybourne	N/A	70%	**65%**
Laurel House	N/A	65%	**81%**

* 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.

Year-end overall average compliance in Gloucester for these standards during this year is **73%** which is a slight improvement on the 72% achieved in 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 next year.

Herefordshire Services

Criterion	Year End compliance (2015/16)	Year End Compliance 2016/17)	Year End Compliance (2017/18)
Overall Average Compliance	**N/A**	**74%**	**71%**
Cantilupe Ward	**N/A**	85%	**82%**
Jenny Lind Ward	**N/A**	71%	**68%**
Mortimer Ward	**N/A**	69%	**65%**
Oak House	**N/A**	70%	**68%**

Year-end overall average compliance in Herefordshire for these standards during this year is **71%** which is a 3% reduction on 2016/17 compliance. There will be an increased focus on ensuring that these standards are met throughout next year.

Trust wide 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 (Q4)	Direction of travel and previous compliance (Q3)
1.	Has a Risk Summary been completed?	100%	⇔ (100%)
2.	Has the Clustering Assessment and Allocation been completed?	87%	⇧ (83%)
3.	Has HEF been completed? (LD only)	100%	⇧ (0%)
4.	Has the Pre-Discharge Planning Form been completed?	30%	⇩ (33%)
5.	Have the inpatient care plans been closed within 7 days of discharge?	22%	⇔ (22%)
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?	93%	⇧ (86%)
8.	Has the 48 hour follow up been completed if the Community Team are not doing it?	94%	⇩ (96%)

Of the eight individual criteria assessed, compliance has remained the same for three criteria, increased for three criteria and decreased for 2 criteria.

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 the Quarters 1-3 all young people who transitioned into adult services had a joint CPA review. However, during Quarter 4 there were 4 young people who made this transition, only 3 of these received 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%	75%

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	Not applicable

During the Quarters 1-2 all young people who transitioned into adult services had a joint CPA review. In Quarters 3-4 no young people transitioned into either adult mental health, or adult learning disability services.

To improve our practice and documentation in relation to this target, a number of measures were developed during 2017-18 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 teams. Team Managers will monitor those who are coming up to transition discuss them with care coordinators in caseload management to see whether transition is clinically indicated.

These measures will continue to be used to promote good practice and as the target was not achieved we will maintain this as a quality priority in 2018/19.

We did not meet 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 4 2017/18 – January to March 2018) 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	82 (70 positive)	87% TARGET 92%
	Herefordshire	21 (20 positive)	
	Total	103 (90 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	84 (67 positive)	84% TARGET 74%
	Herefordshire	20 (20 positive)	
	Total	104 (87 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	85 (72 positive)	88% TARGET 69%
	Herefordshire	19 (19 positive)	
	Total	104 (91 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	80 (69 positive)	88% TARGET 76%
	Herefordshire	15 (15 positive)	
	Total	95 (84 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 hasn't been fully achieved this quarter continues to receive a high percentage of positive responses. Going forward for 2018/19, targets were reviewed in line with the national Community Mental Health Survey undertaken by the CQC. Targets have been set using the CQC response data rather than this year's results of the Quality Survey questions

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?*"

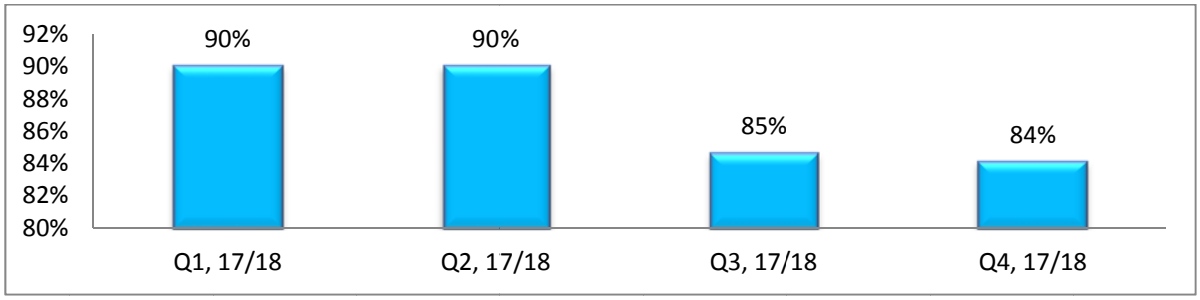
Our Trust played a key role in the development of an Easy Read version of the FFT. Roll out of this version ensures that everybody is supported to provide feedback.

The table below details the number of combined total responses received by the Trust each month in Quarter 4. 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	257 (222 positive)	86%
November 2017	276 (220 positive)	80%
December 2017	417 (357 positive)	86%
Total	**950** (799 positive) **(last quarter = 864)**	**84%** **(last quarter = 85%)**

The Quarter 4 response rates are similar to 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. This method has continued to be embedded during Quarter 4 2017/18 with good response.

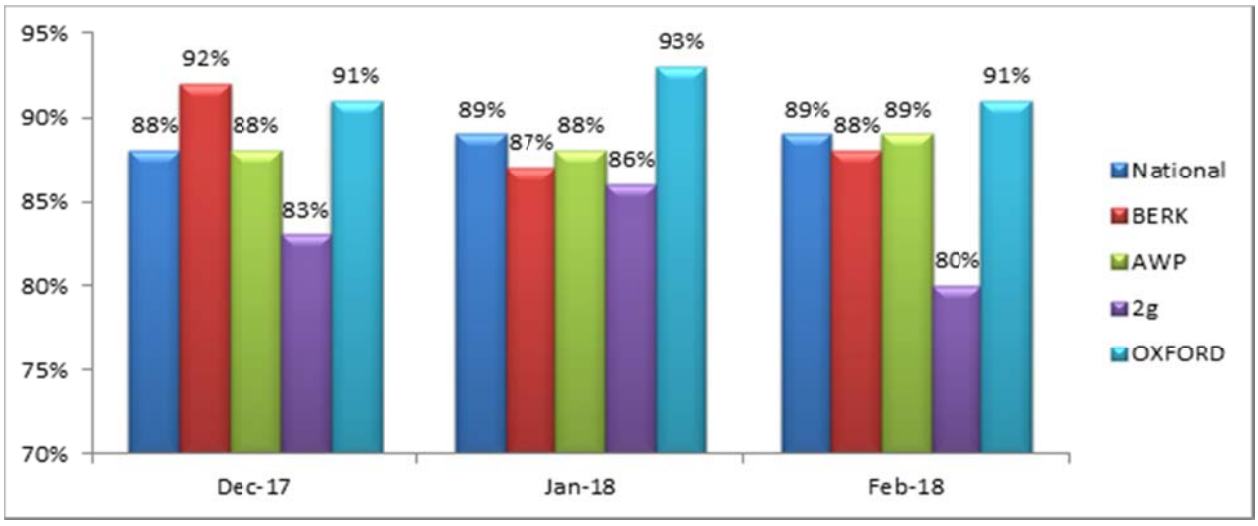
FFT Scores for 2gether NHS Foundation Trust for the past year. The following graph shows the FFT Scores for the past rolling year, including this quarter. The Trust receives consistently positive feedback.



The FFT score for Quarter 4 has remained consistent 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 Trust and other Mental Health Trusts across England

The chart below shows the FFT scores for December 2017, January and February 2018 (the most recent data available) compared to other Mental Health Trusts in our region and the national average. Our Trust consistently receives a high percentage of recommendation in line with other Mental Health Trusts in the region (March 2018 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

Complaints

Between 1 April 2017 and 31 March 2018 the Trust received **65** formal complaints, a reduction in actual number from the previous year. However, Figure 1 below (the numbers of complaints received by [2]gether in 2017/18 by month compared to the average over preceding 4 years) provides a trend line suggesting that the numbers of complaints received has been relatively consistent in relation to the number of people seen over a period of two years.

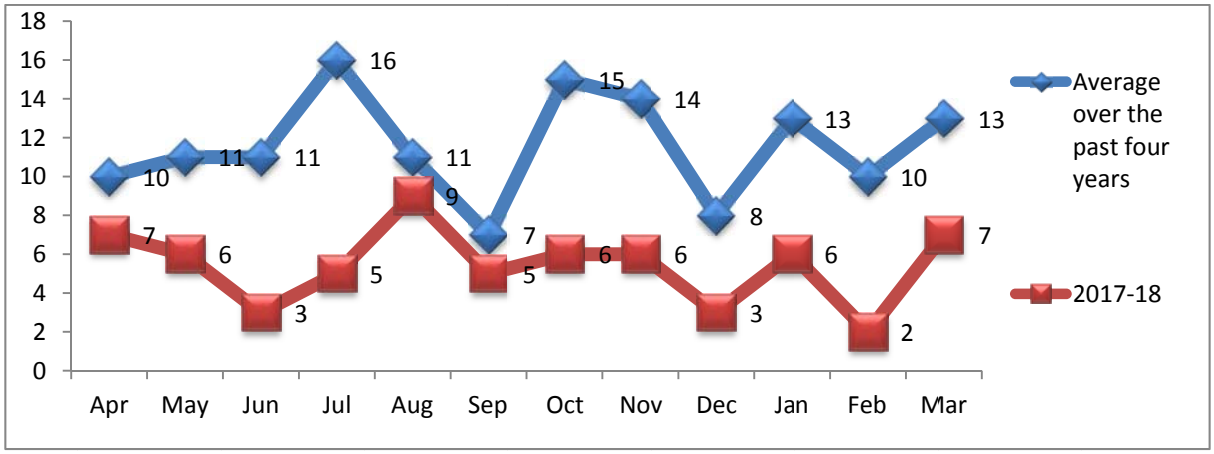


Figure 1

When the numbers of complaints are measured against the number of individual contacts within our services the percentage of complaints is very low (trend line shown for 2016/17 and 2017/18 in Figure 2).

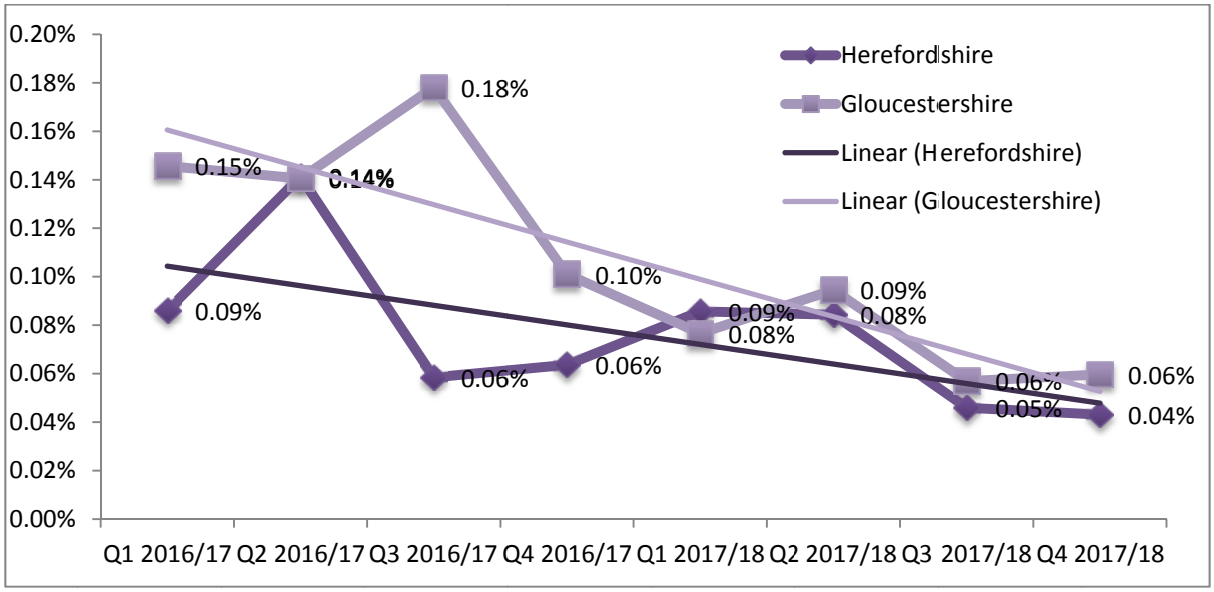


Figure 2

People who contact the Service Experience Department should receive a response within three working days. The SED will seek to resolve any concerns in the most timely and proportionate manner. Those who wish to pursue a formal complaint will have their complaint issues clarified and sent to them in writing for confirmation – this is known as the acknowledgement of complaint process.

A continuous year on year improvement in written acknowledgement of complaints within the expected three day timeframe has been demonstrated. **100%** (**65**) of complaints were acknowledged within the three day time standard this year.

During 2017/18 a greater proportion of concerns raised with the Service Experience Department were supported through the management of 'concerns' process.

Analysis of this information for 2017/18 shows that there has been a 39% reduction in the number of formal complaints (n=65), the number of concerns has remained relatively consistent with that of 2016/17 (reduction of 3%) (n=189) (Figure 3).

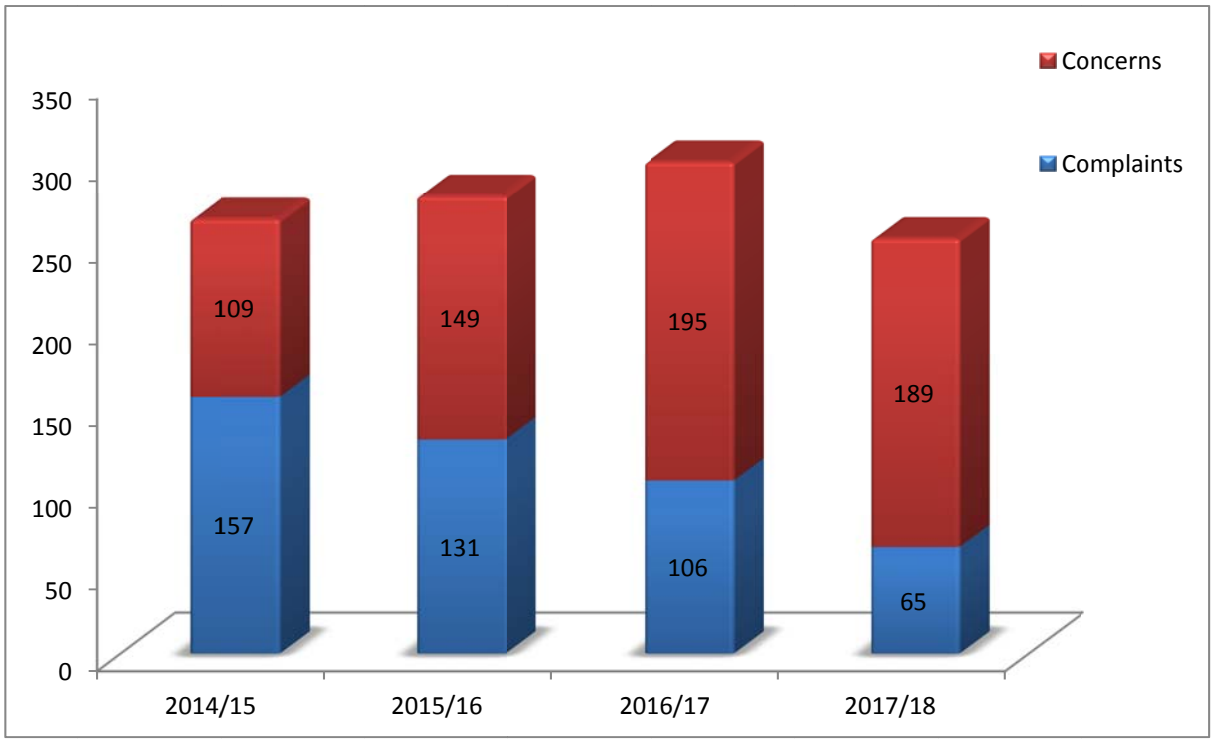


Figure 3

There has been 16% decrease in the combined number of complaints and concerns reported to the Service Experience Department during 2017/18. It is important to acknowledge that the SED also record additional contacts made directly with the department and these are categorised as requiring advice or signposting and also recorded on Datix.

During 2016/17 164 contacts for advice or signposting were recorded, this type of contact has increased by 40% in 2017/18 with a total of 273 advice and signposting contacts recorded.

In total, an increase of 12% can be seen in 2017/18 for the total number of combined contacts made with the SED concerning either complaints, concerns or advice and signposting (2016/17 = 465 individual contacts recorded 2017/18 = 527 individual contacts recorded).

People are encouraged to seek an independent investigation of their complaint via an external review either by the Parliamentary Health Services Ombudsman (PHSO), Local Government Ombudsman or the Care Quality Commission (CQC) if they are not satisfied with the outcome of ^{2}gether's investigation or if they feel that their concern remains unresolved.

People are encouraged to seek an independent review of their complaint if they are dissatisfied with the complaint outcome or if they feel that their concern remains unresolved. Complainants are able to contact the Parliamentary Health Service Ombudsman (PHSO), Local Government Ombudsman (LGO) or Care Quality Commission (CQC) depending upon the issues contained within their complaint

The PHSO, LGO or CQC have requested information relating to 8 complaints during the last 12 months. These 8 complaints were all complaints reported and investigated by our Trust prior to 2017/18.

Status of the 8 complaints:

- 1 was investigated formally by the CQC. The investigation has concluded and closed with recommended actions for our Trust;
- 1 is currently under review with LGO to decide if formal investigation is to take place;
- 3 were taken forward for formal investigation by the PHSO. Two investigations have been concluded and 1 remains ongoing. Out of the two concluded investigations 1 was closed with no further action by our Trust and the other made recommendations for our Trust;
- 3 were closed with no further action from the PHSO.

2 of these cases have been closed by the PHSO requiring no further action from our Trust. 1 case remains under review with the LGO as to whether it will be taken forward for formal investigation. 1 case was formally investigated by the CQC**.**

4 complaints heard by our Trust have been investigated externally during 2017/18.

This is fewer than last year, although would represent 6% of complaints received during 2017/18, which is almost the same percentage as last year (5%). The slight increase can be accounted for due to decreased numbers of complaints received during 2017/18.

1 additional complaint initially raised in 2016 was taken forward by the PHSO for investigation during 2016/17. The investigation was concluded and closed during 2017/18 with no further action required.

A complaint investigated by the PHSO and one investigated by the CQC identified learning for our Trust. Action plans were developed and implemented in response on each occasion. Both action plans have been fully completed and closed during 2017/18.

The quarterly Service Experience Report to the Trust Board outlines in detail the themes of complaints, the learning and the actions that have been taken. Learning from complaints, concerns, compliments and comments is essential to the continuous improvement of our services.

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 2017/18 the number of reported suspected suicides was **28,** 2 more than at the end of last year. This is seen in Figure 4.

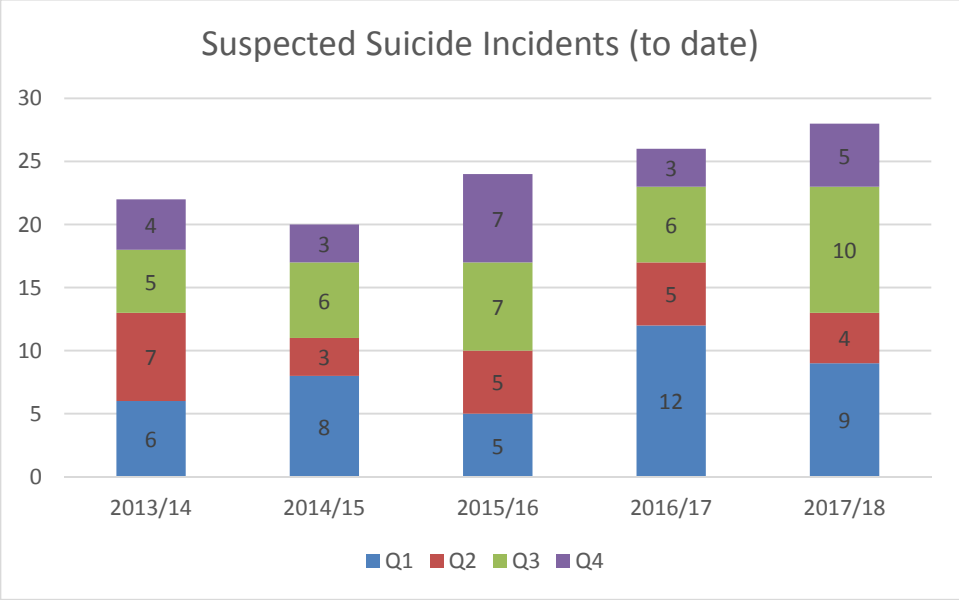


Figure 4

What we also know is that we are seeing more and more service users on our caseload year on year, so we measured this important target differently this year. This is also 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 2017/18 the median value remained at 0.09.

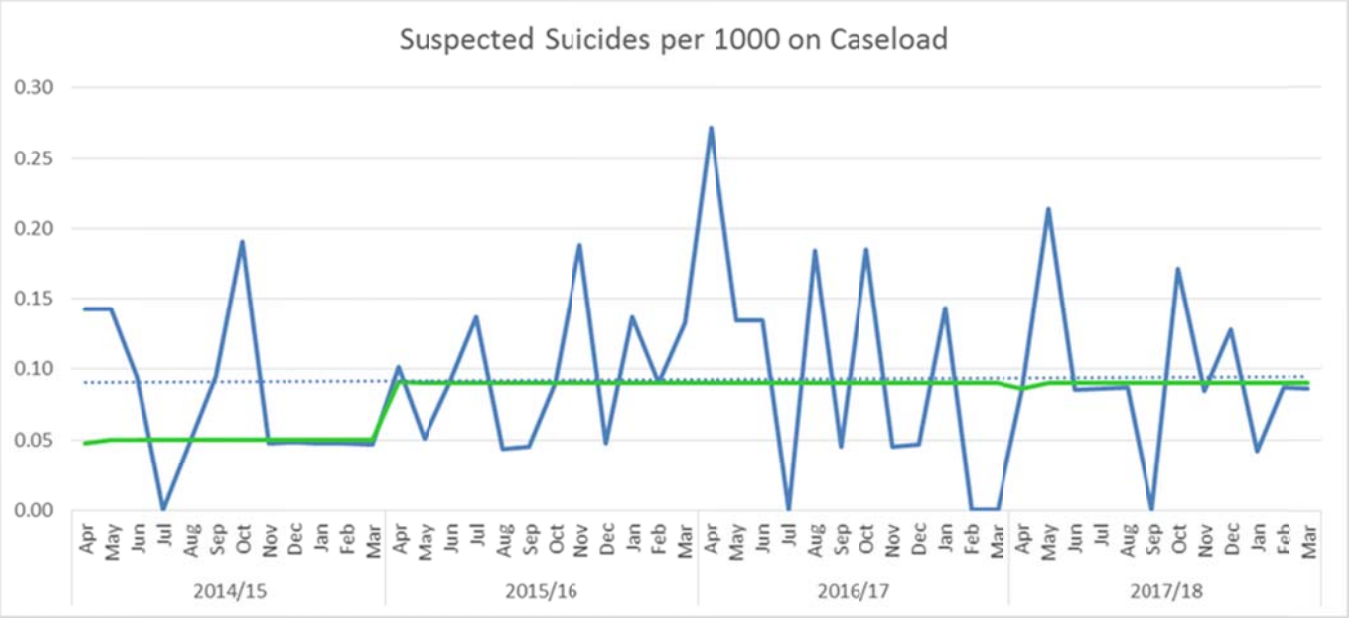


Figure 5

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.

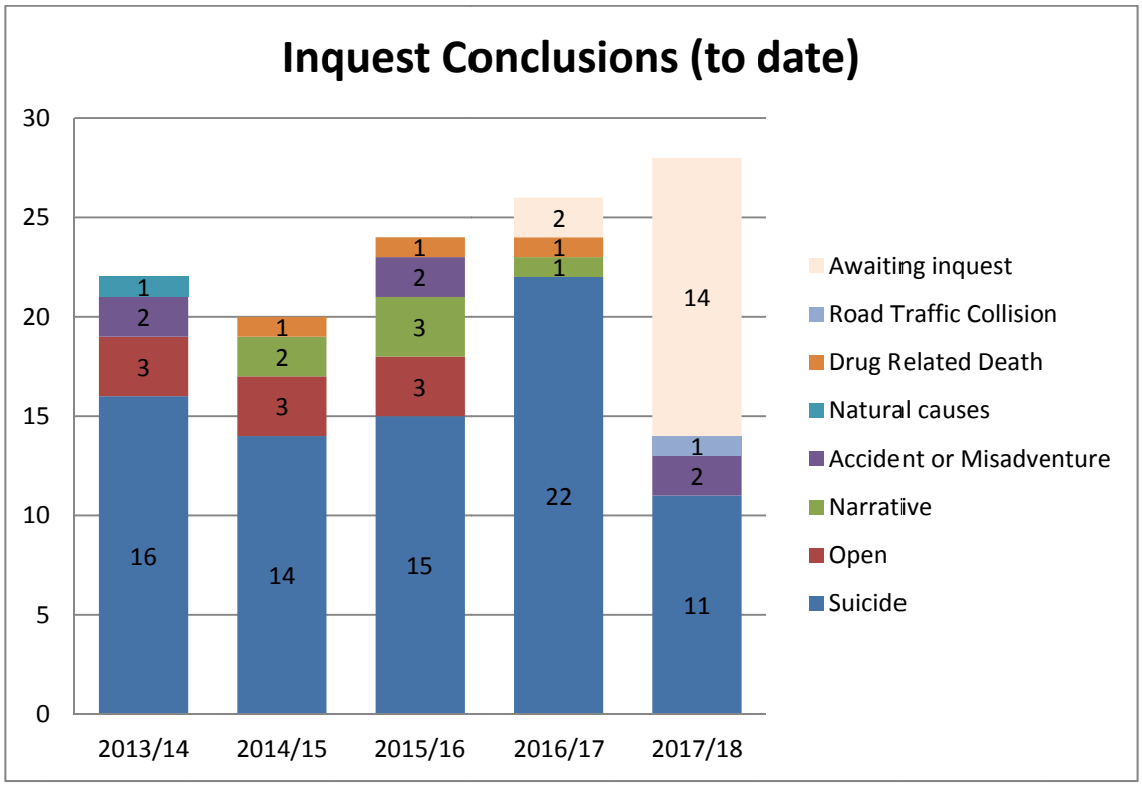


Figure 6

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).

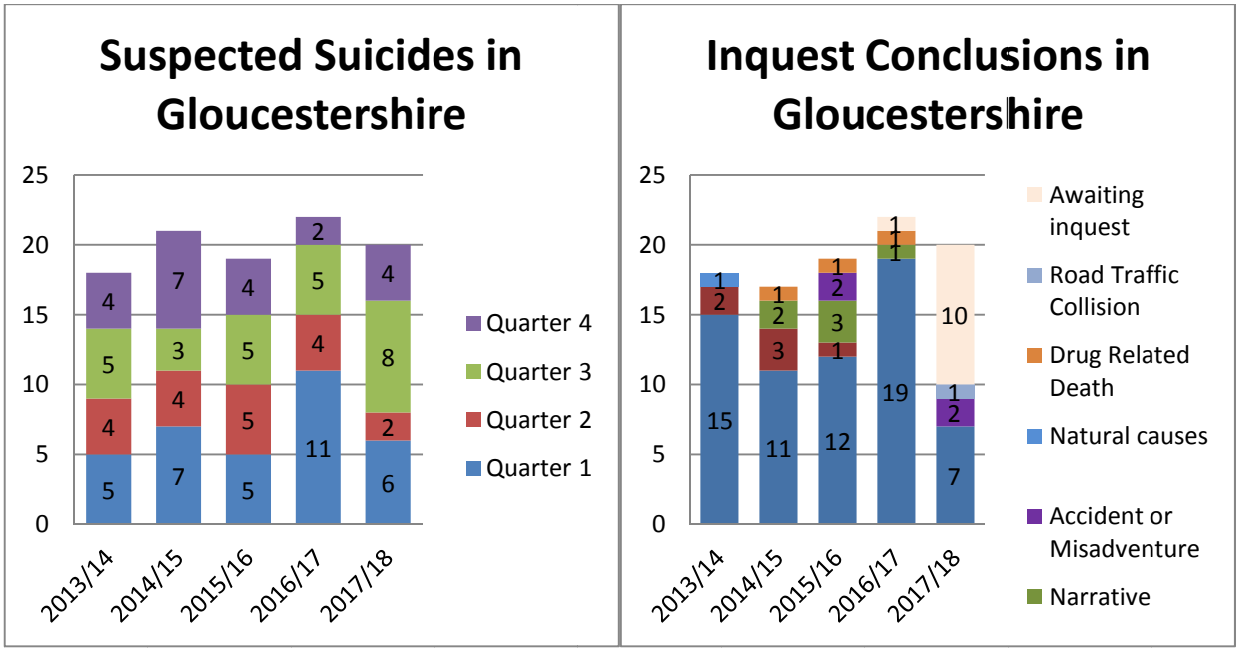


Figure 7

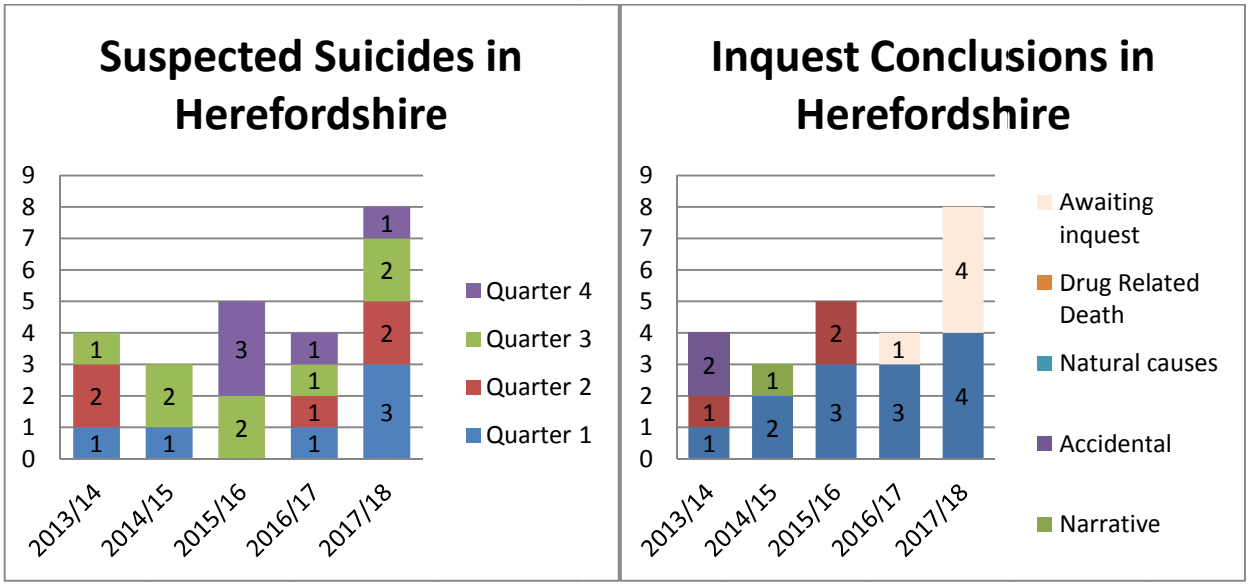


Figure 8

We will continue to work hard to identify and support those people experiencing suicidal ideation and aim to establish the interventions that will make the most impact for individuals. We launched the StayAlive App during 2017/18; this is a pocket suicide prevention resource for both people who are having thoughts of suicide and those who are concerned about someone else who may be considering suicide. This is available on AppStore and Google Play.

We have not met this target.

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 **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	72	59	11	**142**
Herefordshire	20	3	5	**28**
Total	**92**	**62**	**16**	**170**

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 9 which was an overall increase.

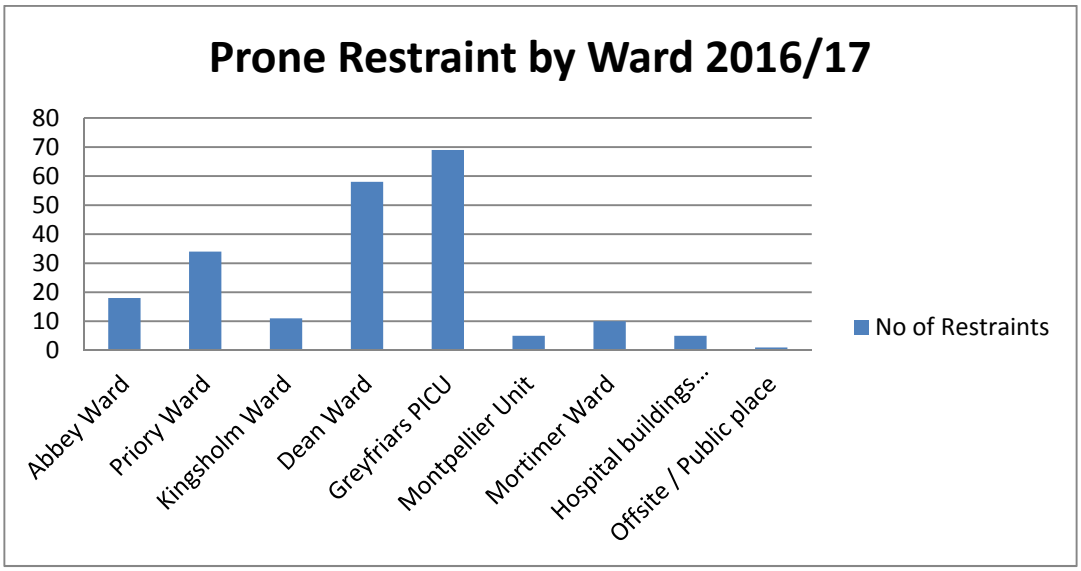
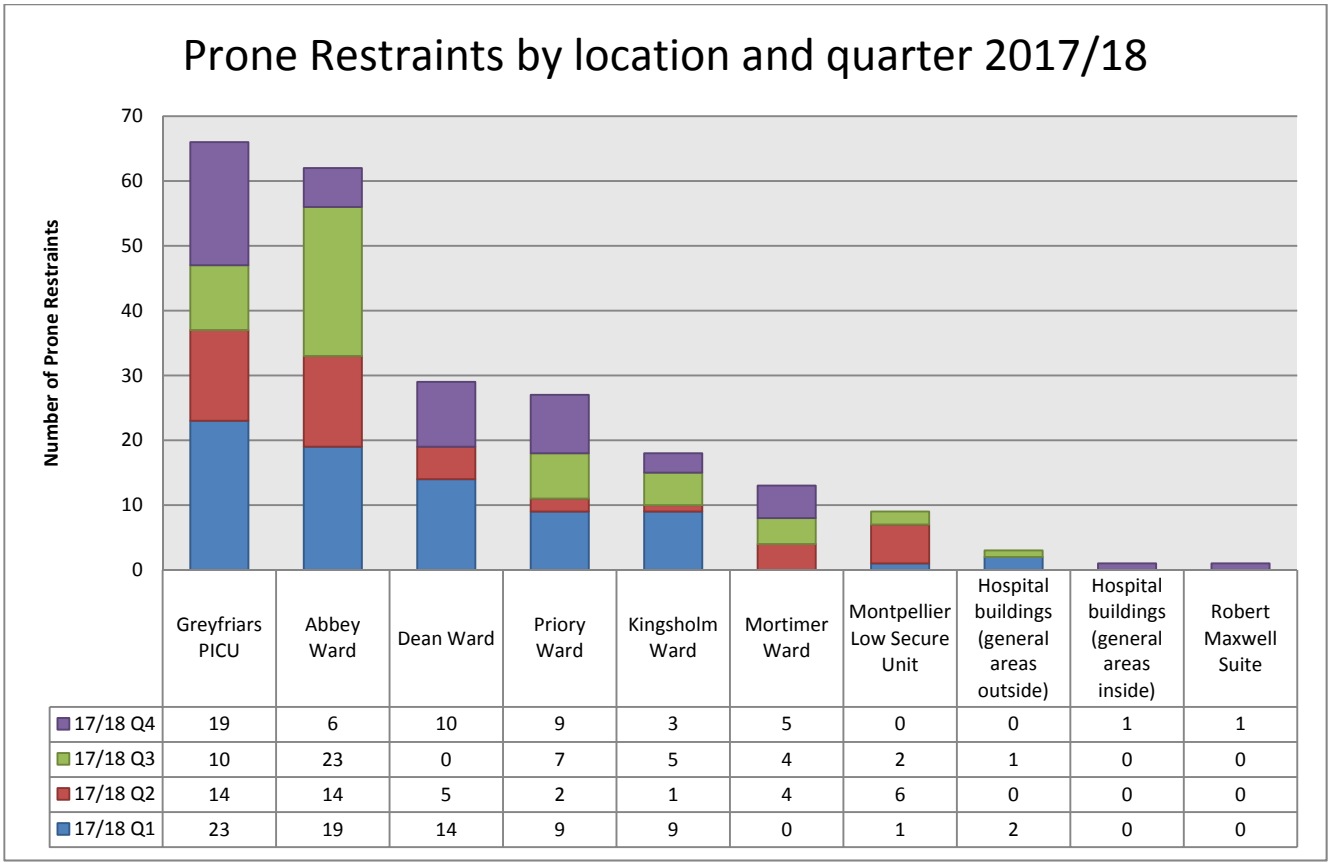


Figure 9

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 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 were introduced during 2017/18 and it is anticipated that we will ultimately see a corresponding reduction in the use of prone restraint over time

By the end of 2017/18, **229** instances of prone restraint were used so we did not see a 5% reduction by year end.



	Greyfriars PICU	Abbey Ward	Dean Ward	Priory Ward	Kingsholm Ward	Mortimer Ward	Montpellier Low Secure Unit	Hospital buildings (general areas outside)	Hospital buildings (general areas inside)	Robert Maxwell Suite
17/18 Q4	19	6	10	9	3	5	0	0	1	1
17/18 Q3	10	23	0	7	5	4	2	1	0	0
17/18 Q2	14	14	5	2	1	4	6	0	0	0
17/18 Q1	23	19	14	9	9	0	1	2	0	0

Figure 10

In reviewing our restraint data in detail over the past 2 years, we have, however, seen an encouraging increase in the use of supine restraint as an appropriate less risky alternative to prone restraint. In 2018/19 our aim will, therefore, be to see an increase in the use of supine restraint as an alternative to prone restraint. Our target will be to see a greater percentage of supine restraints compared to prone.

Figure 11 overleaf shows numbers of supine and prone restraint over the past two years.

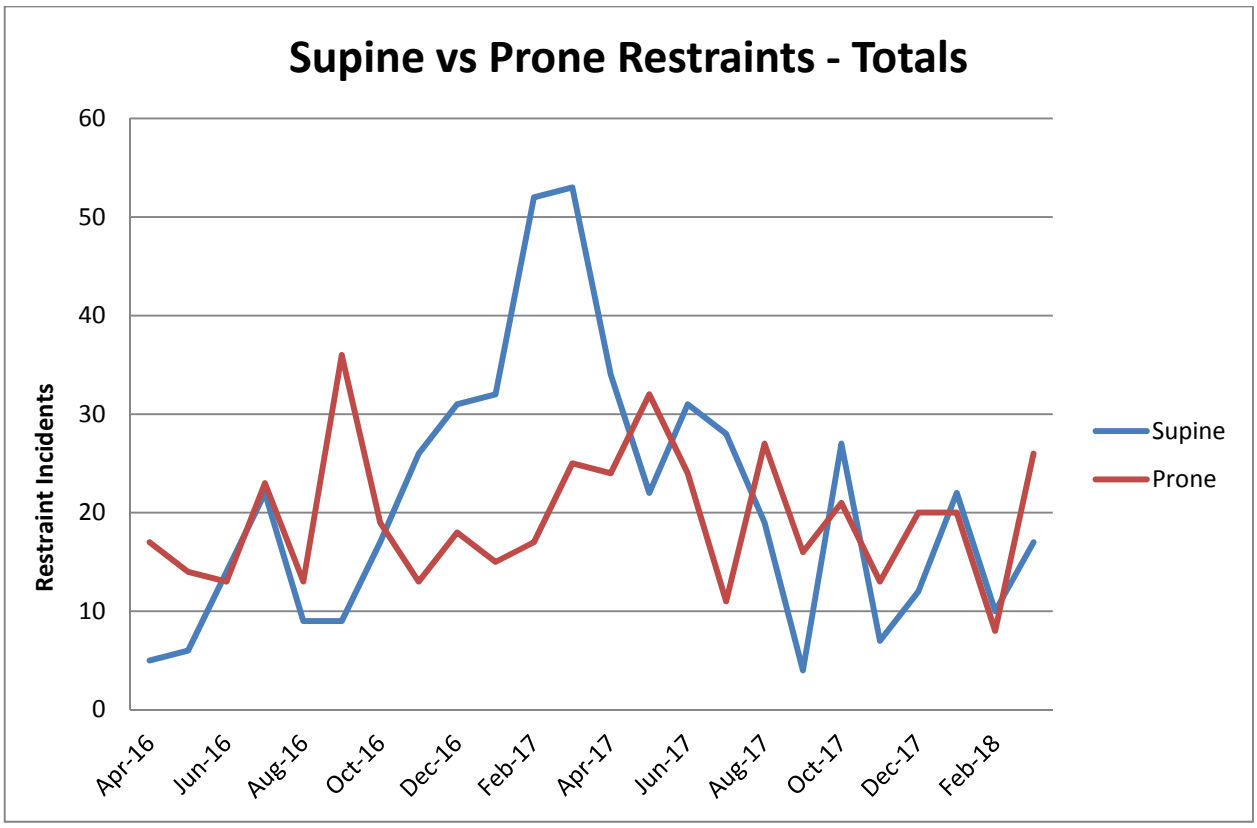


Figure 11

We have not yet met this target.

Serious Incidents reported during 2017/18

By the end of 2017/18, **50** serious incidents were reported by the Trust, **5** of which were subsequently declassified; the types of these incidents reported are seen below in Figure 12.

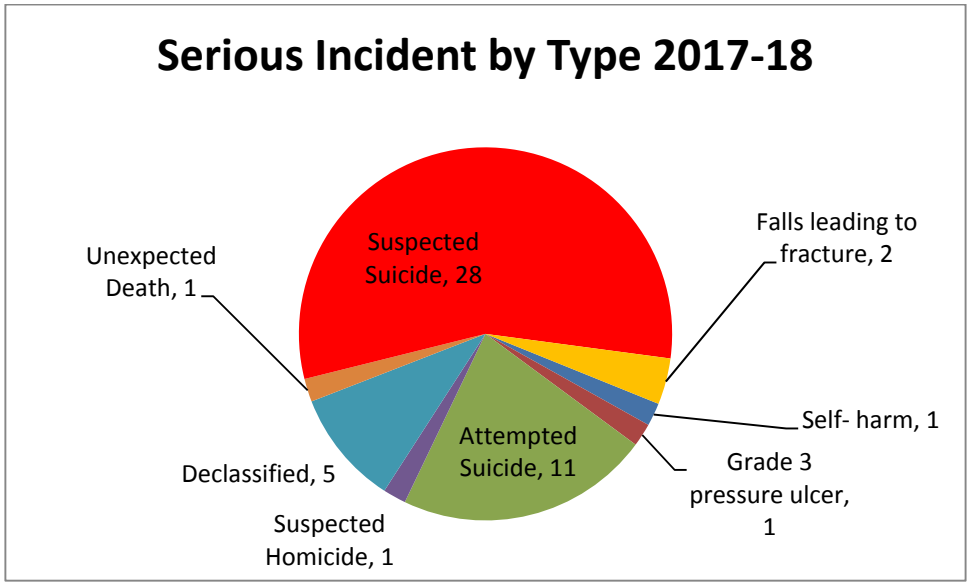


Figure 12

Figure 13 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 appointed a whole time equivalent Lead Investigator commenced this important work in May 2017, and 2 further dedicated Investigating Officers are now available via the Trust's Staff Bank.

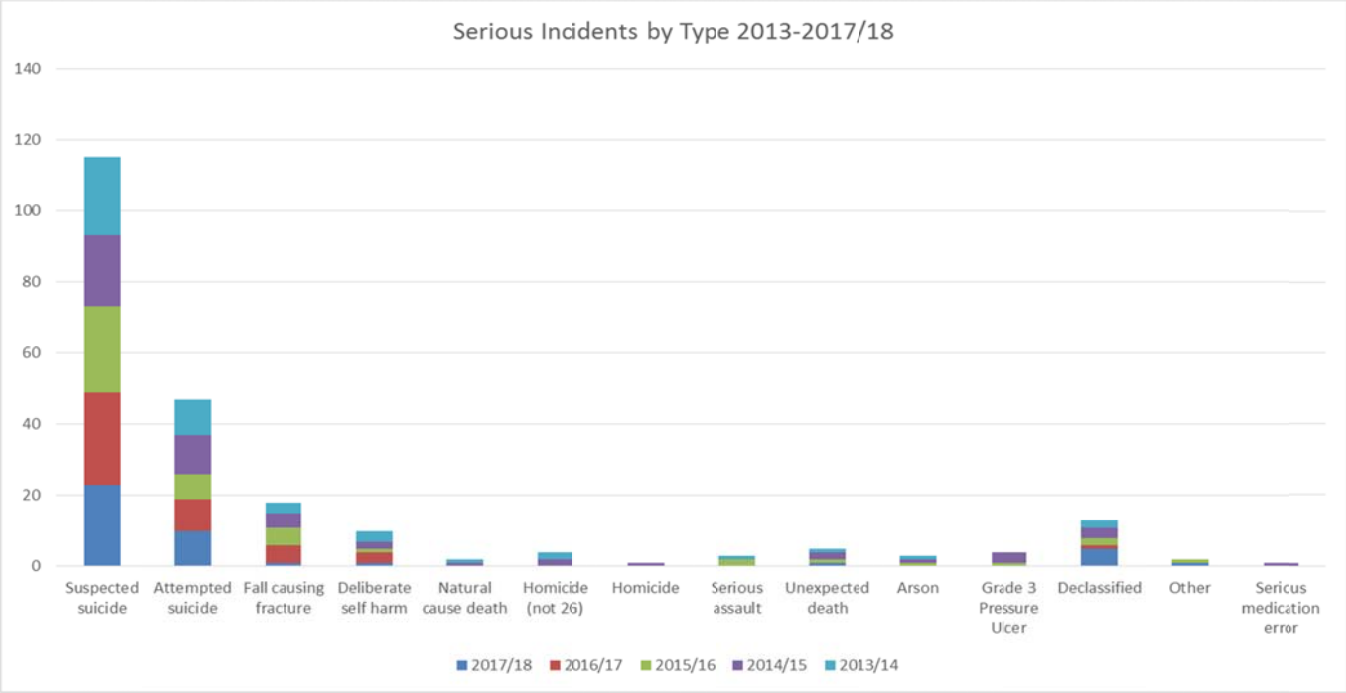


Figure 13

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 2018/19 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 in 2015, 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.

We are aware that further work is required to ensure that all incidents of moderate harm are appropriately reported and that the service user experiencing this harm is fully informed and supported. This will be a key area of further development and consolidation throughout 2018/19.

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 2017/2018

The following table shows the NHSI mental health metrics that were monitored by the Trust during 2017/18.

		2016-2017 Actual	National Threshold	2017-2018 Actual
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	**71.3%**	50%	**70%**
2	Ensure that cardio-metabolic assessment & treatment for people with psychosis is delivered routinely in the following service areas: -inpatient wards -early intervention in psychosis services -community mental health services (people on CPA)	 - - -		 **95%** **92%** **90%**
3	Improving access to psychological therapies (IAPT): Proportion or people completing treatment who move to recovery (from IAPT database) Waiting time to begin treatment (from IAPT minimum dataset - treated within 6 weeks of referral - treated within 18 weeks of referral	**-** **37.8%**	50% 75% 95%	**50%** **67%** **85%**
4	Admissions to adult facilities of patients under 16 years old.	-		**1**
5	Inappropriate out-of area placements for adult mental health services	-		**24**

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

The Trust participates in the annual NHS Staff Survey alongside quarterly Staff Friends and Family Tests (FFT). While staff also have a wide variety of other ways to feed back their views and experiences of work, the NHS Staff Survey provides the most in-depth analysis of how staff view the Trust as an employer and as a provider of mental health and learning disability services.

The responses to each of the questions asked are grouped into 32 key findings, progress against which can be measured year on year. These key findings and the questions within the survey are set nationally.

For the second year running, all staff in post were invited to take part in the survey. Previously the survey had only been sent to a random sample of staff. The overall response rate in the most recent survey was **45%** (improved from 40% the previous year). This equated with **921** staff taking the time to contribute their views (up from 777 the previous year). The 2017 survey has arguably provided the richest and most accurate picture of the staff views in the Trust to date.

Overall staff engagement has remained steady with the result being derived from three 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.

The Trust score was **3.88** (from a possible 5) and was better than the national average for mental health/learning disability trusts, and better than the national average for all NHS organisations.

The results of the 2017 Survey showed the Trust to be better than average in 17 Key Findings (53%) and better than average or average in 27 (84%) of the overall 32 key findings. There were no statistically significant improvements in any of the categories. However, there was a statistically significant deterioration in two key findings:

- KF29 - % of staff reporting errors, near misses or incidents witnessed in the last month
- KF18 - % of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves.

It is encouraging to note that the number of staff recommending the organisation as a place to work or receive treatment has again increased and was higher than the national average. Staff motivation at work and ability to contribute to improvements at work also both remain above the national average.

After a disappointing score in 2015, followed by significant improvements in 2016, the percentage of staff reporting good communication between senior managers and staff has again improved and is equivalent with the national average for mental health trusts.

Effective team working saw an improvement as did satisfaction with resourcing and support, both Key Findings being higher than the national average.

The Survey results are also used to inform progress against the Workforce Race Equality Standard (WRES), introduced in 2014. Four of the nine WRES indicators are taken from the survey. Both white and BME staff groups reported that there were equal opportunities for career progression and promotion, at rates better than the national average. The percentage of BME staff experiencing harassment, bullying or abuse from patients mirrors the average rate for mental health trusts in England. The percentage of Trust BME staff experiencing harassment, bullying, discrimination or abuse from colleagues is less than half the national average.

Nationally within the NHS, levels of bullying and harassment arguably remain high but as a Trust we continue to work to eliminate this. Over the last 12 months we have increased the number of Dignity at

Work Officers and we continue to promote Whistleblowing alongside our confidential dialogue system known as Speak in Confidence as part of the wider suite of measures introduced to offer support to staff.

Following internal reviews and discussions of the findings, the Trust will focus on three priority areas 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.

Each Locality has also reviewed their local ratings and been asked to agree priority areas and actions to focus on in the coming year.

More recently, in quarter 4 at the end of 2017/18, the Trust ran its 12th Staff Friends and Family Test with staff rating the Trust on the following basis:

- **90.5%** of staff would recommend the Trust as place to receive treatment - an increase by 3.5 % points to the best score since the introduction of the test.

- **77%** of staff would recommend the Trust as a place to work - risen from 73%, also the best score to date.

While this is encouraging, the Trust continues to work with staff and managers towards achieving further longer term improvements in staff experience and engagement.

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, being 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

Gloucestershire Health and Care Overview and Scrutiny Committee

On behalf of the Health and Care Overview and Scrutiny Committee I welcome the opportunity to comment on the 2gether NHS Foundation Trust Quality Account 2017/18.

This has been a significant year for the Trust following the decision to integrate with Gloucestershire Care Services NHS Trust, and the appointment of both a Joint Chair and Joint Chief Executive. The committee is supportive of the aim to provide seamless mental and physical health services to patients, service users and carers, and looks forward to hearing the detail of the proposals as they emerge.

I consider that this is an open and honest Quality Account that does not shy away from the challenges faced by the Trust, is clear where improvement is still needed, and has both patients and staff wellbeing at its centre.

Last year the committee was concerned with the number of suspected deaths by suicide, and whilst the way in which this target is measured is different this year, notes that there has been an increase in these deaths in Gloucestershire.

I welcome the target to reduce the use of prone restraint on patients and the move to using supine restraint.

The committee is pleased to see the improvement in performance against IAPT targets, but does note that there is still work to do to reach the required level of support. Committee members are also pleased to see the mainly positive outcomes from the Patient Led Assessments of the Care Environment (PLACE), and hopes to see an improvement in the overall food score in the next assessment.

The committee welcomes the award, by the Carers Trust, of a second gold star as part of the Triangle of Care scheme.

The committee is pleased to note that further improving personalised discharge care and improving the transition process for children and young people who move into adult mental health services are specifically identified as priorities.

I would particularly like to thank the Trust for its work with the committee and Ruth FitzJohn and Shaun Clee for their commitment to mental health and wellbeing services in Gloucestershire.

The committee looks forward to working with Ingrid Barker and Paul Roberts as they lead the Trust on its journey to integration with Gloucestershire Care Services NHS Trust.

Cllr Carole Allaway Martin
Chairman
Health and Care Scrutiny Committee

Healthwatch Comments on 2gether NHS Foundation Trust Quality Account 2017-18.

Thank you for the opportunity for Healthwatch Herefordshire to comment on the 2gether Quality Account 2017-18.

Healthwatch Herefordshire are very pleased to support the annual report. We know that the Trust has been working hard to improve service quality and we support their continued aim for further improvement in the future.

As the report demonstrates though there are a number of areas which you highlight as needing further improvement. We are particularly concerned to see further progress in the IAPT access and outcomes measures, we strongly support the continued implementation of the Triangle of Care system and also service users we have contact with confirm your findings that care planning on discharge needs more attention. We also hear from service users that the community nursing arrangements are not working consistently across the County and we would hope to see this addressed.

Our recently formed Mental Health Forum is proving a valuable source of useful feedback and we look forward to developing links with it and 2gether to work to assist with service development and improvement in the future.

Yours Sincerely

Ian Stead – Chair, Healthwatch Herefordshire

Healthwatch Gloucestershire's Response to 2gether NHS Foundation Trust Quality Statement 2017/2018

Healthwatch Gloucestershire welcomes the opportunity to comment on 2gether NHS Foundation Trust's quality account for 2017/18. Healthwatch Gloucestershire exists to promote the voice of patients and the wider public with respect to health and social care services. Over the past year we have continued to work with 2gether NHSFT to ensure that patients and the wider community are appropriately involved in providing feedback and that this feedback is taken seriously. Over the past year Healthwatch Gloucestershire came under a new provider but has continued to work with 2gether NHSFT.

We welcome the ongoing work based on the CQC report that remains a driving force for positive change. We support the Trust's priorities of personalised discharge planning, but we note that this has been an ongoing issue for some time and share concerns that progress on this isn't being made as quickly as the Trust may want.

It is encouraging to note that the Quality Measures are meeting the targets for User Experience and would suggest that these could be more challenging to have more of a positive impact.

We welcome the adaptations to the Friends and Family Test (FFT) to include an Easy Read version for users of the service with Learning difficulties, and it is heartening to note that these remain fairly consistent across the year. We would welcome improvements to the FFT scores so that they became more aligned to National and regional providers' scores.

We are concerned that the actual number of suicides of those who use the Trust's services continues to rise despite remaining a priority. Although we understand that case load has also risen, this constitutes a worrying trend and at best shows (using the new measurement) that the numbers of suicides in the Trust remains static. We note that the Trust has developed the Stay Alive App and will be interested to see how well this works for those with suicidal ideation and their friends and family.

Referral to treatment times for the Improving access to psychological therapies (IAPT) service are not at present meeting national targets. The Trust has not outlined any actions to improve these targets and therefore we would like to understand more about future plans and what interim services may be available for those waiting to use the service.

We note that the Trust has highlighted a priority of reducing the number of prone restraints and welcome the new training in place to reduce risk. We will be interested to see how this is evaluated in the next year, and the positive impact it has on patients.

Healthwatch Gloucestershire looks forward to working with 2gether over the coming year to ensure that the experiences of patients, their families and unpaid carers are heard and taken seriously.

Alan Thomas
Interim Chair,
Healthwatch Gloucestershire
Shadow Steering Group

Herefordshire CCG response to 2gether NHS Foundation Trust Quality Accounts

Herefordshire Clinical Commissioning Group (CCG) welcomes the opportunity to provide comments on the Quality Report prepared by 2gether NHS Foundation Trust (2gNHSFT) for 2017/18.

The report is well written, concise and easy to understand.

The 2017/18 Quality Report demonstrates that the trust has overcome most of the challenges, concerns and opportunities that the Trust faced in 2016/17. Herefordshire CCG continues to regularly attend the Trust Quality Committee meetings and are made to feel welcome and contribute constructively at the Contract Quality Review Forum.

The CCG acknowledge 2gNHSFT's continuing focus on patient and carer experience and the delivery of comprehensive high quality of care across a range of integrated health and social care services across the county, which underpins all clinical work delivered by the Trust.

The CCG notes that the Trust did not reach its targets of (for Hereford patients):

- A further improvement in personalised discharge care planning in adult and older peoples wards, including the provision of discharge information to primary care services within 24 hours of discharge

The CCG is pleased to note that this remains a priority for the trust.

The CCG endorses the continued work on the research strategy as it enters its third year, including its ambition to be a 'world class centre of practice-based research and developments to make life better'; the building on the review of the Assessment and Care Management CPA and Assessing and Managing of Clinical Risk and Safety policies. We also welcome the work on the Alzheimer's disease and dementia research with Cobalt Health and look forward to its integration into primary health care as it further develops.

We were pleased to note there continues to be a high level of 2gNHSFT engagement in both national and local clinical audits and research as well as participation in national confidential enquiries, with a 100% response rate. Which have led to changes in practice for example, the development of Level 3 Child Protection (safeguarding) training internally and the learning from the Covert Medicines Administration audit.

We further endorse the work on data quality which underpins the effective provision of care and treatment, including the use of Masterclasses to underpin the CPA audit and the development of the patient treatment list (PTL) to current care pathways.

The CCG reviews 2gNHSFT's incident responses on a regular basis and find robust systems and processes in place with evidence of duty of candour has been undertaken in each report and evidence that learning is embedded within the wider Trust workforce.

The CCG endorses all 2gNHSFT's priorities for improvement as contained in this report in the expectation that they will lead to improved delivery against effectiveness, service user experience and safety, supporting improved outcomes for service users.

Following a review of the information presented within this report, coupled with commissioner led reviews of quality across all providers, the CCG is satisfied with the accuracy of the report.

Helen Richardson
Chief Nursing Officer

NHS Gloucestershire CCG Comments in Response to [2]gether NHS Foundation Trust Quality Report 2017/18

NHS Gloucestershire Clinical Commissioning Group (CCG) welcomes the opportunity to provide comments on the Quality Report prepared by [2]gether NHS Foundation Trust (2gNHSFT) for 2017/18 in line with NHS Improvement guidance '*Detailed requirements for quality reports 2017/18*' published January 2018.

The report clearly identifies how the Trust performed against the agreed quality priorities for improvement for 2017/18 and also outlines their priorities for improvement in 2018/19. The CCG endorses the quality priorities included in the report whilst acknowledging the difficult financial challenges 2gNHSFT have to address in the future, particularly in the implementation and delivery of the Gloucestershire STP. We will continue to work with the Trust where targets have not been met.

2gNHSFT had a comprehensive CQC inspection during February and March 2018 and we note that the outcome of that inspection is still awaited. We note that the comprehensive CQC inspection during October 2015, where the overall outcome was rated as 'good' continues to inform many of the Trust's quality initiatives. The CCG will continue to work with the Trust to monitor the implementation of the CQC action plan developed to address any areas identified for further improvement in 2018/19.

The CCG note the development of a new Quality Strategy for 2018 – 2020 and we will work with the Trust to monitor implementation to ensure the delivery of high quality, effective services to improve the lives of service users, their families and carers.

We acknowledge that the Trust did achieve many of their targets in 2017/18 and were pleased to note good progress in supporting service users with their physical health, the provision of information on who to contact in a crisis and reducing the number of service users who went absent without leave. The CCG acknowledge the significant work and commitment of staff to become Smokefree. We were pleased to note the Trust's achievements in being in the top three mental health trusts for the number of frontline staff vaccinated against flu, and of being amongst the top three mental health providers nationally in the CQC's community mental health survey for 2017. However, 2gNHSFT did not achieve a number of targets and the CCG will work with the Trust to ensure these priorities will continue to be a focus for achievement in 2018/19.

We wish to acknowledge the extensive work undertaken by the Trust and progress to date against the Gloucestershire Improving Access to Psychological Therapies (IAPT) recovery plans. This continues to remain a high priority for the CCG, and we will continue to work with 2gNHSFT in 2018/19 to improving access to IAPT services to meet national targets.

2gNHSFT were compliant in meeting the CQUIN requirements and achieved targets in 2017/18 with the exception of Goal Number 3 - Improving Services for people with mental health needs who present to A&E. However, this was due to circumstances outside the control of 2gNHSFT and this has been acknowledged by the CCG. We will continue to work with the Trust on the achievement of their CQUIN goals for 2018/19 and delivery of clinical improvements and transformational change as set out in the Five Year Forward View and NHS Mandate.

The CCG are pleased to note the Trust's focus on continuing improvement in identified priorities for effectiveness, service user experience and safety in 2017/18. We note achievement of targets in 2017/18, and whilst there are a number of areas where targets were partially or not achieved, the CCG are content that the Quality Report provides a balanced view.

The CCG also acknowledge the Trust's commitment to Learning from Deaths, identification of learning and actions put in place to improve patient safety and the quality of care for service users. 2gNHSFT has continued to engage in partnership working with other provider organisations to share this learning across the wider healthcare system in Gloucestershire. The CCG will continue to work with the Trust to monitor progress against these requirements in 2018/19.

The CCG acknowledge 2g's continued strong focus on service user and carer experience and quality of caring and whilst not all targets were met in improving the experience of service users in key areas, the Trust continues to receive a high percentage of positive responses. We are pleased to note that the FFT score for Q4 has remained consistent with other quarters and they continue to maintain a high number of people who would recommend their services.

We were also pleased to note that 2gNHSFT scored well overall in comparison to other mental health Trusts in the 2017 CQC Community Survey.

The CCG also wish to acknowledge the Trust has again achieved very positive results in the Patient Led Assessments of the Care Environment (PLACE) 2017 and were placed above the national average for Mental Health and Learning Disability settings with the exception of one unit.

We recognise that the Trust's response rate to the Staff Survey 2017 saw an overall increase in the response rate, and that overall staff engagement has remained steady, whilst this survey has provided the richest and most accurate picture of staff views. We note the Trust score was again higher than the nation average when compared to other Mental Health and Learning Disabilities Trusts, and in 2017 was better than the national average for all NHS organisations.

We were pleased to note there continues to be a high level of clinical participation in local clinical audits, and also a positive increase in activity in relation to Clinical Research.

The CCG will continue to work with 2gNHSFT during the current merger with Gloucestershire Care Services (GCS) and resulting reorganisational change to ensure the trust is in a strong position to manage both present and future challenges in delivering mental health and learning disabilities services that provide best value with a clear focus on providing high quality, safe and effective care for the people of Gloucestershire.

Gloucestershire CCG wish to confirm that to the best of our knowledge we consider that the 2017/18 Quality Report contains accurate information in relation to the quality of services provided by 2gNHSFT. During 2018/19 the CCG wish to work with 2gNHSFT, all stakeholders and the people of Gloucestershire to further develop ways of receiving the most comprehensive reassurance we can regarding the quality of the mental health and learning disability services provided to the residents of Gloucestershire and beyond.

Dr Marion Andrews-Evans
Executive Nurse & Quality Lead
NHS Gloucestershire CCG

Herefordshire Health and Social Care Overview and Scrutiny Committee

Thank you for inviting comment on your quality account for 2017.

Congratulations on your ethos of continuous improvement.

It is noted that there is considerable improvement needed on the arrangements for transition between children's and adults' services, although it is noted that this is being explored. The latest Care Quality Commission report is awaited with interest.

Having looked at some of the performance data in the report, it would be interesting to have more detailed information regarding the root cause analysis relating to deaths in order to provide greater understanding and clarity in this area.

With regard to the performance against targets by percentage, it understood that these are performance targets and it is good to see where these are exceeded. However, these should be 100% targets in all cases, for example all patients/relatives should be discharged with the knowledge of who to contact if support is required.

The priorities covered in the account are appropriate. However, anecdotally, relatives may feel vulnerable if not fully informed or equipped to meet someone's needs upon discharge.

It has been noted that there are concerns regarding the lack of locally accessible inpatient treatment for eating disorders, and we would encourage and welcome any consideration of more local provision, including a shared provision with our neighbours.

Cllr Polly Andrews, Chair of the Adults and Wellbeing Scrutiny Committee
Cllr Carole Gandy, Chair of the Children and Young People Scrutiny Committee

The Royal College of Psychiatrists

Summary of Participation in National Quality Improvement Projects managed by The Royal College of Psychiatrists' Centre for Quality Improvement

[2]gether NHS Foundation Trust			
Programmes	Participating services in the Trust	Accreditation Status	Number of Services Participating Nationally
AIMS Rehab: A Quality Network for Mental Health Rehabilitation Services	Honeybourne Recovery Unit	Accredited	66
	Laurel House	Accredited	
AIMS-WA: A Quality Network for Working-age Adult Wards	Mortimer Ward, Stonebow Unit	Not yet assessed	145
	Abbey Ward, Wotton Lawn Hospital	Accredited	
	Dean Ward, Wotton Lawn Hospital	Accredited as excellent	
	Kingsholm Ward, Wotton Lawn Hospital	Accredited as excellent	
	Priory Ward, Wotton Lawn Hospital	Accredited as excellent	
ECTAS: Electro Convulsive Therapy Accreditation Service	Stonebow (Hereford)	Accredited	80
	Wotton Lawn (Gloucester)	Accredited as excellent	
EIPN: Early Intervention in Psychosis Network	GRIP (Gloucestershire)	Accreditation not offered by this Network	155
	Herefordshire Early Intervention Service	Accreditation not offered by this Network	
HTAS: Home Treatment Accreditation Service	Cheltenham Crisis Resolution and Home Treatment Team	Accredited	54
	Gloucester Crisis Resolution and Home Treatment Team	Accredited	
	Stroud and Cirencester Crisis Resolution and Home Treatment Team	Accredited	
MSNAP: Memory Services National Accreditation Project	Gloucester Memory Service	Accredited (no longer member)	75
QNCC: Quality Network for Community CAMHS	Gloucester CYPS	Participating but not yet undergoing accreditation	42
	Eating Disorder Service	Participating but not yet undergoing accreditation	
QNOAMHS: Quality Network for Older Adults Mental Health Services	Cantilupe Ward	Accredited	87
	Jenny Lind	Accredited as excellent	
	Chestnut Ward	Accreditation deferred	
	Willow Ward	Accreditation deferred	
	Mulberry Ward	Participating but not yet undergoing accreditation	
QNPICU: AIMS PICU: Psychiatric Intensive Care Units	Greyfriars PICU	Accredited as excellent	38

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

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS foundation trust annual reporting manual 2017/18 and supporting guidance;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2017 to March 2018
    - papers relating to Quality reported to the Board over the period April 2017 to April 2018
    - feedback from Gloucestershire commissioners dated May 2018
    - feedback from Herefordshire commissioners dated May 2018
    - feedback Governors dated 17 January 2017
    - feedback from Herefordshire Healthwatch dated May 2018
    - feedback from Gloucestershire Healthwatch dated May 2018
    - feedback from Gloucestershire Health and Care Overview and Scrutiny Committee dated May 2018
    - feedback from Herefordshire Overview and Scrutiny Committee dated May 2018
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated April 2018
    - the 2017 national patient survey
    - the 2017 national staff survey
    - the Head of Internal Audit's annual opinion over the trust's control environment dated May 2018
    - CQC inspection report dated 28 January 2016

- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the quality report has been prepared in accordance with MHs Improvement's annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

….....Date.....Chair

.....Date.....Chief Executive

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:

Paul Roberts
Chief Executive
2gether NHS Foundation Trust
Rikenel
Montpellier
Gloucester
GL1 1LY

Or email him at: paul.roberts@glos-care.nhs.uk

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 9 **Paper D**

Report to: Trust Board – 31 May 2018
Author: Mark Scheepers & Amjad Uppal
Presented by: Mark Scheepers
SUBJECT: **Gloucestershire LeDeR Mortality Review**

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

Learning from Deaths (LfD) is required from all trusts. Deaths, whether these were natural or unnatural, expected or unexpected and whether there were problems with care all have to be reported nationally. For people with Learning Disabilities (LD), there is a requirement to participate in a national programme.

The LeDeR Programme (mortality review of people with a learning disability) is being led by the University of Bristol and follows on from the Confidential Inquiry into the Premature Deaths of People with LD (CIPOLD); the findings of which demonstrated that on average someone with LD lives 20 years less than someone without.

The Gloucestershire CCG 2018-2019 LeDeR Governance highlight report is shared with the Board for information and assurance; the summary of the national findings is on page 2.

LEVEL OF ASSURANCE PROVIDED

Moderate

RECOMMENDATIONS

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

Corporate Considerations	
Quality implications	Understanding the reasons for patient deaths will hopefully help to identify any trends of importance.
Resource implications:	"Internal table-top reviews" are co-ordinated by a Band 3 administrator, with input from the Nurse Consultant, Clinical Director, another Consultant psychiatrist and the Band 4 mortality administrator.
Equalities implications:	Principles of the LeDeR programme and mortality review is to ensure that there has been equal care and access to care for all.
Risk implications	Learning from Deaths is on the risk register, although the process is refined, progress has been slow.

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

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

Reviewed by:		
Dr Amjad Uppal	Date	29/05/2018

Where in the Trust has this been discussed before?		
	Date	

What consultation has there been?		
	Date	

Explanation of acronyms used:	

Gloucestershire LeDeR Mortality Review
Governance Highlight Report
Report 2018-2019
May 2018

Responsible committee:	LeDeR Mortality Review Steering Group
Target audience:	Internal report for those agencies involved in the programme. LeDeR Mortality Review Steering Group Members LeDeR Mortality Review Peer Support Group Gloucestershire Clinical Commissioning Group - Quality Learning Disabilities Lead Commissioner National LeDeR Programme NHS England
Date of approval: 4th May 2018	
Review date:	
Version	0.3
Document type	Quality Report
Key Words	Learning Disabilities, Mortality, Health inequalities

Author:		
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Version Control: Date	**Version**	**Status**
27.4.18	0.1	First draft prepared for consideration & approval by Chair
4.5.18	0.2 & 0.3	2nd & 3rd version following feedback from Chair & approved by Sponsor

1. **Introduction & Background**

The LeDeR Programme (mortality review of people with a learning disability) is being led by the University of Bristol and follows on from the Confidential Enquiry into Premature Deaths of people with LD (CIPOLD) the findings of which demonstrated that on average someone with a LD lives 20 years less than someone without. Further information about the Programme can be found click here.

The national LeDeR Annual Report for 2017 was published on 4th May 2018 – an can be downloaded for information – click here

Summary of the National findings

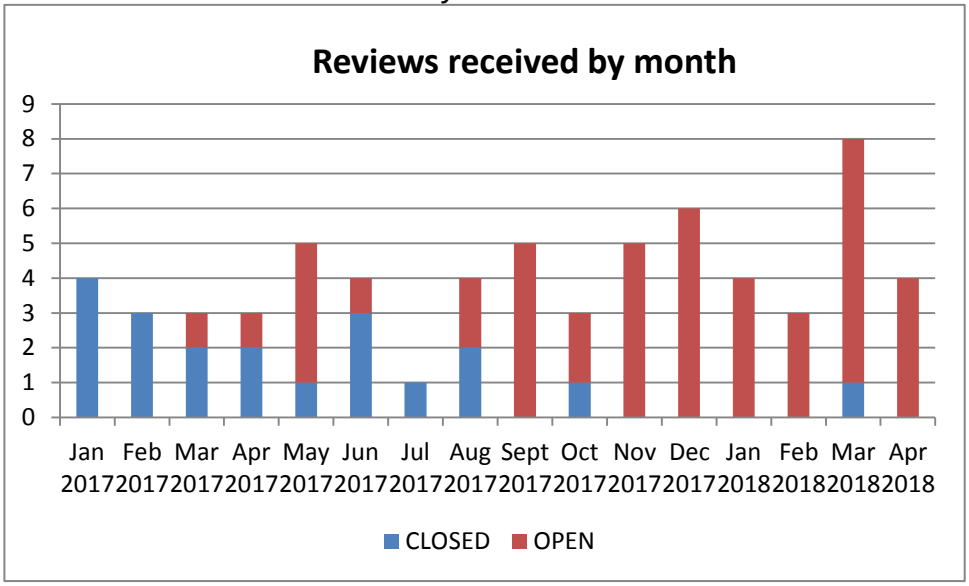
- By the end of November 2017, all but two of the 39 LeDeR Steering Groups were operational.
- The most significant challenge to programme delivery has been the timeliness with which mortality reviews have been completed, largely driven by four key factors: a) large numbers of deaths being notified before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

Key information about the people with learning disabilities whose deaths were notified to the LeDeR programme includes:

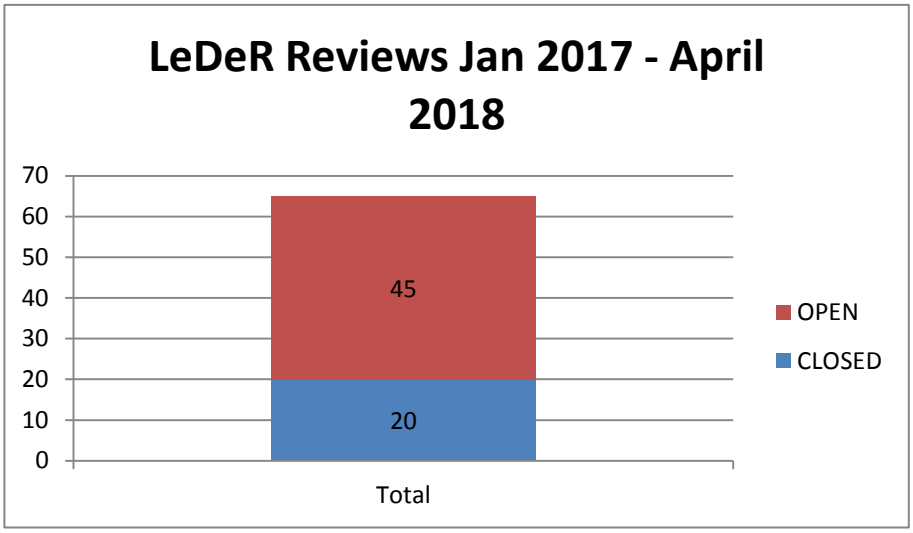
- Just over half (57%) of the deaths were of males
- Most people (96%) were single
- Most people (93%) were of White ethnic background
- Just over a quarter (27%) had mild learning disabilities; 33% had moderate learning disabilities; 29% severe learning disabilities; and 11% profound or multiple learning disabilities.
- Approximately one in ten (9%) usually lived alone
- Approximately one in ten (9%) had been in an out-of-area placement.

2. Gloucestershire Performance to date

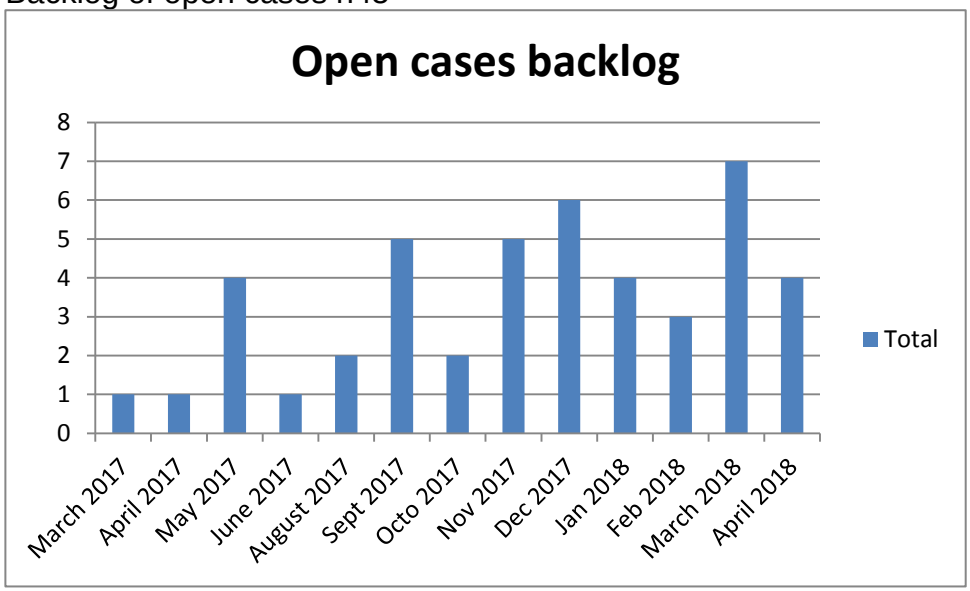
Number of Reviews received by Month



Number of Reviews allocated



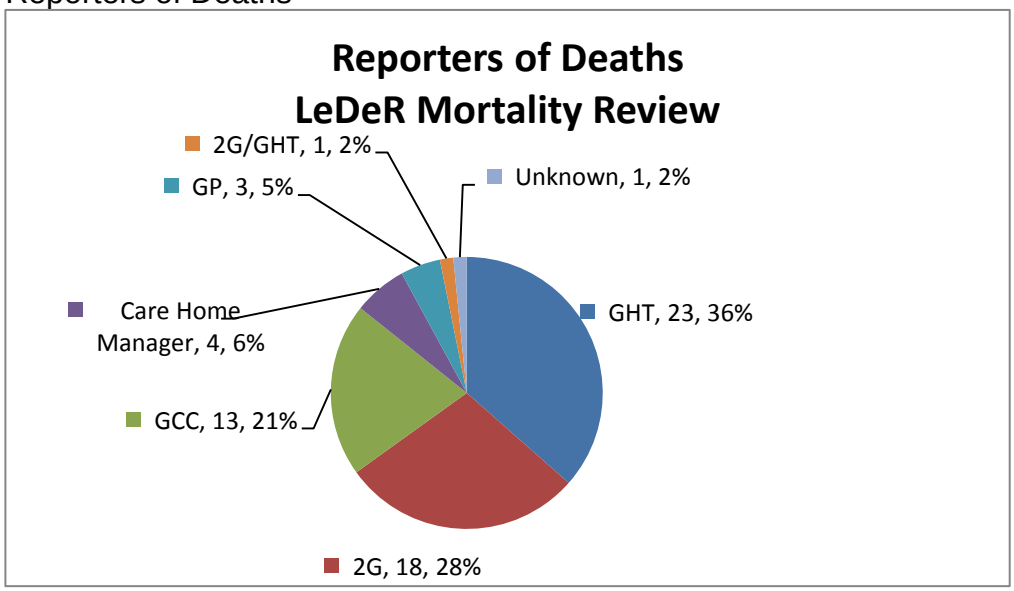
Backlog of open cases n45–



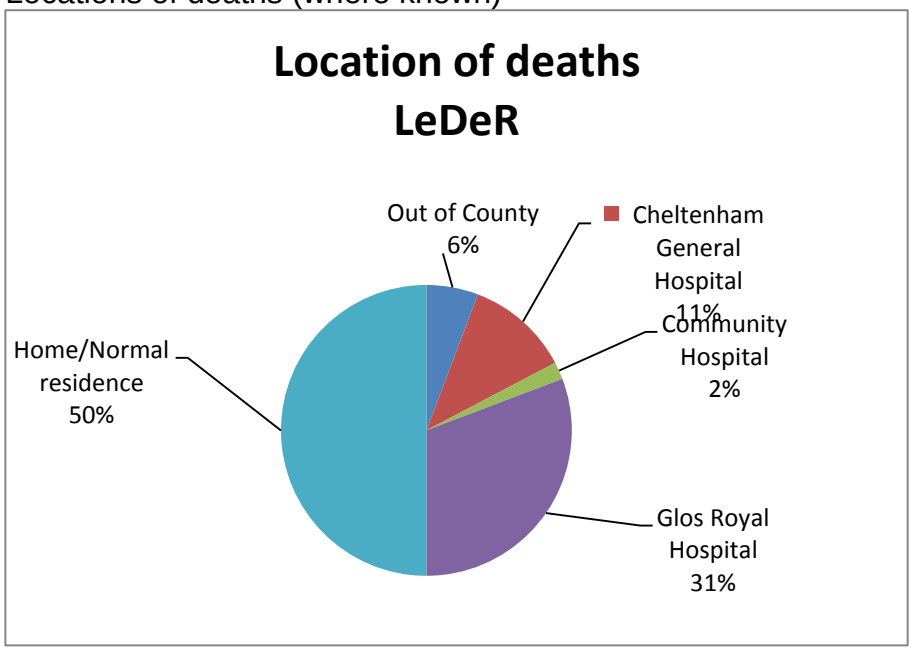
Unallocated cases backlog n19

Month review received	Number of unallocated reviews
Dec 2017	2
Jan 2018	4
Feb 2018	3
March 2018	6
April 2018	4
Grand Total	**19**

Reporters of Deaths



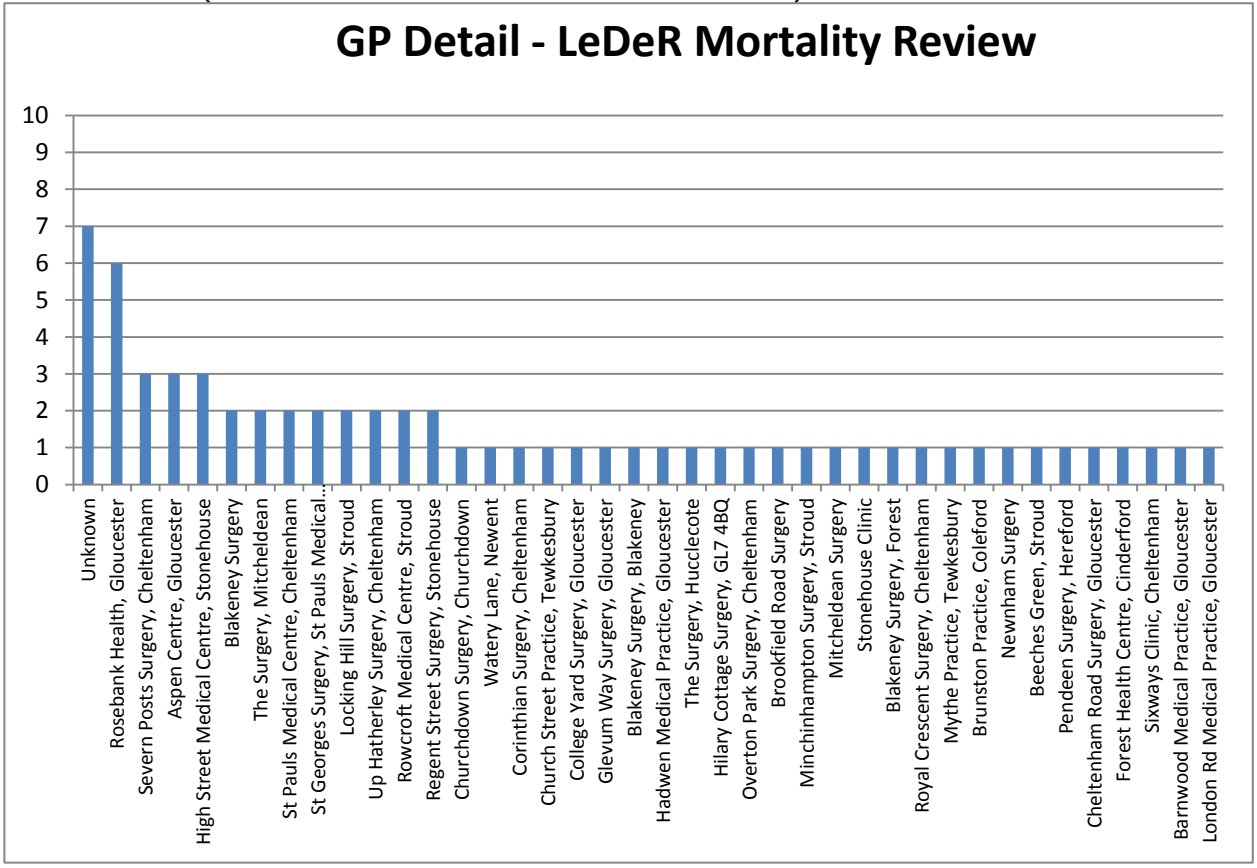
Locations of deaths (where known)



Comparison with national LeDeR data

	NHS England South Region (n261)	England from Jan 2018 (n848)	England from Jan 2017 – Dec 2017 (n1338)
Hospital	61%	66%	64%
Usual place of residence	32%	28%	30%
Other	7%	6%	6%

GP Practices (where detail is listed on death notification)



Duplicate Cases Reported by locality/month

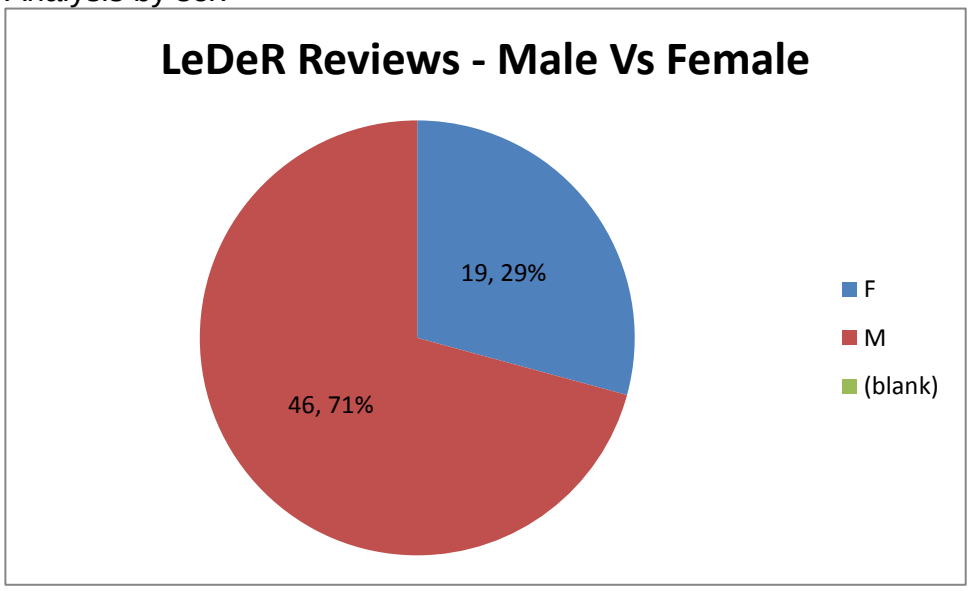
Locality & Month	Yes - with 25248061	Yes 25188498 & 25234691	Yes 25240011 & 25242286	Yes 25244232 & 25246325	Grand Total
Stroud & Berkeley Vale		**2**		**1**	**3**
Dec 2017		1			1
Mar 2018		1		1	2
Gloucester			**2**		**2**
Mar 2018			2		2
Cheltenham	**1**				**1**
April 2018	1				1
Grand Total	**1**	**2**	**2**	**1**	**6**

3. Analysis of cases received (n65)

Analysis by Location

Locality	CLOSED	OPEN	Grand Total
Gloucester	4	14	18
Cheltenham	2	11	13
Stroud & Berkeley Vale	5	7	12
Forest	4	8	12
Unknown	3	4	7
Tewkesbury	1	1	2
Out of county	1		1
Grand Total	**20**	**45**	**65**

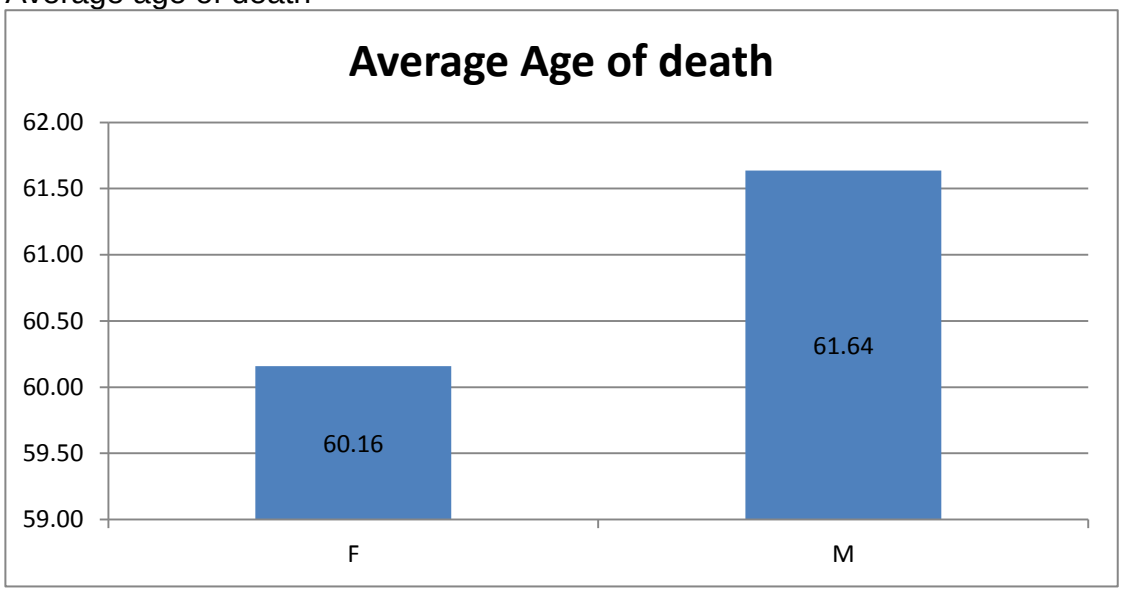
Analysis by sex



Comparison with national LeDeR data

	Gloucestershire (n65)	NHS England South Region (n279)	England from Jan 2018 (n910)	England from Jan 2017 – Dec 2017
Male	71%	60%	56%	58%
Female	29%	40%	44%	42%

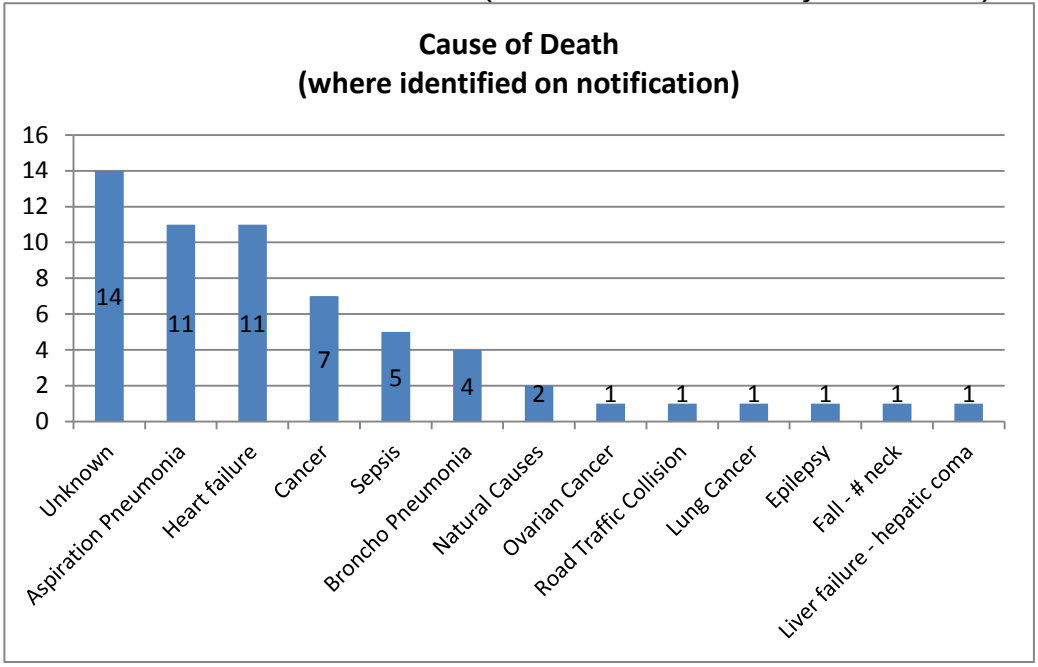
Average age of death



Comparison with national LeDeR data

	Gloucestershire (n65)	**NHS England South Region**	**England from Jan 2018**	**England from Jan 2017 – Dec 2017**
Median age of death (LeDeR Reviews)	61.19	60 **(n279)**	59 **(n910)**	58
Average life expectancy			Male 79.1 Years old Female 82.8 years old	
National LeDeR Difference against Gloucestershire			> 1 year	> 2 years
Local LeDeR age vs national life expectancy			Male <17.46 years Female < 22.64 years	

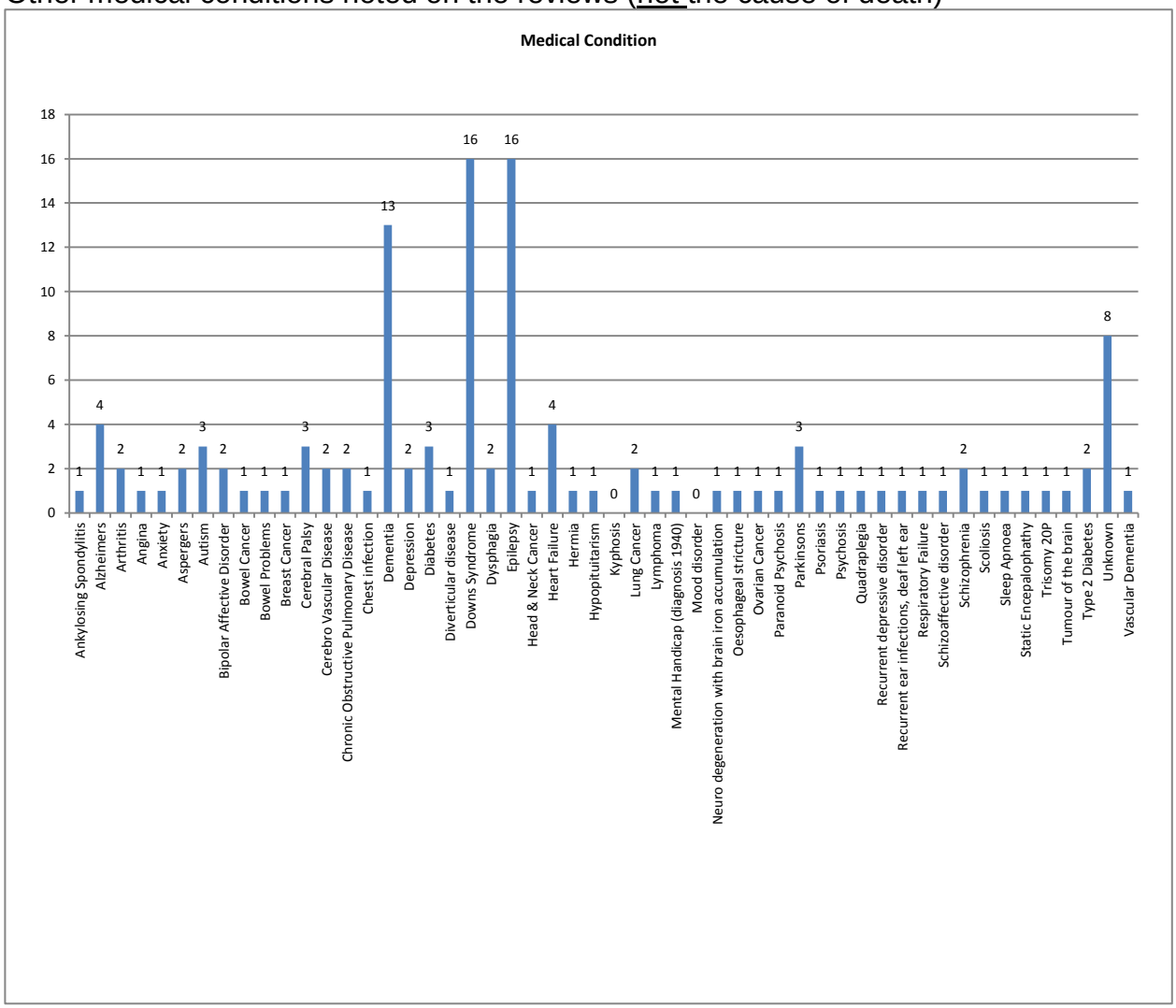
Cause of death - where recorded (unknown = cases not yet reviewed)



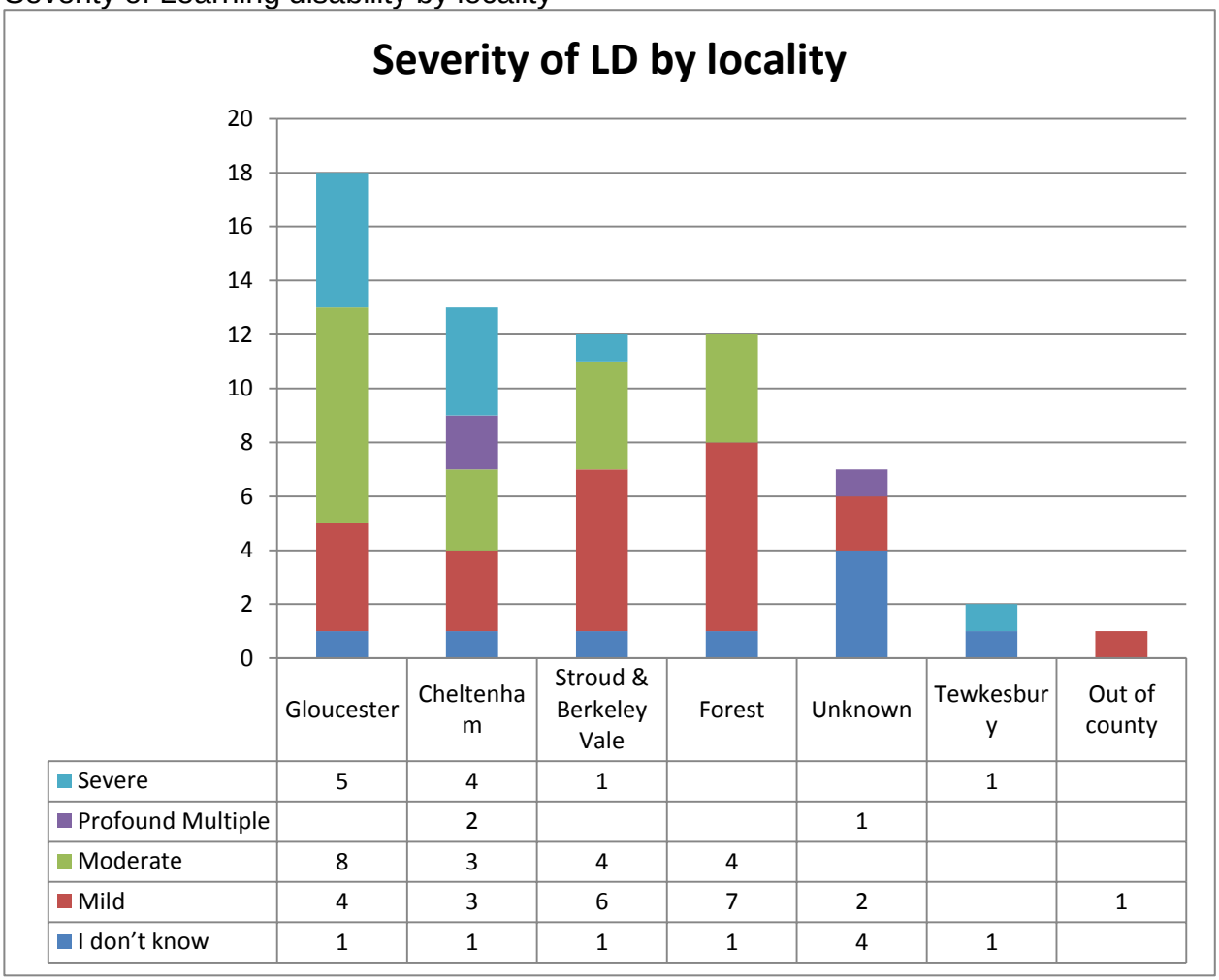
Comparison with national LeDeR data

	NHS England South Region (n107)	**England from Jan 2018 (n346)**	**England from Jan 2017 – Dec 2017 (n610)**
Respiratory diseases	34%	34%	31%
Cancers	13%	12%	10%
Circulatory system	19%	14%	18%
Other	35%	40%	41%

Other medical conditions noted on the reviews (not the cause of death)



Severity of Learning disability by locality



	Gloucester	Cheltenham	Stroud & Berkeley Vale	Forest	Unknown	Tewkesbury	Out of county
Severe	5	4	1			1	
Profound Multiple		2			1		
Moderate	8	3	4	4			
Mild	4	3	6	7	2		1
I don't know	1	1	1	1	4	1	

4. **Actions undertaken since last report**

1. NHS England funding (£11.5k) received to support clearing the backlog. We have recruited 7 new reviewers since the last report, mainly from the Transforming Care Independent Supporters. These reviewers will be paid £300 per day. Reviews are expected to take 1½ days to complete (on average)
2. Copies of 2Gether NHS F Trust mortality reviews have been obtained and uploaded to the LeDeR System to support reviewers to undertake proportionate and considered reviews.
3. Work in ongoing with NHS Providers and key stakeholders to develop a more robust wider mortality surveillance review process.
4. Participation in a national LeDeR film about the role of the local area contact and some of the learning we have found since undertaking the reviews.
5. Attendance at the national LAC Away day to further strengthen the quality assurance process.

6. Themes & Actions identified from reviews completed

Theme	Action	RAG
Primary Care Annual Health Checks Communications	1. Further enhance the information on the G-Care website ✓ 2. Attend Locum GP Conference ✓ 3. Updates via What's new this week ✓ 4. Wider Annual Health Check action plan utilising the national AHC Toolkit[1] ✓ 5. Review of the training provision from Strategic Health Facilitation Team ✓ 6. AHC Toolkit & communications will be launched on 22nd May 2018	
Healthy Lifestyles	1. Further enhance the information on the G-Care website ✓ 2. Engage with Public Health ✓ 3. Updates via What's new this week ✓ 4. Work with ICE Creates to support reasonable adjustments & pilot a clinic in Treasure Seekers Hub in Gloucestershire ✓	
Mainstream service protocols and recording	1. Further enhance the information on the G-Care website to reduce clinical variation ✓ 2. Escalate to the LD CPG the need to work with Health providers to implement suitable reasonable adjustments – ***Awaiting NHS Improvement LD Standards to be published***	
Quality & Audit	1. Escalate to the LD CPG the need to review the Quality Checker programme nationally through NHS England and how this differs from commissioned offer from Inclusion Gloucestershire	
Mainstream service protocols and reasonable adjustments	1. Glos Care Service to audit and provide feedback via LD Clinical Programme Group in relation to their "Did Not attend" protocols vs "Was not brought" ✓ 2. Work with Safeguarding to develop a local promotional/training film for clinicians about Was not brought	
Record keeping	1. Escalate to Integrated Governance & Quality Committee that paper records are hard to read and handwriting in medical records needs to improve 2. Escalate to Integrated Governance & Quality Committee that the documentation of mental capacity needs to improve across all health settings.	
Communications End of Life Care (EOLC)	1. Escalate to End of Life Clinical Programme Group that information provided to everyone (patient/family/carers) should be consistent ✓ 2. Active membership of LD commissioner within the EOLC CPG	

[1] https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2017/03/Communications-Toolkit-Dont-Miss-Out.pdf Accessed on 8.11.2017

5.	**Concerns & Issues to escalate** 1. Number of reviewers isn't enough to cover the open cases we have. Further consideration of changing the reviewer model is required to meet demand. We have trained some independent reviewers and issued an honorary contract with access to NHS.Net email account and potentially could utilise this resource if funding for their time was available ongoing. We have also discussed holding review days where we hold a panel type approach with access to systems on laptops 2. Capacity of reviewers who are completing this on top of their day to day work. 3. Backlog of cases dating back to March 2017. 4. Access to training when University of Bristol stops providing training in May 2018
6.	**Recommendations** 1. Ongoing publicity amongst LD Providers, carers and general public on the benefits on following healthy lifestyles – new Healthy Lifestyles service 2. Follow up on the letter to NHS England re: value of the programme and seeking national support to resource thee local programme adequately. 3. Write to all local Chief Executives in Gloucestershire for continued support and resources: a. Release of staff to undertake maximum of 3 reviews each b. Support staff to participate in multi-agency approach (if required) c. Support the learning and service improvements initiated as a result of the completed reviews.

Learning Disablities Mortality Review (LeDeR) Programme

NHS England

NHS Gloucestershire Clinical Commissioning Group

Telephone: 0117 331 0686
Email: leder-team@bristol.ac.uk
Website: www.bristol.ac.uk/sps/leder/
Facebook: www.facebook.com/lederteam
Twitter: @leder_team
Gloucestershire Local Area Contact:
Cheryl.hampson@gloucestershire.gov.uk

Gloucestershire LeDeR NEWSLETTER April 2018

Improving the lives of people with learning disabilities by learning from deaths

Welcome to the **fifth** edition of the Gloucestershire Learning Disabilities Mortality Review Programme newsletter. We hope you enjoy reading about the LeDeR Programme is evolving locally. Thank you for your support!

Focus on… Dysphagia & Aspiration Pneumonia

The Confidential Inquiry into Deaths of People with Learning Disabilities (CIPOLD 2013) found that respiratory disorders were the most prevalent immediate cause of death in people with learning disabilities. Difficulties with swallowing (dysphagia) would have contributed to some of these deaths. Dysphagia can disrupt the normal process of feeding, eating and drinking and can lead to increased risk of choking, aspiration and asphyxiation, poor nutritional status and weight loss. Dysphagia is therefore associated with increased morbidity, mortality and reduced quality of life.

Key considerations for reviewers

1. Did the person experience repeated chest infections (three episodes within 6 months or four episodes within 12 months involving the lower airways)? If so, were these considered in combination to assess whether the person was at risk of aspiration pneumonia?
2. Did the person have any risk factors for aspiration pneumonia identified, and a management plan to minimise these risks put in place?
3. Did the person have a full swallowing assessment by a speech and language therapist if there appeared to be any difficulties with their swallowing?
4. Was the person in regular receipt of oral and dental care?

The key indicators of dysphagia are:

- Difficulty initiating a swallow or delayed swallowing
- Difficulty forming food into balls (bolus formation) in readiness of swallowing
- Coughing
- Choking
- Regurgitation
- Sore throat and hoarseness
- Dysarthria (difficult or unclear speech)
- Halitosis ('bad breath')
- Weight loss

Call for more reviewers!

We are currently recruiting for more LeDeR Reviewers. If you are interesting in learning more about care for people with LD or are passionate about driving service improvement and have the support from your manager to undertake 3 reviews per year. 1 day training available - see link below

https://www.surveymonkey.co.uk/r/LeDeRtraining

Focus on…

Gloucestershire LeDeR Reviews

From 1st January 2017 LeDeR has been rolled out across the whole of Gloucestershire and is no longer a pilot project.

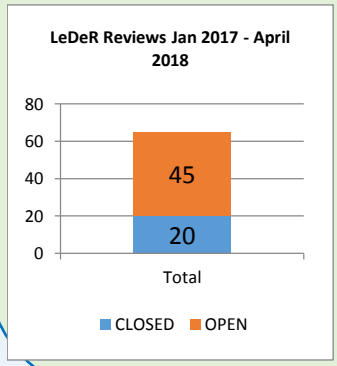
65 notifications have been received to date
20 initial investigations have been undertaken
45 reviews remain open to reviewers
19 reviews remain unallocated (no reviewers to allocate to)

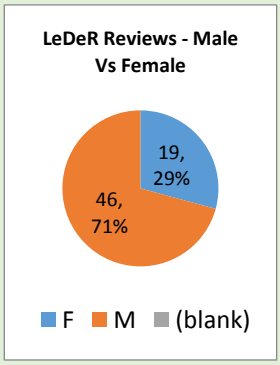
Main causes of death (where reported)

- Aspiration Pneumonia – 15 notifications
- Heart failure – 11 notifications
- Cancer – 9 notifications
- Unknown reason – 12 notifications
- Sepsis – 5 notifications
- Natural causes – 2 notifications

Check out the local Learning Disabilities resource hub on G-Care – https://g-care.glos.nhs.uk/pathway/422/resource/11

Some recent statistics…





Learning Disabilities Mortality Review (LeDeR) Programme

Local Organisation LeDeR Contacts

- Local Area Contact = Cheryl Hampson
- 2Gether NHS Foundation Trust = Crispin Hebron
- Gloucestershire Care Services NHS Trust = Clare Hicks
- Gloucestershire Hospitals NHS Foundation Trust = Bev Farrar & Carol Forbes
- Glos County Council = Mark Bedford
- Clinical Commissioning Group = Marion Andrew-Evans
- Carers representative = Ann Attwood
- User led org rep (inclusion Glos) =Vicci Livingstone Thompson

National Update…

- National rollout progress by region
- Interim annual report
- Focus on Derbyshire
- Involving Families
- YouTube LeDeR Channel + more

http://www.bristol.ac.uk/sps/leder/news/newsletters/

Dates for your diary

All to be held at Sanger House, Brockworth

LeDeR Mortality Review Steering Group – Chair Marion Andrew- Evans

14th May 2018 – 2pm – 4pm Wheatstone Room
25th July 2018 – 10am – 12noon Board Room
18th Sept 2018 – 2pm – 4pm Biffen Room

LeDeR Mortality Review Peer Support Group – Chair Cheryl Hampson

8th May 2018, 2pm – 4pm, Wheatstone Room
9th July 2018, 2pm – 4pm , Wheatstone Room
11th Sept 2018 10am – 12 noon, VCR Room

If you require parking please contact Wendy Stone 0300 421 1550

Aspiration Pneumonia

This occurs when food, saliva, liquids or vomit is breathed into the lungs or airways leading to the lungs, instead of being swallowed into the oesophagus and stomach. This can cause irritation of the lungs, which may progress to bacterial infection, damage to the lungs and respiratory failure.

Aspiration pneumonia can occur with dysphagia, during periods of impaired consciousness (e.g. during a seizure), or with other conditions such as gastro-oesophageal reflux or chronic obstructive pulmonary disease (COPD). People receiving nasogastric feeds or with a tracheostomy are at particular risk, as are those with poor mobility or posture problems, frailty, oral health problems, or using certain medications.

Key indicators of aspiration pneumonia are:

- Cough and/or coughing up purulent sputum
- Difficulty breathing and increased respiratory rate
- Chest pain
- Fever
- Headache
- Nausea and vomiting
- Reduced appetite and weight loss
- Change in voice quality
- Change in facial expression/colour

Additional sources of information

Guidelines for identification and management of swallowing difficulties in adults with learning disabilities
www.guidelines.co.uk/wpg/dysphagia-with-learning-disability

Management of Dysphagia

NICE Guidelines state that anyone presenting with dysphagia should be offered an endoscopy within two weeks, where oesophageal or stomach cancer is suspected. Any one choking should be assessed by Speech and Language therapist (SLT) within 24 hours.

Dysphagia management should be led by a multi-disciplinary team with input from dentist, medical specialists, OTs, Nutritionists/Dieticians) whose key responsibilities will include:

- Diagnosis and treatment of dysphagia/swallowing disorders
- Development of co-ordinated assessment protocols, joint goals and timely intervention
- Joint management plans with written documentation
- Multi-disciplinary audit of practice

Notify a death
Anyone can notify us of a death online:
https://www.bris.ac.uk/sps/leder/notification-system/
or by phone:
0300 777 4774

Agenda item **10** **Enclosure** **Paper E**

Report to: Trust Board, 31 May 2018
Author: Dr Amjad Uppal, Medical Director and Paul Ryder, Patient Safety Manager
Presented by: Dr Mark Scheepers, Associate Medical Director/Clinical Director
Marie Crofts, Director of Quality

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 January to March 2018 (end Q4 2017/18). During 2017/18 there were 795 patient deaths recorded, of which 264 (33.2%) received a table-top review only, 54 (6.8%) were closed after a case record review and 26 (3.3%) were notified as Serious Incidents.

Of the 795 patient deaths notified, 451 remain open (43.2%) and require a Mortality Review. 415 of those (92%) await a table-top review, 34 (7.5%) require additional discussion at MoReC (a Care Record Review).

This, the final iteration of the 2017/18 mortality review data under the Learning from Deaths policy provides limited assurance about the progress of this process within 2gether and a solution is offered at para 4.2 of the paper.

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 4 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	23 May 2018

Where in the Trust has this been discussed before?		
Mortality Review Committee (MoReC) *Sadly, this committee was postponed due to illness*	Date	18 May 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 January to March 2018.

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 Committee 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 Committee (MoReC).

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, and 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 January to March 2018 (end Q4 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 third 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 raised at the Gloucestershire Mortality Steering Group, led by Gloucestershire CCG, the growing number of overdue table-top reviews. These deaths largely occur within the Community Dementia Nursing teams, predominantly the ACI Monitoring caseload. The additional administration support previously sourced to address this did not come to fruition. The Gloucestershire Mortality Steering Group has suggested that whilst the focus nationally remains on hospital inpatients (and specifically on Eating Disorders and Psychosis within Mental Health) that it would be reasonable for 2gether to ring-fence the ACI-Monitoring caseload deaths as data collection only. This patient cohort is of a significant size and yet opportunities for learning are marginal due to their expected natural cause, once work has been undertaken to establish cause of death (from e.g. GP, acute hospital or Coroner), location of death, who certified death, any family concerns, and any known details of health deterioration immediately prior to death), all of which takes considerable admin time to accomplish. It would seem appropriate that 2gether continue to record these natural deaths when patients are open to the ACI-Monitoring caseload, are seen annually for medical review only, and have input from no other 2gether team. These data will be revisited if the national focus should move towards dementia care at a later date.

4.3 The data on page 7 of this paper highlights the disconnect between the numbers of deaths (which continue to be reported for 2017/18) of 795 to date, against the number of active Mortality Reviews which have been completed of 344. This leaves 451 reviews yet to be undertaken. Recent work completed for the Quality Report indicated that 54% of all deaths reported on Datix sit within the ACI-Monitoring caseload only.

4.4 The Patient Safety Manager has proposed that the necessary changes to the Learning from Deaths policy are discussed at the Quality & Clinical Review Sub-Committee (QCR) and the Trust Governance Committee in June, before taking those changes back to the Gloucestershire Mortality Review Steering Group in July 2018.

4.5 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 continues to be developed by the Strategic Transformation Partnership and is led by the CCGs in both counties to enable cross-provider information sharing to ensure the most appropriate health care provider reviews a death, and that there are clear opportunities to pass concerns between organisations. 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.

MoReC Data - correct to 17 May 2018

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	38	0	0	11	0	0	4	0	0	53	
May-17	50	0	0	12	0	0	3	0	0	65	168
Jun-17	43	0	0	4	0	0	3	0	0	50	
Jul-17	34	0	0	10	0	0	2	0	0	46	
Aug-17	31	0	0	3	0	0	1	1	0	36	117
Sep-17	29	0	0	5	0	1	0	0	0	35	
Oct-17	26	0	0	5	0	0	3	0	0	34	
Nov-17	13	0	0	2	0	0	3	0	0	18	56
Dec-17	0	0	0	0	0	0	4	0	0	4	
Jan-18	0	0	0	0	0	1	1	0	0	2	
Feb-18	0	0	0	0	0	0	1	0	0	1	3
Mar-18	0	0	0	0	0	0	0	0	0	0	
	264	0	0	52	0	2	25	1	0	344	

Open Mortality Reviews

Month	Awaiting Information to Complete Table-Top Review	Awaiting Table Top Review	Awaiting Care Record Review (MoReC)	Awaiting Clinical Review (SI's)	Total	Quarterly Total
Apr-17	0	1	0	0	1	
May-17	0	1	1	0	2	15
Jun-17	2	8	2	0	12	
Jul-17	5	2	2	0	9	
Aug-17	5	2	1	0	8	32
Sep-17	9	1	5	0	15	
Oct-17	17	3	6	0	26	
Nov-17	18	58	7	0	83	182
Dec-17	0	71	2	0	73	
Jan-18	0	81	4	0	85	
Feb-18	0	62	2	1	65	222
Mar-18	0	69	2	1	72	
	56	359	34	2	451	

Total Deaths (Open and Closed)

Month	Total Deaths (Open and Closed)	Quarterly Total
Apr-17	54	
May-17	67	183
Jun-17	62	
Jul-17	55	
Aug-17	44	149
Sep-17	50	
Oct-17	60	
Nov-17	101	238
Dec-17	77	
Jan-18	87	
Feb-18	66	225
Mar-18	72	
	795	

Learning from Deaths Summary 2017/18

Quarter 1 – 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 following being sent to the patient and their GP

There are also the lessons learned from the following SIs:

- SI-01-18
- SI-02-18
- SI-04-18
- SI-05-18
- SI-07-18
- 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.
- INC10876 – Although not identified as contributory to the patient's death there was a period of sickness for the Care Co-ordinator. It is felt that clarity should be sought on the process for caseload cover during periods of sickness. This should be sent out as a reminder to all staff through team managers.

There are also the lessons learned from the following SIs:

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

Quarter 3 – Learning From Deaths

- INC12301 – There is noted good practice due to staff considering the effect of mental health medications on the patient's physical health. However there was no evidence of the patient's physical health conditions being recorded and kept updated on the patient's record. With the recent introduction of access to Summary Care Records

(SCR) this level of information should be more easily accessible to staff. When patients have chronic mental illness, due to the risk of premature mortality associated with the patient group it is felt reasonable for SCR to be accessed and physical health information updated as a standard part of the annual review process.

There are also the lessons learned from the following SIs:

- SI-29-18
- SI-30-18
- SI-31-18
- SI-32-18
- SI-33-18
- SI-35-18
- SI-38-18
- SI-39-18
- SI-40-18
- SI-41-18
- SI-42-18

Quarter 4 – Learning From Deaths

- INC15556 – The national guidance on withdrawing antipsychotic medication for elderly patients states that withdrawal should be completed once the patient is stable. In this particular case the withdrawal of the antipsychotic medication led to a rapid deterioration of the patient's mental state which subsequently led to failure of placement and admission to a mental health hospital. This is to be considered by clinicians on a case by case basis. Further learning on this case showed that where possible, once End of Life discussions take place there should be timely involvement of the family at the earliest possible opportunity in those discussions.

There are also the lessons learned from the following SIs:

- SI-44-81
- SI-46-18
- SI-47-18

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SERIOUS INCIDENT INVESTIGATION

LESSONS LEARNED SUMMARY SI-29-18

Incident Category:

Patient death

What happened?

- **The patient was found deceased at home by his son.**

What did the Investigation find?

- **The patient was struggling with a period of low mood and although he had a loving and supportive family he felt he was a burden to them. The patient also had a number of physical health concerns and he also suffered an unexpected stroke which caused him to need more intensive input for his physical health as part of the rehabilitation.**
- **The patient's mood improved following his GP commencing an anti-depressant medication and the patient receiving support and validation for his feelings.**
- **There was good evidence of effective engagement with the patient and the wider family.**
- **The incident came as a shock to family and services as the patient had presented as much improved and had informed both family and services that he was no longer having any suicidal thoughts.**

What can we learn from this incident?

- **Team's are reminded to follow the Triangle of Care principles to effectively communicate with patient's families, where consent has been given, to gain their thoughts on care and risk management plans.**
- **Families are provided with team contact information. It should be reinforced that they should make contact with the team to raise any concerns they may have for the patient.**
- **Information around children the patient has contact with should be documented regardless of if it is felt there are any risks.**
- **All information provided to services at the point of referral should be added to clinical records.**

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SERIOUS INCIDENT INVESTIGATION

LESSONS LEARNED SUMMARY SI-30-18

Incident Category:

Patient death

What happened?

- **The police accessed the patient's home address where the patient was found deceased in circumstances suggestive of an overdose.**

What did the Investigation find?

- **The patient had multiple diagnoses and had an extensive history of self-harming behaviour in the form of overdoses, attempted hanging and jumping from height.**
- **The patient's mental health would fluctuate in response to psychosocial stressors and substance misuse.**
- **The patient had physical health concerns which impacted her independence causing further stress.**
- **Good practice and an excellent quality of care was noted from the treating team. A very person-centred and flexible approach was used to provide a mix of psychological, social and pharmacological approaches.**
- **There were 2 occasions where documentation was not at the expected level with regards to risk assessment and safeguarding documentation.**

What can we learn from this incident?

- **The completion and recording of risk information fell outside of expected best practice standards.**
- **The trust will look at ways in which it communicates with GPs and other external agencies to see if this can be improved.**
- **The trust will look at ways in which notable best practice is shared across the organisation to highlight the high level of excellent care being provided.**

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SERIOUS INCIDENT INVESTIGATION

LESSONS LEARNED SUMMARY SI-31-18

Incident Category:

Patient Death

What happened?

- **Patient who had recently been discharged from the Crisis Team caseload was found hanged at their home address.**

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

- **The patient had a short inpatient admission and support from the Crisis Team following an attempted hanging.**
- **The patient had a long history of alcohol dependency, which increased risks of impulsive self-harm.**
- **The patient was the main carer for their mother and had been for a number of years.**
- **There was no evidence that the patient had engaged with housing, Addaction or other support services as planned by the Crisis Team.**
- **The patient was assessed as a LOW risk of suicide, but their actuarial indicators should have increased the acknowledged level. However, a higher assessed level of risk would not have changed the management plan.**

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

- **When the patient was discharged from the inpatient unit and from Crisis, a medical discharge summary letter was not sent to the patient's GP surgery. A Crisis and Contingency Management Plan was not produced.**
- **The patient was not recorded as a carer despite this being a major stressor for them.**
- **A face to face assessment rather than telephone contact prior to discharge from Crisis, a conversation with family (mother), and clinicians gaining assurance that he was engaged with other support services would have been preferred practice.**
- **There was a missed opportunity to assess the patient's mental state when he was arrested and taken to the police cells. He was not referred to Mental Health Services by the police or seen by health services within the custody suite. The lack of a Criminal Justice Liaison Service in Herefordshire is noted.**

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.**

SERIOUS INCIDENT INVESTIGATION

LESSONS LEARNED SUMMARY SI-38-18

Incident Category:

Patient Death

What happened?

- **A patient was involved in a collision with a train with fatal consequences.**

What did the Investigation find?

- **The patient had a well established diagnosis of Paranoid Schizophrenia**
- **The patient engaged well with mental health services and regularly saw their Care Co-ordinator. Occupational Therapist and Support Worker. They had the same Care Co-ordinator for nine years**
- **The patient had a number of rituals and behaviours which increased his level of distress if they was unable to complete them.**
- **The patient declined informal admission and a period of respite in a community setting.**
- **The patient was discussed regularly within team meetings and reflective practice sessions to ensure his care did not stagnate.**
- **There was evidence throughout the notes that risks were reviewed at appropriate times. Documentation around risks and management plans were clearly documented and followed by the clinicians.**
- **Whilst all practitioners involved understood the patients consent to share, the consent to share documentation had not been updated for several years.**

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

- **Consent to share paperwork should be updated on a regular basis, even if no changes are made.**
- **The patient and their family benefitted greatly from the consistency provided by the same Care Co-ordinator over a 9 nine period**

SERIOUS INCIDENT INVESTIGATION

LESSONS LEARNED SUMMARY SI-39-18

Incident Category:

Patient Death

What happened?

- **A patient ingested a quantity of weed killer with fatal consequences.**

What did the Investigation find?

- **The patient had a long history of anxiety and difficulties with coping with social stressors.**
- **The patient had previously ingested weed killer, taken an overdose and had a history of alcohol dependency.**
- **The patient was coping with the death of her mother, change in accommodation and family member moving abroad at the time of the incident.**
- **The patient did not have any care plans in place during this period of care.**
- **Risks were clearly reassessed at each interaction with the patient.**
- **There was a significant delay in offering supportive contact to the family following the patient's death.**

What can we learn from this incident?

- **Staff are reminded to link care plans in the Progress Notes to the appropriate section of the clinical RiO record.**
- **All managers (including on-call managers and the Executive Team) are reminded of the distinct difference between delivering the initial news of a persons death to a family (a police role) and calling them after an unexpected death to offer supportive contact and condolences where the family are already aware of the tragic news.**

SERIOUS INCIDENT INVESTIGATION

LESSONS LEARNED SUMMARY SI-40-18

Incident Category:

Patient harm

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?)***

- **Over the previous year the patient made several suicide attempts following the breakdown of his marriage and accruing significant financial debts.**
- **The patient was frequently assessed and offered support from Mental Health Services.**
- **There was variation in how risk assessments were completed and how practitioners weighed up and considered risks factors which increased and decreased the patient's level of risk of self-harm and suicide.**
- **There were written and verbal communication problems between the Mental Health Services and the General Practitioner.**
- **The discharge Contingency Plan was of poor quality and was not clear as to what the future options were for the patient.**
- **Services did not always act with the Host Principle in mind.**

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

- **It is good practice that the host team is responsible for onward referral and retains the responsibility for the patient until accepted by another team (the Host Principle).**
- **When there is disagreement as to which service is the most appropriate for an individual going forward, this should be escalated to the relevant team managers and/or Service Managers (CSMs) to resolve.**
- **Contingency plans need to be meaningful, clear, up to date, and easy to follow by other services.**

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SERIOUS INCIDENT INVESTIGATION

LESSONS LEARNED SUMMARY SI-41-18

Incident Category:

Unexpected Death

What happened?

- **Patient was observed falling to the floor, whilst having a seizure and suffered a laceration to their head, they were taken to the Emergency Department and later transferred back to the in-patient unit. Shortly afterwards, the patient was found on the floor having another seizure and they were transferred back to the Emergency Department with significant head injuries. The patient died 2 days later from a brain haemorrhage.**

What did the Investigation find?

- **The Medical Emergency Response Team operated efficiently in managing the situation and accessing onward referral on both incidents.**
- **There was no medic to medic handover when the patient was transferred back to the in-patient unit, and discussions are ongoing regarding whether attendance at A&E amounts to 'an admission' or not.**
- **There was a delay in contacting the patient's family after the second incident, but at that stage the seriousness of the situation was not apparent.**
- **The inpatient staff found it difficult to receive progress updates on the patient's condition whilst they were in the Critical Care Unit.**

What can we learn from this incident?

- **The transfer policy between mental health inpatient wards and the Gloucester Hospitals Trust should consider whether an attendance to the Emergency Department should require a medic to medic handover before transfer.**

SERIOUS INCIDENT INVESTIGATION

LESSONS LEARNED SUMMARY SI-42-18

Incident Category:

Patient death

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

- **The patient was discovered deceased at home having utilised a plastic bag.**

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

- **The service provided by 2gether Trust and all other agencies involved was comprehensive, responsive and collaborative.**
- **Extremely thorough care co-ordination was provided by the practitioner within the Recovery Team throughout her involvement with the patient.**
- **There was excellent communication and collaboration between the medium secure inpatient team and the Recovery Team around discharge and care planning. There was also excellent inter-agency working in relation to Safeguarding issues and risk management.**

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

- **There were no care and service delivery problems noted by the investigator or the internal review panel. Conversely, there was much good practice noted particularly from the Recovery Team Care Coordinator.**
- **The Medium Secure Hospital commented positively that it is unusual to have such a high level of input from community services when patients are in hospital.**
- **Discharge planning from the Medium Secure Hospital was graduated in terms of home leave which was thoroughly tested prior to eventual discharge.**
- **There were no recommendations made.**

SERIOUS INCIDENT INVESTIGATION

LESSONS LEARNED SUMMARY SI-44-18

Incident Category:

Patient Death

What happened?

- **A patient was involved in a collision with a train with fatal consequences.**

What did the Investigation find?

- **The patient had a diagnosis of Bipolar Affective Disorder.**
- **The patient did not have any care plans in place during their care in the community.**
- **There was good evidence of communication between the Consultant Psychiatrist and GP practice when new medication was being initiated.**
- **The patient was assessed as a LOW risk of Suicide at the time of their death.**

What can we learn from this incident?

- **The patient received a high standard of care from mental health services, including appropriate treatment for Bi-polar Affective Disorder.**
- **All service users will have care plans in place, which they have participated in the development of.**

SERIOUS INCIDENT INVESTIGATION

LESSONS LEARNED SUMMARY SI-46-18

Incident Category:

Patient death

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

- **The patient was discovered hanged at supported accommodation and had left a letter indicating intent.**

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

- **The patient's confidence and self esteem had been affected by high levels of Dyslexia and Dyspraxia and childhood experiences. There was history of suicidal ideation and attempts.**
- **The patient had been assessed and offered a service by Mental Health Intermediate Care Services and Lets Talk but had declined contact. The patient was supported on two occasions by the Crisis Resolution & Home Treatment Team when thoughts of suicide had been increased by the consumption of alcohol.**
- **The patient had been discharged by services prior to the incident.**
- **His family, and staff from the supported accommodation, had not been aware of his discharge and his family had not had the opportunity to engage with his care plan or receive advice as to how best to support the patient in the future.**
- **The Contact Centre had triaged down an "urgent" referral to a "routine" referral without attempting to contact the referrer.**

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

- **Remember the Triangle of Care Model - whilst recognising the need for flexibility in response to a patient's wishes. Staff should ask directly if there are any significant people the patient thinks the team should contact.**
- **The Contact Centre must attempt to contact referrers directly when the urgency of a referral is downgraded.**
- **Staff must ensure that the discharge status is clearly understood by patients, and where appropriate, information should be shared with families, carers and support services.**

SERIOUS INCIDENT INVESTIGATION

LESSONS LEARNED SUMMARY SI-47-18

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?)***

- **Following a long history of alcohol dependency and associated suicide attempts the patient had managed to maintain a more settled state until diagnosed with a terminal illness in 2017, which required frequent medical appointments and medication for cancer.**
- **The patient developed a Benzodiazepine dependency and a reduction programme was stopped prior to his death as the impact this had on the patient's suicidal ideation outweighed the benefits.**
- **The patient was offered a notable and flexible service by the Specialist Nurse In General Practice service, Mental Health Liaison Team and the Crisis Resolution & Home Treatment Team, with examples of good communication between teams.**
- **On the patient's last admission to Accident & Emergency department the Mental Health Liaison Team did not have access to the patient's hospital records to have the full understanding of his physical healthcare needs.**
- **His family had not been aware of the reasons for the patient being discharged home.**
- **Frequently the patient would only agree to engage with the Specialist Nurse In General Practice service , which extended the remit of a General Practice role.**

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

- **The Social Inclusion team will take account of the feedback from families involved in SIs about their experience of communication with services, when implementing the Triangle of Care model.**
- **To develop appropriate access to acute hospital health records.**
- **The role of the Specialist Nurse In General Practice will be clarified to teams.**

Agenda Item	**11**	**Enclosure**	**Paper F**

Report to: 2gether NHS Foundation Trust Board – 31 May 2018
Author: Nikki Richardson, Non-Executive Director
Presented by: Nikki Richardson, Non-Executive Director

SUBJECT: **NON EXECUTIVE DIRECTOR AUDIT OF COMPLAINTS QUARTER 4 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 have been closed between 1 January and 31 March 2018.

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

2. SUMMARY OF FINDINGS

2.1 Case 1

2.1.1 This case was a highly sensitive situation in that the couple were in a custody battle over their child. The complaint was in relation to information provided to the Court by a member of 2gether staff. The complaint was dealt with in a timely manner and we responded in the timescales set out.

2.1.2 The initial complaint was a complex communication from one parent which the Service Experience Department took time to clarify with the complainant who signed off an agreed list of issues of concern.

2.1.3 The issues of confidentiality were clarified with the complainant from the outset as the service user had confirmed that they didn't want personal information shared with the complainant and this would impact on the information that would be shared with the complainant.

2.1.4 The investigation responded to some of the issues raised thoroughly and clear learning was identified. However, the investigation report, although factually correct, did not consider the impact that actions had on the complainant or that information presented might be open to interpretation, whatever the intention when it had been written. Some of this was addressed when the investigation was reviewed by the next level of management.

2.1.5 The response from the CEO took this further and, in addition to apologies for direct actions or omissions, apologies were also given for the ambiguity of some of the information and for the impact on the complainant. The letter was clear and sympathetic and learning was identified, although no timescales were given.

2.1.6 **Assurance**
SIGNIFICANT ASSURANCE on the complaints process
LIMITED ASSURANCE on the investigation
SIGNIFICANT ASSURANCE on the response sent to the complainant

2.2 Case 2

2.2.1 This complaint was made by a family who felt the service had left them without support for their loved one, who had dementia.

2.2.2 The complaint was dealt with in a timely manner and we responded in the timescales set out.

2.2.3 The investigation was very thorough and all the issues were identified, although the process would have been much more straight forward for the service if the information had been more succinct and confined to the issues. The investigation addressed all the issues and learning. The investigating manger also immediately put in place actions to provide the service user and the family with support. The CEO letter was clear, apologetic and addressed all the issues raised and confirmed the actions that would be put in place.

2.2.4 **Assurance**
SIGNIFICANT ASSURANCE regarding the management of this complaint although the investigation report could have been more succinct.

2.3 Case 3

2.3.1 In this case, a complaint was made by a carer that a referral was made in respect of his actions to a regulatory organisation without the matter being raised with him. He reported that he was first aware of the issue was when he was contacted by the regulatory organisation and sanctions were imposed upon him.

2.3.2 Although the complaint was dealt with in a timely manner and we responded in the timescales set out, some errors were made in the initial communication to the complainant which he needed to correct. A documented apology for the errors would have been appropriate but was not evident in the paperwork provided.

2.3.3 A very detailed investigation was carried out. Although the final outcome was to agree there should have been communication with the carer about the concerns in respect of his actions, the investigation focused on the need to report the matter, which was never in question. As a result, a lengthy and complicated investigation report was produced which included copied sections of the patient's records. The Service Experience Department had to refer the complaint back to the Service Director which fortunately, did not delay the final response to the complainant.

2.3.4 The final letter to the complainant from the CEO did address the issues and was sympathetic and offered an apology. Lessons learned were included. The complainant wrote to the Trust thanking them for the response and confirmed all his issues were addressed to his satisfaction.

2.3.5 **Assurance**
SIGNIFICANT ASSURANCE on the complaints process
LIMITED ASSURANCE on the investigation
FULL ASSURANCE on the response sent to the complainant

3. CONCLUSION

3.1 I am pleased to offer significant assurance regarding these complaints in respect of the complaints process and the CEO letters. I felt the letters were of a particularly impressive standard and showed transparency and appropriate empathy. The complaint investigations in all three instances were of more concern. In all three instances, I felt the reports were un-necessarily complex and made the production of the final letters more difficult. In one instance, the investigator spent a considerable amount of time investigating an issue the complainant had not raised and the process needed Director intervention.

I was assured that lessons from each case were identified. However, the NED audit process does not currently identify if actions have been completed or embedded in practice where appropriate.

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

Agenda Item 12 **PAPER G**

Report to: 2gether Trust Board, 31st May 2018
Author: Angie Fletcher, Service Experience Clinical Manager
Lauren Edwards, Deputy Director for Engagement
Presented by: Jane Melton, Director of Engagement and Integration

SUBJECT: **COMPLAINTS: ANNUAL REPORT 2017-2018**

This Report is provided for:

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

EXECUTIVE SUMMARY

This report presents high level information and analysis about complaints and concerns received by the Trust in 2017 / 18. The data have been considered in a number of ways to review any themes and trends. An indication and assurance of learning from the feedback and the high level action taken by the trust is provided in line with our support of the NHS Constitution and our values to deliver best quality care viewed through the eyes of service users and carers.

(1) Assurance

This report provides **full assurance** that 100% of complainants are contacted within 3 days or less to acknowledge and further clarify their concerns.

This report provides **significant assurance** that the Trust has made considerable effort to listen to, understand, and resolve complaints over the past year. The themes of complaints received during 2017/18 have been reviewed and comparisons made with information from previous years. Data have been recorded and analysed to ensure that complaints and concerns from individuals are responded to promptly and effectively.

During 2017/18 the Trust provided treatment and care for 46,628 people. We recorded 65 formal complaints, suggesting that 0.14% of the people we supported felt the need to make a formal complaint. The number of complaints received during 2017/18 (n=65) is lower than the previous year (n=106). Although the numbers of formal complaints has reduced, there is **significant assurance** that individuals are increasingly prepared to share their concerns. This is evidenced by the increased number of concerns resolved out with the formal NHS complaints process.

This report provides **significant assurance** that the Trust seeks to learn from service experience feedback and to share this learning across the organisation in order to further improve service experience.

(2) Improvement – practice developments

A number of practice development objectives are planned for the coming year including to:

- Review current processes and continue to work with locality colleagues to seek earlier resolution and more timely responses to formal complaints.
- Review and improve dissemination of learning from complaints and to ensure that service user feedback is embedded in practice and that assurance mechanisms are in place.
- Raise the profile of PALS presence within our services to enable more feedback to be gained and timely response and resolution of concerns.
- Continue to triangulate complaints with concerns, comments, compliments and survey information to gain rich information to inform practice and service development.
- Further develop the style and tone of Final Response Letters.
- Implement a system of measuring satisfaction with the complaints handling process from people who complain.
- Collaborate with colleagues at Gloucester Care Services (GCS) to share and learn from best practice locally.
- Take part in the review and implement any recommendations to the complaints process received from scrutiny of the complaint resolution process.

RECOMMENDATIONS

The Board is asked to approve that the content of this report.

Corporate Considerations	
Quality implications:	The Complaints Annual Report offers assurance that the Trust continues to enable continuous improvement to services quality by implementing learning from service experience.
Resource implications:	The Complaints Annual Report offers assurance to the Trust that resources are being used to support the best service experience for service users and carers.
Equalities implications:	No individual is excluded from using the NHS Complaints process. The Complaints Annual Report offers assurance that the Trust is attending to its responsibilities regarding equalities for service users and carers.
Risk implications:	Feedback from service experience offers an insight into how our services are received. Compliant information provides an important mechanism for identifying performance, reputational and clinical risks.

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

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

Reviewed by:		
Jane Melton, Director of Engagement and Integration	Date	22nd May 2018

Where in the Trust has this been discussed before?		
Governance Committee	Date	27th April 2018

What consultation has there been?		
	Date	

Explanation of acronyms used:	NHS – National Health Service SED – Service Experience Department PALS – Patient Advise and Liaison Service CYPS – Children and Young People's Service CAMHS – Child and Adolescent Mental Health Services FRL – Final Response Letter PHSO – Parliamentary Health Services Ombudsman CQC – Care Quality Commission LGO – Local Government Ombudsman NED – Non Executive Director NPAC - Nursing Professional Advisory Committee TBC – To be confirmed

2gether
Making life better

2gether
NHS Foundation Trust

Annual Report: Complaints

1st April 2017 – 31st March 2018

CONTENT

Complaints Annual Report

1st April 2017 – 31st March 2018

This report 	This report is about the complaints that [2]gether Trust gets. It also looks at people's concerns. Concerns are like complaints but are managed less formally and more quickly.	
	We saw over **46,000** people in 2017/18.	
Complaints 	**65** people complained. This is a lot less than last year (106). This is less than most other mental health Trusts.	
Concerns 	189 people told us their concerns. This is a little less than last year (195).	
Acknowledge 	ALL people who complained were contacted within 3 days. We talked to them about the issues and how they wanted us to help.	
Overall 	12% more people contacted the Service Experience Department for help or advice. We want people to tell us what they think. This helps us to make services even better.	
Ombudsman 	The ombudsman checks if we manage complaints properly. 6% of complaints were passed to the ombudsman. This is about the same as last year.	
Next steps 	Next we will: - Carry on speaking to lots of people about our services - Carry on making sure we learn from what people tell us - Investigate and answer complaints more quickly	

Key

			Full assurance
↑	Higher/more activity		Significant assurance
↔	Activity remains similar		Limited assurance
↓	Lower/less activity		Negative assurance

[2]gether NHS Foundation Trust
Complaints Annual Report – 2017/18

1. INTRODUCTION

1.1 This report presents information regarding complaints received by the Trust between 1st April 2017 and 31st March 2018.

1.2 The Complaints Annual Report is an external audit requirement as part of the assurance processes for the Quality Report/Account. Quarterly Service Experience Reports provide the Board with aggregated information gained from an in-depth analysis of service user and carer experience information from a variety of sources, including complaints.

1.3 The Complaints Annual Report provides a brief overview of the national and local context. It goes on to provide specific information about the number of complaints received throughout the year, emerging themes from complaints, a summary analysis of the issues that have arisen, and the lessons learned by our Trust. Comparative data is provided with previous years and where available, with other healthcare organisations. Some examples of individual experiences are also highlighted in vignettes to provide insight into individual complaints and context to the report. The report concludes with recommendations for developments in complaint handling, recording and reporting in the coming year.

2. CONTEXT

2.1 National context

Nationally and locally, understanding the experiences of service users and carers remains essential to allow evaluation and improvement of our services. Practice experience coupled with current national guidance[1] has informed developments within the Service Experience Department, including the ways in which we handle and resolve complaints. Key actions and areas for further development required nationally include:

- Raising awareness of the importance of encouraging service user feedback and making sure people know how to complain.
- Ensuring that people who raise issues feel confident that their complaint will be dealt with fairly and effectively.
- Assurance that complaints will be investigated consistently and transparently using a robust framework.

[1] https://www.ombudsman.org.uk/mental-health

https://www.ombudsman.org.uk/about-us/our-principles/principles-good-complaint-handling

- Responding to complaints with open, honest and sensitive feedback regarding the findings of complaint investigations, highlighting opportunities for learning and actions taken.

2.2 Local context

2.2.1 The Service Experience Department has continued to focus on and improve complaint management processes during 2017/18 with the outcomes summarised in Table 1. This builds on developments from 2016/17.

Table 1: progress against identified areas for development during 2017/18

2017/18 objectives	Progress	Assurance level
To implement Non-Executive Director (NED) Complaints Audit to enable review of national best practice in investigation and complaint management	Quarterly NED audits of complaints have been implemented throughout 2017/18. Feedback, findings and recommendations have been reported to our Trust Board and actioned in order to improve the way we manage formal complaints.	FULL
To ensure reasonable adjustments are made to the complaints process to increase awareness to further assure its accessibility to everyone using our services	SED have reviewed each contact with the department to ensure reasonable adjustments are made. Our PALS service has implemented regular visits (inpatient and community) to offer further opportunities for feedback.	FULL
To review and update the Trust's Complaints Policy to reflect changes in local practice and national guidance	The Complaints Policy has undergone extensive review with stakeholders, service users, carers and Trust colleagues to ensure it is in line with best practice.	FULL
To work with colleagues across the Trust to review and improve dissemination of learning from complaints and to ensure that service user feedback is considered and embedded in practice.	The SED are present at locality governance meetings and profession-specific forums to discuss and feedback on monthly and quarterly reports.	SIGNIFICANT
To provide training and support to investigators to ensure they are confident in applying national and local best practice for complaint investigation.	Complaints Manager has provided regular training to individual teams and professional groups within the Trust and has trained a total of 37 senior colleagues. The SED have adopted a "coaching" approach to support complaint investigators.	FULL
To continue to triangulate complaints with concerns, comments, compliments and survey information to gain rich information to inform practice and service development.	Quarterly reports continue to be produced and developed to ensure information is triangulated, reviewed and analysed to inform areas for service improvement. This information also contributes to the Trust's system of aggregated learning.	FULL

2017/18 objectives	Progress	Assurance level
To embed the new Datix web data collection system in practice and utilise the additional functionality to develop and share information with Locality Boards and Clinical Teams.	Datix has been further refined this year to allow detailed collection and interrogation of data for learning to be shared regularly with Trust colleagues.	FULL
To continue the development of the style and tone of Final Response Letters (FRL)	Developments have been noted within audits of complaints undertaken by our NEDs. The SED have not received any negative feedback about the letters this year.	SIGNIFICANT
To ensure that people who use our services are aware of how to make a complaint/ feedback.	The review and update of our Trust website during 2017/18 has made it easier for people to contact SED electronically with any type of feedback – this being the most common method of communication. Easy read versions of complaint information and feedback forms are available for use. Text message feedback has been established.	SIGNIFICANT

2.3 Stakeholder Sub Committee

2.3.1 In October 2017 the Stakeholder Sub-committee replaced the Service Experience Committee. The purpose of the Stakeholder Sub-Committee is to ensure that our Trust understands the views of stakeholders and enables them to influence the development and direction of services to ensure that high quality, effective services are provided to the satisfaction of people who use services and those who advocate for them.

2.3.2 The Stakeholder sub-committee is held on a quarterly basis and membership is drawn from people who use Trust services, carers, Healthwatch, carer representative groups and partner organisations.

2.4 Quarterly Service Experience Reports

2.4.1 The learning from complaints and other feedback is shared through the Trust's governance structures in order to disseminate learning and to inform practice. Key themes are highlighted in quarterly reports and assurance is sought from Locality Directors regarding local implementation. During 2017-18 quarterly analysis of themes and trends to learn from service users' and carers' experiences has been undertaken and regular reports have been developed and shared with each locality. The Service Experience Department endeavours to have a senior representative present at each locality governance meeting in order to support discussion and respond to queries.

2.5 Training and practice development to resolve complaints

2.5.1 Training at Corporate Induction includes a session led by the Service Experience Department informing all new [2]gether colleagues about the functions of the department, advising about local complaint handling processes, and sharing examples of service user feedback.

2.5.2 Combined Serious Incident investigation and Complaint investigation training for senior colleagues continues to be offered regularly by our Training Department, along with a senior member of the Service Experience Department, to support the development of the appropriate skills required for complaint resolution.

2.5.3 During 2017/18 the Service Experience Department have reviewed how they work with those undertaking the investigation of complaints. As well as our Complaints Manager providing additional training sessions to support complaint investigators, a coaching style has been adopted by the SED to support investigators through the required processes to ensure robust and impartial investigations are undertaken.

2.6 Audit of complaints

2.6.1 The Trust continues the good practice of commissioning quarterly audits of the complaints handling process by Non-Executive Directors (NED) of the Trust Board.

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

2.7 Building a culture of using patient feedback by team work across the Trust

2.7.1 Regular meetings have taken place between SED, Service Directors, Locality leads and Team Managers. Some examples of action taken as a result of liaison and feedback from colleagues include:

- Increased support is provided by SED to colleagues investigating complaints and this has led to more robust and focused investigations.
- Trust-wide learning has been included in all locality activity reports to ensure learning is shared and implemented throughout our services.
- Our PALS officers and inpatient colleagues have developed good working relationships, resulting in the SED team being involved at early and appropriate stages when concerns are raised by people admitted to our wards.

3. COMPLAINT INFORMATION 2017 - 2018

3.1 Data collection and analysis

3.1.1 The complaint and PALS data is entered into a database and analysed using the Datix computer software system. As well as recording the number of formal complaints and PALS contacts, other data is entered into Datix. This includes:

- The nature of the complaints and concerns regarding services provided by our Trust.
- The number and nature of compliments forwarded to the SED from a variety of sources.
- The number and nature of contacts made with the SED requiring signposting or advice activity
- Categorisation of all concerns and complaints to enable detailed analysis of themes.

3.1.2 The data are analysed to show the total number of complaints and/or concerns by ward, department, service and profession.

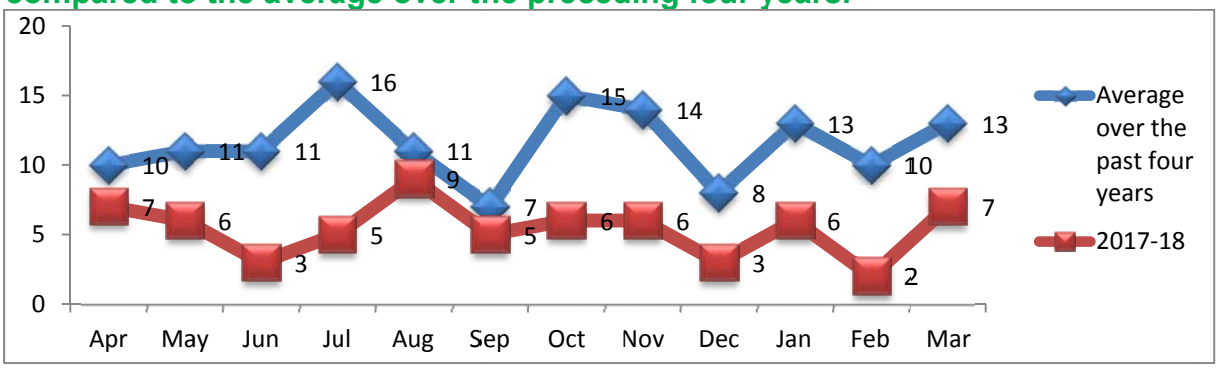
3.1.3 During 2016/17, the categorisation of concerns and complaints was identified as being a somewhat subjective process. During 2017/18 a system has been developed to review all data entered onto Datix by Service Experience Department colleagues at the end of each month to ensure accuracy and consistency. The reviews are overseen by the Clinical Manager for Service Experience in order to minimise variation.

3.2 Numbers of reported formal complaints

3.2.1 Between the 1st April 2017 and the 31st March 2018 our Trust saw 46,628 people. We recorded **65** formal complaints, suggesting that **0.14%** of service users / carers felt the need to make a formal complaint. This represents a **39%** reduction on the number of complaints received compared to the previous year (n=106 complaints).

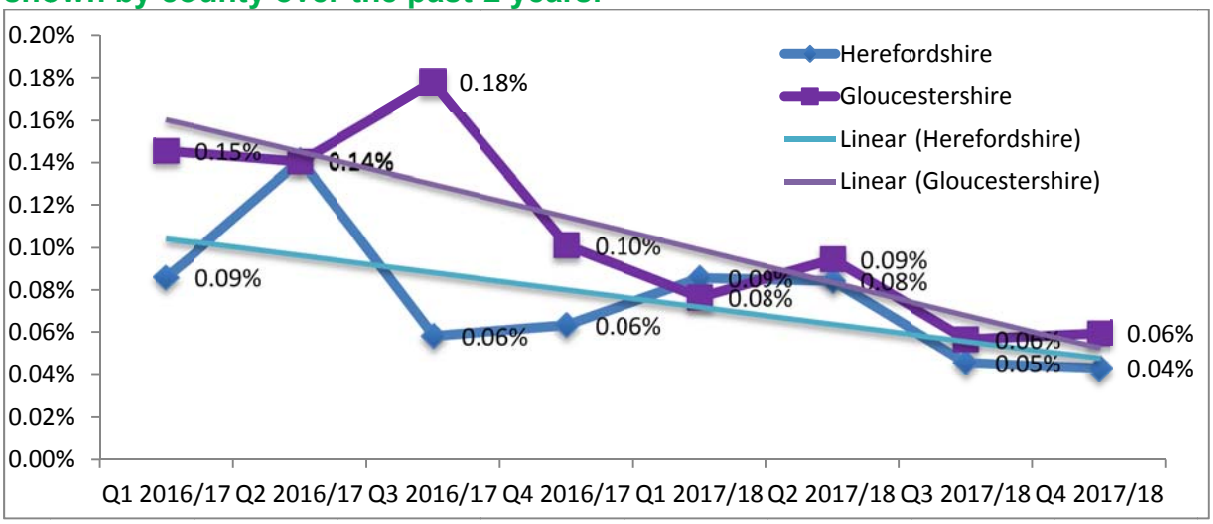
3.2.2 Despite a reduction in the numbers of formal complaints received during 2017/18, similarities can still be drawn with the pattern of formal complaints per month during the previous 4 years. Figure 1 shows, a comparable outline of spikes in complaint numbers at similar times of the year. Illustrating this enables the SED to consider workforce resource implications so that response targets continue to be met at times of increased activity. This information is also shared with operational colleagues in order to support their exploration of any operational challenges which may coincide with anticipated peaks in complaints.

Figure 1 – The monthly number of complaints received in 2017/18, compared to the average over the preceding four years.



3.2.3 Complaint numbers recorded over the past two years have continued to show a downward trend when analysed in relation to the total number of individual contacts with our services (Figure 2).

Figure 2: Percentage of complaints recorded by contacts with services shown by county over the past 2 years.



3.2.4 *NHS Digital* captures information about the number of individual complaint *issues* that are contained within each formal complaint, as well as numbers of individual complaints. The number of complaint issues reported to *NHS Digital* this year by our Trust was **267** and these were contained within the **65** individual complaints.

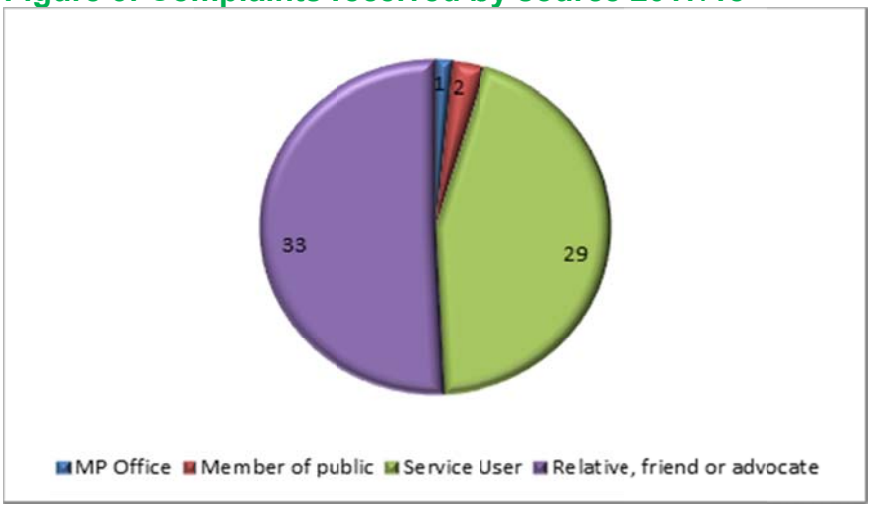
3.2.5 This year the number of complaint issues within each complaint ranged between **1** and **19**. This is an average of 4 issues per individual complaint, a reduction of 20% from the 2016/17 average of 5 issues per individual complaint. It should be noted that single complaint in 2016/17 had 29 individual issues, influencing the average significantly.

3.2.6 The outcome of investigations, that is whether individual complaints (not individual issues) were classified as Upheld, Partially Upheld or Not Upheld, is also reported to *NHS Digital*. Analysis of themes emerging from outcome data is undertaken in Section 5 of this report.

3.3 Source of complaints

3.3.1 The sources of complaints remain similar to previous years. Figure 3 illustrates that 45% (n=29)of complaints were from people who had accessed our service themselves and contacted our Trust directly to raise their concerns. This year a similar proportion of complaints were made by family members or carers compared to 2016/17 (52% in 2016/17 and 51% in 2017/18, n=33). In total 95% of complaints were made by service users, their partners, carers or relatives, compared to 88% in 2016/17. This increase may be linked ongoing actions across the Trust to make it easier for people to complain.

Figure 3: Complaints received by source 2017/18



3.3.2 The SED does not currently request demographic information from people who raise concerns or complaints. Plans are being developed to contact people following the closure of their complaint in order to understand their satisfaction with our complaint processes. Demographic data will be requested at this point. This is further explained in Section 6 of this report.

3.4 Methods used to raise complaints

Table 2: Complaints by method of submission 2017/18

The trend for submitting complaints electronically continues to grow in line with previous years. The development of our Trust's external website has supported people to contact the SED directly to raise concerns or complaints, rather than via their care team.
5 complaints received this year were reported via this method, suggesting the positive development of this resource.

Method	Total
Email	23
In person	2
Feedback form	8
Letter	11
Online forms	5
Telephone	16

3.5 Time taken to acknowledge complaints

3.5.1 In 2017/18 **100%** (n=65) of complainants were contacted within 3 days or less to acknowledge and further clarify their concerns. This is a further improvement on the 99% achieved in 2016/17.

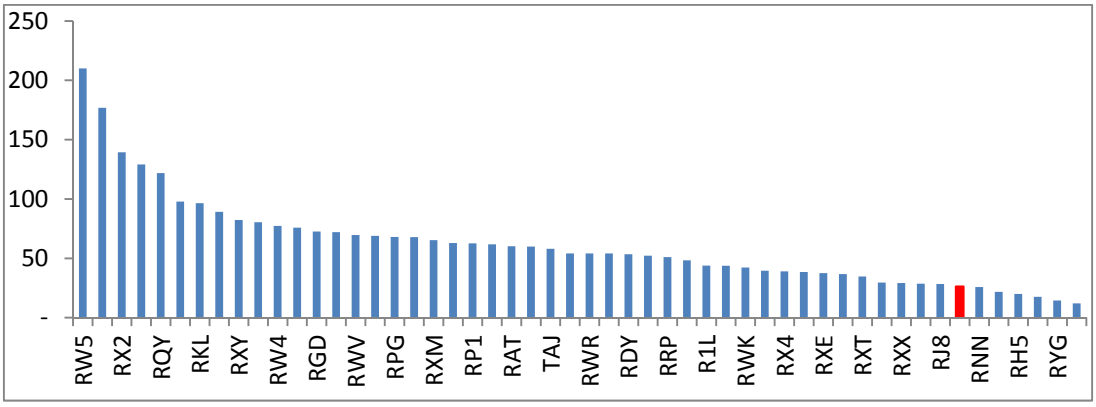
3.6 National complaint data benchmark

3.6.1 *NHS Digital* collect a count of written complaints made by (or on behalf of) service users about NHS services each year. Since 2015 the data collection method (known as KO41a) has been revised in both format and frequency. Our Trust has continued to comply with the requirement to provide quarterly data for the KO41a submission

3.6.2 Aggregated quarterly reports are now being produced by[2] *NHS Digital* who have advised that their methodology is provisional and experimental and so care should be taken when interpreting the results.

3.6.3 Figure 4 shows the national benchmarking data for the numbers of formal complaints reported per 1000 staff by Mental Health Trusts in England during Quarters 1- 3 2017/18 (Quarter 4 2017/18 is not yet available). Our Trust results are shown in red as RTQ with a total of 48 formal complaints recorded at the close of Quarter 3 2017/18. This is significantly lower than the national average.

Figure 4: Benchmarking data of reported formal complaints per 1000 staff combined total of quarters 1-3 2017/18



3.6.4 It is important to note that the number of concerns and contacts supported by the Service Experience Department has risen. This could suggest that the Trust's approach to encourage feedback and to listen and respond to people in a more timely and proportionate way in order to resolve the issues they have raised informally is working. People are made aware of the processes for managing both concerns and complaints so that they can make an informed decision at the outset regarding the route that they wish to follow.

[2] https://digital.nhs.uk/catalogue/PUB30235

Even if an issue is initially pursued as a concern, people are advised that they can choose to escalate this to a formal complaint at any stage in the process.

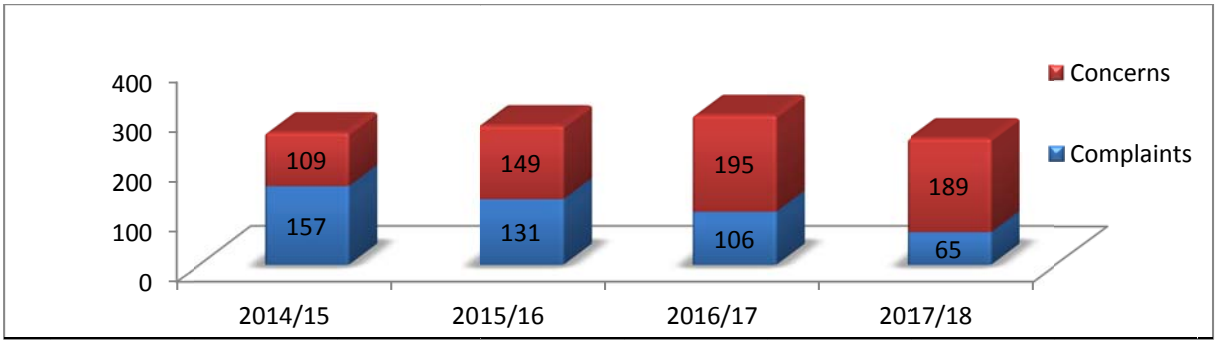
3.6.5 Responses to people's feedback has been more often undertaken in a way that enables timely action and local resolution for those involved as illustrated in Section 3.7.

3.7 Comparison of the management of complaints and concerns

3.7.1 During 2017/18 a greater proportion of issues raised with the Service Experience Department have been addressed through the *management of concerns* process.

3.7.2 Analysis of this information for 2017/18 shows that there has been a 39% reduction in the number of formal complaints (n=65), the number of concerns has remained relatively consistent with that of 2016/17 (reduction of 3%) (n=189) (Figure 5).

Figure 5: Illustration of complaints and concerns 2014/15, 2015/16, 2016/17, and 2017/18



3.7.3 There has been a 16% decrease in the combined number of complaints and concerns reported to the Service Experience Department during 2017/18 compared to 2016/17.

3.7.4 The SED also record additional contacts made directly with the department and these are categorised as requiring advice or signposting and also recorded on Datix.

3.7.5 During 2016/17, 164 contacts for advice or signposting were recorded. This type of contact has increased by 40% in 2017/18, with a total of 273 advice and signposting contacts recorded.

3.7.6 In total, an increase of 12% can be seen in 2017/18 for the total number contacts made with the SED concerning complaints, concerns and advice and signposting (2016/17 = 465 individual contacts recorded; 2017/18 = 527 individual contacts recorded).

3.7.7 Managing issues at the time that they are raised encourages a swift and local resolution through negotiation between clinical and operational staff, the complainant, and other service areas and organisations. This approach could

be the reason for the reduction in the number of formal complaints our Trust has received this year.

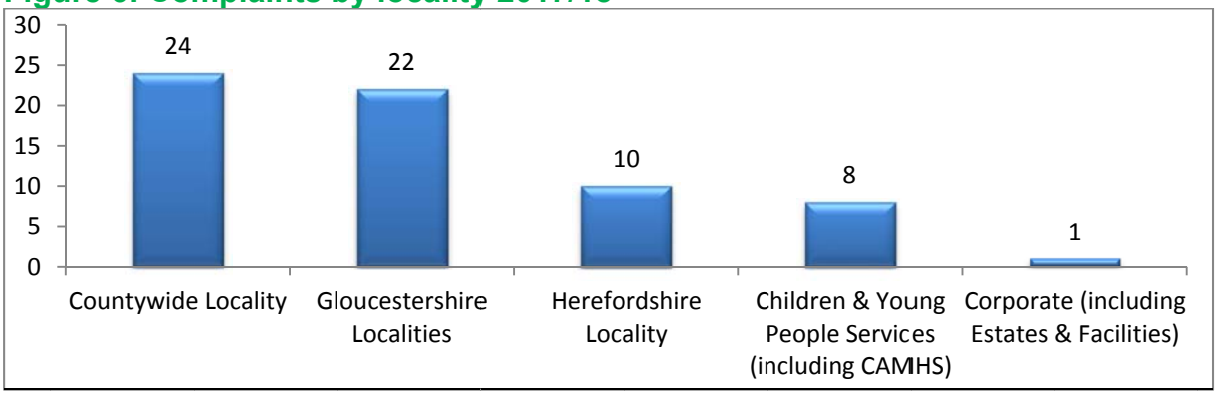
4. ANALYSIS OF COMPLAINTS RECEIVED (pre-investigation)

4.1 Reported complaints (pre-investigation) by locality and service type

4.1.1 The Datix system allows more information to be recorded and subsequently analysed in relation to complaint data. Continuing with the good progress made in 2016/17, the SED have been able to utilise Datix to record and evaluate complaint data not only for each locality but also down to service-level within each locality.

4.1.2 The number of complaints by locality is shown in Figure 6. The rate of complaints compared to the number of people (5,445) seen is the highest (of each 'locality' group at 0.44%. One reason for this could be the level of illness acuity of those served by this service area. However, continued analysis of complaint themes is undertaken. Rates of complaints are even lower and reasonably consistent across all other localities; including when compared to the number of service user contacts (Gloucestershire Localities saw 30,305 people = 0.07% complaints; Herefordshire services saw 9221 people = 0.11% complaints; CYPS / CAMHS saw 4688 people = 0.17% complaints.

Figure 6: Complaints by locality 2017/18

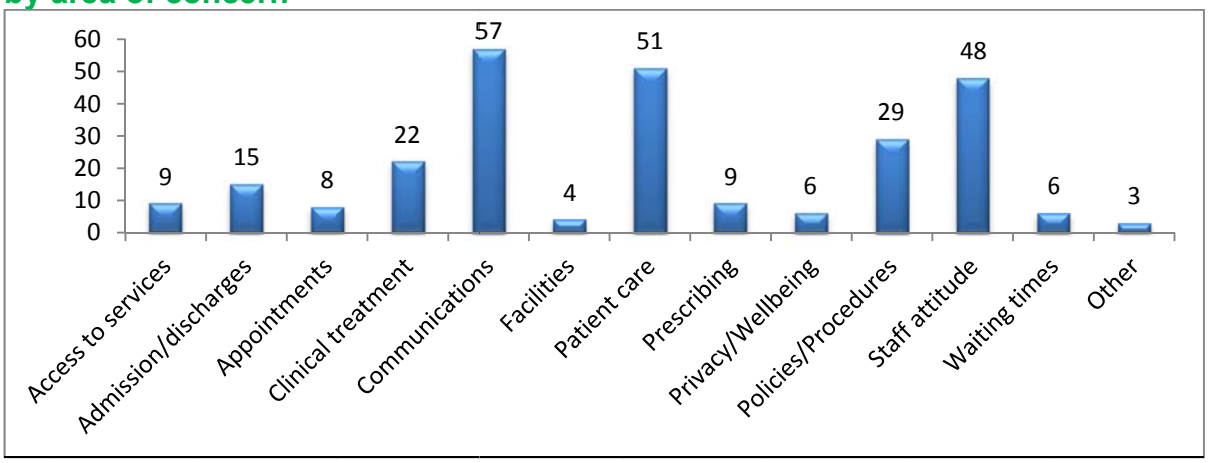


4.1.3 Information is shared on a monthly basis with localities in order to allow each service to discuss any potential trends and implement learning from the complaints.

4.2 Reported complaints (pre-investigation) by type and sub-type 2017/18

4.2.1 The types of issues identified within formal complaints during 2017/18 are presented in Figure 7. Analysis of complaint issues as reported (pre-investigation) allows us to have an overview of how people have experienced our services. The main themes identified within these data are that complaints most often relate to communication, clinical treatment and patient care. Dissatisfaction with staff attitude and behaviour also remains an issue in many of the complaints.

Figure 7: Issues (n=267 total) of complaints as reported (pre-investigation) by area of concern



4.2.2 Further analysis of these themes is undertaken in Section 5 of this report, focusing on the outcome of completed complaints.

4.3 Complaints by staff group

4.3.1 The number of complaint *issues* involving different disciplines and staff groups has continued to be recorded for *NHS Digital* this year. The majority of complaint issues relate to the nursing staff group and data is presented in Table 3.

4.3.2 Professional leads are made aware of any themes relating to their professional group.

Table 3: Percentage of complaint issues as reported (pre-investigation, outcome unknown) by staff group compared to staff group as a percentage of the workforce.

	% of complaint issues relating to staff group	% total workforce figures by staff group
Medical	**16%** (n=42)	**4%**
Nursing	**58%** (n=155)	**29%**
AHPP	**10%** (n=26)	**9%**
Support staff	**3%** (n=8)	**16%**
*** Infrastructure staff**	**4%** (n=12)	**28%**
Social Care	**3%** (n=7)	**2%**
Non-attributable	**6%** (n=7)	

Workforce configuration information has been sourced from Human Resources and was correct as at 05/04/2018.

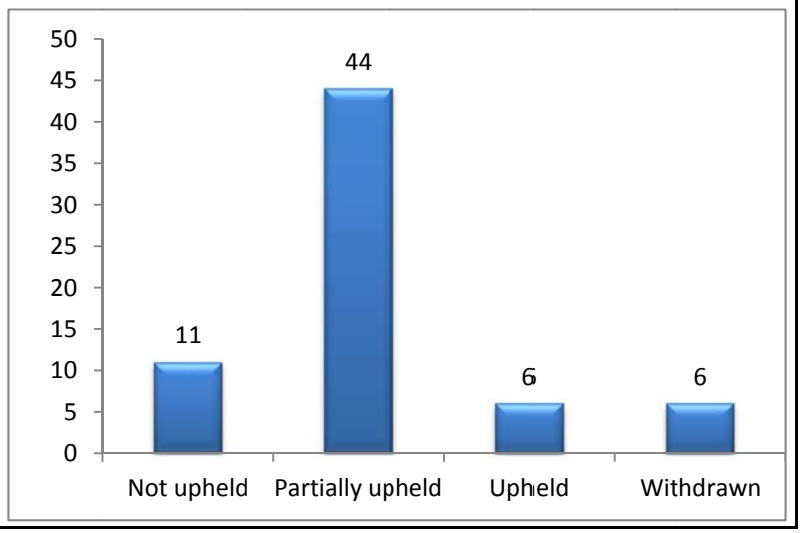
** Infrastructure staff refer to admin & clerical; estates and ancillary.*

4.3.3 These data show that that the highest proportion of complaint issues relate to medical and qualified nursing colleagues. This is consistent with our 2016/17 data and also with national NHS complaint data.

5. ANALYSIS OF INVESTIGATED COMPLAINTS

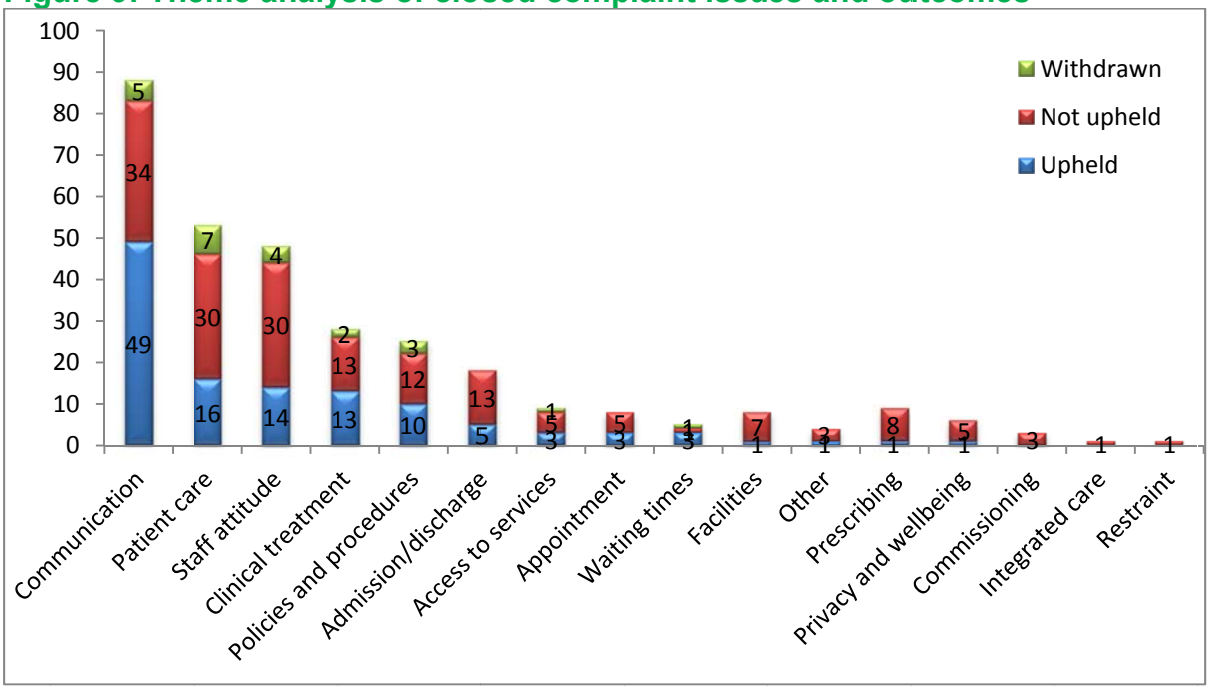
A total of 67 complaints were closed during 2017/18[3]. Figure 8 shows the overarching status of the 67 complaints closed by the Trust in 2017/18. This shows that 75% of the complaints closed had at least one issue within it upheld reinforcing the importance of the complaints process as a measure of quality and engagement.

Figure 8: Overall outcomes of individual complaints 2017/18

Outcome	%	Chart showing individual numbers
Not upheld *No element of the complaint was upheld*	16%	
Partially upheld *Some elements of the complaint were upheld*	66%	
Upheld *All elements of the complaint were upheld*	9%	
Withdrawn *Complaint withdrawn*	9%	

5.1 Overarching themes from investigated complaints

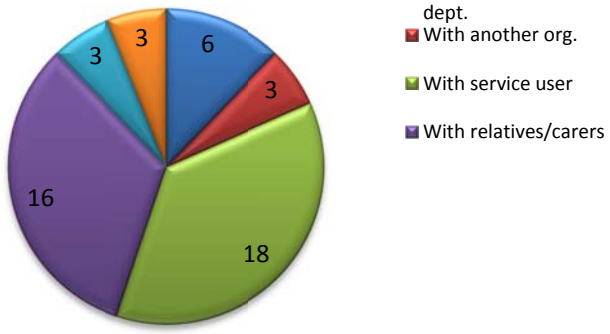
Figure 9: Theme analysis of closed complaint issues and outcomes



[3] NB – some remained open from 2016/17.

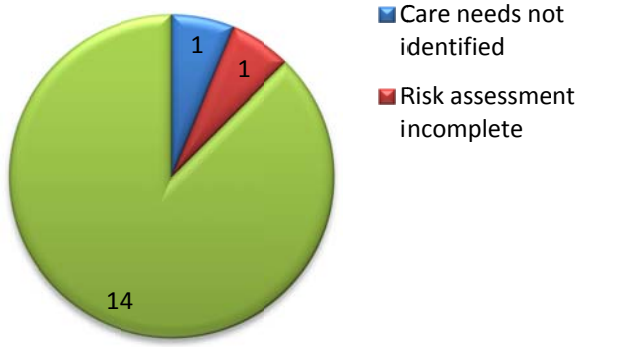
5.1.1 Communication, Patient Care and Staff attitude are the main themes emerging from analysis of individual issues of complaint (Figure 9). These areas have been reviewed and explored in further detail below with an indication and assurance of further action for practice development.

Figure 9.1: Thematic analysis of complaint issue theme: Communication (upheld issues)



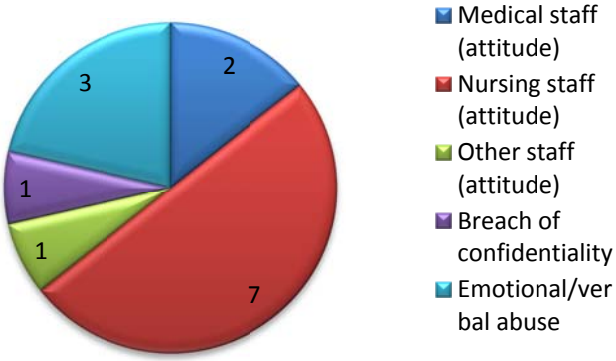
Assurance of action
- Triangle of Care
- Locality leads sign off actions with individuals
- Feedback to and action with individuals as appropriate.
- Always Event project re: involving people in care planning

Figure 9.2: Thematic analysis of complaint issue theme: Patient Care (upheld issues)



Assurance of action
- Always Event project re: involving people in care planning
- Supervision, Team reviews, QCR support and challenge.

Figure 9.3: Thematic analysis of complaint issue theme: Staff attitude (upheld issues)



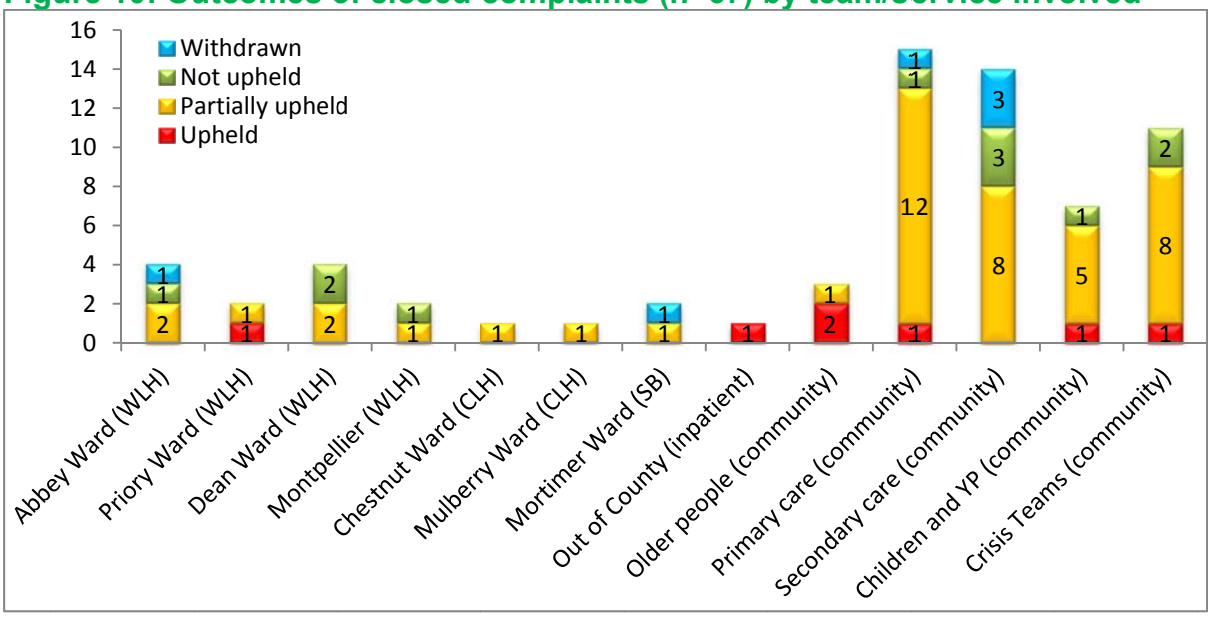
Assurance of action
- Deep dive in to complaints about behaviour has been commissioned and is being undertaken by Psychology colleagues
- Linking findings with professional groups

5.2 Outcomes from investigated complaints by service area

5.2.1 Figure 10 shows that the largest numbers of complaints upheld relate to our community services (both primary and secondary care teams), followed by

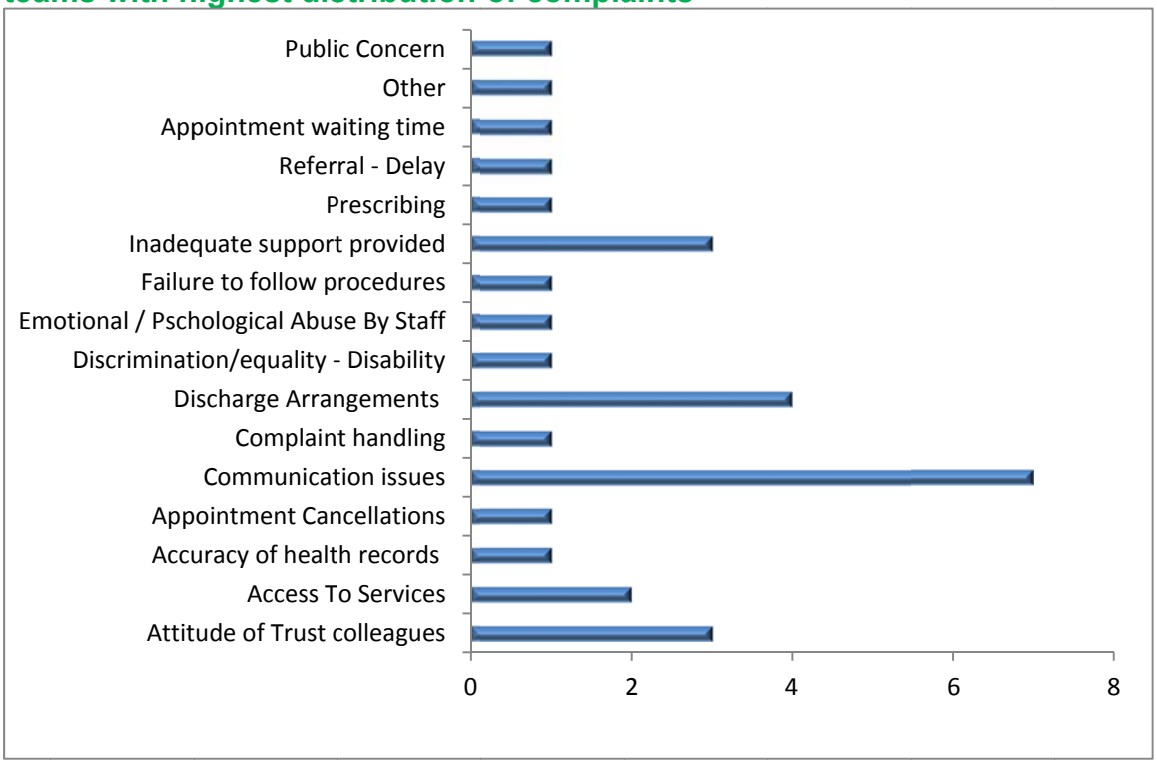
complaints received about our Crisis Resolution and Home Treatment Teams. This is not an unexpected trend as these services have the highest number of contacts with service users and their families. Analysis shows that the distribution of complaints across services is proportionate to the number of clinical contacts.

Figure 10: Outcomes of closed complaints (n=67) by team/service involved



5.2.2 The themes from closed complaints relating to the three service areas with the highest distribution of complaints that were either upheld of partially upheld is shown in Figure 11.

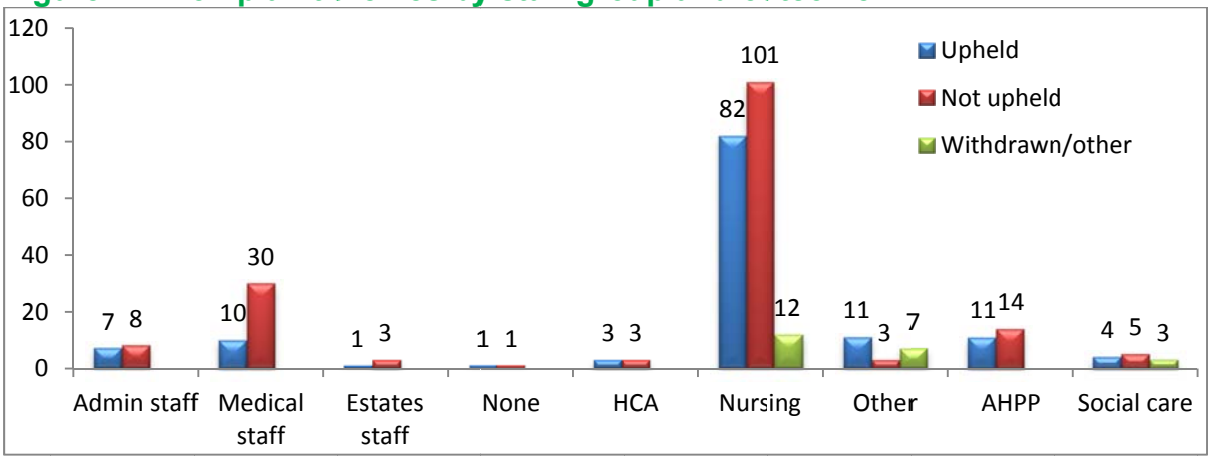
Figure 11: Analysis of complaint themes (upheld/ partially upheld) from teams with highest distribution of complaints



5.2.3 Communication with carers continued to be a consistent theme throughout 2017/18 (although a small number of complaints). During 2017/18, our Trust has rolled-out the Triangle of Care initiative across our clinical settings and to embed the principles in practice throughout the Trust. The Trust has been awarded a second Triangle of Care gold star and is committed to continuing to support clinicians to practice in this inclusive way.

5.3 Outcome of complaint issue by staff group

Figure 12: Complaint themes by staff group and outcome



5.4 Analysis of themes arising from investigated complaints by staff group

Table 4: Analysis of main complaint themes in relation to professional groups (investigated complaints).

Nursing *82 upheld issues*	**Medical** *10 upheld issues*	**Allied Health Professionals & Psychology (AHP&P)** *11 upheld issues*
40 upheld issues related to communication with service users and/or carers/relatives by nursing colleagues	**5** upheld issues related to aspects of medical treatment provided.	**4** upheld issues related to the values and behaviours demonstrated by AHPP colleagues.
21 upheld issues related to aspects of nursing care provided.	**2** upheld issues related to the values and behaviours demonstrated by medical colleagues	**3** upheld issues related to communication with service users and/or carers/relatives by AHPP colleagues
7 upheld issues related to the values and behaviours of Nursing staff		

5.4.1 The main themes identified within each professional group remain reflective of our overall Trust themes and trends. Professional leads are kept sighted to the themes in order to help identify development needs.

5.5 Complaints closed within agreed timescales

5.5.1 The SED continue to carefully monitor response rates to ensure that best practice is adhered to. When delays are encountered the SED apologise and keep complainants informed of the progress in relation to the response to their complaint. Table 5 shows response rates to complaints during each quarter for 2017/18 and the explanation for any delays.

Table 5: Percentage of complaints closed within agreed timescales 2017/18

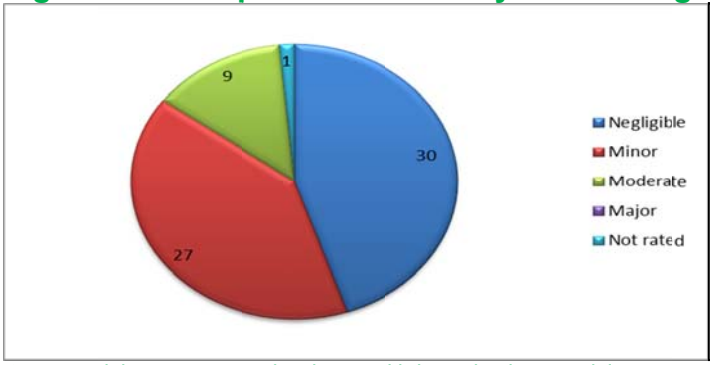
Quarter	% closed within agreed timescale	Comments
1	81%	This is higher than the previous quarter (Q4 2016/17=78%) and was due to delays in the investigation processes.
2	93%	This increased from Quarter 1. Only one complaint investigation was overdue in this time period.
3	67%	6 letters of response were delayed due to issues of investigation, review of investigation, and review of final response letters.
4	77%	Responses delayed during Quarter 4 were due to investigation issues.

5.6 Level of organisational risk of complaints

5.6.1 Following the investigation of each complaint, a risk assessment is completed by a clinical member of the Service Experience Department. The categorisation of risk is based on the National Patient Safety Agency format which considers the likelihood of an issue recurring and the potential consequences if it did.

- **Negligible** – simple, non-complex issues
- **Minor** – several issues relating to a short period of care
- **Moderate** – multiple issues relating to longer period of care/involving other organisations
- **Major** – multiple issues relating to serious failures, causing serious harm

Figure 13: Complaint numbers by level of organisational risk 2017/18



This year's complaint risk ratings are consistent with those reported in previous years. The majority of complaints were assessed as being negligible or minor. The number of risks assessed as major this year is zero.

One complaint was not rated as it was withdrawn by the complainant

Data includes withdrawn complaints, so may differ from numbers of complaints investigated featured in this report.

6. SATISFACTION WITH THE COMPLAINT RESOLUTION PROCESS

Resolving complaints to the satisfaction of people who complain remains a key focus for our Trust. Service users and carers who have raised concerns or complaints are routinely offered the opportunity to meet with clinical and service experience staff in order to attempt to achieve local resolution.

6.1 Reopened complaints and resolution meetings held in 2017/18

6.1.1 Four complaints investigated during 2017/18 were reopened this year for further clarification or investigation. When required actions were complete and liaison with the complainants to ensure satisfaction with our processes was undertaken, the complaints were closed and no further action was required by our Trust. This is a decrease in the number of reopened complaints compared to 2016/17 and could be reflective of the work undertaken by the SED at the point a complaint is raised to achieve a timely resolution.

6.1.2 9 Local Resolution Meetings (LRM) were held during 2017/18 facilitated by the SED along with clinical and operational colleagues. Eight LRM related to complaints that were reported and investigated during 2016/17. One LRM related to a complaint investigated during 2017/18. Some complaints remain under investigation or have recently closed and so resolution meetings may still occur for those complaints reported during Quarter 4 2017/18.

6.1.3 In 2016/17, 10% of complainants required a further meeting to seek resolution. The reduction seen in 2017/18 correlates with the lower number of complaints received. It could also suggest that people whose complaint was received this year are largely satisfied with the response to their complaints. This is a reflection of the work to ensure investigations are robust and that letters of response clearly explain the findings in a clear and empathic way.

6.1.4 In the 2016/17 cohort of people who complained there were a small number of comments received which suggested their dissatisfaction with the Final Response Letter that they received.

6.1.5 During 2017/18 the SED and the Chief Executive's Office have continued to develop and improve the letters of response. Overall, the Non-Executive Director audits of complaints undertaken during 2017/18 have found response letters to be improved from previous audit findings. The audits also highlight areas in which improvements can still be made. The Service Experience Department will continue to seek and review this feedback in order to ensure continuous improvement.

6.2 Referrals to external agencies by complainants

6.2.1 People are encouraged to seek an independent review of their complaint if they are dissatisfied with the complaint process, outcome, or if they feel that their concern remains unresolved. Complainants are able to contact the Parliamentary Health Service Ombudsman (PHSO), Local Government Ombudsman (LGO) or Care Quality Commission (CQC), depending upon the issues contained within their complaint.

6.2.2 Table 6 summarises the complaints referred to external bodies by complainants this year. Assurance levels are provided regarding the Trust's compliance where recommendations were received.

Table 6: summary of complaints referred to external bodies in 2017/18

External body	Summary of complaint	Response from external body	Outcome and learning	Assurance level
CQC	Service user concerned re: application of the Mental Health Act and accuracy of healthcare records	Formal investigation	Upheld with recommendations for ²gether. Learning re: aspects of complaint handling.	**FULL**
LGO	Relative concerned re: management of service user's care, diagnosis and treatment.	Under review to consider whether formal investigation is required	To be confirmed	TBC
PHSO	Relative concerned re: complaint management and accuracy of healthcare records.	Closed - no investigation		
PHSO	Service user concerned re: management of care and communication issues with staff.	Closed - no investigation		
PHSO	Concerns about accuracy of healthcare records.	Closed - no investigation		
PHSO	Service user concerned re: diagnosis and available treatment options.	Formal investigation	Closed – no actions required by ²gether	
PHSO	Service user concerned re: the accuracy and release of healthcare records.	Formal investigation	Upheld with recommendations for ²gether Learning re: undertaking and documenting a Risk Assessment	**FULL**
PHSO	Relative concerned re: care and treatment.	Formal investigation	To be confirmed	TBC

6.2.3 Table 6 shows that one complaint investigated by the PHSO and one investigated by the CQC identified learning for our Trust. Action plans were developed and implemented in response to the external recommendations. Both action plans are fully completed, with apologies issued to the complainants by the Trust. This has been done to the satisfaction of the PHSO or CQC and closed during 2017/18. These matters have been previously reported to the Board.

7. LEARNING FROM COMPLAINTS

The Service Experience Department has continued to work in partnership with colleagues across the Trust to develop and implement systems to identify learning in order to improve our services and experience of services. Monthly and quarterly reports detailing Service Experience activity, themes and learning for each locality are shared with service leads. SED also identify learning from complaints for inclusion in our Trust's ongoing system of aggregated learning. The scrutiny of the assurance provided around learning and positive change actions following complaints is undertaken with locality Governance Leads at the Quality and Clinical Risk sub-committee on a monthly basis.

Table 7 outlines examples of individual complaints and the actions taken in response. Examples and actions taken are linked to thematic complaint data (seen within Figure 9).

Table 7: Examples of LEARNING from complaints and ACTIONS taken during 2017/18

Example	You said – our LEARNING	We did – our ACTION
Communication and access to care and treatment	*I wouldn't have started therapy sessions if I had known they were time limited.*	We apologised that you were not informed at the commencement of your contact with our service about the timescales for therapy. We have updated our staff to ensure this is explained at the very beginning of contact with people.
Communication with carers	*My daughter was moved to another hospital in the early hours of the morning – this was very distressing for us all and we didn't know why.*	We explained the reasons why it was necessary on this occasion and apologised we had not explained sooner. We gave you assurance that we had issued further advice to staff about night time transfers.
Communication with service user	*I telephoned the team when I was distressed and was told they would call me back. I was not contacted by them until the following day.*	A system is now in place to ensure that when a person is identified as distressed or needing a same day response the team are alerted to this for timely follow up.
Accuracy of healthcare records	*My healthcare records contained inaccurate information.*	We apologised for this and offered to amend and update your clinical records to be factually accurate
Communication and discharge arrangements	*My 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.
Communication with service user	*I had been asked for details of people living in my household but was 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.
Communication with relative	*My brother was detained in hospital and I was 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.

8. AREAS FOR DEVELOPMENT

8.1 A number of practice development objectives are planned for the coming year including to:

- Review current processes and continue to work with locality colleagues to seek earlier resolution and more timely responses to formal complaints.
- Review and improve dissemination of learning from complaints and to ensure that service user feedback is embedded in practice and that assurance mechanisms are in place.
- Raise the profile of PALS presence within our services to enable more feedback to be gained and timely response and resolution of concerns.
- Continue to triangulate complaints with concerns, comments, compliments and survey information to gain rich information to inform practice and service development.
- Further develop the style and tone of Final Response Letters.
- Implement a system of measuring satisfaction with the complaints handling process from people who complain.
- Collaborate with colleagues from Gloucestershire Care Services (GCS) to share and learn from best practice in complaints resolution locally.
- Take part in the review and implementation of any recommendations received from scrutiny of the complaint resolution process.

9. CONCLUSION

9.1 [2]gether NHS Foundation Trust is committed to learning from people's experiences of our services obtained through feedback from surveys, concerns, complaints, comments and compliments. In this way we will provide the best quality service experience and care in line with our Service Experience Strategy.

9.2 The Service Experience Department will continue to work with service users, carers, operational colleagues and the wider community to further develop robust systems for complaint handling and to ensure that learning from feedback is used to inform practice and service developments.

Agenda item 14 **Enclosure Paper H**

Report to: 2gether NHS Foundation Trust Board – 31st May 2018
Author: Paul Roberts, Joint Chief Executive and Colin Merker, Deputy Chief Executive
Presented by: Paul Roberts, Joint Chief Executive and Colin Merker, Deputy Chief Executive

SUBJECT: **Chief Executive's Report**

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

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

EXECUTIVE SUMMARY
This paper provides the Board with:

1. 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. Commencement and induction

I am delighted to have taken up my post as Joint Chief Executive of 2gether NHS Foundation Trust and Gloucestershire Care Services NHS Trust (GCS) on 16th April. I am delighted to be attending my first public meeting of the Board of Directors, I have already attended a meeting of the Council of Governors and we have had a number of informal meetings of Board Members jointly with GCS.

I have been made very welcome by Trust colleagues and have commenced a 100 day programme of induction and clarifying the programme management and timescales for the proposed merger between the two Trusts. A high proportion of my time is being spent visiting front-line services in both organisations and I have already been struck by the professionalism and commitment of colleagues across the organisation and in the pride that they take in the delivery of, in many cases, outstanding services. I am grateful to the Executive Directors, and in particular to Deputy Chief Executive Colin Merker for the support they have given me by continuing to lead the Trust on a day to day basis to allow me to do this.

This report has been written jointly by Colin and me.

2. Progress on the strategic intent to merge with Gloucestershire Care Services NHS Trust (GCS)

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

Progress has been made through the Strategic Intent Leadership Group (SILG) and the Programme Management Executive with establishing programme management arrangements for the merger and developing a detailed Programme Plan.

Both deputy Chief Executives: Colin Merker and Sandra Betney reporting to me, SILG and to both Boards have taken significant roles in progressing key aspects of the programme and Philip Baillie has taken up the post of integration programme director.

As I am finalising this report we will be sharing an outline timetable for the merger programme with the wider organisation and with key partners together with summary descriptions of the two organisations to aid wider mutual understanding of our roles.

In April two leadership events were held for clinical leaders and senior managers across both Trusts to start the detailed process of exploring and realising the opportunities to benefit from the close integration of physical and mental health services. This week a further event is being held with partner organisations and service user representatives to explore the same issues and shortly a programme will be commenced that engages a wide range of interested partners in developing the service strategy for a an integrated organisation. It is envisaged that Board members will participate in this programme to inform strategic decision-making.

3. CQC Comprehensive Inspection of Services

We received our Draft CQC Comprehensive Inspection report for factual accuracy checking and returned this to CQC colleagues for their consideration of our comments on the 15th May 2018 as requested.

We await the publication of our formal report which we expect will be at the end of May 2018.

Colleagues across the Trust worked hard to support the inspection visits and to enable us to respond to the factual accuracy review of the draft report.

We look forward to receiving the final report in the near future and will give an oral update at the meeting.

4. Carter Mental Health Community Services Work

The Lord Carter report into the “Operational Productivity and Performance in English NHS Mental Health and Community Health Services: unwarranted variations” was published on 24th May 2018 (as this report was being finalised).

The Trust was asked to be part of the Lord Carter review as a “high performing” Mental Health Trust.

The Trust has participated in a number of significant work programmes relating to staffing and/or clinical practice, as well as having returned a wealth of data relating to the full operational and strategic delivery of our services.

An initial review of the report indicates a number of key themes which will need to be reviewed over the coming months by the Trust many in conjunction with Gloucestershire Care Services NHS Trust as part of our joint work on merger. These themes include: clinical and workforce productivity, estates rationalisation, extending the “Getting It Right First Time” Programme into community and mental health

services, standardised commissioning frameworks, improved procurement and the development of further plans for use of technology and mobile working.

5. "One Gloucestershire" Integrated Care System

The proposal for establishing an integrated care system (ICS) in Gloucestershire was one of four approved by NHS Improvement and NHS England as this paper was being finalised. This means Gloucestershire will be one of only fourteen ICSs nationally. The paper approved at the NHSi and NHSE Board meeting said: "These systems demonstrate strong leadership teams, capable of acting collectively, and with an appetite for taking responsibility for their own performance…. They have also set out ambitious plans for strengthening primary care, integrating services and collaborating between providers. Although they experience the operational and financial pressures that other systems do, our assessment is that they are more likely to improve performance against NHS Constitutional standards and financial sustainability by working together as a system".

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

6. Herefordshire and Worcestershire STP – Integrated Care System Development Programme

Where as in Gloucestershire, 2gether is part of the Gloucestershire STP's successful bid to become and Integrated Care System (ICS) pathfinder, in Herefordshire and Worcestershire the Midlands and East NHS Executive are sponsoring all of their STP's to participate in an Integrated Care System Development Programme to be led by the National ICS Support Team.

This will be demanding for colleagues within the Trust at what is a challenging time in general in progressing our merger proposals. We will use both of these opportunities to ensure we maintain excellence and further improve Community Mental Health and Community Physical Health Care Services and maximise the opportunity for demonstrating that Mental Health and Community Services are a fundamental and key partner in a successful integrated care system. There will be many opportunities to share learning and development between Gloucestershire and Herefordshire over the coming months as the two systems aim to achieve the same benefits of integration through differing routes.

7. Integrated Care Alliance Board (ICAB)

As part of the 'One Herefordshire' element of the Herefordshire and Worcestershire STP proposals, a number of new structures are being introduced to enable the 'health and social care system' to work differently together.

As colleagues know, we are a small but key provider of the Mental Health and Learning Disability services in Herefordshire. Community Physical Health Services are provided as part of the Wye Valley Trust portfolio alongside the Acute Physical Health Care Hospital services. GP's in Herefordshire are also well organised, as they operate as a "Corporate" group through the Taurus GP Confederation in the delivery of GP/Primary Care services.

In order to enable the system to embrace opportunities for working differently, to eliminate unwarranted variations and to drive innovation and clinical and financial efficiencies, the Integrated Care Alliance Board (ICAB) has been established. ICAB will provide an arena within which the Herefordshire Health and Social Care providers can explore new ways of working, collectively influence service delivery and make recommendations about what and how services should be commissioned.

The ICAB will also explore the same opportunities for integration of Mental Health and Community Physical Health Care Services that we will be exploring and through our merger proposals in Gloucestershire but in a system with different organisational architecture. In order that clinical colleagues in our Herefordshire Services can drive this programme of works, we are organising a series of integrated care workshops which will enable colleagues to voice ideas and concerns so that we can help shape the future health and social care system appropriately.

Our Herefordshire Integrating Care Group, will need to work closely with our Gloucestershire Merger Group, so that we can ensue best practice is considered in both localities and in Herefordshire we can ensure that implementation of any ICAB agreed proposals do not affect our contractual and governance responsibilities.

There are a number of existing groups/forums where we can continue to make a difference in both Health and Social Care Communities, but we need to ensure that we are appropriately supporting staff and the new system governance and planning arrangements to ensure Mental Health and Learning Disability services remain recognised for the vital role they play in making life better for so many of Herefordshire and Gloucestershire's vulnerable people.

8. BSc in Mental Health Nursing, University of Gloucestershire

It has been confirmed that the University of Gloucestershire has been validated to run the BSc in MH Nursing from September 2018. In addition they have been validated to run the degree apprenticeship programme from this date also. This apprenticeship programme will offer the opportunity for widening access to registered nursing for potential students whilst remaining employees of the Trust. This validation is the conclusion of hard work and commitment from both key individuals within the Trust and University of Gloucestershire colleagues.

The next step is to ensure recruitment of the 32 Mental Health nursing students for September 2018.

9. National issues

At the joint meeting between NHS England and NHS Improvement last week further details were announced of the increased joint working between NHS England and NHS Improvement. The two organisations will share a number of Board level roles and "the focus of decision-making will be centred more on regional directors" with the appointment of seven new joint regional teams. The South West Region (incorporating Gloucestershire) remains the same with the establishment of a new region for the Midlands as a whole (incorporating Herefordshire).

At the same meeting an outline proposal to establish an "NHS Assembly" to oversee the continued implementation of the Five Year Forward View and the co-design a new ten-year plan was also agreed. The Assembly will be drawn from national

clinical, patient and staff organisations, partner sectors and NHS bodies and partnerships.

10. Engagement

Internal Board Engagement

01.03.18 The Acting Chief Executive attended the STP Delivery Board meeting.
The Director of Organisational Development conducted a Patient Safety Visit to Mulberry Ward & Willow Ward.

05.03.18 Members of the Executive Team delivered Team Talk.
The Director of Finance and Commerce attended Corporate Induction.
The Executive Team attended a Development Executive meeting to discuss the Risk Register.
The Executive Team attended a Senior Leadership Forum.

06.03.18 The Director of Service Delivery attended an Induction site visit to Wotton Lawn and attended the CYPS CAHMS Board meeting.
The Director of Organisational Development conducted a Board Visit to the Eating Disorder Services.

07.03.18 The Director of Service Delivery attended the Gloucestershire Locality Board meeting.
The Director of Organisational Development conducted a Board visit to Governance, Risk & Patient Safety Teams.

08.03.18 The Acting Chief Executive attended Council of Governors.

09.03.18 The Director of Quality attended an Infection Control meeting.

12.03.18 The Executive Team attended an Executive Business Committee meeting.
Members of the Executive Team attended a Programme Management Executive meeting and Workshop with Gloucestershire Care Services colleagues.
The Director of Finance and Commerce chaired the Capital Review Group.

13.03.18 The Director of Service Delivery conducted a site visit to Berkeley House.
The Acting Chief Executive attended a meeting regarding Contract Value Increase and also attended the Governor Induction session.

14.03.18 The Acting Chief Executive and Director of Service Delivery attended a Mental Health Legislation Scrutiny Committee.
The Acting Chief Executive and the Director of Organisational Development participated in a Strategic Intent Leadership Group along with Gloucestershire care Service colleagues.

The Medical Director took part in a Consultant Interview Panel.

15.03.18 The Acting Chief Executive attended an Integrated Locality Board Workshop.
The Director of Quality conducted a Board visit to Gloucester Recovery Team and AO Team at Pullman Place.
The Director of Finance and Commerce chaired the Transformation (CIP) Project Board.

16.03.18 The Director of Quality attended the QCR Sub Committee meeting.

19.03.18 The Executive Team attended a Development Executive meeting to discuss the Financial Plan.
Members of the Executive Team participated in the recruitment of a Non-Executive Director.

20.03.18 The Acting Chief Executive attended a JNCC meeting.
The Director of Quality attended the Infection Prevention and Decontamination Committee at Stonebow Unit.

21.03.18 The Director of Service Delivery conducted a site visit to Hereford services and the Locality Service Director.
The Director of Quality attended a Safecare – Summary meeting and Preparation review Training at Wotton Lawn.
The Medical Director did a Patient Safety Visit at the Stonebow Unit, Hereford.

26.03.18 The Executive Team attended an Executive Business Committee meeting.
Members of the Executive Team attended a Programme Management Executive meeting and Workshop with Gloucestershire Care Services colleagues.

27.03.18 The Director of Service Delivery visited sites, teams and services within the Gloucestershire Locality.
The Director of Quality participated in the CQC interview for the Well Led interview.
The Director of Finance and Commerce chaired the Capital Review Group Meeting.
The Director of Finance and Commerce attended the Charitable Funds Meeting.

28.03.18 The Executive Team attended Trust Board.

29.03.18 The Acting Chief Executive, Director of Service Delivery and Director of Organisational Development attended Delivery Committee meeting.

03.04.18 The Acting Chief Executive and Director of Service Delivery conducted a Board visit to Stroud AP Team.

The Director of Finance and Commerce conducted a Board Visit to the North MH Intermediate Care Team.

04.04.18 The Director of Quality conducted a Patient Safety visit to Honeybourne Unit.
The Director of Service Delivery conducted a site visit to wards at Wotton Lawn.
The Director of Service Delivery attended an IAPT meeting.
The Director of Quality participated in the recruitment of the Chair for the Drug & Therapeutic role.
The Director of Finance and Commerce and the Director of Engagement and Integration attended the Audit Committee.
The Medical Director took part in the panel interviews for the Chair of D&T Committee.

05.04.18 The Director of Finance and Commerce attended the STP Delivery Meeting.

06.04.18 The Director of Service Delivery attended an Introductory visit to teams and services at Charlton Lane Hospital.
The Director of Quality participated in the interview process for the Programme Director.
The Medical Director met with a complainant.

09.04.18 Members of the Executive Team attended a Programme Management Executive meeting and Workshop with Gloucestershire Care Services colleagues.

10.04.18 The Director of Quality attended a meeting regarding Temp Staffing Strategic planning.
The Director of Service Delivery participated in a Strengthening OAPs Guidance - webinar 1.

11.04.18 The Director of Quality attended a Lead Nurse Meeting.

The Director of Quality conducted a Board visit to Herefordshire AOT and Early Intervention Teams.

12.04.18 The Director of Quality attended Safeguarding Committee meeting.

16.04.18 Members of the Executive Team delivered Team Talk.
The Executive Team attended a Development Executive meeting.
The Executive Team attended a Senior Leadership Forum.

17.04.18 Members of the Executive Team attended a Joint Board Seminar with Gloucestershire Care Services colleagues.
The Deputy Chief Executive and Director of Organisational Development attended a Strategic Intent Leadership Group meeting.
The Director of Organisational Development chaired People Committee.

18.04.18 The Director of Service Delivery visited sites, teams and services within the Countywide Locality.
The Director of Finance and Commerce attended Development Committee.

19.04.18 Members of the Executive Team attended the official opening event of Pullman Place.
The Director of Organisational Development conducted a Board visit to the Jenny Lind Ward and Acute Day Unit, Stonebow.

20.04.18 The Director of Engagement and Integration chaired the Quality and Clinical Risk Sub-Committee.

23.04.18 The Executive Team attended an Executive Business Committee meeting.
Members of the Executive Team attended a Programme Management Executive meeting and Workshop with Gloucestershire Care Services colleagues.
The Deputy chief Executive attended a Dementia CPG meeting.

24.04.18 The Director of Service Delivery visited sites, teams and services within the CYPS Locality.
The Deputy Chief Executive attended a Gloucestershire Strategic Forum meeting.
The Director of Organisational Development chaired the Safety, Health & Environment Committee.

25.04.18 The Deputy Chief Executive and Director of Service Delivery attended Delivery Committee meeting.
The Director of Finance and Commerce conducted a Board Visit to Chestnut Ward.

26.04.18 Members of the Executive Team attended a Shaping our Future Joint Workshop.
The Executive Team attended Trust Board.
The Deputy Chief Executive attended a Non-Executive Directors meeting.

27.04.18 The Director of Quality attended Governance Committee, A Temporary Staffing Demand Project Board and Also a Nurse Summit meeting

30.04.18 The Executive Team attended a Development Executive session

Board Stakeholder Engagement

02.03.18 The Acting Chief Executive took part in a teleconference to discuss Integrated Care Services.

05.03.18 The Medical Director met with the Three Counties Medical School.

06.03.18 The Acting Chief Executive attended a Contract Negotiation meeting with Gloucestershire Clinical Commissioning Group.

07.03.18 The Acting Chief Executive attending a Contract Negotiation meeting with Herefordshire Clinical Commissioning Group.
The Director of Quality attended a Patient Safety Collaborative Learning Session.

08.03.18 The Acting Chief Executive meeting with Gloucestershire's Assistant Chief Constable.
The Director of Quality attended a Patient Safety Collaborative Learning Session.

09.03.18 The Acting Chief Executive attended a Joining Up Your Information meeting with Gloucestershire Clinical Commissioning Group.
The Acting Chief Executive attended a NHSE West Midlands Mental Health Delivery Plan session.

13.03.18 The Director of Quality attended a Gloucestershire Safeguarding Children Board meeting at Shire Hall.
The Director of Quality attended a STP Clinical Reference Group meeting with Gloucestershire Clinical Commissioning Group.
The Acting Chief Executive and Director of Finance participated in a conference call regarding Provider Sustainability - Mental Health and Hereford.
The Acting Chief Executive attended a Risk Management meeting regarding Corporate Governance.
Director of Finance and Commerce attended a Joint RSG/PDG meeting.

14.03.18 The Director of Quality was on the judging panel at the Tea party and Bake off, held at Charlton Lane Hospital.
The Director of Service Delivery attended a Contract Management Board with Gloucestershire Clinical Commissioning Group.
The Medical Director met with the Herefordshire Coroner.
Director of Finance and Commerce attended the 2gether Contract Board Meeting in Gloucestershire.

15.03.18 The Director of Quality and Director of Finance attended a Contract Management Board meeting in Hereford.

16.03.18 The Acting Chief Executive and Medical Director attended a Mental Health Commissioning and LMC meeting with Gloucestershire Clinical Commissioning Group.

19.03.18 The Acting Chief Executive attended a Clinical Programme Board Meeting.

21.03.18 The Medical Director was interviewed by the CQC.

22.03.18	Members of the Executive Team participated in interviews with the Care Quality Commissioners. The Acting Chief Executive had a telephone call with the NHSi's Director of Nursing relating to a complaint. Members of the Executive Team participated in interviews with the Care Quality Commissioners. The Medical Director attended an inquest in Gloucestershire.
27.03.18	Members of the Executive Team attended Extraordinary Delivery Board with Gloucestershire Clinical Commissioning Group.
05.04.18	The Director of Quality attended a Retention Direct Support Programme cohort 3 launch.
10.04.18	The Director of Engagement and Integration chaired a meeting with colleagues from Healthwatch Gloucestershire. The Director of Engagement and Integration chaired a meeting with colleagues from Pied Piper. The Director of Finance and Commerce attended the Joint RSG/PDG Meeting.
11.04.18	The Director of Engagement and Integration attended a One Herefordshire Health and Care Shadow Alliance meeting.
16.04.18	The Medical Director attended an inquest in Herefordshire.
18.04.18	The Deputy Chief Executive attended a Forest of Dean Integrated Locality Board.
19.04.18	The Director of Service Delivery and Director of Finance and Commerce attended a Hereford Contract Management Board meeting. The Director of Engagement and Integration attended a Triangle of Care Celebration.
20.04.18	The Director of Service Delivery and the Director of Engagement and Integration attended a Combined transformation Workshop.
24.04.18	The Director of Quality attended a STP Clinical Reference Group.
25.04.18	The Deputy Chief Executive attended a Gloucestershire STP Progress & Development Meeting with Gloucestershire Clinical Commissioning Group. The Director of Engagement and Integration attended a Cobalt Board meeting.
30.04.18	The Deputy Chief Executive attended a Hereford and Worcester - ICS development programme meeting. The Medical Director attended an inquest in Gloucestershire.

National Engagement

08.03.18 The Director of Organisational Development chaired the South West HRD Network meeting.

15.03.18 The Director of Organisational Development attended the HRD Network meeting.

Agenda item 15 **Enclosure** **Paper I**

Report to:	2gether Board Meeting – 31 May 2018
Author:	Kate Nelmes, Head of Communications
Presented by:	Jane Melton, Director of Engagement and Integration
SUBJECT:	**Membership Data Annual report 2017/18**

This Report is provided for:

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

EXECUTIVE SUMMARY

- This paper provides a full analysis of the 2017/18 financial year membership data for 2gether NHS Foundation Trust.
- The Trust's new Membership Strategy was agreed in September 2016. Our focus is on retaining members and recruiting new members, with a specific emphasis on recruiting young members, members from black and minority ethnic backgrounds and men, who are all under-represented.
- An annual report on membership was requested by the Board to provide a year-on-year comparison of membership data.
- There are **7805** members of our Trust at the end of the 2017/18 financial year. This represents an increase of 362 members (5%) over the year.

RECOMMENDATIONS

That the Board notes the 2017/18 financial year-end membership data and analysis.

Corporate Considerations	
Quality Implications:	An active and representative group of members will assist the organisation to enhance understanding of service experience, tackle stigma and provide links across our constituencies.
Resource implications:	Further membership activity may require additional resource to utilise membership benefits to best effect.
Equalities implications:	Understanding the diversity of membership will assist targeted recruitment and retention to best effect. Ensuring diversity in membership will offer a range of important views and participation to influence 2gether's work.

Risk implications:	There are risks of marginalising certain groups within the local community if attention is not paid to membership demographics.

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

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:		
Jane Melton, Director of Engagement and Integration	Date	20 April 2018

Where in the Trust has this been discussed before?		
Regular updates have been provided throughout the year to the Cllr of Governors Annual Membership report to CoG	Date	8 May 2018
What consultation has there been?		
	Date	

Explanation of acronyms used:	

1. Context

1.1. A new membership strategy was agreed by Governors in September 2016 in line with the Trust's Engagement and Communications Strategy. Our focus is on those groups currently under-represented within our membership base, including men, younger people (under 19) and people from a black and minority ethnic background. Our membership base in Herefordshire is also far lower than it is in Gloucestershire, so this is another area of priority.

1.2. So far work on implementing the strategy has included the recruitment of a membership volunteer who for six months provided membership administration support. A new Membership Advisory Group has been formed with dedicated involvement from Trust Governors and members. This has met three times with meetings scheduled for the remainder of 2018/19. This group has, so far, reviewed the Trust's membership form and explored ideas for a new membership pack, as well as new methods of attracting and engaging with members. A survey was also conducted in April 2017 among existing members, in order to gain feedback on our membership programme.

1.3. Work has also been taking place to cleanse our membership data, to ensure we are accurately reporting and have a clear starting point for increased recruitment. This work has included removing members who are no longer engaging with us, including those who have moved without leaving a forwarding postal or email address, and ensuring that we are only counting staff members who are within the relevant categories for membership.

1.4. Work is currently underway to ensure we are compliant with the new **General Data Protection Regulation (GDPR),** which comes into effect on May 25 2018. Members have been notified of the new regulations, and, through an article in the Trust newsletter, have been informed about what GDPR means for them, including how to withdraw their membership if they wish to. This may mean we see an initial reduction in membership figures. GDPR will also mean we need to ensure that we can quickly and effectively destroy information we hold on members if requested, and it also means we will no longer be able to transfer staff members to public members when they leave the Trust's employment. All leavers will now be written to and asked to actively 'opt in' to membership. This will also impact membership figures.

1.5. The actions presented here seek to compliment the Trust's Engagement and Communication Strategy 2016-2020 which is structured to influence more people in our community to become champions of the services that we deliver to make life better.

1.6. The membership data in this paper will help to inform the appropriate focus and tactics to enable recruitment, retention and engagement of members. This report will focus on overall change within membership data.

2. Membership figures

2.1 Membership data, at 31st March 2018, is as follows:

- There are **7805** members of our Trust **(**representing a **total increase of 362** members overall**)**
- **5675** are Public Members and **2130** are Staff Members
- Our public membership increased by **320** over the year
- Our staff membership increased by **42**
- **296 public membership** records were removed with **221** members removed due to 'no forwarding address'
- On average, 31 new members of the public joined the Trust every month, which is an increase on the rate for 2016/17 when 24 members of the public joined each month. This is below the target we set ourselves to recruit an average of 40 new public members each month.
- Most new members are recruited through our website and public events, such as stands during awareness weeks. Our most successful member recruitment event in 2017/18 was the open day at Gloucestershire Police Headquarters, when we recruited 80 new members.
- We've seen a particular increase in members in Herefordshire due, in part, to work by the Social Inclusion Team to recruit more members and volunteers there.

2.2 Number of Public Members at 31 March 2018

Table 1 represents the actual numbers of members per constituency. However, the actual numbers do not provide information about the relative numbers of members in relation to the size of the associated constituency. This is considered in the additional tables below. Information regarding the demographics of ethnicity, disability, age and gender are also provided.

Table 1 Public Membership Numbers by Constituency at 31st March 2018

Cheltenham	Cotswolds	Forest of Dean
890	375	576
Gloucester	**Stroud**	**Tewkesbury**
1488	872	622
Greater England	**Herefordshire**	
417	435	

Figure 2 provides the percentage spread of membership by constituency whilst Table 2 shows the relative percentage of membership. This data suggests that membership in Herefordshire is significantly lower than in Gloucestershire. However, the number of members in Herefordshire has risen from 355 to 417 in the last 12 months (an increase of 17%). Gloucester City has the largest proportion of Trust members and the largest population.

Figure 2 Membership data by constituency as at 31 March 2018

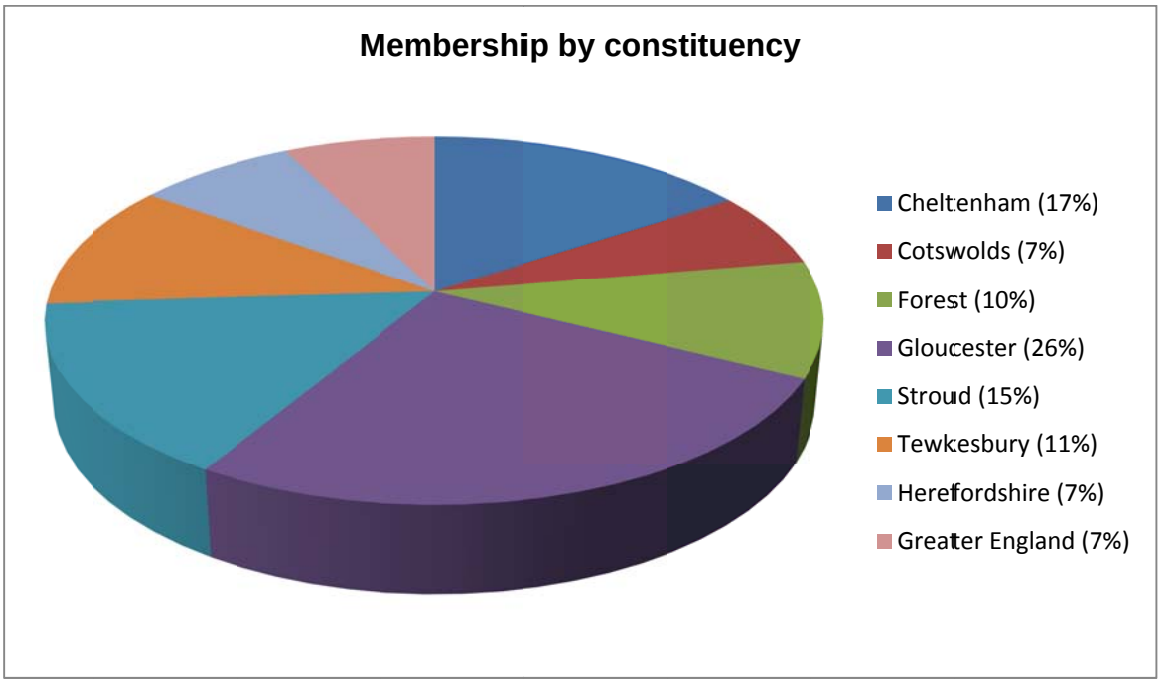


Table 2 **Public Membership as a total percentage of constituent population (excluding Greater England)**

Constituency	Members	Population	% members in constituent population
Cheltenham	890	115,732	0.77
Cotswolds	375	82,881	0.45
Forest of Dean	576	81,961	0.70
Gloucester	1488	121,688	1.22
Stroud	872	112,779	0.77
Tewkesbury	622	81,943	0.76
Herefordshire	435	183,477	0.23
TOTAL	5,258		

2.3 Ethnicity of Trust Members

Tables 3 and 4 suggest that the Trust has successfully recruited a reasonably representative group of people by ethnicity. This is particularly the case in Gloucestershire, although in both counties there is more work to undertake.

Table 3

Ethnicity - Gloucestershire		
	White British/White Other	**Black and Minority Ethnic**
Gloucestershire Census 2011	92% (596,984 people)	5% (27,337 people)
Public membership	95%	5%

Table 4

Ethnicity - Herefordshire		
	White British/White Other	**Black and Minority Ethnic**
Herefordshire Census 2011	94% (183,477 people)	2% (3,308 people)
Public membership	99%	1%

Table 5 **Ethnicity of members in relation to the associated populations of Gloucestershire and Herefordshire**

Ethnicity	Gloucestershire	Glos Members	%	Herefordshire	Hfd members	%
White British	546,599	4468	0.81	171,922	423	0.24
Mixed	8,661	49	0.57	1,270	2	0.16
Black/Black British	5,150	69	1.34	331	0	0.00
Asian/Asian British	10,522	106	1.07	1,162	0	0.00
White Other	23,048	122	0.53	8,247	9	0.11
Chinese/Other	3,004	11	0.36	545	1	0.18
Total	**596,984**	**4823**		**183,477**	**435**	

2.4 Disability status of Trust Members

In relation to members' self-report of their disability status, a much larger proportion of Trust members report a disability than do the general population of Gloucestershire and Herefordshire. These figures are represented in Table 6 with 14% of Trust members in Gloucestershire reporting disability and 15% of people in Herefordshire.

Table 6 Disability status of members in relation to the associated population of Gloucestershire and Herefordshire

Disability – Gloucestershire	
Census data 2011	0.5%
Public membership (Glos)	14% (661 of 4823 members)

Disability – Herefordshire	
Herefordshire Census 2011	0.2%
Public membership (Hfd)	15% (59 of 435 members)

2.5 Age Distribution of Trust members

A wide distribution of membership age range is reported in Table 7. Whilst the largest number of members are between the ages of 20 and 64, in relation to the population size for adults who are older than 65, the Trust reports a higher percentage. Work is required to increase membership representation from younger people.

Table 7 Age group of members in relation to the associated population of Gloucestershire and Herefordshire

Age	Total Hfd & Glos	% of people in age group	Total Public Membership	% of membership (disclosed)
10 – 15	54,528	8%	10*[1]	1%
16 – 19	38,260	6%	47*	1%
20 – 44	236,952	34%	1,630	29%
45 – 64	216,612	31%	1,899	33%
65 – 74	78,706	11%	808	14%
75+	71,665	10%	741	13%
Did not disclose			**540**	**9%**
Total	**696,723**	**100%**	**5675**	**100%**

Table 8 Gender of Trust members

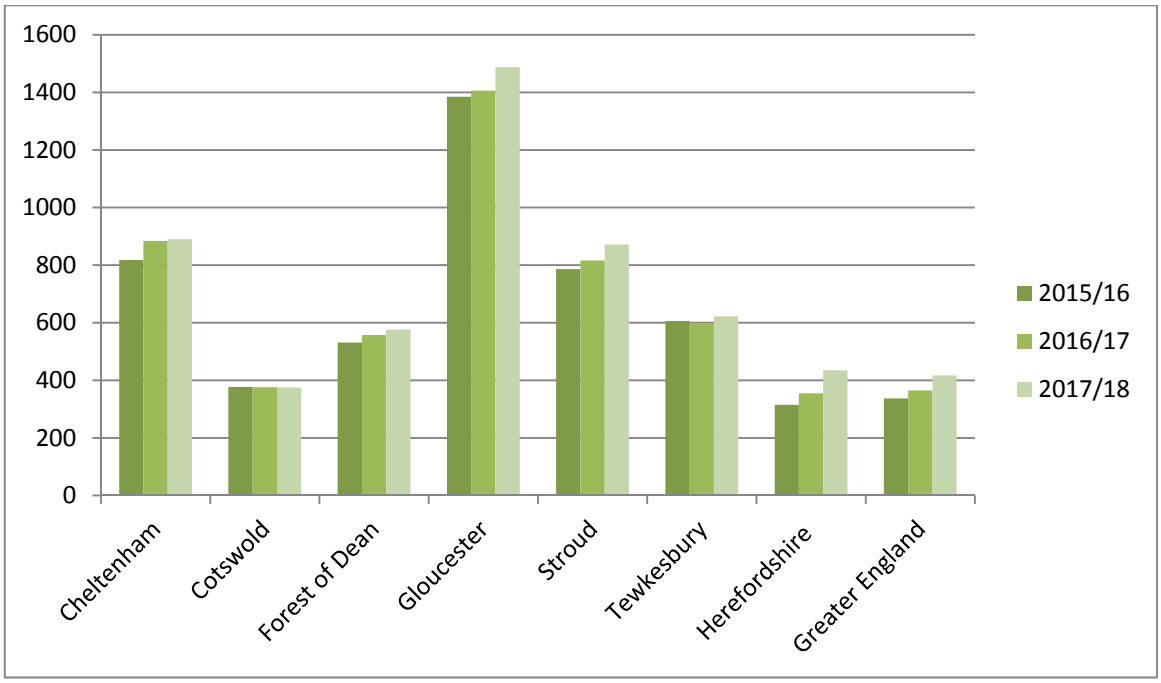
Gender – total public membership	
Male	1898
Female	3777

[1] * Please note that the 2011 Census age groups differ to how we currently collate membership data. The age range noted against the census age group 10 – 15 for members is 11 – 16; and the age range noted against the census age group 16 – 19 for members is 17 – 19.

2. Comparison of Annual Public Membership Data (2016/17)

The following chart (Figure 3) shows a modest overall increase in public membership between 31st March 2017 and 31st March 2018. The graph indicates that overall, membership has been relatively constant in each constituency but with our largest constituency increases by population in Gloucester City and Herefordshire.

Figure 3 Comparison of membership between 2015/16 and 2016/17



3. Conclusion

Analysis of the membership data suggests that:

- Membership currently appeals more to women than men, to people aged between 20 and 65 and to those with self-reported disability.
- Further tactics need to be developed to encourage membership from males, younger people, people from minority ethnic groups and from people who are without disability in order to reflect an accurate representation of the constituents of Gloucestershire and Herefordshire.
- The number of members from Herefordshire remains significantly lower than in Gloucestershire. Gloucester City has the largest proportion of Trust members.

4. Recommendations

- The Membership Advisory Group devise tactics for increasing membership in Herefordshire, and among men, younger people and people from minority ethnic backgrounds. This will include reviewing the membership form and pack sent out to new members.

- That the Communications Team reviews the Trust's Membership Strategy as our merger work with Gloucestershire Care Services NHS Trust progresses, to identify any opportunities to increase membership or highlight any development required in light of the move towards becoming a joint organisation.

- That the Social Inclusion Team works alongside the Communications Team, Governors and Membership Advisory Group to ensure membership is promoted through our partnerships and at events.

- The Communications Team continues to work on, and regularly review, the membership database to ensure it remains GDPR compliant.

Key Performance Indicators for 2018/19 are:

- A 10% increase in members recruited in Herefordshire.
- A 5% increase in members recruited in the Cotswolds.
- A 5% increase in membership among men.
- A 5% increase in membership among younger people (under 21s).
- A 5% increase in membership among people from a Black and Minority Ethnic background.

Agenda Item 16 **Enclosure Paper J**

Report to: Trust Board - 31 May 2018

Authors: Stephen Andrews, Deputy Director of Finance, Dr Chris Fear, Director of Clinical Research, Mark Walker, Research and Development Manager and Jane Melton, Director of Engagement and Integration.

Presented by: Jane Melton, Director of Engagement and Integration

SUBJECT: **Research Update Report**

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

EXECUTIVE SUMMARY

This paper provides an update of development, delivery and governance of research activity during Phase 1 of the implementation of the Trust's research strategy 2016 - 2020.

Assurance

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

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

Development

Co-development of the Phase 2 Strategy Implementation Plan will be led by our new Head of Research and Development and reviewed by the Development Committee on behalf of the Board.

Development activity with our strategic partners will continue to realise the benefits of research activity for and with service users, carers and staff.

RECOMMENDATIONS The Trust Board is asked to: Note the content of this paper and progress being made

Corporate Considerations	
Quality implications:	Research governance is a key part of the quality agenda to ensure that research participants remain safe, have best outcomes and best service experience. New developments in commercial research trials have received significant Clinical and Executive Board oversight and support.
Resource implications:	Recruitment to research trials continues to need to increase to prevent financial impacts on future budgets related to the NIHR activity-based funding model. Failure to consistently meet the new metrics in relation to recruitment and approvals will result in financial penalties from the CRN and potentially reduce the funding available in future years.
Equalities implications:	Promotion and support of research ensures the greatest number of services users, carers and staff have the opportunity to get involved in research – this remains challenging with a small team across two counties. Influencing research protocol development to ensure that underrepresented groups have an opportunity to engage in / inform research development (for example, people with learning disabilities; children and young people)
Risk implications:	A risk register for research related activity has been developed and is reviewed regularly at the Research Overview Sub-committee. It provides a stronger focus on risk management for clinical trials, and continued development of research activity.

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

(Indicate which strategic objectives are progressed (P) or challenged (C))

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

(Indicate which core values are progressed (P) or challenged (C))

Reviewed by:		
Dr Jane Melton, Director of Engagement and Integration	Date	May 2018

Where in the Trust has this been discussed before?		
Development Committee (in part) Governance Committee (in part)	Date	February 2018 October 2017

What consultation has there been?		
	Date	

Explanation of acronyms used:	NIHR – National Institute for Health Research CRN – Clinical Research Network WTE – Whole time equivalent R+D – Research and development WoE – West of England PI – Principle Investigator CAMHS – Children and Young People Mental Health Service LD – Learning Disability WAA – Working Age Adult ROC – Research Overview Committee CCG – Clinical Commissioning Group ABF – Activity-based funding

1. Introduction

1.1 In 2016 the Trust Board agreed a strategy for Research and Development with the vision to:

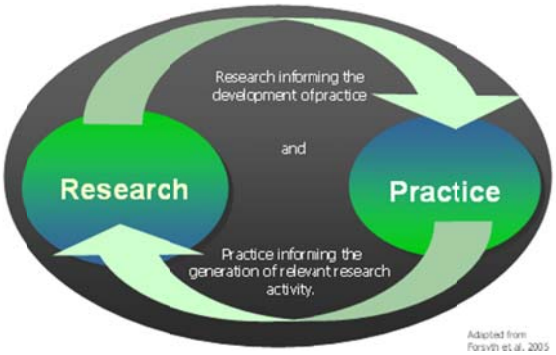
'Become a world-class centre of practice-based research and development to help make life better by 2020'

1.2 Our goal is to be a strong partner for research innovation and investment; a well-regarded contributor to an evidence-based, healthcare service and a generator and user of research evidence to inform delivery of best outcomes for and with service users and carers.

1.3 We aim to develop a secure infrastructure that supports senior leaders to be research active, opens opportunities for funding research programmes, and connects us with academia through formal partnerships.

Figure 1 Developing a collaborative culture of research and development

1.4 Figure 1 provides an illustration of how 2gether is building a culture where research and development is a dynamic and collaborative process and partnership between practice and academia in order to deliver innovation for best care.



1.5 NHS Research is funded from income streams that are independent of the other NHS budgets. Research activity in the NHS is managed through the National Institute for Health Research (NIHR), which was established in April 2006. It provides the framework by which the Department of Health fund the research, research staff and research infrastructure of the NHS in England as a national research facility. The NIHR also actively encourages partnerships with the commercial sector which provides an additional source of funding in relation to hosting Commercially Sponsored Clinical Studies

1.6 This paper is structured to provide an update on each of the objectives set in the Trust's Research and Development Strategy.

2. Objective 1 - Build a local research centre

2.1 The Fritchie Centre was officially opened in August 2016 marking a significant investment to provide modern, research facilities and demonstrated the Trust's strategic intent and commitment to expanding its research provision. Click here to see website information.

Baroness Fritchie officially opening the Fritchie Centre

2.2 The resource is well regarded and the co-location with the Managing Memory Team, as well as being adjacent to Charlton Lane Hospital, has been important for strong connection with practice. The Research2gether Team work flexibly to enable research support throughout the organisation.

3. Objective 2 - Develop strategic partnerships for research development activity

3.1 Our official partnership with Cobalt commenced in July 2016 when we signed a Memorandum of Understanding. Click here to see website communication.

Quarterly meetings between the Director of Engagement and Integration and the Cobalt CEO have continued since the partnership commenced. A presentation was made to the Cobalt Board in April 2018 to update members about the achievements of the partnership.

Peter Sharp (CEO Cobalt) with Prof Jane Melton (2gether)

3.2 In the last year we have signed contracts with two pharmaceutical companies to undertake medicines-based trials with international trial sites. Positive feedback has been received about our engagement and delivery and further invitations to engage have been forthcoming. A system is in place for review of such commercial study proposals via the Executive Committee.

3.3 The Director of Engagement and Integration shares the role (with the Director of Strategy at GHNHSFT) of representing provider organisations at the West of England CRN Executive meeting.

3.4 A policy for the use of prospective consent "Count Me In" was agreed by 2gether's Executive Committee in January 2018. This is expected to have a significant positive impact on trial recruitment as the pool of people who will receive the opportunity to take part in research will be significantly increased with this methodology. Patients will be able to "opt-out" if they wish.

4. Objective 3 - Attract funds / resource to develop our research portfolio

4.1 The Trust received £316,000 of research income in 2017/18 compared to £155,000 in 2016/17 and £131,000 in 2015/16. The Trust expanded the number of research projects it was involved in during this time. The Trust has a small dedicated research team which is funded from the income it generates.

4.2 The main source of income is from the **West of England Clinical Research Network (WoE CRN)**. The National Institute of Health Research (NIHR) utilises an activity based funding (ABF) model, based on the number of recruited 'subjects' and weighted depending on the complexity of the study. A review of the financial allocation methodology was undertaken last year by the WoE CRN. As a result and because our performance figures for last year exceeded our target, 2gether gained an increase in allocation from the CRN for the upcoming year. Development funds are also available to bid for during the year from the CRN. In addition we are actively pursuing an opportunity to benefit from the input of peripatetic research staff hosted by the CRN. 2gether's performance against 2017/18 recruitment targets set by our primary commissioners, the West of England CRN can be seen in Table 1.

Table 1[1]: 2017/18 Research Recruitment by [2]gether NHS Foundation Trust RAG rated against year-end goals

Trust	Commercial recruitment	Non-commercial recruitment	Total	Weighted recruitment (ABF)	% year-to-date recruitment goal achieved
2Gether NHS Foundation Trust	1	384	385	2041.5	192.50%

4.3 The **West Midlands CRN** provided modest funding for research in Herefordshire in 2017/18. However, we have received notification that this is not going to continue into 2018/19. We will work with partners in the West Midlands CRN to develop opportunities for research in Herefordshire for the future so that service users, carers and communities in this area can be represented and benefit from the opportunity.

4.4 **Cobalt** currently sponsors two, Band 6 Research Nurses in [2]gether to co-deliver research studies particularly in relation to people with dementia.

4.5 Additional research income can be secured through delivery of **commercial** trials which are reimbursed according to a nationally agreed funding template. In 2017/18, [2]gether commenced involvement in our first two commercial studies. A report to outline cost and benefits will be presented to the Development Committee as the studies conclude.

4.6 [2]gether has been selected as a partner site to undertake research about chronic depression. This is being led by **East London NHS Foundation Trust** over a 5 year period. Resources to undertake the research are part of the hosting agreement.

4.7 A grant was awarded last year for a service evaluation project to further improve outcomes for people with persistent physical symptoms in Gloucestershire. This was sponsored by the **Health Foundation** and was undertaken in partnership with Bath University, Gloucestershire Clinical Commissioning Group and [2]gether's Let's Talk service in Gloucestershire.

5. Objective 4 - Secure significantly more commercial and NIHR studies

5.1 Table 1shows the recruitment to NIHR portfolio studies in [2]gether for 2017/18 and includes the first recruit into one of our Commercially Sponsored studies, CREAD2.

5.2 We have been averaging 30 new studies a year Since 2014/15. It may be challenging to further increase the number of NIHR Studies significantly, due to the current team being close to capacity and the limited number of relevant studies available on the national portfolio. However, we are exploring ways that we can increase the number of commercially-sponsored studies that [2]gether takes part in. As mentioned above, we opened two in 2017/18 and have another at 'feasibility' stage. A number of additional commercial studies

[1] Source: West of England CRN

are being considered through expressions of interest and we are waiting to hear whether we have been selected as a suitable site for these.

5.3 The Annual Plan submitted by 2gether to the CRN West of England sets out an intention to double the number of open commercial studies from 2 to 4 in 2018/19 and we are on target to achieve this goal.

6. Objective 5 - Inspire local practitioners

6.1 Members of the research team regularly attend the Principle Investigators (PI) peer supervision forum to offer PI training and support.

6.2 Principal Investigator training materials have been produced by the CRN West of England and the Head of Research and Development is exploring ways in which this can be used locally to support clinicians who wish to undertake this role. New PIs from a number of disciplines have come forward. This is important in light of the recognised risk relating to the availability of Principal Investigators in 2gether which will affect our ability to support a larger portfolio of studies as well as attract more commercial activity.

6.3 The research team has hosted engagement workshops with clinical services such as Memory Assessment Service, Medical Education and Junior Doctors which promote involvement with current research studies but also offer information and support on how to develop research or take on research roles such as PI or research champion.

7. Objective 6 - Leadership for Research and Development

7.1 Dissemination of research results is undertaken in traditional ways through electronic messaging, messages via Team Talk and networking conference events. This remains an area for further development within and beyond the Trust.

7.2 A number of research orientated forums with oversight for research have developed in 2gether as a result of the enhanced profile of research in the Trust. For example, a medical peer supervision forum for PIs, Commercial Research Forum and a Research & Quality Improvement Group led by psychology colleagues are established.

7.3 Events to generate interest in research as well as to cascade results have been held through the year and others are planned. Research 4 Gloucestershire and Cobalt have hosted seminars and presentations have been made as part of professional events (for example AHPP conference in October 2017). We have an active programme of student nurses, research assistant volunteers, trainee doctors and psychology students all supporting research studies in a number of different ways adding to the reach of dissemination.

8. Objective 7 – Gain University status for our work

8.1 The Research 4 Gloucestershire Statement of Intent was signed by partner organisations in June 2017. It is anticipated that this partnership across NHS providers, Social Care, Public Health, Gloucestershire CCG and Cobalt with

the University of Gloucestershire will provide new collaborative research opportunities across the county. The first meeting of the Research 4 Gloucestershire steering group took place in December 2017 and an agreed work plan is being developed to deliver the shared objectives.

9. Objective 8 – Publish and disseminate

9.1 [2]gether's website (and intranet site) has been developed to provide greater information about our research activity, to encourage involvement and dissemination. See for example: https://www.2gether.nhs.uk/research/

9.2 Principle Investigators are encouraged to attend sponsor-hosted dissemination events across the country. Recent dissemination events include the DAPA trial (physical activity in dementia), SCIMITAR (smoking cessation trial) and MAS (memory assessment). There is often a delay between final analysis of results and wider dissemination and it can be challenging to maintain sponsor engagement, as they will often recruit across multiple sites nationally.

10. Objective 9 – Maintain and further develop a strong research team

10.1 In the earlier part of the implementation of our research strategy we benefited from the contribution of Prof Gordon Wilcock in an honorary capacity. This provided significant foundational knowledge and connections with pharmaceutical companies [2]gether commenced involvement in commercial research activity.

10.2 In December 2017 we recruited to a Director of Clinical Research as part of our governance and development structure.

10.3 [2]gether's Head of Research and Development post became vacant in January 2018. We have successfully recruited to this role.

10.4 Investment from Cobalt and a modest increase in CRN allocation this year has provided greater capacity in the Research [2]gether Team and further possibility for growth and involvement in commercial portfolio studies. The research team consists of 5.62 WTE made up of research nurses and administrative colleagues. They undertake much of the research data collection research that is carried out and also are responsible for recruiting the patients to each trial.

10.5 In collaboration with the CRN we now have a comprehensive research training programme. Research active staff are able to access the programme to aid their professional development for research activities, and we have linked with our colleagues at Collingwood House to help find ways to centrally promote these opportunities internally.

11. Objective 10 – Proactive engagement and positive feedback

11.1 The Research [2]gether Team continues to explore new ways to recruit participants to research trials, alongside the traditional route of clinical services. This includes Alzheimer's Cafes, Gloucestershire County Council services, Join Dementia Research (JDR) a national database and increasingly through social media such as Facebook adverts and Twitter.

11.2 We continue to highlight the role and work of People in Health West of England (which promotes pubic involvement amongst professionals and members of the public in health research) through our Communications Team and Social Inclusion Team. These opportunities are often national or academic programmes looking for involvement. Events are spread across the region and open to the public.

11.3 [2]gether supported the West of England CRN 16/17 patient experience questionnaire to research participants. Forty research participants from our Trust provided feedback. 82% of respondents reported being kept well informed during the research study and 82% felt it was important to know the results of their research study. 87% said they would be willing to take part in another research study positive responses recorded about our research staff being knowledgeable, friendly, professional and informative.

"Research is very important to us. It gives my wife something to motivate her and take pride in and I am very keen to support any and all initiatives that lead towards better treatment, help and support for dementia."

11.4 Directors, consultants and research leads having conversations with Radio Gloucestershire about the ambitions, achievements and partnership involved with our research activity. For example, Dr Tarun Kurevilla spoke about clinical research examples on Drive Time Radio Gloucestershire in summer 2017.

12. Reporting arrangements

12.1 An annual report providing assurance of research governance is presented to the Trust's Governance Committee. Progress in achieving the Trust's strategy for Research and Development is reported at each Development Committee. The Trust hosts a quarterly sub-committee, the Research Overview sub-committee which is chaired by the Director of Engagement and Integration.

12.2 The recruitment of patients to trials (activity) and the performance in initiating and delivering research against the NIHR targets is reported directly, every quarter, to the Trust Chief Executive by the NIHR Coordinating centre. The Trust has a commercial Trials meeting chaired by the director of Clinical Research.

12.3 Finance reports are provided each quarter to the West of England network.

13. Next Steps

13.1 Closer integration and merger with Gloucestershire Care Services NHS Trust will bring further and progressive opportunities for developing research for practice. Conversations are taking place to understand the opportunities and to co-develop ideas for future collaboration.

13.2 The Sustainability and Transformation Partnerships represent a further opportunity for research and new knowledge about the delivery of care to inform future pathways.

13.3 Phase 2 objectives and key performance indicators are being developed and will be presented to the Trust's Development Committee.

13.4 Evaluation of merger transformation plans will be considered as a priority.

13.5 Influencing research protocol development to ensure that underrepresented groups have an opportunity to engage in / inform research development (for example, people with learning disabilities; children and young people).

14. Summary

This paper has provided a brief update about research development, delivery and governance in ^{2}gether NHS Foundation Trust.

Appendix 1

Research Study Recruitment to NIHR portfolio at [2]gether NHSFT in 2017/18

CPMS ID	Short Name	Managing Specialty	Status	Opening Date	Closure Date	Participants
32191	An anonymous survey of mindfulness, self-compassion, wellbeingand mental health.	Mental Health	Closed to Recruitment, No Follow Up	10/02/2017	31/03/2018	80
3808	AD GENETICS	Dementias and Neurodegeneration	Open, With Recruitment	01/06/2001	01/02/2020	54
17304	VALID WPs 3/4: Pilot trial and RCT of COTiD-UK	Dementias and Neurodegeneration	Closed to Recruitment, In Follow Up	24/09/2014	04/07/2017	42
35981	FAM-Survey	Mental Health	Open, With Recruitment	24/11/2017	24/04/2018	40
31632	Dementia Carers Instrument Development:DECIDE Psychometric evaluation	Dementias and Neurodegeneration	Closed to Recruitment, No Follow Up	05/01/2016	25/01/2018	31
5655	NCISH	Mental Health	Open, With Recruitment	01/04/1997	31/03/2019	15
8647	DPIM - bipolar disorder	Mental Health	Suspended	01/10/2010	31/12/2017	15
33823	Tackling chronic depression (TACK) Phase 1	Mental Health	Open, With Recruitment	23/05/2017	31/03/2019	15
18481	The Adult Autism Spectrum Cohort - UK	Mental Health	Open, With Recruitment	08/01/2015	01/09/2019	13
20810	Caregiver obligations, preparedness and willingness to care	Dementias and Neurodegeneration	Closed to Recruitment, No Follow Up	26/02/2016	27/03/2018	11
19695	REACT Trial	Mental Health	Closed to Recruitment, In Follow Up	22/04/2016	30/09/2017	10
15071	The RADAR trial	Dementias and Neurodegeneration	Open, With Recruitment	01/04/2014	31/05/2018	8
32617	Investigation of wellbeing interventions in NHS staff	Mental Health	Open, With Recruitment	20/02/2017	31/05/2018	8
34784	Patient preferences for psychological help	Mental Health	Open, With Recruitment	03/10/2017	31/07/2018	8
18451	PPiP2	Mental Health	Open, With Recruitment	01/01/2015	30/08/2020	6
20146	Evaluation of Memory Assessment Services: Main Study (phase 2)v1	Dementias and Neurodegeneration	Closed to Recruitment, No Follow Up	12/10/2015	31/08/2017	6
32779	Voices Impact Scale (VIS): Evaluation	Mental Health	Closed to Recruitment, No Follow Up	01/11/2016	06/04/2018	5
33002	everyBody Plus: Web-based self-help programme for BN, BED ard OSFED	Mental Health	Open, With Recruitment	27/06/2017	31/01/2019	4
33131	TRIANGLE: A novel patient and carer intervention for Anorexia Nervosa	Mental Health	Open, With Recruitment	30/06/2017	01/03/2019	4
17573	The effectiveness of perinatal mental health services	Mental Health	Closed to Recruitment, No Follow Up	10/02/2015	06/03/2018	3
4117	Molecular Genetic Investigation	Mental Health	Open, With Recruitment	01/04/2006	31/12/2019	2
10392	DPIM - schizophrenia	Mental Health	Suspended	01/10/2010	31/12/2017	2
18830	Quality and Effectiveness of Supported Tenancies (QuEST) WP4	Mental Health	Closed to Recruitment, No Follow Up	01/06/2015	30/09/2017	2
30754	Psychological Adjustment in Progressive Multiple Sclerosis	Neurological Disorders	Closed to Recruitment, No Follow Up	12/01/2016	31/07/2017	1
32274	CREAD 2	Dementias and Neurodegeneration	Open, With Recruitment	23/06/2017	15/05/2018	1

Agenda item 16 **Enclosure No** **Paper K**

Report to: 2gether NHS Foundation Trust Board 31st May 2018
Author: Stephen Andrews, Deputy Director of Finance
Presented by: Andrew Lee, Director of Finance & Commerce

SUBJECT: **Finance report for period ending 30th April 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 1 position is a surplus of £111k which is £42k above the planned surplus.
- The month 1 forecast outturn is an £834k surplus in line with the Trust's control total.
- The Trust has an Oversight Framework segment of 2 as at 18th April 2018.
- The Trust has finalised 2018/19 contracts with Gloucestershire CCG, Herefordshire CCG, and NHS England.
- Budgets were approved by the Board in March for 2018/19.

RECOMMENDATIONS

It is recommended that the Board note the month 1 position

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

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

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

Reviewed by: Andrew Lee, Director of Finance & Commerce		
	Date	23rd May 2018

Where in the Trust has this been discussed before?		
	Date	

What consultation has there been?		
	Date	

Explanation of acronyms used:	CCG – Clinical Commissioning Group PSPP – Public Sector Payment Policy FOT – Forecast Outturn STP – Sustainability and Transformation Plans STF - Sustainability and Transformation Funds IAPT – Improving Access to Psychological Therapies

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	as at April 2018
Income	FOT vs FT Plan	100.0%	
Operating Expenditure	FOT vs FT Plan	100.0%	
Year end Cash position	£m	9.8	
PSPP	%age of invoices paid within 30 days	98.0%	94% paid in 10 days

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	>101%	>100% - 101%	=<100%
CASH	<£8m	£8-£10m	>£10m
Public Sector Payment Policy - YTD	<80%	80% - 95%	>95%
Capital Income - Monthly vs FT Plan	<90%	90% - 100%	>100%
Capital 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 1 is a surplus of £111k which is £42k better than the plan.
- Income is £100k over recovered against budget and operational expenditure is £62k over spent, and non-operational items are £4k 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	(4,957)	(413)	(401)	12	(4,957)	0
Stroud & S Cots Locality	(5,166)	(430)	(416)	14	(5,166)	0
Gloucester & Forest Locality	(4,405)	(367)	(353)	14	(4,405)	(0)
Social Care Management	(4,992)	(416)	(455)	(39)	(4,992)	0
Entry Level	(6,077)	(506)	(519)	(12)	(6,077)	(0)
Countywide	(31,316)	(2,612)	(2,568)	44	(31,316)	(0)
Children & Young People's Service	(6,099)	(508)	(534)	(25)	(6,099)	0
Herefordshire Services	(13,132)	(1,100)	(1,092)	8	(13,132)	0
Medical	(15,276)	(1,273)	(1,309)	(36)	(15,276)	(0)
Board	(1,422)	(119)	(191)	(73)	(1,422)	(0)
Internal Customer Services	(1,845)	(154)	(127)	27	(1,845)	(0)
Finance & Commerce	(6,483)	(539)	(505)	34	(6,483)	0
HR & Organisational Development	(3,489)	(291)	(271)	19	(3,489)	0
Quality & Performance	(3,118)	(260)	(254)	5	(3,118)	(0)
Engagement & Integration	(1,466)	(122)	(124)	(2)	(1,466)	0
Operations Directorate	(1,149)	(96)	(95)	1	(1,149)	0
Other (incl. provisional / savings / dep'r	(5,892)	(489)	(540)	(51)	(5,892)	0
Income	117,119	9,764	9,866	102	117,119	0
TOTAL	**834**	**69**	**111**	**42**	**833**	**(0)**

The key points are summarised below;

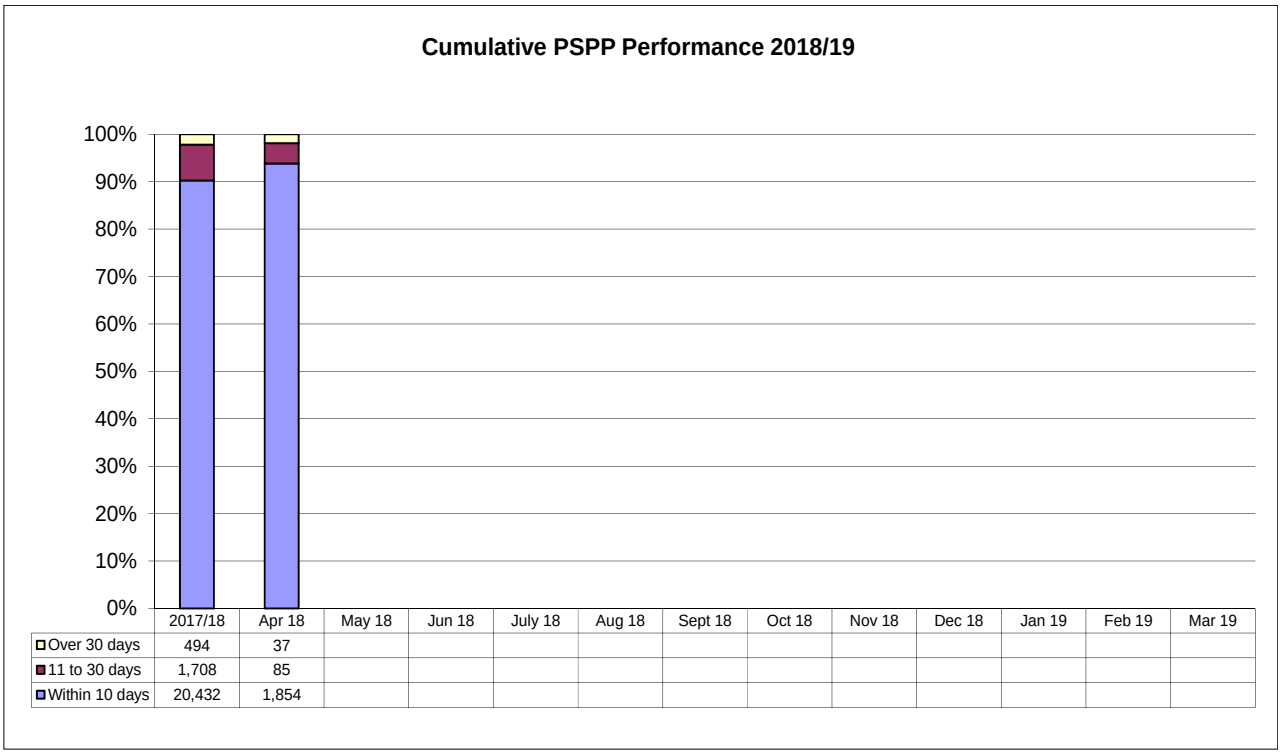
In month

- The Social Care Management over spend relates to Community Care and is offset by additional income
- Board is overspent due to spend on STP plans for which budget has not yet been issued from reserves.
- The Medical over spend has been caused by the net increased cost of agency expenditure over vacancies - £197k on agency costs in month 1.
- Income is over recovered due to additional income for activity related Community Care work and additional development funds which weren't budgeted.

Forecast

- All budgets are forecasting they will meet their budget at year end as no significant risks have arisen in month 1.

The cumulative Public Sector Payment Policy (PSPP) performance for month 1 is 94% 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:



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

Agenda item 17 **Paper L**

Report to: [2]gether NHS Foundation Trust Board – 31 May 2018
Author: John McIlveen, Trust Secretary
Presented by: Anna Hilditch, Assistant Trust Secretary

SUBJECT: **PROVIDER LICENCE DECLARATIONS**

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

The Trust Board is required each year to self-certify regarding compliance with the conditions of its provider licence and the systems and processes for ensuring such compliance. There is now no requirement to submit these to NHS Improvement, however, the Board is required to publish one of its declarations (G6) within one month of the Board agreeing that declaration. NHS I will contact a select number of Trusts from July to ask for evidence that they have self-certified. This evidence will normally be the relevant Board minutes and papers, or a declaration template supplied by NHS I.

1. Corporate Governance Statement

It is a requirement of the governance condition of the Trust's licence that the Board signs off a Corporate Governance Statement within three months of the end of each financial year.

The Corporate Governance Statement requires the Trust Board to confirm:

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

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

In making its Corporate Governance Statement declaration, the Board can rely on a range of evidence which is summarised in Appendix 1 of this report. The Board is asked to confirm **compliance at the date of the statement** and **forward compliance**, for each section of the Corporate Governance Statement.

2. Training of Governors

The Board is required to make a declaration regarding the provision of necessary training to Governors, pursuant to Section 151(5) of the Health and Social Care Act 2012. The joint Board/Governor engagement work undertaken during the year has produced a number of outputs intended to support Governors to undertake their role. The Board is therefore recommended to make a declaration of 'Confirmed' in respect of the provision of Governor training.

3. Compliance with Licence conditions

Foundation Trusts are also required to make an annual declaration that they have systems and processes for compliance with provider licence conditions (General Condition G6). Appendix 2 provides evidence which the Board may rely on to make this declaration. The Board is invited to make a declaration of 'Confirmed' in respect of this declaration.

The Board must sign off this self-certification by 31 May, and must publish its self-certification declaration by 30 June 2018.

All declarations must be made *having regard to* the views of Governors. The Board is therefore asked to note that the Council of Governors received a report at its meeting on 8 May to provide assurance regarding the process for making these declarations. The appendices to this Board report were provided to Governors as background information alongside the summary report. Governors noted the report and no concerns were raised in respect of systems and processes for compliance with licence conditions. Governors noted that the Council of Governors had previously considered undertaking a skills appraisal in order to identify training requirements for Governors. While this had not come to fruition, Governors felt it would be a valuable exercise to inform the merger transition work in relation to the Council.

A declaration regarding the availability of resources (CoS7) relates only to foundation trusts designated as providing 'Commissioner Requested Services'. The Trust is not designated as a provider of CRS, and therefore a separate declaration in respect of CoS7 is not required.

RECOMMENDATIONS

It is recommended that the Board:

a) Has regard to feedback received from Governors in respect of these declarations

b) Agrees to make a declaration confirming compliance in respect of each of the statements listed in the Corporate Governance Statement.

c) Agrees to make a declaration of 'Confirmed' in relation to the Governor training declaration.

d) Agrees to make a declaration of 'Confirmed' by the due date of 31 May in respect of systems for compliance with licence conditions (Condition G6) for the financial year just ended

e) Agrees to publish on the Trust website the declaration in respect of systems for compliance with licence conditions (Condition G6) by 30 June.

Corporate Considerations	
Quality implications	None identified
Resource implications:	None identified
Equalities implications:	None identified
Risk implications:	Should risks to compliance with the governance condition of the Trust's licence be identified, NHS I may require other actions or assurance, or may choose to maintain a watching brief.

WHICH TRUST STRATEGIC OBJECTIVE(S) DOES THIS PAPER PROGRESS OR CHALLENGE?	
Continuously Improving Quality	P
Increasing Engagement	
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:		
Executive Committee	Date	23 April 2018

Where in the Trust has this been discussed before?		
Executive Committee	Date	23 April 2018

What consultation has there been?		
Council of Governors		8 May 2018

Explanation of acronyms used:	CQC – Care Quality Commission CCG – Clinical Commissioning Group NHS I – NHS Improvement GCS – Gloucestershire Care Services NHS Trust

1. INTRODUCTION

1.1 It is a condition of the Trust's licence that the Trust makes certain self-certification declarations at the end of each financial year regarding its corporate governance systems and processes.

1.2 Declarations must be made by the Board, having regard to the views of Governors.

2. CORPORATE GOVERNANCE STATEMENT

2.1 The Corporate Governance self-certification refers to the provisions within the governance condition of the Trust's provider licence. The self-certification requires Trust Boards to confirm

- Compliance with the governance condition (FT4) at the date of the statement; and

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

2.2 The governance condition of the licence concerns the Trust's internal systems and processes. Hence, the reference to risks within the Corporate Governance declaration relate to risks to those systems and processes, rather than wider risks to the achievement of the Trust's objectives.

2.3 Where a statement in the declaration indicates a risk to compliance with the governance condition of the Trust's provider licence, NHS I will consider whether any actions or other assurances are required at the time of the declaration, or whether it is more appropriate to maintain a watching brief.

2.4 The Board has during the course of the year received a number of documents which provide evidence of compliance. Appendix 1 provides a summary of the available evidence to support the Board in making its declaration.

2.5 The Board is required to consider risks to compliance with the Trust's licence conditions, and set out mitigating actions taken to address those risks. The licence conditions are primarily concerned with the establishment of systems and processes to maintain compliance, and as such there are no obvious risks to the maintenance of such systems and processes. The proposed merger with GCS and the impact of the merger process, particularly on Executive capacity, has already been identified as a risk for the Trust and may in the future affect the Board's capability to provide effective organisational leadership on the quality of care provided, or the Board's financial position, or both. However, a number of mitigations are in place to address this, and the assurance in respect of this risk is categorised as *significant.* Mitigating actions include:

- Full Board decision to proceed with the proposal to merge.
- Implementation of a system of governance to address risks and scope solutions
- Programme budget in place and included in the 2017/18 and 2018/19 financial forecasts/planning.
- Appointment of a Programme Director to provide additional capacity.

2.6 Accordingly, the Board is recommended to make a declaration of 'Confirmed' in respect of compliance at the time of the declaration, and in respect of forward compliance for the current year, and in the interests of transparency to include the risk to forward compliance and mitigation as set out in paragraph 2.5 above.

3. GOVERNOR TRAINING DECLARATION

3.1 Additionally, the Board is required to make a declaration that it has provided Governors with the necessary training, pursuant to Section 151 (5) of the Health and Social Care Act 2012, to enable Governors to fulfil their roles. The Act does not specify the nature or content of training to be provided.

3.2 A number of training and development opportunities are provided to Governors, including an induction to each new Governor, a range of material made available to Governors through a website portal, making available a

number of places on training, development and networking events organised by third parties such as GovernWell, service presentations to the Council of Governors, and a programme of Governor visits to Trust sites.

3.3 The Board is therefore asked to confirm that it is satisfied that the Trust has provided the necessary training to Governors to ensure they are equipped with the skills and knowledge they need to undertake their role.

4. GENERAL CONDITION G6 – SYSTEMS FOR COMPLIANCE WITH LICENCE CONDITIONS

4.1 General Condition 6 requires that the Trust takes necessary precautions against the risk of failure to comply with the conditions of its licence, any requirements imposed by the NHS Acts, and the requirement to have regard to the NHS Constitution in providing health care services for the purpose of the NHS.

4.2 The licence condition states that the steps the Trust must take should include:

'*the establishment and implementation of processes and systems to identify risks and guard against their occurrence'*, and

'regular review of whether those processes and systems have been implemented and of their effectiveness'.

4.3 The declaration asks the Board having reviewed the evidence, to confirm (or otherwise) by the due date of 31 May that:

'*Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied, as the case may be that,* ***in the Financial Year most recently ended****, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.'*

4.4 An overview of the provider licence conditions is given at Appendix 2. Much of the evidence given in support of the Corporate Governance Statement (listed at Appendix 1) may also be relied upon by the Board in order to make the declaration regarding the processes and systems in place to comply with the Trust's licence conditions and general obligations.

4.5 The Board is therefore recommended to respond 'Confirmed' in respect of the declaration above.

4.6 The Trust is required to publish its G6 declaration by 30 June. As the minutes of this meeting will not be approved by that date, a template provided by NHS Improvement will be used to publish the Board's declaration on the Trust website.

5. HAVING REGARD TO THE VIEWS OF GOVERNORS

5.1 The Board is required to make the above declarations "having regard to the views of Governors". As agreed by the Council of Governors last year, a separate report has been made available to Governors providing assurance regarding the process for the Board to make these declarations. The appendices to this Board report have also been made available to Governors alongside the summary assurance report. Governors noted the report and at their Council meeting on 8 May and no concerns were raised in respect of systems and processes for compliance with licence conditions. Governors did comment that a skills audit for Governors would be useful in taking forward the transformation work in relation to the merger with Gloucestershire Care Services.

5.2 The Board is therefore asked to have regard to the views of Governors regarding these declarations.

6. RECOMMENDATIONS

6.1 The Board is asked to:

a) Have regard to feedback received from Governors in respect of these declarations

b) Agree to make a declaration confirming compliance with each of the statements listed in the Corporate Governance Statement.

c) Agree to make a declaration of 'Confirmed' in relation to the Governor training declaration.

d) Agree to make a declaration of 'Confirmed' by the due date of 31 May in respect of systems for compliance with licence conditions (Condition G6) for the financial year just ended

e) Agree to publish on the Trust website the declaration in respect of systems for compliance with licence conditions (Condition G6) by 30 June.

APPENDICES

The appendices provide the following information:

Appendix 1: Corporate Governance Declaration - Evidence

Appendix 2: Provider Licence conditions - Overview and Additional Evidence

Appendix 1

Governance Statement	Evidence for current compliance	Risks to future compliance and mitigating actions, or supporting information	Suggested declaration
The Board is satisfied that [2]gether NHS Foundation Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	• Organisational leadership through Board • Local accountability through Council of Governors • Engagement programme with stakeholders • Scheduled Board meetings including public meetings • Committee structure and Committee meeting programme • Committee structure reviewed and realigned with strategic priorities during the year • Establishment of Quality and Clinical Risk Committee, a sub-Committee of Governance Committee, to provide focus and challenge on quality and clinical risk issues • Performance dashboards to Delivery Committee • Performance exception reports to Board • Quality monitoring and reporting to Governance Committee • CCG observers at Governance Committee • Quality Strategy aims translate into service planning objectives • Quality Report and indicators • Financial reporting monthly to Board • Financial control systems in place • Information Governance function and reporting • Risk management framework and reports to Board and Committees • Assignment of key risks to relevant Committees and ongoing risk identification • Quarterly update and review of risk register • Implementation of upgraded Datix incident reporting system • Risk reporting to Board and Committees • Council of Governors statutory roles in holding NEDs to account • Service experience function and reports to Board	No unmitigated risks identified	Confirmed

	• Patient safety reports to Board and Governance Committee • Patient Stories agenda item at public Board meetings • Meeting evaluation checklist used at each Board meeting • Mental Health Legislation Scrutiny Committee and Managers' Forum • Whistleblowing and other organisational policies and procedures in place • External auditors appointed • Internal audit programme • Clinical audit programme • Compliance with FT Code of Governance • Trust Constitution • Trust vision and values • Annual Governance Statement • Mandatory disclosures in Annual Report • Statutory and mandatory training • Corporate induction for all new starters • Fit and proper person test for Board appointments • Revised Conflicts of Interests policy • Declarations of Interests • Single Oversight Framework segmentation of 2 • 'Good' rating in Openness and Learning From Mistakes league table • CQC inspection and Well-Led inspection preparation		
The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	• Monthly CEO Reports to Board highlight relevant new publications/guidance • Policy and guidance standing agenda item at Development Committee • External Auditor Sector development report • NHS I Bulletins received by Exec Directors and Trust Secretary • Annual Reporting Manual guidance	No unmitigated risks identified	Confirmed

The Board is satisfied that [2]gether NHS Foundation Trust implements effective board and committee structures	• Committee structures reviewed in 2016/17. • Committee membership streamlined • Reversion of capital monitoring to Development Committee • Strengthened Capital Review Group • Good clinical presence on Board • Committee summary reports to Board • Committee annual reports to Board • Audit Committee annual effectiveness review • Locality Governance structures • Sub-committees mapped	No unmitigated risks identified	Confirmed
The Board is satisfied that [2]gether NHS Foundation Trust implements clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees	• Constitution sets out Board responsibilities • Committee duties reviewed and realigned to strategic priorities • Committee Terms of Reference reviewed annually and substantive changes approved by the Board • Committee agenda planners refreshed at each meeting • Scheme of Delegation in place setting out delegated responsibilities and powers reserved to Board • Revised Standing Financial Instructions in place	No unmitigated risks identified	Confirmed
The Board is satisfied that [2]gether NHS Foundation Trust implements clear reporting lines and accountabilities throughout its organisation	• Clear Executive portfolios • Defined management and committee structure • Chief Executive is Accounting Officer • Director of Quality , Medical Director and Director of Engagement & Integration lead on quality and service experience matters • Lead Executive for each Committee • Committees reviewed in year • Assignment of organisational risks to appropriate Committees • Committees are accountable and report regularly to the Board • Reporting lines agreed for Localities, Expert Reference Groups and sub-committees	No unmitigated risks identified	Confirmed

	• Staff appraisals and objectives linked to organisational objectives		
The Board is satisfied that 2gether NHS Foundation Trust effectively implements systems and/or processes to ensure compliance with the Licence holder's duty to operate efficiently, economically and effectively	• Going concern report to Audit Committee • Board Finance Reports • Savings Plans in place • Quality Impact Assessments process in place, overseen by Governance Committee • Budget setting process • Strategic Plan • Capital Programme • Performance dashboard reports to Delivery Committee • Performance exceptions reports to Board • Quality reports to Governance Committee/QCR • Outcomes reporting • Clinical audit programme • Internal audit programme • External auditor • CQC registration • Aggregated Learning Reports to Governance Committee • Single Oversight Framework segment 2 rating • Service/business planning process • Service plans include actions for 5 Year Forward View	No unmitigated risks identified	Confirmed
The Board is satisfied that 2gether NHS Foundation Trust effectively implements systems and/or processes to ensure compliance with the Licence holder's duty to operate efficiently, economically and	• Executive Committee meetings • NED oversight on Board and Committees • MHLS Committee meeting • Delivery Committee meetings • Governance Committee meetings • Audit Committee meetings • Board and Committee agenda planners • Monthly performance dashboards and exception reports • Locality reviews at Delivery and Governance Committees	No unmitigated risks identified	Confirmed

effectively	• Service performance focus reports to Delivery Committee • Executive Safety walkabouts • Board visits • CQC compliance quarterly reports to Governance Committee		
The Board is satisfied that [2]gether NHS Foundation Trust effectively implements systems and/or processes to ensure compliance with health care standards binding on the Licence holder including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions	• Performance dashboard reports to Delivery Committee • Safety/quality oversight by Governance Committee • Expert Reference Groups • Board performance exception reports • CQC compliance reports • CQC inspection report • Medical revalidation programme • Mental Health Legislation Scrutiny Committee oversight • Executive safety walkabouts • Board visits • Clinical audit programme • Statutory and mandatory training requirements • Clinical policies • PLACE visits • Mental Health Act/Mental Capacity Act policies • Mental health Act Managers in place • Quality Report • Francis action plans • Regulatory inspection reports/action planning • Inquest reports/action planning • Quality Impact Assessments for efficiency and transformation proposals • QIAs reviewed by Medical Director, Director of Quality and Director of Engagement & Integration • Practice Development Strategy and Triangle of Care implementation • Nursing Strategy and action plan	No unmitigated risks identified	Confirmed

	• Social care strategy • Organisation Development Strategy and implementation plan • Staff Survey action plan		
The Board is satisfied that [2]gether NHS Foundation Trust effectively implements systems and/or processes for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licence holder's ability to continue as a going concern)	• Budget setting process • Savings and transformational change programmes • Fully funded capital programme • Surpluses in previous years to achieve strong liquidity position • Use of liquidity position for strategic plan transformation • Monthly finance reports to Delivery Committee and Board • Standing Financial Instructions • Mid year financial reviews • Authorised signatory lists • Scheme of Delegation • Audit Committee Going Concern reports • Audit Committee Losses/Special Payments reports • Counter Fraud Service and annual action plan • Development Committee oversight of development opportunities and business cases • Tender submission procedures • Governor approval process for significant transactions • Organisation Development Strategy and implementation plan • NHSR Clinical Negligence Scheme for Trusts • NHSR Risk Pooling Scheme for Trusts • Annual financial plan approved by Board before the start of the year • Agency staffing controls	No unmitigated risks identified	Confirmed
The Board is satisfied that [2]gether NHS Foundation Trust effectively implements systems and/or	• Board/Committee agenda planners • Monthly Finance and Performance reports • Performance Point system to provide up to date high quality data	No unmitigated risks identified	Confirmed

processes to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making	• Clinical audit programme provides assurance on data quality • Data quality policy • Data quality requirement in Information Governance Toolkit • Finance and performance reporting aligned to Board/Committee cycle • Chief Executive's Reports to Board		
The Board is satisfied that [2]gether NHS Foundation Trust effectively implements systems and/or processes to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence	• Risk register reviews by 'owning' Committees and overseen by Audit Committees and Board • Board Assurance Map review by Executive Committee, Audit Committee and Board • Performance early warning reports to Delivery Committee • Internal audit programme • Clinical audit programme • Risk identification as standing Committee agenda item • Incident Reporting policy and culture • Whistleblowing policy and procedure • Quality Impact Assessments process	No unmitigated risks identified	Confirmed
The Board is satisfied that [2]gether NHS Foundation Trust effectively implements systems and/or processes to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and	• Annual operational planning process • Service planning process involves service users and Governors • Annual plan/operational plan submission to NHS I • Alignment of service planning wheel and organisational objectives • Plans aligned to commissioners' stated intentions • Development Committee oversight • Executive Committee oversight • Governor consultation on business plan • Quarterly monitoring reports to Delivery Committee	No unmitigated risks identified	Confirmed

where appropriate external assurance on such plans and their delivery	• Performance reports • Finance reports • Quality report – external consultation • Lead Executive identified re Healthwatch issues • External auditors report on Quality report		
The Board is satisfied that [2]gether NHS Foundation Trust effectively implements systems and/or processes to ensure compliance with all applicable legal requirements	• Access to retained lawyers • Internal auditors • External auditors • Executive leads for each key area of business • Trust Secretariat responsible for constitutional and corporate governance matters/updates • Legal briefings/updates received from a variety of sources • Executive Committee oversight • Audit Committee • Charitable Funds Committee • Information Governance policies and procedures • Clinical policies and procedures • Mental Health Legislation Scrutiny Committee and MHA Managers • Directors' fit and proper person tests on recruitment • FT Code of Governance compliance reports • GDPR work programme	No unmitigated risks identified	Confirmed
The Board is satisfied that systems and processes in place ensure that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided	• Medical Director, Director of Quality and Director for Engagement & Integration are clinicians • Non-Executive Director engagement and review provides rigorous quality challenge	The process necessary to achieve authorisation for the planned merger with GCS may impact on Executive Director capacity and therefore on the Trust's financial position, its ability to deliver its commissioner responsibilities, relationships with wider system partners, and the Trust's reputation.	Confirmed

		This risk has been included in the corporate risk register and a number of mitigating measures are in place, including the recruitment of additional capacity in the form of a Programme Director. This risk has therefore been assigned a **significant** level of assurance.	
The Board is satisfied that systems and processes in place ensure that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations	• Quality Impact Assessments for savings plans • Quality Strategy • Quality Report is key element of organisational vision and values • Quality Report defines key quality themes for the coming year • Service Plan includes specific element on Quality, Service Users and carers, Staff and Volunteers • Quality Strategy aims translate into Service Planning objectives requirements for staff • Burdett principles and exception checklist applied at each Board meeting • Evaluation of each Board meeting covers Patient Experience, Quality and Risk	No unmitigated risks identified	Confirmed
The Board is satisfied that systems and processes in place ensure the collection of accurate, comprehensive, timely and up to date information on quality of care	• Monthly performance dashboard to Delivery Committee • Performance Exception reports to Board • Quarterly update reports on Quality Report • Monthly Patient Safety report to Board • Data Quality assurance processes in place	No unmitigated risks identified	Confirmed

The Board is satisfied that systems and processes in place ensure that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care	• Monthly performance dashboard to Delivery Committee • Performance Exception reports to Board • Quarterly update reports on Quality Report • Monthly Patient Safety report to Board • Monthly performance reports to Delivery Committee and Board • Data Quality assurance processes in place	No unmitigated risks identified	Confirmed
The Board is satisfied that systems and processes in place ensure that [2]gether NHS foundation trust including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources	• Quality Report consultation • Quarterly update reports on Quality Report shared with stakeholders including CCGs, Health Watch and Overview and Scrutiny Committees, and feedback encouraged • Engagement & Communication strategy • Governors select local indicator for Quality Report audit • Patient survey • Staff Survey • Complaints and Comments process • Patient and Staff Friends & Family Tests • Stakeholder Committee • Patient Story is regular agenda item at public Board meetings • Service Experience function and reports to Board • Quality Outcomes published through public Board papers and in Annual report • Joint Negotiating and Consultative Committee • Local Negotiating Committee and Medical Staff Committee • "One Gloucestershire" STP Clinical and non-clinical workstreams • Triangle of Care	No unmitigated risks identified	Confirmed
The Board is satisfied that systems and processes in place	• Quality Governance assigned to Exec Directors • Non-Exec Director oversight of Quality • Clinical Directors	No unmitigated risks identified	Confirmed

ensure that there is clear accountability for quality of care throughout [2]gether NHS foundation trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate	• Service Directors • Heads of Profession • Lead Nurses • Board Committee and sub-committee structure • Locality Governance Committees have reporting line to Board through the Governance Committee		
The Board of [2]gether NHS foundation trust effectively implements systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licence holder's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.	• Board recruitment processes • Governor appointment of Non Exec Directors • Appointment & Terms of Service Committee for Executive recruitment • Budgeted establishment • Delegated recruitment processes • Recruitment and selection policy • Appraisal and revalidation policies • Ward staffing levels information	No unmitigated risks identified	Confirmed

Appendix 2

PROVIDER LICENCE CONDITIONS – OVERVIEW AND ADDITIONAL EVIDENCE

	Licence Condition	Condition summary	Evidence for compliance
General Conditions			
G1	Provision of Information	Provision of information to NHS I	Operating plan Strategic plan submission Ad hoc submissions to NHS I via portal
G2	Publication of information	Publish information as directed by NHS I	Information on website eg Board profiles
G3	Payment of fees to Monitor	Pay fees to NHS I as required	Not applicable - no fees requested to date
G4	Fit and Proper Persons	Not to appoint unfit persons as Directors or Governors	Exclusion criteria in constitution for Directors and Governors Directors' recruitment procedures Governor election rules *'Fit & Proper Persons: Directors'* test incorporated into Board recruitment
G5	NHS I guidance	Have regard to NHS I guidance	Code of Governance compliance Single Oversight Framework compliance
G6	Systems for compliance with licence conditions	Have systems in place to comply with licence conditions	Outlined in the appendices to this report
G7	CQC registration	Be registered with the CQC	CQC registration in place
G8	Patient eligibility & selection criteria	Set and apply transparent criteria to determine who can receive health care	Commissioner service specifications
G9	Application of Section 5 – Continuity of Services	States that the Continuity of Services conditions apply where commissioner-requested services are provided	Not applicable
Pricing			
P1	Recording of Information	Record pricing information if required by NHS I	Not required to date.
P2	Provision of Information	Provide information to NHS I	Provision of information via portal
P3	Assurance report on submissions to NHS I	Provide an assurance report re Condition P2 if required by NHS I	Not required to date
P4	Compliance with the National Tariff	Comply with national tariff	There is no national tariff in place for mental health PbR
P5	Constructive engagement re local tariff	Engage with local commissioners re tariff modifications	Agreements in in place with both Gloucestershire CCG and Herefordshire CCG re price tariff.

	Licence Condition	Condition summary	Evidence for compliance
	modifications		Regular monthly meetings take place where performance reports are presented and discussed.
Choice & competition			
C1	Patients' right of choice	Patient notified of choice of provider	Not applicable to Mental health Services
C2	Competition oversight	Not to restrict or distort competition	Legal advice obtained where appropriate when bidding for services/entering partnerships
Integrated care			
IC1	Provision of integrated care	Not to act detrimentally to the provision of integrated care	Local Health Economy 'Better Care Fund' proposals IAPT/primary care services integration Collaborative approach in Herefordshire
Continuity of services			
CoS1	Continuing provision of Commissioner Requested Services	Continue to provide CRS as specified except in certain circumstances eg with Commissioner agreement	Not applicable as Trust does not provide Commissioner Requested Services
CoS2	Restriction on the disposal of assets	Not to dispose of any asset without written consent from NHS I	No assets disposed of that provide Commissioner Requested Services
CoS3	Standards of corporate governance and financial management	Apply suitable systems of corporate and financial governance	See evidence in Appendix 1 of this report
CoS4	Undertaking from the ultimate controller	Undertaking from any parent company not to cause a breach of the provider licence	Not applicable
CoS5	Risk pool levy	To pay a risk pool levy to NHS I	Not applicable
CoS6	Cooperation in the event of financial stress	To cooperate with NHS I and others in the event of financial stress	Not applicable
CoS7	Availability of resources	Ensure and certify the availability of financial, physical and human resources for the next 12 months	Not applicable as Trust does not provide Commissioner Requested Services
NHS Foundation Trust Conditions			
FT1	Information to update the register of FT's	Provision of certain documents to NHS I	Provision of annual accounts and annual report Provision of current version of the

	Licence Condition	Condition summary	Evidence for compliance
			constitution Updates regarding relevant Board and Lead Governor changes
FT2	Payment to NHS I in respect of registration and related costs	Payment of a licence fee to NHS I	Not applicable
FT3	Provision of information to advisory panel	Provision of any information requested by an advisory panel	Not applicable – no information requested
FT4	NHS FT governance arrangements	Apply and certify appropriate systems and processes for good corporate governance	Internal Audit reports Head of Internal Audit opinion External Audit

Agenda item 18 **Enclosure Paper M**

Report to: 2gether Trust Board – 31 May 2018
Authors: Leigh Clarke/ MH Operational Group members
Presented by: Duncan Sutherland, Non-Executive Director/MHLS Committee Chair

SUBJECT: **Mental Health Legislation and Scrutiny Committee – Annual Report 2017/18**

Can this report be discussed at a public Board meeting?	Yes

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

EXECUTIVE SUMMARY

This Mental Health Legislation and Scrutiny Committee (the Committee) Annual Report outlines the activities of the Committee between April 2017 and March 2018.

Section 5 of the report sets out a number of requirements linked to the Committee's Terms of Reference in which both evidence and a level of assurance are provided. While the majority of requirements are listed as significant or full assurance, three areas have been deemed to be limited, including;

- Comply with the Mental Capacity Act (MCA) and Deprivation of Liberty Standards (DOLS): The limited assurance rating relates to 'Capacity to consent to treatment', which has been deemed internally (audit) and externally (CQC monitoring visits) as requiring additional improvement.
- Procedures are in place and operating satisfactorily to inform detained patients and their nearest relatives about applicable provisions of the MHA and of their rights: The limited assurance rating has been applied as new audit data is awaited to determine whether or not a new automated reminder system has improved both the giving and recording of Section 132 rights.
- Review issues raised through the CQC annual monitoring visits and actions plans resulting from them: The limited assurance rating has been applied due to both slipped timeframes for actions to be achieved and for those aspects of the MHA Code of Practice that are continually flagged by the CQC.

The Committee is able to provide significant assurance on the controls it has in place for ensuring the Trust monitors and sustains compliance with the MHA, MCA, HRA (and their associated codes of practice) and where necessary takes action to address non-conformities.

LEVEL OF ASSURANCE PROVIDED

Significant Assurance is offered that there are systems and processes in place to review, measure, analyse, improve and monitor the Trust's compliance with the Mental Health Act/ Mental Capacity Act and the Human Rights Act

RECOMMENDATIONS

The Board is asked to note the contents of this report and the current level of assurance.

Corporate Considerations	
Quality implications	Appropriate compliance with the MHA, MCA and HRA is a fundamental requirement of a competent Mental Health Service provider. Addressing the actions highlighted by the regulator is a priority to ensure that we meet the necessary standards consistently.
Resource implications:	None identified outside of currently agreed budgets.
Equalities implications:	Ensuring people with mental health needs are treated equitably within the framework of the various legislation is a fundamental requirement of the Trust.
Risk implications:	Legal, reputational and safety as they relate to individuals patients, carers, staff and the organisation.

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	Inclusive open and honest	P
Excelling and improving	P	Can do	P
Responsive	P	Efficient	P
Valuing and respectful	P		

Reviewed by:		
Colin Merker (Executive Director of Service Delivery) Mental Health Operational Group	Date	- February 2018

Where in the Trust has this been discussed before?		
MH Operational Group	Date	February 2018
MHLS Committee		March 2018

What consultation has there been?		
MH Operational Group	Date	February 2018

Explanation of acronyms used:		
	CoP	Code of Practice
	CQC	Care Quality Commission
	MDT	Multi-Disciplinary Team
	MHA	Mental Health Act
	SOAD	Second Opinion Appointed Doctor

1 INTRODUCTION

1.1 Purpose Statement

1.1.1 ²gether NHS Foundation Trust as a provider of Mental Health and Community Services is required to demonstrate that its systems, structures and controls for how it provides services are compliant with; the Mental Health Act (MHA), Mental Capacity Act (MCA), Human Rights Act (HRA) and associated codes of practice.

1.1.2 The Mental Health Legislation and Scrutiny Committee is the Committee responsible for ensuring compliance on behalf of the Trust Board by holding the Executive to account and providing assurance to the Trust Board that appropriate integrated; systems, processes and reporting arrangements are established, monitored and maintained.

1.2 Scope of report

1.2.1 This report covers the structures, systems and activities that are in operation across the Trust to ensure ²gether NHS Foundation Trust's continued compliance with; the Mental Health Act (MHA), Mental Capacity Act (MCA), Human Rights Act and associated codes of practice. Internal and external monitoring mechanisms that support the provision of assurance are included in table 1 below.

Table 1: Internal and external monitoring mechanisms

Internal Monitoring	External Monitoring
• Mental Health Legislation and Scrutiny Committee meetings - Minutes - reviewed Terms of Reference • Mental Health Operational Group - Minutes - reviewed Terms of Reference • Mental Health Task and Finish Groups - MHA Audit review • Mental Health Act Managers Forum (including issues reports) • Policy/Procedure submissions and approvals • Key Performance Indicators • Mental Health Audits • Training	• CQC Monitoring visits • CQC Inspection • CQC Functional visit • Commissioner monitoring

1.3 Mental Health Legislation Scrutiny Committee members attendance

Date / Core Member	08/03/17	10/05/17 Cancelled	12/06/17	12/07/17	12/09/17 Cancelled	08/11/17	10/01/18
Quinton Quayle	✓	-	✓	✓	-	✓	✓
Colin Merker	✓	-	✓	✓	-	✓	✓
Nikki Richardson	✓	-	✓	✓	-	✓	✓
STATUS	Quorate	-	Quorate	Quorate	-	Quorate	Quorate

1.4 The following officers were in attendance at the Committee;

Role	Date / Officer	08/03/17	10/05/17 Cancelled	12/06/17	12/07/17	12/09/17 Cancelled	08/11/17	10/01/18
Section 12 approved doctor – Gloucester	Kelwyn Williams	✓	-	✓	✓	-	✓	o
Section 12 approved doctor – Hereford	Dr Ramandeep Dargan	✓	-	✓	o	-	✓	o
Deputy Director of Nursing	Alison Curson	o	-	✓	o	-	✓	✓
Head of Profession for Social	Sarah Bennion	✓	-	o	✓	-	✓	✓
Head of Health Records/MHA Practice Policy Lead	Philip Southam	✓	-	✓	o	-	✓	✓
MCA/DOLS Organisational Lead	Tina Kukstas	o	-	o	o	-	✓	o
Senior Operations Lead - Gloucester	Marieanne Bubb-McGhee	✓	-	✓	✓	-	✓	o
Senior Operations Lead - Hereford	Sally Simmonds (Jez Leat)	✓	-	✓	o	-	o	o
EDT Representative	Margaret Algar	✓	-	o	o	-	✓	✓
Assistant Director of Service Continuity	Leigh Clarke	✓	-	✓	✓	-	✓	✓
Trust Secretary	John McIlveen	o	-	o	o	-	o	o

2 DEVELOPMENTS IN 2017/18

- **MHA Operational Group** – Established in January 2017 the Group was formed to focus on those operational aspects of the MHA and CoP that are identified (through a variety of data sources) as requiring additional attention due to the frequency and/or the degree of difficulty in finding solutions to address a particular issue(s)/challenge(s).

- **CQC Monitoring Report Formats** – Significant changes to the way in which CQC monitoring visit reports and their corresponding action statements are received, analysed, completed and monitored has provided for a more informed MHA Legislation and Scrutiny Committee and a means to actively address reoccurring issues operationally.

- **Human Rights Act Self-Assessment** – The development and introduction of a Human Rights Act (HRA) framework to support the gathering and assessment of evidence to ensure the Trust meets its statutory and legal requirements as they pertain to the HRA.

- **Section 132 rights dashboard** – The introduction of a dashboard from the section 132 rights audit to help identify areas of non-compliance.

- **Mental Health Theme analysis/ aggregated learning** – The development and introduction of a briefing paper specifically focused on learning from e.g. CQC Monitoring visits, Audits, MHA Managers Hearings etc.

- Introduction of new **MDT templates** incorporating aspects of the MHA and MCA.

3 OVERALL LEVEL OF ASSURANCE

3.1 The Committee is able to provide **Significant Assurance** based on the controls it has put in place and its continued action in directing the activities of the Trust where non-conformities with the MHA, MCA, HRA and their associated codes of practice are identified.

4. KEY STRATEGIC RISKS 2017/18

During 2017/18 the Committee has highlighted a number of key strategic risks which will help to inform the work programme for the Committee into 2018/19. These risks include;

- AMHP Service provision
- Compliance with legislative requirements including; the Mental Health Act, Mental Capacity Act, Deprivation of Liberty Standards and the Human Rights Act.
- Health based place of safety (Herefordshire and Gloucestershire) to accommodate changes to the Policing and Crime Act 2017.

5. MENTAL HEALTH LEGISLATION SCRUTINY COMMITTEE ACTIVITY 2017/18

5.1 Activity Summary

Key:

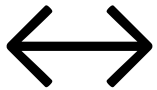
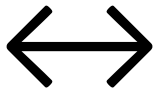
	Full assurance - A sound system of controls has been effectively applied and manages the risks to the achievement of the objectives.
	Significant assurance - A sound system of controls has, for the most part, been consistently applied, minor inconsistencies have occurred but there is no evidence to suggest that the system's objectives have been put at risk.
	Limited assurance - Gaps in the application of controls as designed by management put the achievement of objectives at risk.
	No assurance - Gaps in the application of controls as designed by management have opened the system to risk of significant failure to achieve its objectives and left it open to abuse or error.

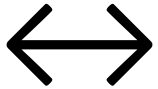
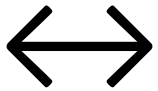
Ref	Assurance requirements	Evidence	Level of assurance 2016/17	Level of assurance 2017/18	Direction of improvement	Commentary
1	Comply with the Mental Health and Human Rights Acts and any associated codes of practice.	• MH Legislation & Scrutiny Committee Minutes (08/03/17 | 12/06/17 | 12/07/17 | 08/11/17 | 10/01/18); • 08/03/17 – Audit – Detained patients and Section 132 rights • 12/06/17 – Recoding of capacity and consent with respect to Section 63 and 58 of the MHA Audit. • 02/17 – SOAD Audit • 12/07/17 – Detained patients and section 132 rights audit • 11/01/17 – Capacity to consent to admission (re-audit) • 12/11/17 – Section 17 leave Audit • 14/03/18 – Human Rights Report • Review of DOLS Applications • MH Operational Group minutes (22/02/17 | 21/06/17 | 23/08/17 | 18/10/17 | 22/01/18) • CQC Theme analysis / Aggregated Learning • CQC Monitoring Visit Ward Reports (including action tracker and compliance statements) • Mental Health Act Managers Hearings Issues reports (including action tracker) • Key Performance Indicators • Training: Bevan Brittan – Capacity and Best Interest assessment training	Significant assurance	Significant assurance	↔	The MH Operational Group on instruction and direction from the MH Legislation and Scrutiny Committee has undertaken to target key areas of weakness in 2017/18 with a refined focus on issues including; • Timely requests of SOADS • Capacity to consent to treatment • The photographing of patients for use during AWOL • Advanced decisions and statements • S132 monitoring and compliance • MDT template standardisation The additional support and resource made voluntarily provided by a range of clinical and non-clinical colleagues has made a huge difference in both measuring issues and identifying solutions to support improvement. These improvements include e.g. • Modifications to Policy • More education and support • Funding for CCTV • Review of processes & procedures

Ref	Assurance requirements	Evidence	Level of assurance 2016/17	Level of assurance 2017/18	Direction of improvement	Commentary

2	Comply with the Mental Capacity Act (MCA) and Deprivation of Liberty Standards (DOLS).	• MH Legislation and Scrutiny Committee Minutes 08/03/17 | 12/06/17 | 12/07/17 | 08/11/17 | 10/01/18);
		  • 12/06/17 – Recoding of capacity and consent with respect to Section 63 and 58 of the MHA Audit.
		  • 11/01/17 – Capacity to consent to admission (re-audit)
		  • Review of DOLS applications reports
		  • CQC Monitoring Visit Ward Reports
		• MH Operational Group minutes (22/02/17 | 21/06/17 | 23/08/17 | 18/10/17 | 22/01/18)
		• The Policy on the 'Mental Capacity Act and the Deprivation of Liberty Safeguards' was updated in 2017.
		• MCA/DOLS lead educational visits to community services in relation to Advanced Decisions/Statements have and continue to be carried out.
		• Easy read MCA Action Card
			Limited assurance	Significant	↑	The Mental Health Operational Group has undertaken a number of discussions in 2017/18 with regards to capacity and consent to both admission and treatment. While capacity to consent to treatment compliance has increased, capacity to consent to treatment has remained in the low-mid 60% range.
						
						Activities including; monitoring MDT sessions and reviewing notes of capacity discussions, reviewing where capacity discussions are recorded within RiO and taking account of different recording methodologies (the development of an aide memoire, signposting auditors to 4 main areas has been produced).
						
						A review of the audit standards and criteria for assessing Capacity to Consent (primarily to treatment) has been undertaken and proposed changes will be presented to the Scrutiny Committee.
						
						Compliance monitoring and improvement remain areas requiring some additional improvement.

3	Provide a robust performance and compliance framework and effective arrangements for ongoing review and monitoring of statistical information on MHA activity.	• Key Performance Indicators • 14/03/18 - Review of the Mental Health Act - The rise in the use of the MHA to detain people in England • 08/03/17 – Review of National CQC report on the application of the MHA. • Section 132 rights dashboard • CQC Compliance Declarations/ dashboards/ action tracker/ action log. • Aggregated learning/ theme analysis.	Significant assurance	Full Assurance	↑	As part of the review into the scheme of MHA audits, consideration is being given to both the coverage of audits and the means to report findings to ensure they can be attributed to a ward/service to help focus improvement actions. Some preliminary thought has gone into how compliance with the MHA/MCA and HRA could best be presented based on

Ref	Assurance requirements	Evidence	Level of assurance 2016/17	Level of assurance 2017/18	Direction of improvement	Commentary
		• CQC Monitoring visits log and action tracker. • The adding and removal of risks from the Trust's risk register to reflect non-compliance and to support monitoring and improvement.				the vast criteria that could be included/excluded e.g. a dashboard.
4	Staff acting on the Hospital Managers' behalf under the Scheme of Delegation are competent to undertake their delegated tasks and to monitor their performance.	• MH Legislation and Scrutiny Committee Minutes 08/03/17 | 12/06/17 | 12/07/17 | 08/11/17 | 10/01/18); • Mandatory MHA/MCA training for all Clinical Staff	Significant assurance	Full Assurance		The Mental Health Legislation and Scrutiny Committee has been given delegated responsibilities from the Board to ensure the Trust complies with its obligations under the MHA/MCA and HRA. E-Learning package in place to provide information on the MHA and MCA to Clinical Staff.
5	Arrangements are in place and are operating satisfactorily for the completion and review of relevant legal documentation relating to compulsory admission and detention of patients.	• MH Legislation and Scrutiny Committee Minutes 08/03/17 | 12/06/17 | 12/07/17 | 08/11/17 | 10/01/18); • 12/07/17 / 12/11/17 – Review of applications for detained patients (including the provision of 132 rights) • 08/03/17 – Review of DOLS applications	Full Assurance	Full Assurance		No comments
6	Procedures are in place and operating satisfactorily to inform detained patients and their nearest relatives about applicable provisions of the MHA and of their rights.	• MH Legislation and Scrutiny Committee Minutes; • New Section 132 rights dashboard, completed on a quarterly basis. • CQC Monitoring Visit Ward Reports	Limited assurance	Limited assurance		Monitoring and reporting compliance with the re-giving of Section 132 rights is working very effectively. An automated reminder (inpatients) provides additional prompts to ensure rights are given. Compliance with the re-giving of rights remains low with patients who are on a Community Treatment Order. Further work is required to determine how more sustainable compliance can be achieved.

Ref	Assurance requirements	Evidence	Level of assurance 2016/17	Level of assurance 2017/18	Direction of improvement	Commentary
7	Policies and procedures relating to the MHA are reviewed and ratified.	(Policies and dates as represented on the Trust intranet). • CTO's responding to carers' concerns – Review date 01/07/18 • *Mental Health Act Information Policy – Review date 01/10/15* • *Receipt, Scrutiny and Ratification of MHA – Review date 01/05/20* • Renewal of Detention and CTO Policy – 30/09/20 • *Allocation of Responsible Clinicians Policy – Review date 31/01/15*	Significant assurance	Significant assurance		All policies are not out of date and overdue for review. • Receipt, Scrutiny and Ratification of MHA – Review date 01/05/17 (Being ratified by Scrutiny Committee on the 14/03/18) • Mental Health Act Information Policy – Review date 01/10/15 (Being ratified by Scrutiny Committee on the 14/03/18) • Allocation of Responsible Clinicians Policy – Review date 31/01/15 (Being ratified by Scrutiny Committee on the 14/03/18).
8	To consider any matters referred from the MHA Managers' Forum	• MHA Managers Forum (Quarterly) • Named individuals to support investigations into issues that arise at hearings. • MHA Managers Issues Report (Scrutiny Committee) including action tracker and aggregated learning report.	Full Assurance	Full Assurance		• Philip Southam and Leigh Clarke oversee the review of issues and the level of investigation required to understand more fully the issue and its implications. • A MHA Managers spreadsheet is maintained to support the identification of themes and to help direct any quality improvement activity. • Actions resulting from MHA Managers issues forms are documented and tracked in relation to completion dates. • A recent aggregated learning report has been compiled to support both the review of themes and any action that could/should be taken to support change/improvement.

Ref	Assurance requirements	Evidence	Level of assurance 2016/17	Level of assurance 2017/18	Direction of improvement	Commentary
9	To review issues raised through the CQC annual monitoring visits and actions plans resulting from them.	MH Legislation and Scrutiny Committee Minutes Quarterly CQC Monitoring Visit Reports Ward Action Statements CQC Monitoring Visit monitoring spreadsheet Quarterly Operational CQC Compliance updates	Limited assurance	Significant assurance		During 2016/17 systems and processes have been put in place to; support the review of CQC observations, to identify suitable actions and to monitor their implementation. Although progress has been made in developing structures and systems a number of issues remain that appear to have not progressed significantly enough to provide significant assurance. Issues raised by the CQC in 2016/17 include; • **Staff training** (with a particular focus on MHA and MCA) – this has been an improving picture throughout the year with an E-Learning Course adding to the current MHA and MCA face to face training courses on offer. Uptake of the training has on the whole been very good, with a few areas reporting challenges in releasing staff to complete e.g. inpatient areas and staff bank. • **Section 17 Leave** (primarily related to an administrative issue with forms not showing whether the patient and nearest relative have received copies) – being reviewed by the newly formed MHA Operational Group. • **Section 132 rights** (regular recording and giving of rights) – A new automated reminder system on RiO was introduced in the latter part of 2016 to support staff in remembering to give and record S132 rights to patients on a regular

Ref	Assurance requirements	Evidence	Level of assurance 2016/17	Level of assurance 2017/18	Direction of improvement	Commentary
						basis. Data is yet to be made available to determine the effectiveness of this system to support the Trust in complying with the MHA Code of Practice. • N**o evidence of advance decisions or statements** – Resolution identified and being taken forward by Tina Kukstas and Judith Boniface. • **Assessment of capacity to consent to treatment** – being reviewed by the newly formed MHA Operational Group. • **Insufficient evidence of patients' views and wishes being recorded in their care plans on RiO** – being reviewed by the newly formed MHA Operational Group.
10	To review issues arising from Managers' Hearings.	MH Legislation and Scrutiny Committee Minutes MHA Managers issues reports (including investigations) Review of MHA Managers Hearing issues reports	Significant assurance	Full assurance	↑	Requirement to confirm that MHA Managers are satisfied with the current arrangements for raising issues from hearings and the subsequent process for investigating the causes and reporting the findings.
11	To ensure appropriate training programmes are in place for staff and MHA Managers	MHA and MCA full day courses New MHA E-Learning Package Training completion statistics MHA Managers have a training programme in place to support their knowledge and Development.	Significant assurance	Full assurance	↑	E-Learning training compliance for MHA/MCA is over 90% in each of the Delivery Localities. Training for MHA Managers in 2017/18 has included; ECA, Advocacy,

6. PRIORITIES FOR 2018/19

6.1 To continue to build and strengthen the MH Operational Group in supporting the activities and responsibilities of the MH Legislation and Scrutiny Committee.

6.2 To define, measure, analyse and improve aspects of the MHA/MCA/HRA that the Committee believes the Trust is not compliant with (e.g. Policies, practice, process, structures and/or lines of accountability).

6.3 To review the range of data sources available to the Committee to help build a picture of good practice and areas requiring additional improvement.

6.4 Continue to provide a robust forum to ensure the Trust's continuing compliance with MHA, MCA, HRA and their associated codes of practice.

6.5 Continue to meet its requirements as set out in the MH Legislation and Scrutiny Committee Terms of Reference.

6.6 Overseeing where necessary the implementation and monitoring of actions and activities from the CQC comprehensive inspection and subsequent monitoring visits.

6.7 To ensure consistency and standardisation (where appropriate) of systems, structures and processes that support compliance across Gloucestershire and Herefordshire.

6.8 To progress work associated with the key strategic risks identified in section 3 of this paper.

7 RECOMMENDATIONS

7.1 The Board is asked to note the contents of this report; and the current level of assurance

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PAPER N1

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Charitable Funds Committee

DATE OF COMMITTEE MEETING: 27 March 2018

KEY POINTS TO DRAW TO THE BOARD OF TRUSTEE'S ATTENTION

STATEMENT OF FINANCIAL ACTIVITIES

The Committee noted the balances and movements within the Charitable Funds and of approvals over £1k taken under delegated powers for the period 1st April 2017 to 31st December 2017. The effect of spending plans and approved commitments did not lead to any potential overspends. The anticipated fund balances were reviewed in accordance with the charity's reserve policy and the reserves were adequate.

As at 31st December 2017 the fund balance stood at £97,347.20. Management and admin costs totalled £5,563; this included Month 1-9 accrual for External Audit Fees at £3,375. It was reported that the Trust's current external auditors only offered the full audit service; they did not provide the cheaper audit inspection service. The Charitable Fund was currently under the limit set for the requirement of an audit; however, an alternative auditor may need to be sought if the fund increased. Total expenditure in the period was £12,207.27 (£45,826.11 year to date).

The Committee discussed the provision of Gloucester Rugby tickets for Service users and the Committee asked that assurance be sought from the Service Directors that all service users received equal opportunities to attend events. Managers needed to consider how many people would benefit and whether the provision was open and diverse. Currently Service Directors were able to authorise spending under £5k, however, it was agreed that any spend over £1k would be checked by the Director of Finance until fund balances had improved. It was agreed that guidance would be provided on what the Charitable Funds should be used for. It was also agreed that each Service Director would be asked to report to the Committee on how they ensure that spending is equitable.

REPORT ON SPENDING OF THE CHARITABLE FUNDS - HEREFORDSHIRE

The Committee received a report on charitable funds spending in Herefordshire during 2017. The Charitable Funds had helped to provide a range of activities over and above those funded by commissioners.

Activities included a music therapist engaged to work with Learning Disability Service Users and a singer song writer had provided live music sessions. The SHAPE programme, singing for the brain, stories for the mind, dance and therapeutic art sessions were also funded. A yoga practitioner provided sessions for young service users; working on health wellbeing and life style issues and classes were also being provided at Belmont and Stonebow for staff. The benefits of yoga for staff were being monitored but it was seen as part of being a caring organisation. Some training was also being provided through the fund. The beneficial effect of such activities was welcomed.

CHARITABLE FUND STRATEGY

The Committee received a revised Charitable Funds Strategy at its last meeting. The Strategy, which included the potential use of a professional fundraiser, was discussed and debated at length and, although the Committee was supportive of most of the direction of travel outlined in it, some additional information was requested. This paper now addressed the issues raised previously

The Committee approved the proposal to procure a professional fundraiser, noting that there was no obligation to appoint if no suitable candidate came forward. If a fundraiser was appointed that person would report directly to the Director of Finance. This appointment would be discussed with procurement and a brief report would be provided to members setting out expectations which would include attendance at every Charitable Fund Committee meeting and the provision of an update report. Duncan Sutherland would chair the interview panel for the appointment of the Professional Fundraiser.

TERMS OF REFERENCE

The Committee's Terms of Reference were last reviewed in November 2016 and were now due for a further review. No major changes were proposed as a result of this review, however the title of the Terms of reference had been amended to reflect the fact that the Committee formally reported to the Board of Trustees, rather than the Foundation Trust Board. The Committee noted the revision to its terms of reference and agreed that it would draw the attention of the Board of Trustees to this change, in the Committee's summary report to the Board. It was also agreed that the Terms of Reference would come back to the Committee following any appointment of a Professional Fundraiser.

OTHER ITEMS

The Committee also noted:

- There had been no Charitable Funds expenditure requests over £5k received since the last meeting.
- One donation over £100 was received in the period
- No legacies over £100 were received in the period

ACTIONS REQUIRED BY THE BOARD

The Board of Trustees is asked to note the content of this report.

SUMMARY PREPARED BY: Duncan Sutherland ROLE: Chair

DATE: 22 May 2018

2gether NHS Foundation Trust

PAPER N2

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Audit Committee

DATE OF COMMITTEE MEETING: 4 April 2018

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

INTERNAL AUDIT

Draft Internal Audit Annual Report

The Committee received the draft Internal Audit Annual Report which outlined the work carried out by PwC for the year ended 31 March 2018. The Head of Internal Audit opinion was 'Generally satisfactory with some improvements required'. The Committee was pleased to note that this was the second highest category available. Some areas of weakness were identified, including cyber awareness and staff education, bank and agency staff procedures and contract governance mechanisms. However, it was noted that 2gether had made good progress in improving and strengthening its internal control environment during 2017/18, with a positive direction of travel in terms of the number and severity of issues noted in the course of the IA reviews.

In relation to the one high risk recommendation around Phishing (cyber security), it was agreed that this was a key risk but that there was a need to focus on the training and awareness for staff to ensure that an improvement in compliance could be seen. Guidance and alerts for staff had been issued, and awareness raising exercises had taken place. The Committee supported carrying out a re-audit in 2018/19.

The Committee noted the excellent performance during the year in implementing actions from IA reports, noting that 46 actions had been agreed and 44 of these had been implemented.

Internal Audit Annual Plan 2018/19

The Committee received the draft internal audit plan for 2gether, noting that this was driven by the Trust's organisational objectives and priorities, and the risks that may prevent the Trust from meeting those objectives. In order to carry out the appropriate level of work it was estimated that the resource requirement for the Trust's internal audit service for 1 April 2018 to 31 March 2019 was 150 days. The Committee discussed some potential changes and additions to the plan, and it was agreed that Marcia Gallagher (Chair) and the Director of Finance would be given delegated authority to revise and approve the final plan.

Internal Audit - Cost Improvement Plan Review (Low Risk)

The purpose of this review was to assess the key controls and procedures in place to ensure successful CIP delivery. Good oversight of the CIP process and clear channels of reporting across the Trust was noted. There was strong communication between the finance team and Project Manager which enables regular monitoring of CIP schemes to identify and respond to any savings gaps or other issues. Two low risk findings and one advisory point were identified. The Committee noted that QIAs were signed off by the Medical Director, Director of Quality and the Director of Finance. In 2017/18 there were some QIAs which had been agreed, but had not been signed off in a timely manner. The Committee was assured that all CIPs for 2018/19 had agreed QIAs and all of these had now been signed off. A report was received at the Governance Committee offering assurance around the QIA sign off process; however, it was noted that this report had not made clear that all CIPs/QIAs had been agreed but *not* signed off and it was suggested that this report be revisited to ensure that this was explicit in future.

Internal Audit - Ligature Review (Medium Risk)

This audit was designed to undertake a review of the processes behind identifying and managing ligature risk within the Trust. The Internal Audit reviewed the processes and controls which surround the completion of the Greater Manchester ligature audit tool, and assessed whether these are designed and operating effectively to enable management and those charged with governance and professional duty

of candour to be fully informed of the audit results and associated patient safety. The Audit found that the Trust demonstrated a keen interest in ensuring robust processes regarding ligature risk were in place and showed a positive attitude towards implementing change where recommended. Three medium risk points and three low risk points were identified. One of these "Medium" Risks related to the lack of a clear process for tracking and documenting actions to be implemented as a result of the ligature audits. There were examples of cases where a ligature risk and a corresponding anti-ligature action were identified in 2016; however, upon inspection in 2017, the exact same risk score and action was documented, showing that no action had been taken and no evidence as to why or how the risk was being managed.

It was agreed that this audit report would be presented to the Governance Committee and for it to be formally referred to the QCR Committee for action. A re-audit would then be scheduled to be carried out during Q4 of 2018/19 to ensure that time had been given for the actions to be fully implemented.

Internal Audit - Service Line Reporting (Low Risk)
In 2015, 2gether purchased "Cost Master" to implement Service Line Reporting (SLR). The Internal Audit review has been conducted in two phases. The first phase was delivered in the 2015/16 and focused on the project management structure and governance framework and was medium risk rated. This second phase has covered data quality and validity of management information produced from the system. The review noted 6 findings: 1 medium risk, 4 low risk, and 2 advisory as well as a number of areas of good practice. The medium risk finding predominantly related to data quality issues, and the incorrect apportionment method that had been used in relation to a Psychologist at Wotton Lawn. Four low risk findings were raised for Control Design of governance processes surrounding Cost Master.

Internal Audit - Information Governance Toolkit Audit (Low Risk)
The IG Toolkit audit report would be presented at the May meeting for formal sign off. This report had generated a Low Risk overall.

EXTERNAL AUDIT

The Committee received the KPMG Progress report, summarising the key points to note since the last meeting of the Audit Committee in February 2018. Work during the quarter included:

- Completion of interim audit visit, documenting the systems and controls that support the production of the financial statements;
- Completion of the initial Value for Money risk assessment
- Discussed and agreed the performance indicators to be reviewed as part of the work on the Quality Report; and
- Prepared the technical update

Benchmarking Report
The Committee also received a benchmarking report covering Quarter 3 of 2017/18. KPMG had benchmarked aspects of the management information contained within the Trust's Provider Finance In Year Monitoring Return to compare the Trust's position relative to the other NHS Trusts and FTs within their portfolio. The data set included 35 providers at the date of the report and based on unaudited returns. The Committee agreed that this was a helpful snapshot of the provider environment and the data put 2gether in a positive position.

COUNTER FRAUD

This report provided details of Counter Fraud activity for the period April 2017 to March 2018. Good assurance on the preventative work taking place was received. Some of the key highlights from this report, included:

- The progress made against the 2017/18 LCFS Work Plan and activity to date;
- Membership of the Midland Fraud Forum
- Outcome of the 2017 Self Review Tool
- A review of current and ongoing fraud cases

A Counter Fraud Survey was launched in January in order to measure fraud awareness levels in the organisation. The survey was sent to 792 staff. 383 completed the online survey which equates to a

48% response rate (Typical response rates to this type of survey range from 10% to 14%). Overall the findings from the survey demonstrated that the level of awareness within the Trust is very strong.

The Work Plan 2018/19 comprised 145 days and provided full coverage of the four key areas of the NHS Counter Fraud Authority strategic plan. The Committee asked that an update be provided at the next meeting on what was going to be put in place to manage the risk of fraud during the merger period.

FINANCIAL SHARED SERVICES (FSS) KEY PERFORMANCE INDICATORS

The Committee received the Key Performance Indicator Report for 2017/18 which covered agreed performance against KPIs for Financial & Procurement Systems, Creditors and Staff Payments, Financial Accounts, Pensions and Payroll. A draft SLA had now been produced but further work was needed to agree KPIs. A number of areas of concern were discussed, including:

- Duplicate payments
- Value for Money costings
- Overpayments
- The Head of Procurement had left and a recruitment process was underway to fill this post.
- It was noted that the FSS Annual Customer Survey had not been carried out during Q4. Key resources from the Finance team had been diverted to focus on another project at GHT.

In terms of arrangements for monitoring and discussing procurement matters, it was noted that an operational procurement meeting took place on a monthly basis and formal plans were received at that meeting, which had good representation from 2gether. There was a need to improve audit trails and ensure that records from those meetings such as minutes were stored safely. It was agreed that it would be helpful for additional assurance to receive a flow chart of "how we work together" to include reporting channels and a list of the formal meetings in place.

OTHER ITEMS

The Audit Committee also:

- Received the Lessons Learnt report from the Gloucester Hub/Pullman Place development and the Committee agreed that this was a good, open and honest report and had highlighted some good learning. Those actions identified throughout the report had been allocated to the relevant teams and locality boards to take forward as "business as usual".
- The Committee reviewed and approved the Accounting Policies
- The Committee reviewed the book value of the Intangible Assets and agreed that they were reasonable and not materially different from a fair value. The Committee also agreed that the remaining asset lives of the Intangible Assets were realistic and reasonable.
- Received a summary of all 2gether waivers over £25,000 for orders raised during Q4 2017/18. The report included reasons for waiving the tender process as set out in Standing Financial Instructions; however, the Committee asked that a review of the wording used when waiving tenders be considered further to ensure that these were accurate.
- Reviewed the Board Assurance Map
- Reviewed and approved the Annual Governance Statement, subject to the addition of reference to the sickness absence of the Chief Executive and the arrangements that had been put in place to manage this
- Received and noted the Review of Directors Interests and the Receipt of Gifts and Hospitality 2017/18.

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: 22 May 2018

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PAPER N3

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Development Committee

DATE OF COMMITTEE MEETING: 18 April 2018

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

ENABLING STRATEGIES

The Committee discussed the programme of development and review of the Trust's enabling strategies, which form part of the Committee's annual work plan. At a previous meeting the Committee had agreed to pause such work given the proposed merger with Gloucestershire Care Services. The Committee noted, however, the need to ensure that existing strategies remained fit for purpose and, where relevant, compliant with national regulations and legislation. The Committee therefore agreed that lead Executives would maintain a 'light touch' approach to review of these enabling strategies, and would provide assurance to the Committee that such reviews had taken place and that relevant strategies remained fit for purpose.

CAPITAL EXPENDITURE

The Committee received a verbal update on capital expenditure and noted that at Month 11 expenditure was c£600k below plan. The Committee noted that any underspend at the end of the financial year would be carried forward, and that in the case of a number of small schemes which had not gone forward, these would be reviewed before a decision was made as to whether these should be added to the next programme. This update was the first since capital monitoring reverted to the Committee, and the Committee agreed to look at rescheduling its meetings for the remainder of the year in order to receive up to date information on capital expenditure.

COMMITTEE TERMS OF REFERENCE

The Committee received revised terms of reference which took account of the addition of capital expenditure monitoring to the Committee's portfolio. The Committee noted the inclusion of the Assistant Director of Finance – Financial Accounts in the list of officers in attendance at the Committee, in order to provide capital expenditure information. The Committee asked that the Deputy Director of Estates and Facilities also be added to the list of officers in attendance, and agreed the terms of reference on that basis.

RISK REGISTER REVIEW

The Committee received a risk register review report, and noted that there were no risks allocated specifically to the Development Committee. The Committee noted two risks allocated to the Governance Committee which overlapped with the Development Committee's terms of reference, and which both had been classified as limited assurance. The Committee queried whether these levels of assurance were too low given the mitigation in place, and asked the Director of Engagement & Integration and the Risk Manager to review the assurance for these risks. The Committee noted that a further risk would be added to the register regarding delivery of the capital programme.

RESEARCH DEVELOPMENTS

The Committee received a report drafted for presentation to the Board of Directors at Cobalt which comprised a review of the partnership between 2gether and Cobalt over the past 18 months. The review covered studies undertaken by 2gether's Research Team in association with Cobalt for the benefit of dementia patients and their carers; further developments; and engagement and communication activities to meet the objectives of the partnership. The Committee noted the positive feedback from organisations sponsoring the research.

POLICY UPDATE

The Committee noted policies which had been ratified in February-March 2018. These included the policy on handling complaints and concerns, which had been ratified by the Governance Committee. The Development Committee suggested that given the high profile of complaints at the Board in recent months, the Board might find a further discussion of this policy useful, and asked the Director of Engagement & Integration to discuss the matter with the Chair of the Governance Committee.

ACTIONS REQUIRED BY THE BOARD

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

SUMMARY PREPARED BY: Jonathan Vickers **ROLE: Committee Chair**
DATE: 18 April 2018

PAPER N4 a

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Delivery Committee

DATE OF COMMITTEE MEETING: 29 March 2018

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

REVIEW OF DELIVERY COMMITTEE RISKS

The Committee was asked to consider how it captured and monitored risks. IAPT was being closely monitored by the Committee already and a report on Violence and Aggression would be received later at this meeting. The Workforce recruitment risk would now be monitored by the Governance Committee going forward as this would enable risks around workforce both strategic and operational to be considered at one sub Committee.

PERFORMANCE DASHBOARD

The Committee received the performance dashboard for the period to the end of February 2018. Of the 178 performance indicators, 93 were reportable in February with 86 being compliant and 7 non-compliant at the end of the reporting period. The Trust had now reached 92% compliance. 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.

The Committee discussed the issues around non-compliance with indicator 3.38: Transition of CYPS to Adult Mental Health Care within 4 weeks. Transition should be started at the time agreed and a request was made that the pathway be reviewed to ensure that there were no clinical breaches. It was believed these were data quality issues as the progress notes provided positive evidence. The issues were a combination of diagnosis, care coordinator and cluster recovering captured in the correct fields within the period. Community teams were investigating but issues were not yet resolved within the clinical system. Compliance should be reached in April but there was a need to ensure that these transitions were managed properly next year.

LOCALITY EXCEPTION REPORTS

The Committee received the locality exception reports for the Gloucestershire localities and Countywide.

Issues around compliance with IG and other statutory mandatory training were highlighted recently as the Trust submitted the IG Toolkit. There were significant areas which needed to be monitored and it was agreed that a more granular report covering all areas of training compliance would be scheduled to come to this Committee quarterly. Locality reports would also continue to highlight any areas of concern. Staff bank was moving back under the management of the Countywide Locality and those figures would be reported separately in the Locality Exception Reports.

An update was provided on bank/agency and the impact of e-rostering. There was confidence that the roll-out of the e-rostering system would bring improvements. A post-implementation review would be undertaken in April before the system was rolled out further.

SICKNESS REPORT

The Delivery Committee had requested a report from the Countywide Locality to include a detailed review of sickness looking at trends, effect of incidents and types of sickness absence. This report highlighted the outcome of that review.

When considering sickness across Countywide in-patient settings it had become clear that the drivers behind increasing trends of sickness were multifaceted creating a unique profile for each ward. The report highlighted a lack of a consistent process for robustly and consistently monitoring individual cases of sickness. It recognised that monitoring needed to sit with the ward managers who were best place to

understand the conflicting demands and pressures on ward staff. The report had considered vacancy rates and age profiles of the teams. No major issues from incidents of violence and aggression were noted and overtime was not found to be too high.

The Committee noted the report and endorsed the recommended action plan designed to address and improve sickness monitoring across in-patient services.

VIOLENCE AND AGGRESSION REVIEW

The Committee received a report reviewing the high scoring risk around Violence and Aggression currently owned by the Delivery Committee. The Committee noted that significant work had been undertaken to ensure that all areas of the Trust were completing violence and aggression risk assessments and as at 18 March 2018, compliance stood at 94% with the other 6% under review. Detailed, workable risk assessment documents had been put in place along with a number of other control measures.

As a result of a recent RIDDOR report to the HSE following a reportable injury, the Violence and Aggression Policy was reviewed by the HSE, who were assured that all measures that could be taken were in place. The Committee was significantly assured that the risk of violence and aggression was being assessed, prepared for and controlled. It was agreed that the Executive Team would be asked to consider the risk rating of this risk.

OTHER ITEMS

The Delivery Committee also received and discussed:

- The Committee noted the changes made to the Business Continuity Management Plan and to the Fuel Shortage Contingency Plan and endorsed both plans for publication.
- A review of the Committee terms of reference was carried out and these were approved, for onward presentation to the Board for sign off.
- The Committee agreed that Locality reviews would now be quarterly (enabling each Locality to report annually) and noted that service directors had agreed a timetable for both Capacity and Demand reports and Locality reviews.
- The Committee received significant assurance at this stage of the year in relation to the delivery of the 17/18 CQUINs. There was one red rated work stream and 9 amber streams and these were being monitored closely through the CQUIN workshops chaired by the Director of Quality.
- The Committee received an overview of key issues relating to the progress with IAPT Services for Gloucestershire and Herefordshire.
- The Committee received an overview and analysis of the 2017 NHS Annual Staff Survey results the local response rate from staff was 45%, an improvement of 5% on the previous year and a rise from 777 responses to 921.The Committee was significantly assured on staff experience within the Trust. It was agreed that improving staff health and well-being, improving reporting of incidents, making more effective use of patient and service user feedback would be the three priority areas to be focussed on over the coming year.
- The Committee noted the good progress to date on achieving the service planning objectives for 2017/18.
- The Committee received the Emergency Planning Annual Report and Plan and noted some of the notable developments in 2017/18 with the introduction of Escalating Incident Framework, Emergency Response Guides, ICS Incident Coordinators Training and introduction of EPRR Compliance Declarations. The key areas for improvement and development in 2018/19 included the Business Continuity Management/Emergency Response documentation, Review of hazard specific Trust plans, to further develop and educate staff on incident coordinating structures and to further refine and develop triggers for the identification of incident responses.

ACTIONS REQUIRED BY THE BOARD

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

SUMMARY PREPARED BY: Maria Bond **ROLE: Chair**

DATE: 22 May 2018

PAPER N4 b

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Delivery Committee

DATE OF COMMITTEE MEETING: 25 April 2018

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

PERFORMANCE DASHBOARD

The Committee received the performance dashboard for the period to the end of March 2018. Of the 179 performance indicators, 123 were reportable in March with 110 being compliant and 13 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.

There had been 2 admissions of U18s during this period. Both of these admissions were appropriate, however, while the admissions were the best option available an adult inpatient ward was not an appropriate place for a vulnerable young person. The Trust had 18 U18 admissions during 2016/17 and 11 U18 in 2017/18. Ways of working with other agencies were being explored. Demand for U18 care was challenging and there was concern that acuity was increasing and that inappropriate admissions could lead to incidents.

CYPS performance in Q3 and Q4 fell below the 80% threshold for the 8 week Referral to Treatment (RTT) and the 95% threshold for the 10 week RTT wait time targets for the first time in three years. There had been an increase in referrals for level 2 and 3 service provision. A demand and capacity analysis was being undertaken and the outcomes would be discussed with commissioners. Staffing capacity levels in Q2 and Q3 fell below planned staffing establishment, however 5 WTE vacancies had been recruited to within in the last few months. Staff were working extremely hard to ensure that no child suffered clinically due to these targets not being met. The Committee noted however, that NHS benchmarking showed that 2gether CYPS continued to be the top performer for these indicators. The team will bring a demand and capacity report to the May Delivery Committee.

A number of non-compliant indicators around the Eating Disorders Service were noted. RiO reporting needed to be improved in order for the service to be able to better track waiting lists; however, steady improvements were anticipated over the next few months.

LOCALITY EXCEPTION REPORTS

The Committee received the locality exception reports for Herefordshire, Gloucestershire CYPS and Herefordshire CAMHS services.

Discussions were taking place with the Training Department around grouping training into whole days to improve efficiency and compliance rates. The Director of OD was also talking to Gloucestershire Care Services about opportunities for working together to provide induction and other mandatory training.

It was reported that CYPS had successfully recruited into 2 specialist posts where there had been previous recruitment challenges. The Service Director agreed to provide the advertisement for these posts with colleagues for any learning.

CAMHS had achieved recurring investment to improve mental health outcomes of young

people involved with Youth Justice Services. The Committee also noted that the Learning Disability waiting list had been reduced from 111 to 91; work had been carried out by a member of bank staff and the service was now looking for non-recurrent funding for short-term interventions.

IAPT SERVICE IMPROVEMENT PLAN

This report provided an update on progress with 2017/18 performance against the IAPT service improvement plan objectives, and set out forward plan targets for delivery in 2018/19.

Performance against the improvement plan objectives had been successful and real improvements had been secured in reduced waiting times for referral to treatment and improved recovery rates. However, there had been challenges in maintaining performance with access rates and in the achievement of national waiting time standards on a consistent basis. This was due to lower than planned staffing capacity levels in both localities. The successful implementation of the service improvement plans required a significant increase in the IAPT workforce and recruitment remained an ongoing challenge. The Trust had agreed 2018/19 contracts with CCG's in both counties and these included additional investment for IAPT services with plan trajectories to achieve 19% access rate by Q4 18/19. Achievement of plans this year would bring the IAPT service performance in line with the national trajectory set out in the NHSE Mental Health Five Year Forward View (FYFV) for achieving a 25% access target by 2021.

The 2018/19 plan included the delivery of digital IAPT services which had recently been introduced into the care pathway in both localities, to provide low and high intensity interventions. The introduction of digital services improved patient choice in service provision on offer and would significantly contribute toward meeting access targets and waiting standards. Given the challenges in terms of recruitment, assumptions on the impact that digital tools may have on capacity and the access target, the Committee agreed that the proposed plan presented a Medium to High Risk for the Trust in its delivery. The IAPT report would continue to be presented at Delivery Committee monthly.

LOCALITY REVIEW – GLOUCESTERSHIRE LOCALITIES

The Committee received a service overview of the Gloucestershire Localities. A review was underway to look at the Community Service Managers portfolios to enable additional operational oversight of IAPT services by reducing the size of the Entry Level portfolio. The presentation set out how the Localities ensured that service users were listened to. This included having service users as members of the Delivery and Governance Committee and work with the Recovery College. Key service developments planned for 2018/19 were also highlighted.

The Committee received a detailed overview of short and long term sickness absence set out across the different localities for January – March 2018. The overview included the number of episodes of sickness and the number of staff per locality. The Committee noted that there had been 228 episodes of absence during that period for 193 staff.

OTHER ITEMS

- The Committee agreed the proposed timetable for reporting Capacity and Demand reports and Locality reviews in 2018/19, which had been updated following discussions at the March Delivery Committee meeting.

ACTIONS REQUIRED BY THE BOARD

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

SUMMARY PREPARED BY: Maria Bond ROLE: Chair
DATE: 22 May 2018

PAPER N5

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Governance Committee

DATE OF COMMITTEE MEETING: 27 April 2018

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

PATIENT SAFETY AND SERIOUS INCIDENT REPORT

The Committee received an overview and analysis of serious incident reporting to commissioners and high level monthly trend analysis, including Never Events. There had been 3 new serious incidents (SIs) reported during March 2018. 1 SI was reported for Gloucestershire and 2 in Herefordshire. No Never Events had occurred within Trust services and the Committee was significantly assured that the Trust had robust processes in place to report and learn from serious incidents.

The Committee noted the Open Actions Report which demonstrated overdue actions only from the 2016/17 and 2017/18 SI Action Plans as requested by the Committee. Good progress had been made on the closure of actions and there was only 1 amber action outstanding for the 2016/17 action plan.

SUICIDE PREVENTION

The Committee received an overview of the implementation of both inpatient and community suicide prevention toolkits and an overview of suicide prevention activities alongside partner agencies. The Committee also received the findings from the PwC internal audit of the Trust's ligature assessment process and the findings from the Gloucestershire Suicide Audit 2013-15, published in 2017.

The Committee received assurance that the Suicide Prevention Toolkits continued to be utilised in acute inpatient areas and within the community teams which reported the highest numbers of serious incidents. The annual ligature audits had been undertaken within inpatient environments and all community team bases had updated their ligature audits within 2016/17. The Committee was assured that the ligature audit process would be improved by the implementation of the recommendations/actions identified by the PwC internal audit of the Trust's ligature assessment process. Actions were to be progressed by the Assistant Director of Governance & Compliance with updates to the Governance Committee.

BANK AND AGENCY INDUCTION PROCESS

The Committee received assurance that the Trust had continued to undertake a development programme, to address recommendations made following the internal audit of Staff Bank in October 2016. Staff Bank had undertaken two management of change processes during 2017and 2018. The first management of change focused on the form and function review of operational delivery, to allow Staff Bank to meet the needs of the Trust. The key outcomes of this process was addressing opening hours of Staff Bank to operate 7 days per week, 12 hours per day, which would provide the Trust with a higher level of coverage to proactively meet organisational demands, to maximise the use of resources.

As part of this review it was agreed that the Staff Bank recruitment resource would transfer to HR to support the centralised recruitment process for the Trust. Following this transfer the Trust had registered 86 bank workers with 100% of these workers undertaking corporate induction. The Staff Bank Local induction was delivered through email, by sending all new Staff Bank Workers an induction Handbook. There were separate Induction Handbooks for each staff groups. For agency workers, the agency was responsible for ensuring that all checks and training were undertaken.

RISK POLICY – QUALITATIVE AND QUANTATIVE AUDIT

The Committee received the results of the quantitative and qualitative audit for Q3 & Q4 2017/18 against the Trust-wide policy on Assessing and Managing Risk and Safety. The audit of this policy was now part of the Trust's audit cycle and findings were reported to Governance on a six monthly basis.

The quantitative data compared to figures provided for the previous audit in October 2017 showed:-

- Continued 100% compliance for inpatients with risk assessments for the eleventh audit running.
- An increase from 91% to 96% for community service users with risk assessments.
- At the end of quarter 2, 53% of inpatient risk assessments had been completed or updated within 7 days.
- 79% of community risk assessments had been completed or reviewed within the last 12 months, an increase from 68% (11%) in Quarters 1& 2 2017/18.

The Committee noted that the qualitative audit indicated that the quality of risk assessment practice had improved in both Gloucestershire and Herefordshire since the previous audit with, overall, 98% of requirements being met, compared to 91% in the previous 6 month period. Learning from the audits would be cascaded to teams.

ASSESSMENT AND CARE MANAGEMENT PROCESSES AUDIT

The Committee received the outcome of an audit measuring compliance against the Trust's Assessment and Care Management Policy (ACM), carried out in April 2018. As with the previous audits the quantitative data included represented a 100% sample of service users on open caseload.

The Committee was assured that there had been a significant improvement in the compliance data since August 2017 and that there had also been an improvement in the quality of information entered in certain sections on RiO. The Committee noted that the ACM audit would be repeated in 6 months and reported to the QCR committee.

PROFESSIONAL REGULATION – REVALIDATION OF NURSES

The Committee was fully assured that since revalidation commenced on 1 April 2016, 100% of the 512 nurses who were due to revalidate in the Trust, had successfully completed the process with the Nursing and Midwifery Council. There were robust processes in place to ensure that each registered nurse fulfilled the requirements as part of their renewal process. Reminders were sent to nurses and their managers at intervals of 12 months, 6 months and 3 months before the revalidation date. The Committee was also fully assured that all 775 registered nurses (100% compliance) had renewed their nursing registration (PIN number) over the last 12 months.

TEXT MESSAGE COMMUNICATION WITH PATIENTS

A Serious Incident review in 2016 into the death of a Recovery Team patient had made a recommendation about communication with patients. A policy for communicating with patients via email already existed and the IG Committee had considered the issue of text message communication with patients. While text messaging was useful for transmission of routine and non-sensitive information, such as appointment reminders, it was deemed unsuitable for sending confidential clinical information. Whilst some Trusts had policies to cover this issue they were unanimous in saying that text messaging should not be used for communicating sensitive or urgent clinical information. This opinion was reinforced by guidance published for GPs by the Medical Protection Society.

In the light of these risks and issues, a short policy setting out guidelines for clinicians when requests to communicate by text message were received had been drafted. The Committee agreed that boundaries must be put in place as use of text messaging for communicating with patients was likely to happen. The Committee agreed that the Policy was an excellent piece of work and accepted the principle and the content, however, it was agreed that the policy would be referred to the Executives Committee to further consider the content and monitoring.

OTHER ITEMS

The Committee also received and discussed:

- The Committee received the Physical Health Annual Report 2017/18 and was significantly assured on the progress made by the PH Group and supported the ongoing work and forward plan for physical health care within the Trust.
- The Committee received the Resuscitation Services Annual Report 2017/18 and noted the significant assurance provided. However, the Committee noted the limited assurance provided regarding 'collapse to shock time' from the Medical Emergency Scenario audit. An action plan was in place to re-fresh staff and re-audit where appropriate.
- The Committee received a breakdown of the Health & Safety related incidents reported on Datix for 2017/18 and "closed" before 5th April 2018. Significant assurance was received around the accuracy of the 'grade of harm' or 'level of seriousness' as assessed by handlers. The new system

had now been in place for 2 years, handlers had received training, and the system was embedded.

- The Committee received an update on progress regarding Patient Safety and Quality Improvement implementation within the organisation. The Committee was significantly assured around the improvements being made and noted the further developments taking place. A number of new and developing Quality Improvements were outlined which demonstrated the Trust's commitment to clinical continuous improvement. Learning themes were also identified particularly through the work streams of the South of England Improving Quality and Safety in Mental Health Collaborative.
- The Committee received the Complaints Annual Report 2017/18 and endorsed this for onward presenting to the Trust Board in May.
- The Committee agreed the 2018/19 clinical audit programme and noted that there were 133 audits on the audit programme, including 36 brought forward from 2017/18. The performance against the Audit Programme 2017/18 was noted.
- The Committee noted that the Junior Doctor Contract had now been implemented across the Trust. There were no issues to report; this item would be removed from the Work Plan as a standing item
- The Committee received the Safe Staffing data for February and March 2018. The Director of Quality continued to chair the Temporary Staffing Project Board on a monthly basis. In 2018/19 focus would continue on embedding progress as well as reducing medical agency usage. It was noted that inpatient nursing agency had hit the control total for 2017/18 through a reduction in spend of around £1.2m. However the overall Trust agency control total was not achieved.
- The Committee noted the review of its terms of reference and agreed the proposed amendments. The revised Terms of Reference would be presented for approval by the Board in May.
- The Committee approved the Terms of Reference for the new Information Governance Committee

ACTIONS REQUIRED BY THE BOARD

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

SUMMARY PREPARED BY: Nikki Richardson **ROLE: Chair**

DATE: 22 May 2018

Agenda item 20 **Enclosure Paper O**

Report to: Trust Board, 30 May 2018
Author: Ingrid Barker, Trust Chair
Presented by: Ingrid Barker, Trust Chair

SUBJECT: CHAIR'S REPORT

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

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

INTRODUCTION AND PURPOSE

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

- Strategic Intent
- Board Development
- Working with our partners
- Working with our colleagues
- National and Regional Meetings attended and any issues highlighted

RECOMMENDATIONS

This report is for information and the Board is invited to note the report.

1. BOARD DEVELOPMENTS AND OUR JOINT STRATEGIC INTENT

Following the last public Board meeting where I updated on the appointment of Paul Roberts as the Joint Chief Executive for 2gether NHS Foundation Trust and GCS Care Services NHS Trust, I am delighted to welcome Paul formally to the Trust. Since 16th April Paul has been active in getting to know the organisations and the wider health care system partners and is already shaping how we work in partnership as we move forward.

I would like to take this opportunity to welcome Dr. Dominique Thompson who started as a Non-Executive Director with 2gether from 1 May 2018. Dominique's clinical background and experience of primary care will be a very welcome addition and will complement the knowledge and expertise of existing 2gether NEDs.

The Strategic Intent Leadership Group and Programme Management Executive Group which are supporting our joint working plans continue to meet regularly and a range of stakeholder activities have now started to take place to help inform and shape our thinking.

Regular briefings to update colleagues on the Strategic Intent activity has continued.

A Joint Board Seminar event took place in April and further joint Board development opportunities are being planned.

2. WORKING WITH OUR PARTNERS AND THE COMMUNITIES WE SERVE

Maintaining **business as usual** remains a priority across both organisations. As part of this I have continued my regular partnership meetings including:

- Gloucestershire Strategic Forum 30th January, 15th February and 27th March.
- Health and Social Care Overview and Scrutiny Committee meeting on 8th May.
- Health and Wellbeing board on 15th May which is currently working on a number of mental health related priorities such as Adverse Childhood Experiences and the Mental Wellbeing Concordat.

I had a useful meeting with the Gloucestershire Deputy Police and Crime Commissioner who is currently exploring some partnership initiatives relating to mental health and vulnerable children.

3. NATIONAL NETWORKS

Along with the joint Chief Executive, I attended the newly launched Community Trust Network which will help ensure that the voice of community service providers is heard and better understood at national level and can influence national policy. As we move towards closer working with Gloucestershire Care Services NHS Trust this will be of significance.

I attended the NHS Providers national Board meeting on 2nd May, as the elected representative for community service Trusts, and board members have already been briefed on the main issues arising at that meeting. Of note is the NHS Providers report, 'Community Services: Taking Centre Stage', published 21st May.

4. ENGAGING WITH OUR TRUST COLLEAGUES

I continue to meet regularly with Trust colleagues and visit services to inform my triangulation of information. A list of all my activity since the last Board meeting in March is listed at Appendix A.

5. NED ACTIVITY

Regular NED meetings are now being held throughout the year, taking place in service settings in both Trusts so that we also have an opportunity to visit services and grow understanding of each other's organisations. Quarterly joint meetings with GCS Trust NEDs have also been arranged for May, August and November. A list of all NED activity since the last Board meeting in March is listed at Appendix A.

APPENDIX A

CHAIR'S KEY ACTIVITIES (April and May 2018)

- Chairing two Trust Board meetings
- Chairing a Joint Board Seminar
- Chairing an Appointment and Terms of Service Committee meeting
- Chairing a Council of Governor's meeting
- Chairing two meetings of the Strategic Intent Leadership Group
- Attending the Gloucestershire Strategic Forum
- Meeting with the Freedom to Speak Up officers with the Chief Executive
- Attending a meeting of the Health & Care Overview and Scrutiny Committee
- Attending the Health and Wellbeing Board of Gloucestershire
- Attending a meeting of Gloucestershire's Health Chairs
- Chairing a meeting of Non-Executive Directors for both Gloucestershire Care Services and 2gether NHS Foundation Trust
- Meeting with Chris Brierley, Deputy Police and Crime Commissioner
- Giving a presentation at Gloucestershire WI on mental health
- Attending NHS Providers Board, London
- Chairing a NHS Providers Remuneration Committee, London
- Meeting with the Deputy Chair
- Telephone discussion with Chair of Hereford & Worcester STP, Charles Waddicor
- Attending regular meetings with the Joint Chief Executive
- Preparing for and conducting Non Executive Director's appraisals
- Meeting with the Chair of Healthwatch Gloucestershire
- Participating in a teleconference relating to an ongoing complaint and its resolution
- Meeting with the newly appointed Director of Service Delivery as part of his induction
- Attending a site visit to Pullman Place as part of the Induction Programme
- Meeting with the Social Inclusion Manager to discuss arrangements for the Volunteers Tea Party
- Meeting with the former Chief Executive Officer
- Attending the former Chief Executive's farewell event
- Conducting a Governor's visit to Charlton Lane Inpatient facility
- Attending the official opening of Pullman Place
- Meeting with the Lead Governor
- Meeting with the newly appointed Non-Executive Director as part of her induction
- Chairing a meeting with Non-Executive Directors
- Chairing the judging panel for the annual ROSCA ceremony
- Attending a retirement function for the Chief Executive of the Herefordshire Clinical Commissioning Group
- Participating in a visit to Weavers Croft and Cirencester Memorial facility as part of induction
- Meeting with the Service Director for Countywide Locality Services
- Attending the Big Health check day at Oxstalls Sports Park
- Attending the first Community Network meeting, London
- Meeting with Chair of GHFT at Hope House, Gloucester
- Key speaker at FestivALL event held at the Cathedral
- Meeting with Alex Chalk MP

- Attended Stakeholder Event at Gloucester Guildhall

- 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.

NED'S KEY ACTIVITIES (April and May 2018)

Jonathan Vickers (Chair of Development Committee)
Since his last report Jonathan has;

- Prepared for and attended a SI review
- Attended a team meeting at Weavers Croft as part of a Board visit
- Prepared for and attended a joint NEDs meeting
- Prepared for and attended 2 SILG meetings
- Prepared for and attended a meeting of the Delivery Committee
- Read and commented on the papers for the Audit Committee
- Held discussions with Executive and Non-Executive colleagues on various matters
- Prepared for and held appraisal discussions with the Chair
- Prepared for and attended a joint Board seminar with GCS
- Prepared for and chaired a meeting of the Development Committee

Nikki Richardson (Deputy Trust Chair/SID/Chair of Governance Committee)
Since her last report Nikki has;
<u>April</u>

- Prepared for and attended a Public Board Meeting
- Met with Acting CEO and Legal Advisor
- Prepared for and attended Audit Committee
- Covered for Trust Chair during annual leave
- Met with a complainant
- Panel member for a MHA Managers Hearing
- Prepared for and attended Strategic Intent Leadership Group (SILG)
- Attended a meeting with GCS Board
- Personal appraisal review
- Met to discuss complaints
- Prepared for and attended Appointments and Terms of Service Committee
- Prepared for and attended closed Board meeting x2
- Attended a NEDs meeting
- Met with Executive Director of Quality
- Teleconference with Executive Director of Quality and NED colleague

<u>May</u>

- Met with Executive Director of Service Delivery
- Carried out NED review of complaints
- Prepared holding to account presentation for Council of Governors (CoG)
- Attended CoG
- Met with founder of HaVinG Charity
- Attended farewell function for former CEO
- Prepared for and attended SILG
- Attended joint GCS/2g NED meeting
- Attended NED meeting

Marcia Gallagher (Chair of Audit Committee)
Since her last report Marcia has;
April
- Booked call with Director of Finance in preparation for the April Audit Committee
- Held a private meeting with the Internal and External Auditors
- Prepared for and Chaired the April Audit Committee
- Participated in a Mental Health Act panel hearing at Wotton Lawn
- Participated in an interview panel for a Programme Director
- Meeting with GCS Audit Chair
- Board visit with Director of Quality to 27a St Owens Street Hereford to meet with AOT/EI Teams
- Had an Appraisal meeting with the Chair
- Attended a Joint Board meeting with GCS
- Attended a SW Regional Chairs meeting in Taunton for the Chair
- Participated in a Mental Health Act panel hearing at Pullman Place.
- Prepared for and attended the April Delivery Committee.
- Prepared for and attended an AToS Committee.
- Prepared for and attended the Closed Board session
- Attended a NEDs Team appraisal meeting with the Chair .

May
- Meeting with the Director of Service Delivery.
- Prepared for and attended The Herefordshire and Worcestershire STP Chairs meeting in Malvern.
- Prepared for and attended the May Council of Governors meeting.
- Undertook a visit to CYPS at Gaol Street Clinic Hereford.
- Attended the Parliamentary Awards Nominee Certificate Presentation at Pullman Place.
- Attended a Joint NEDs meeting and visit to Stroud General Hospital.
- Met Director of Finance for a Pre Audit Committee meeting.
- Prepared for and Chaired the May Audit Committee.
- Prepared for and attended the May Board meeting at the Kindle Centre Hereford.

Duncan Sutherland (Chair of MH Legislation Scrutiny Committee/Charitable Funds)
Verbal update to be given at the meeting.

Maria Bond (Chair of Delivery Committee)
Since her last report, Maria has:
April
- Prepared for and attended Audit Committee
- Prepared for and attended Charitable Funds Committee
- Attended a MHAM Review at Charlton Lane
- Prepared for and Chaired Delivery Committee
- Met with John Campbell
- Prepared for and attended Board meeting
- Prepared for and attended Governance Committee

May
- Attended team meeting of Stroud Recovery Team with Andrew Lee
- Prepared for and attended SI Review Meeting
- Visited Hereford CAMHS with another NED

- Attended a MHAM review at Weavers Croft
- Attended a Farewell event for former CEO
- Attended a Joint NED's meeting, 2g NEDS meeting and tour of Stroud Hospital
- Prepared for and Chaired Delivery Committee
- Met with John Campbell
- Prepared for and attended Audit Committee

Dominique Thompson
Dominique commenced in post on 1 May 2018. Since that time she has been carrying out local induction visits with Board members and has attended a Council of Governors meeting. Dominique also attended an NHS Providers NED Induction session in London.

2GETHER NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS MEETING
THURSDAY 8 MARCH 2018
BUSINESS CONTINUITY ROOM, RIKENEL, GLOUCESTER

PRESENT:	Rob Blagden	Vic Godding	Katie Clark
	Said Hansdot	Bren McInerney	Ann Elias
	Cherry Newton	Hazel Braund	Mike Scott
	Faisal Khan	Jo Smith	Jennifer Thomson
	Hilary Bowen	Svetlin Vrabtchev	Kate Atkinson

IN ATTENDANCE: Marcia Gallagher, Non-Executive Director
Anna Hilditch, Assistant Trust Secretary
John McIlveen, Trust Secretary
Colin Merker, Acting Chief Executive
Kate Nelmes, Head of Communications
Nikki Richardson, Deputy Chair/Non-Executive Director

1. WELCOMES AND APOLOGIES

1.1 Apologies for the meeting had been received from Ingrid Barker, Jenny Bartlett, Stephen McDonnell, Mervyn Dawe, Euan McPherson, Xin Zhao, Lawrence Fielder and Jan Furniaux.

2. DECLARATION OF INTERESTS

2.1 There were no new declarations of interest.

2.2 Hilary Bowen informed the Council that she was no longer a Governor of Barnwood House Trust.

3. COUNCIL OF GOVERNOR MINUTES

3.1 Bren McInerney said that he had referenced a potential meeting at Tewkesbury Borough Council during his Governor Activity report and asked that this be included in the minutes from the last meeting at section 11, as follows:

"Bren McInerney advised that he was exploring the possibility of attending and speaking at Tewkesbury Borough Council's Scrutiny Committee, to tell them (with support from 2gether) about the role of the Governor and to explore with them what support they could offer him in representing the Tewkesbury constituency. He explained he had discussed this at the Governors pre meeting too. The Chair said this was a matter the Trust Secretary would discuss with Bren after today's meeting."

3.2 Subject to this addition, the minutes of the Council meeting held on 16 January 2018 were agreed as a correct record.

4. MATTERS ARISING, ACTION POINTS AND EVALUATION FORM

4.1 The Council reviewed the actions arising from the previous meeting and noted that these were now complete or progressing to plan.

4.2 Bren McInerney informed the Council that he had spoken to the Trust Secretary briefly after the last Council of Governors meeting in relation to his proposed attendance at the Tewkesbury BC Scrutiny Committee. The Trust Secretary had advised that it was not appropriate for a Governor to attend a Scrutiny Committee, as attendance at a formal setting such as this would normally be something that an Executive Director or other officer of the Trust would do, rather than a Governor whose role is a voluntary one. Governors were of course free to attend such meetings as a member of the public.

4.3 The Council received and noted the Meeting Evaluation feedback from the last meeting in November.

5. MENTAL HEALTH LIAISON SERVICES (MHLS) - PRESENTATION

5.1 The Council welcomed Jim Welch, Martin Griffiths and Becky Flory to the meeting who gave an overview of the Mental Health Liaison Services in Gloucestershire. A copy of the presentation would be emailed out to all Governors for information.

ACTION: A copy of the MHLS Presentation would be emailed out to all Governors

5.2 It was noted that Gloucestershire Hospital's Trust was supported by both Adult and Children and Young Persons (CYP) mental health assessment services. Adult MHLS have been operational since 2004 and services are now available 24/7 since February 2017. This service sees patients aged 16+. The CYP Team has been operational since 2016 and is available 8-8 Monday to Friday and 9-5 on weekends.

5.3 Jim Welch said that 40% of the adult population have at least 1 mental illness. In 2015/16, Mental Health presentations accounted for 2% of Emergency Department (ED) patients, yet they represented 15% of 4 hour breaches. The MHLT achieved 95% 2 hour response and assessment KPI and 90% 24 hour non-urgent assessment KPI during the same period.

5.4 The Council noted that mental health awareness and risk assessment training was now delivered to new nursing staff, junior doctors and senior nurse development programmes, and senior staff are trained to undertake risk assessments reducing the delay to decision makers and improving the quality of patient care.

5.5 The Council were informed about Frequent Attender Management and the work that had been carried out to implement care plans and to reduce the number of attendances and admissions. This had seen a 20% reduction over the last quarter. Jim Welch said that this equated to cost avoidance of approximately £65k a quarter.

5.6 The CYP ED Liaison Team consists of a nurse led team that aims to provide same day urgent mental health assessments for those young people presenting with Self Harm or other mental health difficulties. Alongside these assessments, CYPS EDLT staff would be involved in multi-agency meetings on the ward and multiagency liaison around a young person where necessary, offering regular urgent CHOICE and Deliberate Self-Harm (DSH) follow up appointments as well as offering training, consultation and supervision as requested.

5.7 The Council of Governors noted that this presentation had also been given at the last GHT Governors meeting which had been very well received. It was agreed that this was an excellent service and demonstrated some excellent partnership working with the acute trust. It was noted that there was a similar service that had now been set up in Herefordshire for both adults and CYP.

6. CHIEF EXECUTIVE'S REPORT

6.1 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 January 2018.

Dawn Lewis

6.2 Colin Merker opened his report by informing Governors of the death of Dawn Lewis, a long standing Governor with 2gether, on the 17th February 2018. Dawn had been battling cancer for some time. As a Trust, we owe Dawn a great debt as she helped us tremendously when we secured the contract for the provision of services in Herefordshire. Dawn worked tirelessly to champion Mental Health issues and to hold us to account for doing the best we could for our service users in Herefordshire and the wider Trust. Dawn had a great sense of humour, which was always present even if things were difficult. She was a giant of a lady who will be sadly missed by the many she helped. A card of condolence had been sent to Dawn's family by the Trust.

Finance Update

6.3 At the end of January 2018 (month 10) we had a surplus of £792k which is £107k above our planned surplus before impairments. The month 10 year end forecast outturn is a £967k surplus before impairments, which is £84k above our financial control total. There is the potential for us to receive a Strategic Transformation Fund (STF) incentive payment of £117k if we deliver this position which would take our year end surplus to £1.084m.

6.4 The Governors noted that agency spend at the end of January was £3.621m. On a straight line basis the forecast expenditure for the year would be £4.344m, which would be a reduction of £1.147m on last year's expenditure level, but above our agency control total by £0.940m. It is estimated however, that with the initiatives that have been introduced to further reduce agency usage the year end forecast will be £4.199m. In January however, we saw our agency costs rise due to increased sickness levels because of flu within a number of our inpatient wards leading to higher agency usage. We are currently reviewing the impact of this on our projected year end position. 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.

Interim Director of Service Delivery Appointed

6.5 At the last Council meeting in January, Governors asked for assurance around the timescales and proposed back fill arrangements for the Acting Chief Executive in relation to his substantive "Director of Service Delivery" role.

6.6 Colin Merker said that he was very pleased to announce that following recent interviews, John Campbell has started with 2gether as Interim Director of Service Delivery. John will be working part time (approximately two days a week) with us until the end of March 2018. He will then commence in the role full time, on a fixed term basis, until the end of March 2019. John has significant NHS experience, having previously held a number of senior and director-level roles in a wide range of NHS and voluntary sector health and social care settings.

2018 Mental Health Community Survey

6.7 The Council of Governors was asked to note that the 2018 MH Community survey was now underway. The 2017 survey resulted in 2gether's services being rated in the top 20% of mental health services in England. In fact there were three Trusts classed as 'better than expected' across the entire survey – one of which was 2gether.

6.8 So far, the response to the 2018 survey is encouraging, with 16 per cent at this point in the process, which is amongst the best being reported nationally. However, the more responses we receive, the better our opportunity to find out what our service users and carers really feel about our services and how we can make changes to improve the care we provide.

6.9 Once the survey closes and the results are collated, the full report will be presented to the Board (November 2018) and then also shared with Governors.

Media Story – Car Parking Charges

6.10 An email was shared with Governors in February raising awareness that the local media in Stroud had published a story on the possible introduction of parking charges at Trust sites. The newspaper article contained some false and misleading information on the level of charges that could be introduced and we have raised this with the paper involved as it has raised concerns in a number of areas. The Trust carried out an online survey between December 2017 and January 2018 to help us review the options available to us in relation to addressing current inequities experienced by staff in relation to car parking. This included the possible introduction of car parking charges across the organisation. The survey attracted responses from 454 staff, representing almost a quarter of the workforce. A short life working group, which includes staff side representation, are now collating the findings from the work we have been progressing, so that it can be considered by the Trust Board as we discuss the various options open to us in the coming months. Colin Merker said that he therefore wanted Governors to be aware that no recommendation has been made to the Board on whether fees should be introduced, and, if so, what level they could be at. We will keep colleagues informed as discussions continue.

Five Star Food Hygiene Ratings

6.11 The Council noted the good news stories in relation to food hygiene at Trust sites. Laurel House in Cheltenham received an unannounced visit from Environmental Health in March and the site has retained its five-star rating, which demonstrates a continued commitment to high standards of food safety and compliance with legislation. The team at Oak House in Hereford also had a spot kitchen environmental inspection early in February and have been awarded a five star hygiene rating. This is a particularly significant achievement, given that the premises were inspected during a refit. The Council of Governors expressed their thanks to all those staff involved in achieving this.

National NHS Staff Survey Results

6.12 Colin Merker advised that the national NHS Staff Survey results were published on Tuesday of this week. Our results show that 921 colleagues completed the survey, giving us a response rate of 45% - a 5% improvement from the previous year.

6.13 The results show that our overall staff engagement is better than the national average for Mental Health Trusts and also better than that for NHS Trusts generally. Our results also demonstrate that 78% of colleagues felt we prioritised the care of service users and 77% felt that we acted on concerns raised by service users. They also show that 69% of colleagues would recommend us as a place to work and 75% would feel happy with the standard of care provided by the organisation, should their friend or relative need treatment. These scores all rate highly when benchmarked against the responses for other Trusts.

6.14 2gether's top ranking scores included:

- Staff satisfaction with resourcing and support (3.46 against a national average of 3.35)
- Effective team working (a score of 3.92 against a national average of 3.84)
- Percentage of staff experiencing discrimination at work in the last 12 months (10% against a national average of 14% for mental health Trusts)
- Percentage of staff experiencing physical violence from staff in the last 12 months (1% against a national average of 3%)
- Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months (16% against an average of 22%)

6.15 The lower ranking scores, and areas where we need to focus on in the coming year, included:

- Percentage of staff reporting errors, near misses or incidents witnessed within the last month (89% against a national average of 93%)
- Effective use of patient/service user feedback (3.58 against a national average score of 3.72)
- Percentage of staff attending work in the last three months despite feeling unwell because they felt pressure from their manager, colleagues or themselves (56% against a national average of 53%)
- Percentage of staff/colleagues reporting their most recent experience of harassment, bullying or abuse (58% against a national average of 61%)
- Percentage of staff working extra hours (74% against a national average of 72%)

6.16 The national NHS staff survey remains our most effective barometer for how colleagues feel about the Trust and what it is like to work here. Overall there is a lot we can feel proud of in these survey results, but there is always more we can do to improve our working environment, ensuring colleagues feel supported and empowered to deliver the best quality care and services.

6.17 The full survey results would be presented to Governors at a future Council meeting and Colin Merker asked Governors to consider whether they would find it helpful for a small working group to be formed to focus down on the survey results and to work with Neil Savage and the HR team to develop the presentation. Rob Blagden said that this had been discussed at the Governors Pre-meeting and the following Governors had volunteered to take part in a working group: Kate Atkinson, Ann Elias, Katie Clark, Cherry Newton and Jennifer Thomson.

ACTION: Governor Working group to be arranged to carry out a more detailed review of the Staff Survey Results 2018

Adverse Weather Conditions

6.18 Colin Merker said that he stood humbled at the professionalism and commitment of Trust staff in both Herefordshire and Gloucestershire who went well beyond the extra mile to ensure services continued to operate safely and service users were supported safely across this period of recent adverse weather. This was another example of why we should all be proud of 2gether staff for the tireless and unselfish commitment they make.

6.19 The Governors agreed that staff had gone to extra special lengths to maintain Trust services and asked that a message of thanks from the Governors be included in the weekly “News in Brief” newsletter and added to the intranet.

ACTION: Message of thanks from the Governors to Trust staff for their work during the adverse weather to be included in the weekly “News in Brief” newsletter and added to the intranet

Any other business

6.20 Governors were also reminded about attendance at the official opening of Pullman Place on 19th April. Governors were asked to inform Anna Hilditch if they wished to attend.

6.21 The Council of Governors had been asked to discuss Governor involvement in the judging of the ROSCAs. It was noted that Kate Atkinson had volunteered to take part in the judging this year.

6.22 The Council of Governors agreed that the Chief Executive’s report was very helpful and included a good balance of developments, news stories and recognition. However, it was felt as though the report focussed more on Gloucestershire news and a request was made that future reports include an equal balance of Gloucestershire and Herefordshire developments.

ACTION: Future CEO Reports to include an equal balance of developments and news from Gloucestershire and Herefordshire

7. UPDATE ON JOINT WORKING WITH GLOUCESTERSHIRE CARE SERVICES

7.1 2gether and Gloucestershire Care Services (GCS) 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. This group is responsible to the respective Boards of 2gether and GCS 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.

7.2 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.

7.3 The Council was informed that a preferred candidate for the Joint Chief Executive post had been identified and it was hoped that the details of this appointment would be publicised shortly, following final recruitment checks.

7.4 Mike Scott asked at what point the Council of Governors would be provided with further information about the benefits and key aspects of the merger. Colin Merker said that the Strategic Outline Case would be developed over the next few months and once complete would be shared with Governors.

7.5 Nikki Richardson said that 2gether and GCS were 2 separate organisations and needed to remain independent at this time; however, it was noted that operational colleagues had started to look at maximising opportunities and were considering joint developments.

8. REPORT FROM THE NOMINATIONS AND REMUNERATION COMMITTEE

8.1 The Council of Governors received the summary report from the Nominations and Remuneration Committee meeting which had taken place on 6 February 2018.

Appointment of a Non-Executive Director (NED)

8.2 The interview had taken place on 6 February for a new NED. One candidate was available to attend and participate in discussion groups and the formal interview. Three discussion groups were held – a Board Group, a Governor Group and a discussion group consisting of Experts by Experience. The feedback from these discussion groups was passed to the interview panel to assist in their deliberations. The interview panel consisted of the Trust Chair, Deputy Chair, Lead Governor, two Public Governors and an expert by experience.

8.3 The interview panel had made the decision not to appoint the candidate, who was a very well connected GP and was knowledgeable about the wider health

system; however, it was agreed that there was a lack of understanding about the role of a NED and of the governance of an FT.

8.4 Two other strong candidates had been shortlisted for interview but had been unable to attend on this day. It was proposed that these candidates would be contacted with a view of inviting them to interview on an alternative date *(now arranged for Monday 19 March 2018).*

Deputy Chair Remuneration

Nikki Richardson left the meeting at this point

8.5 The Council of Governors appointed Ingrid Barker as joint Chair of 2gether and Gloucestershire Care Services from 1 January 2018, as the first step in the process for the proposed merger of the two organisations. Late last year NHS Improvement issued new guidance for organisations considering such transactions, the practical effect of which is that joint Chair arrangements are likely to continue into 2019.

8.6 Given this extended timescale, and the additional responsibilities that will necessarily be placed on Nikki Richardson as 2gether's Deputy Chair in terms of supporting Ingrid during that period, the Nominations and Remuneration Committee was asked to support a temporary uplift in the responsibility allowance of the Deputy Chair of £5k per year for Nikki Richardson, backdated to 1 January 2018. If approved, the uplift would be terminated either once the merger between the two organisations has been formally completed, or should the Board decide not to pursue the merger following completion of the business case.

8.7 Each NED received a basic salary and additional responsibility allowances were paid to roles such as Committee Chairs, Deputy Chair and Senior Independent Director (SID). The Trust had carried out a benchmarking exercise on NED pay in 2014 and the basic salary and responsibility allowances were in line with other Foundation Trusts. It was noted that the uplift would be fully funded through the savings made by the joint Chair position.

8.8 Bren McInerney asked where and how the figure of £5k had been agreed. The Trust Secretary said that discussions had taken place about the number of extra hours/days that this commitment would take and alongside HR colleagues, the £5k allowance was agreed.

8.9 The Council unanimously endorsed a proposed temporary £5k increase in remuneration for Nikki Richardson, to be back dated to 1 January 2018.

Nikki Richardson returned to the meeting at this point

NED Appraisal Process 2018

8.10 The process for carrying out the NED appraisals would remain the same as that carried out in previous years. Board members would be asked to provide structured feedback on each of the NEDs via a 360 questionnaire and Governors would also be invited to provide free-form feedback. Each NED would complete a self-assessment against their previous year's objectives, in advance of a 1-2-1 meeting with the Trust Chair. Paperwork would be collated and a

summary report would be presented to the N&R Committee in April, for onward reporting at the May Council of Governors meeting.

9. SERVICE PLAN OBJECTIVES 2018/19

9.1 Every year the trust develops service plans for the forthcoming financial year (April – March.) The service plans contain objectives to provide continuous quality of care to service users, carers, staff and volunteers within financial constraints. These service plans are an integral part of the Trusts Strategy and Operational plans.

9.2 This report detailed the service planning process and timescales for 2018/19 and provided an update on completed and planned activities. Governors were invited to comment and feedback on the proposed service objectives. It was noted that this report had been circulated a few weeks in advance of the meeting to enable Governors to have the chance to review it thoroughly.

9.3 Cherry Newton noted the objective for Herefordshire CAMHS services around moving to new accommodation at Belmont. She said that the service had always been located in a city centre position and Belmont was difficult for people with no transport to get to. Hazel Braund said that she had spoken to 2gether about this, in her role at Herefordshire CCG, and the issues about transport and travel. Colin Merker advised that the new accommodation was much better than the previous location; however, he fully acknowledged the issues around transport. A request was made that an update be provided at the next Council meeting on what the Trust was proposing to do to resolve these concerns about the location of the Herefordshire CAMHS service.

ACTION: Briefing about future plans for Herefordshire CAMHS accommodation, and solutions for transport and travel concerns to be provided at the next Council meeting

9.4 Mike Scott said that he was keen to see the assurance process around the service plan and an outcome report on those objectives achieved/not achieved at year end. Colin Merker noted that the Delivery Committee received quarterly reports on progress with the service plan and actions in place to manage any objectives that were not being achieved. It was agreed that this report could be shared with Governors for information.

ACTION: Quarterly Service Planning report received at the Delivery Committee to be made available to Governors for information

9.5 A request was made that further information be made available to Governors around Overseas visitors. A briefing would be produced and shared for information.

ACTION: Briefing on Overseas Visitors to be produced for Governors for information

10. MEMBERSHIP ACTIVITY REPORT

10.1 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).

10.2 Governors supported a Carers event held to coincide with Time to Talk Day on 1 February. Cherry Newton had been involved in organising this event and she said that it had been a good day but not as many carers were in attendance as she would have hoped. However, positive feedback about the event was received from those who had been able to attend.

10.3 The Governors noted that as of 28 February, the Trust had 262 more public members than we had at the end of 2016/17. Membership now stood at 5617 Public members and 2129 Staff members. The Council agreed that receiving these figures was helpful, but it was not necessarily "how many" members the Trust had but how well we do to engage with those members we do have.

11. FEEDBACK FROM GOVERNOR OBSERVATION AT BOARD COMMITTEES

11.1 A number of Board and Board Committee meetings had taken place since the Council of Governors last met in January 2018 and Governors had been present in an observation capacity at these meetings.

- Mike Scott and Ann Elias had attended the Audit Committee meeting which took place on 7 February. They had an hour pre-meeting with the Chair, Marcia Gallagher before and both agreed that the meeting was very interesting and had offered excellent assurance.
- Said Hansdot attended the Development Committee meeting on 7 February.
- Kate Atkinson had observed the Delivery Committee meeting on 21 February. She said that the Chair and other members of the Committee made her feel that her being there observing was important.
- Jo Smith had attended the Governance Committee on 23 February. Jo said that this had been a complex and detailed meeting but had been managed well by Nikki Richardson (Chair) and Maria Bond (Vice Chair).

12. GOVERNOR ACTIVITY

12.1 Bren McInerney and Said Hansdot would be liaising with the communications team about attendance at this year's Barton and Tredworth cultural fair.

12.2 Mike Scott had discussed the possibility of sending out an email communication to his Greater England constituents.

12.3 Kate Atkinson had attended an event at Cirencester University and she suggested that the Trust could hold an event there to raise further awareness of 2gether's services.

12.4 Hazel Braund said that the four Governors in the Herefordshire area had agreed to meet/liaise together to discuss possible networking opportunities.

12.5 Cherry Newton had attended the Carers event on Time to Talk day and a Healthwatch Herefordshire service user and carer meeting. Cherry had also attended the recent CQC stakeholder meeting for carers held at the Stonebow Unit.

12.6 Jennifer Thomson said that she was liaising with the communications and social inclusion team about setting up a member engagement event in the Forest of Dean. Jennifer also mentioned her involvement with an allotment maintenance group and made reference to the therapeutic benefits of gardening.

12.7 A question was raised as to when the Learning Disability Big Health Check Day would be taking place this year. The date for the Police Open Day was also sought. It was agreed that the dates for these events would be shared with Governors.

ACTION: Date for the 2018 LD Big Health Check day and the Police Open Day to be circulated to Governors

13. ANY OTHER BUSINESS

13.1 There was no other business.

14. DATE OF NEXT MEETINGS

Council of Governor Meetings

Business Continuity Room, Trust HQ, Rikenel		
Date	**Governor Pre-meeting**	**Council Meeting**
2018		
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		
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			
6.4	Jane Melton to provide an overall profile of the National Patient Survey results for each county	Jane Melton	
7.5	Anna Hilditch to liaise with CYPS to arrange a visit to services for Governors	Anna Hilditch	**Complete** Visit to take place on Wednesday 13th June 2018 12.00 – 4.00pm
8 March 2018			
5.1	A copy of the MHLS Presentation would be emailed out to all Governors	Anna Hilditch	**Complete** Emailed our with draft minutes on 13 April 2018
6.17	Governor Working group to be arranged to carry out a more detailed review of the Staff Survey Results 2018	Neil Savage / Anna Hilditch	**Ongoing** Date to be arranged for June
6.19	Message of thanks from the Governors to Trust staff for their work during the adverse weather to be included in the weekly "News in Brief" newsletter and added to the intranet	Kate Nelmes / Rob Blagden	**Complete**
6.22	Future CEO Reports to include an equal balance of developments and news from Gloucestershire and Herefordshire	Colin Merker	To be actioned in future reports
9.3	Briefing about future plans for Herefordshire CAMHS accommodation, and solutions for transport and travel concerns to be provided at the next Council meeting	Colin Merker	Update to be provided as part of Chief Executive's report at the May Council meeting
9.4	Quarterly Service Planning report received at the Delivery Committee to be made available to Governors for information	Anna Hilditch	Reports to be made available to Governors once received at the Delivery Committee
9.5	Briefing on Overseas Visitors to be produced for Governors for information	Nikki Taylor	**Complete** Briefing to be circulated with papers for the May CoG Mtg
12.7	Date for the 2018 LD Big Health Check day and the Police Open Day to be circulated to Governors	Kate Nelmes	**LD Big Health Check Day** Tuesday 22nd May 2018 **Police Open Day** Saturday 15th September 2018

Agenda item **22** **Enclosure** **Paper Q**

Report to: Trust Board, 31 May 2018
Author: John McIlveen, Trust Secretary
Presented by: John McIlveen, Trust Secretary

SUBJECT: **USE OF THE TRUST SEAL – Q4 2017/18**

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

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

PURPOSE

To present the Board with a report on the use of the Trust Seal for the period January – March 2018 (Q4 2017/18).

SUMMARY OF KEY POINTS

Section 10.3 of the Trust's Standing Orders requires that use of the Trust Seal is reported to the Board on a quarterly basis.

"10.3 Register of Sealing - The Chief Executive shall keep a register in which he/she, or another manager of the Authority authorised by him/her, shall enter a record of the sealing of every document. Use of the seal will be reported to the Board quarterly."

During Quarter 4 2017/18, the Seal was not used.

RECOMMENDATIONS

The Board is asked to note the use of the Trust seal for the reporting period.