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Gloucestershire Health and Care
NHS Foundation Trust

TRUST BOARD MEETING

PUBLIC SESSION

Wednesday, 30 September 2020
10:00 – 13:00
to be held via Microsoft Teams

AGENDA

Agenda Item	Title	Purpose		Presenter
Opening Business				
01/0920	Apologies for absence and quorum	Note	Verbal	Chair
02/0920	Declarations of interest	Note	Verbal	Chair
-	Staff Experience Story Presentation	Note	Verbal	
03/0920	Unconfirmed Minutes of the meeting held on 22 July 2020	Approve	Paper	Chair
04/0920	Matters arising and Action Log	Note	Paper	Chair
05/0920	Questions from the Public	Note	Verbal	Chair
Strategic Issues				
06/0920	Report from the Chair	Note	Paper	Chair
07/0920	Report from the Chief Executive and Executive Team	Note	Paper	CEO
08/0920	Organisational Priorities for the Trust	Note	Paper	CEO
09/0920	System Wide Update	Note	Paper	DoSP
10/0920	Winter Planning	Note	Paper To be Tabled	DCOO
11/0920	Mental Health Developments	Note	Paper	COO
12/0920	People Plan • People Plan and Promise • Staff Health and Wellbeing	Note	Presentation Paper	DoHR&OD
Performance and Patient Experience				
13/0920	Covid-19 Active Recovery Update	Note	Paper	DCOO
14/0920	Quality Dashboard Report Data 2020-2021	Note	Paper	DoNQT
15/0920	Finance Report	Note	Paper	DoF
16/0920	Performance Dashboard Report	Note	Paper	DoF
17/0920	Flu vaccination self-assessment	Note	Paper	DoNQT
18/0920	Learning from Deaths (Q1)	Note	Paper	MD
19/0920	Guardian of Safe Working (Q4 and Q1)	Note	Paper	MD

Governance				
20/0920	Audit & Assurance Committee • Committee Summary • Annual Report	Note	Paper	Audit Chair
21/0920	Resources Committee Summary (August 2020)	Note	Paper	Resources Chair
22/0920	Quality Committee Summary (1 Sept)	Note	Paper	Quality Chair
23/0920	Mental Health Legislation Scrutiny Committee Summary (23 Sept)	Note	Verbal	MHLS Chair
24/0920	Council of Governor Minutes (17 June)	Note	Paper	HoCG
Closing Business				
25/0920	Any other business	Note	Verbal	Chair
26/0920	**Date of Next Meetings** **2020** Wednesday, 25 November **2021** Thursday, 28 January Wednesday, 31 March Thursday, 27 May Thursday, 29 July Thursday, 30 September Thursday, 25 November	Note	Verbal	All

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AGENDA ITEM: 03

Unconfirmed MINUTES OF THE TRUST BOARD MEETING

Wednesday, 22 July 2020

Via Microsoft Teams

PRESENT:
Ingrid Barker, Trust Chair
Dr. Stephen Alvis, Associate Non-Executive Director
Sandra Betney, Director of Finance
Maria Bond, Non-Executive Director
Steve Brittan, Associate Non-Executive Director
John Campbell, Chief Operating Officer
Marcia Gallagher, Non-Executive Director
Helen Goodey, Director of Locality Development and Primary Care
Sumita Hutchison, Non-Executive Director
Jan Marriott, Non-Executive Director
Angela Potter, Director of Strategy and Partnerships
Paul Roberts, Chief Executive
Graham Russell, Non-Executive Director
Neil Savage, Director of HR & Organisational Development
Duncan Sutherland, Non-Executive Director
John Trevains, Director of Nursing, Therapies and Quality
Dr. Amjad Uppal, Medical Director

IN ATTENDANCE:
Julie Clatworthy, Trust Governor
Said Hansdot, Trust Governor
Anna Hilditch, Assistant Trust Secretary
Kate Nelmes, Head of Communications
Lavinia Rowsell, Head of Corporate Governance and Trust Secretary
David Smith, Transition Director
Katherine Stratton, Trust Governor
Sian Thomas, Deputy Chief Operating Officer
Lizzie Walpole, PA to Chief Executive

1. WELCOME AND APOLOGIES

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

2. DECLARATIONS OF INTEREST

2.1 There were no new declarations of interest.

3. MINUTES OF THE MEETING HELD ON 20 MAY 2020

3.1 The Board received the minutes from the previous meeting held on 20 May 2020. These were accepted as a true and accurate record of the meeting.

4. MATTERS ARISING AND ACTION LOG

4.1 The Board reviewed the action log and noted that all actions were now complete or included on the agenda. There were no matters arising.

5. QUESTIONS FROM THE PUBLIC

5.1 No questions from the public had been received in advance of the meeting.

6. CHAIR'S REPORT

6.1 The Board received the Chair's Report which highlighted the activity of the Trust Chair and Non-Executive Directors for the period end of March to Mid-July 2020.

6.2 Ingrid Barker opened her report by formally recording the Board's thanks to colleagues across the Trust who had made, and continued to make outstanding efforts to support our community during the Covid pandemic. The tremendous efforts made were recognised and appreciated.

6.3 Thanks were given to the Trust's Interim Lead Governor, Simon Smith who had recently stood down from his role due to family circumstances. Simon had played a key part in ongoing work to develop the Council of Governors following the merger and governors much appreciated his contribution during this period of change. Ingrid Barker said that she was pleased to announce that Dr. Faisal Khan had agreed to take on the role of Interim Lead Governor, with Mervyn Dawe as Deputy. She was grateful to them both for agreeing to take on these roles during the important Council 'review and refresh' period and looked forward to working with them. Ingrid Barker advised that she would be writing to Simon Smith to pass on the thanks of the Board.

6.4 The Board noted the content of the Chair's Report, which also highlighted Board Development activity, partnership working with system partners and engagement with national networks.

7. CHIEF EXECUTIVE'S REPORT

7.1 The Board received the Chief Executive's Report which highlighted the activity of the Chief Executive and Executive Directors for the period end of March to Mid-July 2020.

7.2 Paul Roberts echoed the Chair's earlier thanks and paid tribute to Trust colleagues for their response to Covid. Redeployed staff were starting to return to their substantive roles and shielded colleagues were returning to work with appropriate risk assessment processes in place to manage this. The Trust was now in the recovery phase and work was underway to get services back up and running. The Board noted that a number of discussions had been taking place to look at ways of thanking colleagues directly for their efforts, and these would be taken forward over the coming months.

7.3 The Board noted that Michael Richardson, Deputy Director of Nursing would be taking up a new post in Bristol. Michael had spent 12 years in the Gloucestershire health system, with 8 of these working for GCS and GHC. Paul Roberts said that Michael was a high caliber professional and leader in the system and his expertise would be missed. The Board recorded their thanks to Michael Richardson and wished him well for the future.

7.4 Paul Roberts said that he had had the pleasure of meeting with Jane Daggatt, the Trust's Clinical Lead for Podiatry. Jane was celebrating her 40th year of working for the NHS, which was a tremendous achievement.

7.5 A Senior Leadership Network meeting had taken place yesterday and had focused on Learning Disability services, Communication and Staff Health and Wellbeing. Paul Roberts advised that the protection and welfare of staff was a top priority for the Trust and welcomed this as a key focus area.

7.6 There continued to be a number of national and regional meetings held virtually throughout the Covid pandemic to support the efforts of all the NHS Trusts in the region. Amongst others, these have included:

- MH/LDA (Mental Health/Learning Difficulties and Autism) Covid-19 Response Weekly webinar for Trust CEOs;
- SW Regional Chief Executive meetings, chaired by Elizabeth O'Mahony; and
- MH (Mental Health) CEO's meetings.

7.7 Paul Roberts attended the virtual West of England Academic Health Science Network (AHSN) Board meeting on 5th June. A follow-up meeting took place with Natasha Swinscoe, Chief Executive Officer of AHSN, to discuss the particular challenges and priorities GHC are dealing with at present and are anticipating for the Recovery phase, with a view to seeing where the AHSN can continue to best support our organisation and staff, with a particular focus on mental health initiatives.

7.8 The Board approved its initial Strategic Framework at the Board meeting held in March 2020. Unfortunately Covid-19 activities have meant that we have not yet developed the next level of detail and granularity in understanding exactly what our strategic priorities and objectives will be nor have we had the opportunity to share and obtain feedback on this framework with colleagues and stakeholders who worked with us in its development. A Board Development session is planned for late summer to continue to develop this work.

7.9 The report highlighted the establishment of a new Diversity Network. A separate report would be received later in the meeting where further details and discussions could take place.

7.10 Paul Roberts included reference to the publication of the Cumberledge Report on Medicines and Medical Devices Review. The Trust will be looking at the recommendations of this report and any areas where it can build improvements in the way it operates. The review highlighted the failure of the

NHS to listen to concerns. Paul Roberts said that the need to listen was a message we are building into the DNA of our Trust and continue to work on. Non-Executive colleagues welcomed the addition of this item in the Chief Executive's report and agreed that listening to concerns was key and the work to consider the recommendations from the review would help form the Trust's priorities going forward.

8. SYSTEM WIDE UPDATE

8.1 This paper provided an update on the activities that are taking place across the Gloucestershire Integrated Care System (ICS) and confirms the publication of the Gloucestershire Long Term Plan.

8.2 The focus for the ICS since March 2020 has been a co-ordinated system wide response to the Covid pandemic as a major incident which has been delivered through a bronze, silver and gold command structure, working in partnership with the Local Resilience Forum and co-ordinating the NHS response across partner organisations. The ICS work is now shifting towards focusing on Recovery and system restoration as we move into the next phase but also the system wide planning of any surge management alongside winter planning. There is a focus on ensuring that we are using patient and public feedback plus information from services to help scope out how the health and wellbeing needs of the Gloucestershire population will have changed as a result of Covid and the impact of the associated lock-down measures. There will be a need to continuously learn and adapt our service offer as we understand more about the impact that this has had on our populations.

8.3 The existing ICS programmes are currently reviewing their work programmes and continuing to work on and accelerate high priority areas. The report provided an update on the work of the following ICS Programmes;

- The Enabling Active Communities (EAC) programme looks to build a new sense of personal responsibility and improved independence for health, supporting community capacity and working with the voluntary and community sector.

- The Clinical Programme Approach (CPA) ensures services work together to redesign the way care is delivered in Gloucestershire to provide the right care, in the right place, at the right time.

- The Fit For the Future programme work was temporarily put on hold due to Covid. A revised timeline has now been developed proposing that the programme now resumes with a proposed public consultation in the autumn (subject to usual assurance and governance requirements).

8.4 Angela Potter informed the Board that system working had continued to work well and adapt during the Covid incident response, underpinned by good system relationships.

8.5 Jan Marriott made reference to winter planning and said that there were concerns about an increase in Covid over the winter period. For people

requiring testing, who did not own or have access to a car, she asked how testing was going to be made available as current testing facilities were provided at drive thru sites. John Trevains said that this had been raised as an issue already and agreed to go back to the Testing Cell to seek a response.

ACTION: John Trevains to provide a response in relation to the availability and provision of Covid testing over the winter period

9. BOARD ASSURANCE FRAMEWORK (BAF)

9.1 The Trust's Board Assurance Framework was considered and approved at the November 2019 meeting of the Board as an interim measure in advance of the finalisation of the GHC strategic framework. Due to the Covid-19 pandemic, the finalisation of the strategic framework has been delayed. A Board Seminar, scheduled for 15 September, will focus on finalising the strategy. The BAF and review of Risk Appetite will be considered as part of this session.

9.2 The Board noted that the BAF had been updated in consultation with members of the Executive Team. The corporate risks relating to each of the risk areas were highlighted in the paper and have been reviewed by the relevant governance oversight committee. The following key changes to the BAF since Board consideration in March 2020 were highlighted as follows:

Amendments made: All risks have been reviewed and actions/additional controls added where appropriate.

Strategic risks removed this quarter: Risk 13 (*That the transfer of Herefordshire Services to Worcestershire health and Care NHS Trust impacts on our capacity to progress our strategic objectives before April 2020)* was removed from the register following the successful transfer of Herefordshire services.

Strategic risk added in this quarter: Strategic Risk 00 relating to Covid-19 was added to the register following agreement at the March meeting of the Board and was further reviewed by the Board in April and May. The risk rating has been reduced from 20 (in May) to 16 to better reflect the position and impact of mitigating actions

Movement in risk ratings since the last quarter: Overall, there has been little movement in risk ratings since the March meeting of the Board. The implementation of mitigating actions have been delayed due to resource being reallocated to support the Trust's response to Covid-19, however no concerns have been raised as a result of the delays that need to be brought to the attention of the Board. Updated timescales were provided.

9.3 The Board was asked to note that following consideration by the Executive Team, Risk 10 *(There is a risk that the One Gloucestershire transformation plans become frustrated and impact on our individual Trust aims and objectives and the whole system plans*) had been reduced from 16 to 9. The

rationale for reduction reflects the outcome of the urgent care in the community programme and the recommendation that urgent treatment centres will not be part of the MIIU model moving forward. Ongoing work will form part of any future trust wide transformation.

10. TRUST DIVERSITY UPDATE

10.1 The purpose of this report was to provide an update on the Trust's work to promote and progress diversity at work. Neil Savage informed the Board that the report predominantly focused on diversity within a workforce context and at present did not include reference to all protected characteristics. As the report developed this would be included, as well as consideration of diversity from a patient perspective also. The Board noted that the report also presented a recommendation for the key strategic focus areas for progressing improvement moving forwards.

10.2 The report provided a summary update on the Trust's progress with the following diversity, equality and inclusion workforce work streams:

- BAME COVID Risk Assessments
- Reciprocal Mentoring
- Diversity Network
- Recruitment Advertising
- Leadership Development Programme
- Equality Training
- WRES and WDES
- PHE
- Board Development
- ICS approach

10.3 Steve Brittan noted the work taking place around recruitment advertising and advised that an article had been published recently looking at recruitment and screening was carried out to look at how adverts for jobs are written and formed, and the subsequent impact on the type of applicants responding. He agreed to share this with Neil Savage for information.

10.4 Maria Bond said that it was important to recognise this work and the key issues, and how it worked within GHC at a practical level.

10.5 Sumita Hutchison made reference to the Diversity Network, noting that a letter had been received nationally talking about staff support groups. She said it was therefore pleasing to see that these groups had now been formed; however, she asked whether the Trust had the necessary resources to make them successful. Neil Savage advised that the Trust already had a number of OD Practitioners in place who would provide mentoring and support for these groups going forward.

10.6 Professor Partha Kar's recent article in the Health Service Journal urges the NHS and its organisations to make fundamental changes to their approaches towards promoting racial equality within care systems; recommending the

following four key actions most likely to effectively tackle racism in the longer term:

- DATA - Ditch the term BAME and collect data based on ethnicity
- POSITIVE ACTION - Introduce an NHS version of the Rooney Rule
- DATA - Transparency of Data
- LEADERSHIP - Accountability of leadership

10.7 Neil Savage informed the Board that there were a lot of things happening and a good amount of quantitative data would come from this. It was important to then use this data to create a robust action plan and consider how the Trust would measure success.

10.8 Paul Roberts said that there had been renewed energy and focus on diversity and a lot of reflective and good practice articles were being published. There was a huge amount of learning that GHC could do.

10.9 Ingrid Barker noted that one of the Trust's core priorities was tackling health inequalities and therefore welcomed this report and its content. She said that the Board would need to carry out more work to ensure that all of the workstreams and groups were properly resourced and supported.

10.10 Moving forward, the Board agreed that the Trust needed to look at the recommendations from Professor Kar's review, and look at how it collected data, and ensure that this was segmented properly. It would take action on recruitment and it would hold itself to account openly and transparently. A set of defined success measures would also be developed.

10.11 The Board thanked Neil Savage for this report, and looked forward to receiving regular updates.

11. COVID UPDATE - RECOVERY

11.1 The purpose of this report was to provide an overview of the work carried out to manage the Covid pandemic, including an update on recovery planning, celebrating our success and the proposed next steps.

11.2 The Board noted that the Executive Team were currently meeting weekly and were acting as the Covid Programme Board. However, a new Board had recently been formed which would sit below the Executive to ensure dedicated focus on Covid, providing a fortnightly update back to the Executive. The first meeting of this new Board would be taking place later this week.

11.3 Sian Thomas informed the Board that plans were now in place for the recovery of all services. The Trust had managed to maintain all core services during Covid and some had expanded during that time. Over the summer period work would be taking place to focus on winter planning and a potential second surge.

11.4 Sian Thomas said that it was important to celebrate success, noting that there had been some excellent examples from both frontline and corporate services

of innovative ways of working and efforts in ensuring services were maintained to a high standard.

11.5 Paul Roberts led the Board in expressing his thanks to Sian Thomas and the wider Covid Team for their work and tremendous efforts over the past few months. The Board would continue to receive updates on Covid as part of the Chief Executive's report going forward.

12. PERFORMANCE DASHBOARD

12.1 Sandra Betney presented the combined Performance Dashboard to the Board for the period June 2020 (Month 3 2020/21). This report provided a high level view of key performance indicators (KPIs) in exception across the organisation.

12.2 This report aligned to the organisational response to Covid and associated recovery of services. Although data validation and associated indicator narrative had improved, it was still not as comprehensive as it needed to be. However, it was noted that this continued to be discussed with operational and corporate stakeholders, overseen by the Business Intelligence Management Group (BIMG).

12.3 The Board was asked to note that where performance was not compliant, operational service leads were prioritising appropriately to address issues. A Covid Recovery and Future State Programme will schedule recovery trajectories, more fully account for 2020/21 performance indicators in exception and provide legacy Service Recovery Action Plans (SRAP) updates.

12.4 At the end of June, there were 13 mental health key performance thresholds that were not met and 18 physical health key performance thresholds. It was noted that all indicators had been in exception previously within the last 12 months.

13. FINANCE REPORT

13.1 The Board received the month 3 Finance Report for the period ending 30 June 2020.

13.2 There was a Covid interim financial framework for the NHS in place for April to July. It was expected that this will be extended until September but no formal guidance has been received at present.

13.3 The Trust's position at month 3 was break even. All Trusts are required to show a break even position by NHSI. To reach a break even position the Trust has requested a retrospective top-up of £726k for April - June. £556k of this has been approved by NHSI for April to May.

13.4 To support the transformation agenda the Trust is proposing to invest £414k of merger savings in the Strategy and Partnerships directorate. Sandra Betney noted that when the merger took place, the Board agreed to hold back

any savings to be used to cover any shortfalls related to the merger and subsequent resourcing. The posts to be funded included Quality and Strategic Estates, and would be recurring posts. It was noted that the proposal had been scrutinised and agreed by the Executive Team. Jan Marriott expressed disappointment as more investment was needed for frontline posts such as District Nursing, rather than corporate. Sandra Betney agreed; however, she advised that the savings held back from the merger had been made through corporate/Board streamlining, not from frontline services. Paul Roberts provided assurance that the Trust continued to work hard with commissioners to push for proper funding for frontline posts.

13.5 The cash balance at month 3 was £64.426m.

13.5 Capital expenditure was £0.301m at month 3. The Trust has a capital plan for 20/21 of £9.945m. Sandra Betney advised that there had been significant slippage with the capital plan due to Covid. IT expenditure had been brought forward from 2021/22 and would be going through in month 4 and 5.

13.6 The revised recurring Cost Improvement Plan (CIP) target for the merged Trust is £4.722m and the amount delivered to date was £3.302m.

14. QUALITY DASHBOARD REPORT

14.1 This report provided an overview of the Trust's quality activities for June 2020. It was noted that key data was now reported under the relevant CQC Domains – caring, safe, effective, responsive and well-led.

14.2 The Board noted that there had been an increase in all grades of acquired pressure ulcers across services. John Trevains provided assurance that this was recognised, and an improvement action is being taken to address the issues.

14.3 It was pleasing to note that there had been a continued reduction in Covid related deaths across all services and a further 21 patients were discharged from inpatient services having recovered from Covid. Significant improvement had been seen for people accessing Occupational Therapy and Physiotherapy within agreed timescales and there was a reduction in the number of people falling and experiencing harm within an inpatient setting.

14.4 Regarding Trust Patient safety developments, the Nursing, Therapies & Quality directorate are developing and delivering a programme for improvement based on the 'Civility Saves Lives' approach. Civility Saves Lives is a grass roots campaign aimed at raising awareness of the impact of incivility on team and individual performance, in order to improve patient safety.

15. LEARNING FROM DEATHS – Q4 2019/20

15.1 It is a regulatory requirement for all NHS Trusts to identify, report, investigate and learn from deaths of patients in their care, as set out in the National Quality Board 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, published March 2017.

15.2 The Board was asked to note this report and the learning presented from the mortality review of patient deaths during 2019/20 Q1-4. This was the second quarter of the newly merged organisation and as such, this Learning from Deaths paper included data concerning both the deaths of mental health and physical health patients.

15.3 For the period 1 January to 31 March 2020, 165 mental health (MH) patient deaths and 32 physical health (PH) patient deaths were reported, a total of 197 patient deaths. Amjad Uppal advised that all MH patient deaths were recorded, to include both inpatient and community services. Only inpatient deaths were recorded for PH patients. At the time of reporting, 0 deaths representing 0.0% of the 197 patient deaths were judged to be more likely than not to have been due to problems in the care provided by the Trust.

15.4 Graham Russell noted that there were a lot of "lessons learned" identified from the MH patient deaths and asked whether this was the level that the Trust would expect to see. Amjad Uppal advised that the Trust was always looking to improve and tried to seek lessons to be learned wherever possible; however, he provided assurance that none of the issues identified were unusual.

16. BOARD COMMITTEE SUMMARY REPORTS

16.1 Board Assurance Committee – Covid

The Board received the summary report from the Board Assurance Committee (Covid) meetings held on 28 May, 4 June, 11 June and 18 June 2020. In light of the Covid-19 pandemic, this Committee was established for the purpose of assurance. The Committee provided a mechanism through which Non-executive Directors could receive information for the purpose of assurance on key aspects of the organisational response to the Covid-19 pandemic and consider the impact of any exceptional measures being taken.

The Board noted that this Committee was closed on 23 June as it was no longer required; however, it could be re-instated at any time, if required. Ingrid Barker and Non-Executive colleagues agreed that this had been a very helpful Committee by way of keeping up to date and assured on the work taking place to respond to Covid.

16.2 Audit and Assurance Committee

The Board received the summary reports from the Audit and Assurance Committee meetings held on 28 May and 17 June 2020. The Trust's Annual Report and Accounts were signed off at the meeting on the 17 June, and Marcia Gallagher, Audit Chair expressed her thanks to Sandra Betney and the Finance Team for all of their efforts and hard work in preparing the accounts, noting that they had received a strong unqualified opinion from the External Auditors.

16.3 Resources Committee

The Board received the summary report from the Resources Committee meeting held on 25 June 2020. This summary was noted.

16.4 Quality Committee

The Board received the summary report from the Quality Committee meeting held on 1 July 2020. This summary was noted.

16.5 Charitable Funds Committee

The Board received the summary report from the Charitable Funds Committee meeting held on 3 July 2020. This summary was noted.

Duncan Sutherland informed the Board that the former 2gether NHSFT had acquired a charity called New Highways. Discussions had taken place at the Charitable Funds Committee and it was agreed to transfer the funds from New Highways to the main Charitable Fund, and to dissolve the New Highways charity. This was agreed.

16.6 Appointments and Terms of Service Committee

The Board received a verbal summary from the Appointments and Terms of Service Committee meeting held on 16 July 2020. Ingrid Barker advised that the meeting had received and reviewed the outcome of the appraisals for the Chief Executive and Executive Team, and had reviewed the process for Clinical Excellence Awards (CEA) and ways of encouraging applications from under represented groups.

17. COUNCIL OF GOVERNOR MINUTES

17.1 The Board received and noted the minutes from the Council of Governors meeting held on 19 March 2020.

18. USE OF THE TRUST SEAL

18.1 The purpose of this report was to provide information to the Trust Board on the use of the Trust Seal for the period 1 January – 30 June 2020 (Q4 2019/20 and Q1 2020/21).

18.2 The Trust's Standing Orders require that use of the Trust's Seal be reported to the Trust Board at regular intervals. The common Seal of the Trust is primarily used to seal legal documents such as transfers of land and lease agreements. The Board was asked to note that the seal had been used 9 times since last reported to the Board in January 2020.

19. ANY OTHER BUSINESS

19.1 There was no other business.

20. DATE OF NEXT MEETING

20.1 The next meeting would take place on Wednesday 30 September 2020.

Signed: …….. **Dated: ……**

Ingrid Barker (Chair)
Gloucestershire Health and Care NHS Foundation Trust

PUBLIC SESSION TRUST BOARD: Matters Arising Action Log – 30 September 2020

Key to RAG rating:

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

Meeting Date	Item	Action Description	Assigned to	Target Completion Date	Progress Update	Status
22 July 2020	8.5	John Trevains to provide more detail about plans for the availability and provision of Covid testing over the winter period	DoNQ&T	30 Sept 2020	The GHC Covid testing service is able to provide limited home visits when required, if indicated; and where testing team capacity allows. With regard to Pillar 2 (Public) testing the national PHE model remains based on large scale “drive through sites”. There are home testing kits available that can be couriered to and from people’s home address but there are accessibility challenges with this system for those who could be considered vulnerable. In light of this we are seeking further information from local Public Health colleagues for arrangements for those without access to vehicles through either family, friends or carers this winter.	

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AGENDA ITEM: 06

REPORT TO: **Trust Board – 30 September 2020**

PRESENTED BY: Ingrid Barker, Chair

AUTHOR: Ingrid Barker, Chair

SUBJECT: **REPORT FROM THE CHAIR**

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

This report is provided for:

Decision ☐ Endorsement ☐ Assurance ☑ Information ☑

The purpose of this report is to

To update the Board and members of the public on my activities and those of the Non-Executive Directors to demonstrate the processes we have in place to inform our scrutiny and challenge of the Executive and support effective Board working.

Recommendations and decisions required

The Board is asked to:

- **Note** the report and the assurance provided.

Executive summary

The report details internal and external processes in place to support the Board's understanding of how the Trust is operating, partnership working, the external environment and good practice which can be used to inform continuous improvement. The recent focus has been a session on Strategy and Risk which was extremely informative.

I would also particularly highlight the changes in Non-Executive Directorship – the end of office of Duncan Sutherland and the commencement of Steve Brittan's term of office, and the changes in Council of Governor membership following recent elections.

Risks associated with meeting the Trust's values
None.

Corporate considerations	
Quality Implications	None identified
Resource Implications	None identified
Equality Implications	None identified

Where has this issue been discussed before?
This is a regular update report for the Trust Board.

Appendices:	**APPENDIX 1** Non-Executive Director – Summary of Activity – 1st July – 29th September 2020

Report authorised by: Ingrid Barker	**Title:** Chair

REPORT FROM THE CHAIR

1.0 INTRODUCTION AND PURPOSE

This report seeks to provide an update to the Board on the Chair and Non-Executive Directors activities in the following areas:

- Board developments
- Governor activities
- Working with our system partners
- Working with our colleagues
- National and regional meetings attended and any significant issues highlighted

2.0 BOARD

2.1 Non-Executive Director Update

The Trust is sadly saying farewell today to Non-Executive Director Duncan Sutherland. Duncan was appointed as a Non-Executive Director by 2gether NHSFT in 2016 and following the merger of 2gether and Gloucestershire Care Services in October 2019, kindly agreed to stay with the merged Trust for a further year. Duncan's strategic and commercial insights, along with his warmth for colleagues and service users, has been invaluable during this time both to the Trust and me personally.

I am pleased to be able to report that the final stage in the appointment process for Associate NED Steve Brittan took place on 26th August and he has now been confirmed as a full Non-Executive Director.

The Non-Executive Directors and I continue to meet regularly. A virtual meeting was held on 3rd September and we will continue to have monthly meetings going forward. These meetings have been helpful check in sessions as well as enabling us to consider future plans.

I also continue to have regular individual meetings with all the Non-Executive Directors.

2.2 Board Updates:

Trust AGM

Our Trust Annual General Meeting (AGM) was held on 24th September. Due to the current circumstances this was a virtual event due to the social distancing measures. It's been a momentous year for our organisation. Gloucestershire Health & Care and 2gether merged in October 2019 and by early 2020 we were playing our part in responding to the worldwide Covid-19 pandemic. Whilst the AGM was held in a digital format, I hope it still brought home to attendees how the Trust and our services have

performed over the year and what has been achieved. The virtual format also increased opportunities for a wider attendance which will be considered within our planning for future years.

Board Development

We continue to devote significant time to considering our Board ways of working and how we ensure that transformation remains central to the way we work, whilst the necessary focus is maintained on ensuring clinical safety and colleagues' wellbeing.

A Board Seminar on Strategy and Risk took place on 15th September which was facilitated by the Good Governance Institute. Strategy and Risk are core to governance processes and the opportunity to spend focused time reflecting on good practice, our current practice and potential improvements was extremely valuable.

Board colleagues and I took some time out on the evening of 11th August to have a virtual social event, where we enjoyed cocktails and mocktails; a quiz hosted brilliantly by Duncan Sutherland (which was won by Maria Bond); and it was very enjoyable to have an 'unbelievable truth' session hosted by Sumita Hutchison. We hope to have another event in a few months' time. We are also meeting in a socially distanced way in NED / Executive pairings to maintain good informal contact and relationships. Our pairings have included some invigorating walks, sometimes with our canine friends! It is important that we continue to build our team through informal activities like these during these times when face to face meetings remain challenging.

3.0 GOVERNOR UPDATES

A Council of Governors meeting was held on 16th September where matters discussed included a Strategy Update, the Annual Membership Report and an update from the recent Nomination and Remuneration Committee.

I have held meetings with Lead Governor, Dr. Faisal Khan, on 29th July and 23rd September, where matters discussed included the planned welcome for newly elected governors and consideration of ways of working, reflecting on the ongoing Governors' Review and Refresh work.

I chaired a working group with a number of Governors and the Trust Vice-Chair (Graham Russell) to discuss the outputs from the Review and Refresh focus groups that had taken place in July and August and the proposals from this were taken to the Council of Governors meeting on 16th September.

I am delighted to welcome our new governors Graham Hewitt for Cotswolds, Daniel Brookes and Juanita Paris for Cheltenham, Dawn Rooke and Chris Whitham for the Forest of Dean, Tracey Thomas for Gloucester and Ruth McShane for Greater England and Wales, who have been appointed as public governors following an election process. We will be holding an election for Tewkesbury following Bren McInerney's resignation. I would like to record my thanks to Bren and to other governors who have contributed to the Council over recent years and are not continuing with us.

4.0 NATIONAL AND REGIONAL MEETINGS

Since the last meeting of the Trust Board, I have attended the following virtual national meetings:

- **NHS Providers Board** on 27th August and 2nd September - where we discussed important policy and national operational issues and current challenges and opportunities.

- **National Community Network Chairs** on 29th July - matters included receiving a policy and strategic update from Chris Hopson, CEO of NHS Providers and a presentation about demand and capacity modelling in Cornwall and the Isles of Scilly Health and Care Partnership.

- **Community Providers' Round Table** - I was pleased to join a small group of community providers in a round table discussion with senior Department of Health, Treasury and NHSE/I officials to explore the contribution of and support needs for this sector in the light of Covid.

- **NHS Providers Chairs and CEOs** on 8th September - matters discussed included a number of important policy and national operational issues including a briefing on Test and Trace from Baroness Dido Harding.

- **NHS Confederation NHS Reset Webinars** held on 10th August and 14th September. These recognised the continuing challenges faced by the NHS and the need to move effectively to a new normal taking with us the learnings from the last 6 months.

5.0 WORKING WITH OUR PARTNERS

I have continued my regular meetings with key stakeholders and partners where views on the working of the health and care system and the way we can mutually support each other are key issues for consideration. Highlights are as follows:

- A meeting of the county's **Health Overview and Scrutiny Committee** took place on 15th September where matters discussed included: Winter Planning and Covid-19 Temporary Service Changes. (More about this in the CEO's report).

- I met virtually with the **County's Health Chairs** on 15th September – these sessions are very helpful in supporting our partnership working.

- As a **Governor** of the **University of Gloucestershire Council** I have attended several meetings over the last couple of months. This link will assist with some of the workforce challenges faced by the Trust and the wider system, as well as developing research and other potential links between our two organisations.

- The **Chair of Gloucestershire Hospitals NHSFT**, Peter Lachecki, and I continue to meet virtually on a regular basis to discuss matters of mutual interest.

- I also continue to have regular meetings with the **Independent Chair of the ICS Board (Integrated Care System), Dame Gill Morgan.**

- The **ICS Board** has continued to meet virtually and meetings were held on 20th August and 17th September where we discussed a number of important operational and strategic issues. Partnership work was a key aspect of the County's response during the pandemic and this group helps ensure effective working is supported.

- Along with the Chief Executive and the Head of Corporate Governance, I met with the newly appointed **Chair of Healthwatch Gloucestershire,** Nikki Richardson, and Helen Webb the Healthwatch Gloucestershire Manager who has been in place since December 2019. Healthwatch Gloucestershire is the county's independent health and social care champion. It exists to ensure that people are at the heart of care and is an important partner for us in achieving our ambitions.

- The Chief Executive and I met with the **Chairs of the County's Leagues of Friends** on 24th September. We were joined at this meeting by the Trust's Director of Strategy and Partnerships, Angela Potter, who gave a concise update on the ongoing work within the Trust including updates on Covid. It was as always good to get their input.

6.0 WORKING WITH THE COMMUNITIES AND PEOPLE WE SERVE

The Chief Executive and I have continued our regular annual meetings with the **county's MPs** to update them on Trust activities, including Covid. Meetings have been held with Sir Geoffrey Clifton-Brown (Cotswolds), Richard Graham (Gloucester), Alex Chalk (Cheltenham) and Siobhan Baillie (Stroud). The Meetings with Richard Graham, Sir Geoffrey Clifton-Brown and Alex Chalk were interactive where we were joined by colleagues from services across the Trust where we had the opportunity for the MPs to learn about how our services have been responding during the pandemic, and also to find out what messages they can take back to Government. A series of visits to Trust services will be arranged for Siobhan Baillie, as a relatively new MP, when possible.

7.0 ENGAGING WITH OUR TRUST COLLEAGUES

I was pleased to be invited by the Director of Nursing, Therapies and Quality, John Trevains, to attend one of his regular team meetings on 29th July and see how the team is working.

I attended the Women's Leadership Event on 7th September where we heard from Jane Ginnever, the Founding Director of SHIFT. Jane talked about a number of matters including her journey as a female to becoming a leader; overcoming obstacles and barriers; motivation; overcoming discrimination and bullying. I found it an informative, reflective session and I have heard positive feedback on it.

I was very pleased to visit the Dilke Hospital, Lydney Hospital, North Cotswolds Hospital, George Moore Community Clinic, Vale Hospital and Edward Jenner Court throughout August to say a huge thank you to everyone for their hard work and sterling efforts over the last few months, and also to hand out water bottles which have been purchased with some of the money from the Captain Sir Tom Moore fund that the Trust has received. Other services from across the whole Trust were also visited by Board colleagues in August so that they could personally take the opportunity to thank colleagues.

I attended the Mental Health Act Managers Forum on 22nd September and the Mental Health Legislation Scrutiny Committee on 23rd September.

As part of my regular activities, I also continue to have a range of 1:1 sessions with Executive colleagues, including a weekly meeting with the Chief Executive and the Head of Corporate Governance.

8.0 NED ACTIVITY

The Non-Executive Directors continue to be very active, attending virtual meetings across the Trust and where possible visiting services.

See Appendix 1 for the summary of the Non-Executive Directors activity for July and August 2020.

9.0 CONCLUSION AND RECOMMENDATIONS

The Board is asked to **NOTE** the report and the assurance provided.

Appendix 1

Non-Executive Director – Summary of Activity – 1st July – 31st August 2020

Please note: meetings were held virtually by Microsoft Teams or Zoom except where noted

NED Name	Meetings with Executives, Colleagues, External Partners	Governance meetings	Board membership meetings
Graham Russell	1:1 Director of Nursing, Quality & Therapies Quarterly meeting with Trust Chair and Marcia Gallagher 1:1 Steve Brittan 1:1 Trust Chair Meeting with Homes England Nursing, Quality & Therapy Team meeting Team Talk	FoD Hospital Procurement meetings ICS Board meetings	ATOS Board Discussion Charitable Funds Committee Governors Review and Refresh NED meetings Resource Committees Trust Board
Marcia Gallagher	1:1 Director of Finance 1:1 Director of Strategy & Partnerships 1:1 Trust Chair 1:1 Director of Strategy & Partnership 1:1 Steve Brittan Meeting with Age UK Meeting with Barnwood Trust Meeting with Chief Operating Officer and Joint Director of Primary Care NHS Reset meetings Quality Team meeting Quarterly meeting with Chair and Vice-Chair Senior Leadership Network Talk by Ethel Changa – CNO BAME	FoD Workshop ICS NEDs and Chairs meeting	ATOS Audit and Assurance Committee Board discussion Charitable Funds Committee Extra-ordinary Resources Committee NED meetings New Highways Committee Resources Committee Serious Incident Review Meeting Trust Board

NED Name	Meetings with Executives, Colleagues, External Partners	Governance meetings	Board membership meetings
	Strategy Advisory Group		
Jan Marriott	1:1 CCG Lay Clinical Member 1:1 Director of Strategy & Partnerships 1:1 FSU Guardian 1:1 interview candidate 1:1 Joint Director of Primary Care 1:1 Steve Brittan 1:1 Trust Chair 1:1 with Medical Director ref Mortality reviews ICS Clinical Council Meeting Interview panel for Deputy Director of Nursing, Quality and Therapies Leaving presentation for Deputy Director of Nursing Meeting with Sumita Hutchison and Sonia Pearcey MH Operational Group Visits to Charlton Lane Hospital, Cheltenham ref thank you/water bottles	FOD Hospital Procurement meeting FoD workshop	ATOS Audit & Assurance Committee Board discussion Governor Review and Refresh Workshop NED meetings Quality Committee Resources Committees Trust Board
Maria Bond	1:1 Director of Finance 1:1 Director of Nursing, Therapies & Quality 1:1 Steve Brittan Focus Group (Dep Dir Nursing role) Meeting with Governor	FoD workshop Good Governance meeting	ATOS NED meetings Quality Committee Trust Board Trust Board Development

NED Name	Meetings with Executives, Colleagues, External Partners	Governance meetings	Board membership meetings
	Meetings with interview candidates NHS Reset meetings NTQ team meetings Senior Leadership Network Team Talk		
Sumita Hutchison	1:1 Deputy Director of Nursing 1:1 Director of HR & OD 1:1 FTSU Guardian NHS Reset Trust Diversity Network		ATOS Board discussion Charitable Funds Committee Extra-ordinary Resources Committee Governors Review and Refresh NED meetings New Highways Committee Quality Committee Trust Board
Duncan Sutherland			ATOS Audit & Assurance Committee Board discussion NED meetings New Highways Committee Resources Committee Trust Board
Dr. Stephen Alvis	1:1 Deputy Director of Nursing 1:1 Director of HR & OD 1:1 Director of Nursing, Quality & Therapies 1:1 Steve Brittan Focus Group (Dep Dir Nursing role)		ATOS Board discussion NED meetings Quality Committee Serious Incident Review meeting Trust Board

NED Name	Meetings with Executives, Colleagues, External Partners	Governance meetings	Board membership meetings
	NHS Reset EDI session NHS Reset meetings Senior Leadership Network Team Talk Visit to Wotton Lawn Hospital Visits to Berkeley House, Weavers Croft, Stroud Hospital ref thank you/water bottles		
Steve Brittan	1:1 Deputy Director of Nursing 1:1 Head of Digital Transformation 1:1 Head of Research & Development and Joint Clinical Lead 1:1 Trust Chair 1:1 with Chief Executive 1:1 with Chief Executive Focus Groups (3) Meeting with IT Managers NHS Reset meetings North Glos LD Team meeting Team Talk Tewkesbury Hospital Trust Diversity Network Visits to Colliers Court and Dean House (Forest) ref thank you/water bottles		ATOS Audit & Assurance Committee Board discussion NED meetings Resources Committee Trust Board

AGENDA ITEM: 07

REPORT TO: **Trust Board – 30 September 2020**

PRESENTED BY: Chief Executive Officer and Executive Team

AUTHOR: Paul Roberts, Chief Executive Officer

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

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

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

The purpose of this report is to

Update the Board and members of the public on my activities and those of the Executive Team.

Recommendations and decisions required

The Board is asked to note the report.

Executive summary

The activities reported inevitably continue to be heavily impacted by the response to the pandemic but we are also moving forward other projects, for example the Forest of Dean hospital proposals and looking at ways to ensure continuous improvement across our operation, involving services users and staff to inform us.

An update on changes of Team within the Deputy Executive tier is provided, as well as updates on our Trust Strategies and the NHS People Plan.

We continue to keep a watching brief on the Brexit negotiations and the potential impact on the NHS.

Risks associated with meeting the Trust's values
None identified

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

Where has this issue been discussed before?
N/A

Appendices:	Report attached

Report authorised by:	**Title:**
Paul Roberts	Chief Executive Officer

CHIEF EXECUTIVE OFFICER AND EXECUTIVE TEAM REPORT

1.0 CHIEF EXECUTIVE ENGAGEMENT

Since the last Trust Board meeting in July, a significant proportion of my time has continued to be focused on the Trust's response and management of the Covid-19 pandemic, with an ever increasing focus on the "Phase 3" recovery programme and second surge and winter planning.

Sian Thomas will report on this in more detail in the Winter Planning and Covid-19 Recovery Programme Update Report, but in summary: all of the Trust's services are now in "active recovery", meaning they are generally open but are not all back to full capacity or their pre-Covid model. Many services have a phased plan to increase capacity and some have changed the way they deliver services, including an increased focus on digital delivery. Numerous service enhancements and new service offers have been implemented as part of the recovery planning process, building on the learning gained during the Covid peak.

Due to the changes implemented as part of the Trust's "Covid Secure Work", it has been possible for me and my Executive Team, supported in many cases by Non-Executive Directors, to visit all of the Trust's sites over the last few weeks personally to thank the staff for their hard work and commitment during this challenging period. Staff have been experiencing the pandemic in very different ways - over 500 colleagues have been redeployed into new roles, many have had to adapt to entirely new ways of working, some have had to self-isolate or 'shield', many have worked exceptionally long hours, and are now, on a daily basis, working in PPE – I am truly grateful to all of our staff, both clinical and support, who have worked brilliantly and flexibility to serve our patients and communities. I am currently working out of a different service centre each week, as I value the opportunity to hear first-hand how different colleagues are experiencing their new ways of working.

I have been humbled and inspired by the incredible response from the whole Trust team. The Trust Chair and I wrote to every member of staff, individually to say thank you for their contribution to our Covid response and for their continued dedication and hard work throughout this difficult period.

I have continued to attend a range of meetings, including:

A number of **Executive Development Sessions** were held in August, during which the Executive Team explored individual's experiences through the Covid pandemic, reflecting on the Trust's response and how this will influence future working. The sessions provided an opportunity for the team to look ahead at the Trust's short-term priorities and longer-term strategic development. They provided invaluable time to facilitate leadership development, helping to achieve our core value of always improving.

A **Board Development Seminar** was held on 15th September, which focused on strategic risk management and the development of the Trust's strategic objectives.

The session was facilitated by the **Good Governance Institute,** who help support those who run organisations to continually develop and improve, ensuring organisations are run by talented, skilled and ethical leaders. It was a useful and meaningful session, and we will continue to further develop our strategy over the coming months, taking into consideration the impacts of Covid.

Monthly **Team Talk** sessions have now been reinstated. The sessions are held as a digital event and led by an Executive or a deputy. They are open for all Trust employees to attend and provide an opportunity for the Executive Team to share the latest Trust news and for staff to share their thoughts, feelings and concerns. The sessions typically cover an update on the latest Covid and Workforce news, amongst other recent items of interest. The programme helps to ensure effective communication across the Trust and provides an opportunity for the staff voice to be heard directly by the Executive Team.

Senior Leadership Network meetings were held on 21st July and 25th August and 22nd September. These continue to be run as virtual events to ensure the SLN are regularly keeping in touch and up to date with Trust and national developments. The sessions had a particular focus on the Trust's Covid recovery programme and ways to promote staff health and wellbeing. We were delighted to have presentations from a number of **Experts by Experience**, who provided accounts of their experiences through the crisis and the powerful stories of **colleagues who have suffered from and are recovering from Covid-19**. These proved really helpful in highlighting the very different challenges people have faced and the ways they have managed to cope with, and often overcome, these challenges.

Over the past few months, the Learning & Development Team has been working hard to review and relaunch **Corporate Induction**. The face-to-face sessions re-commenced from the beginning of August, on a weekly basis with reduced numbers to allow adequate social distancing. Each session is attended by either myself or a member of the Executive Team to welcome personally new colleagues and provide an overview of the Trust and how we live our values. It is important that the Executive Team are visible from day one, so that all staff members feel able to approach us with comments, concerns or new ideas. In light of Covid, there was a need to review alternative ways of delivering training and a great deal is now available as eLearning.

I attended a **Council of Governors meeting** on 16th September, at which we welcomed a number of new governors. This is reported on in the Chair's report and elsewhere in this agenda.

The programme for the new **Forest of Dean Hospital** recommenced in the week of 22nd June and I have attended many meetings since then to discuss engagement, consultation, proposed service model, and the workforce and business case. This is an incredibly important piece of work and is reported on in more detail in the System Wide Update report.

Sandra Betney, Deputy CEO and Director of Finance, attended the **JNCF** meeting on my behalf on 9th September. Sandra provided the Chief Executive update on

national, system and Trust level priorities and issues and other members of the Executive team presented verbal updates on their areas. General updates on finance and HR were provided, with Neil Savage, Director of HR & OD, also presenting an overview of the People Plan. Attendees, as usual, had an opportunity to raise any concerns or issues and to comment on any of the items raised.

I attended the first formal meeting of the newly established **Trust Diversity Network** on 27th July. We had a good attendance from colleagues across the organisation and were able to hear feedback from the initial focus groups and discuss the next steps required to move forward with the network. I also had a meeting with the newly appointed **Engagement/Equality Diversity & Inclusion Lead and Workforce Race and Equality Standard Champion (WRES)** at the Gloucestershire Hospitals NHS Foundation Trust.

I have been heavily involved in **engagement between BAME community groups and the NHS in Gloucestershire**, as part of developing the **"Walk in My Shoes"** reverse mentoring programme. A number of Directors from Gloucestershire NHS organisations, Sandra Betney and me for GHC, have been nominated to be part of the programme, which is being led by Valerie Simms of Diverse City.

The Equality, Diversity and Inclusion work has been supported on a national level by NHS England and Improvement and I attended a **NHS BAME Staff Network Leads Webinar,** presented by Prerana Issar (NHS Chief People Officer), on 23rd July. This webinar set out their ambitions, framework, success factors and practical steps for accelerating the development of BAME staff networks in NHS organisations.

I am also involved, along with other GHC Directors, in the **Reciprocal Mentoring Scheme** and have continued to have meetings with my reciprocal mentoring partners. The scheme is based on the concept of reverse mentoring, with the addition of the relationship between the mentor and mentee being reciprocal in nature, enabling allies and equal partnerships designed to create systemic transformational change.

ICS (Integrated Care System) and System Partners

Our Trust plays an important role in the Gloucestershire system with colleagues working committedly to meet the needs of our community. I have regular meetings with the **CEO of Gloucestershire Hospitals NHS Foundation Trust (GHFT)** and the **Accountable Officer for Gloucestershire Clinical Commissioning Group (GCCG)** to keep abreast of any issues facing our partner organisations so that mutual help and support can be provided. I also continue to have regular meetings with senior officers and Leaders at Gloucestershire County Council.

I have attended the monthly **ICS Board** and **ICS Executive** meetings, which have continued to focus on system-wide resilience during this challenging period. The

regular meetings, held with senior colleagues across the health system, help ensure joined up working and provide a forum to discuss items affecting multiple partners. The **ICS CEO** meetings have also now been re-instated moving forward.

I attended the **Health Overview and Scrutiny Committee** on 15th September, which discussed various matters including winter planning, Covid-19 temporary service changes and the Gloucestershire Clinical Commission Group performance report. The Committee is piloting an approach which provides an opportunity for members of the public, who live or work in the county, or are affected by the work of the County Council, to make representations on matters which relate to any item on the meeting's agenda. This approach is designed to improve the public's ability to voice concerns directly and to help promote accountability of all the system partners.

The system **Gold Health System Strategic Command CEOs** call has continued to be in operation over the last three months as part of the **Gloucestershire ICS Covid-19 Response Programme**; albeit recently at a reduced frequency of once or twice a week. This forum has proved very useful in overseeing the system response to the Covid pandemic and in providing a regular liason point between senior leaders in the NHS system.

On 14th August, Bren McInerney invited me to attend a meeting with **Professor Kevin Fenton, Regional Director at Public Health England,** and **local BAME community groups**. The purpose of the meeting was to allow the community groups the opportunity to share a little about themselves, their organisation, and the impact this has on the community they serve. It was a great opportunity to discuss engagement and connectivity with the local community.

Along with our Chair and Head of Corporate Governance, I met with the newly appointed Chair of **Healthwatch Gloucestershire**, Nikki Richardson, and Helen Webb, Healthwatch Gloucestershire Manager. Healthwatch Gloucestershire is the county's independent health and care champion. It was a useful meeting, in which we heard about the experiences of Gloucestershire residents using the local health services, including what they liked and what they felt could be improved. Our way of working is always to involve fully people who use our services, so as a Board we welcomed the feedback Healthwatch Gloucestershire were able to provide.

I have attended the bi-weekly **Gloucestershire MP briefings**, led by CEOs of the Gloucestershire NHS organisations and senior County Council officers and Leaders. These have focussed on the latest developments in the management of the Covid-19 pandemic and, in particular providing updates on acute service issues, PPE, testing and public health updates.

The Chair and I continue to have regular briefings with local Members of Parliament to keep them informed about issues of interest within our services and to allow an opportunity for questions and discussion about local and national NHS issues. Recently, meetings have been held with Mark Harper (Forest of Dean), Sir Geoffrey Clifton-Brown (Cotswolds), Alex Chalk (Cheltenham) and Siobhan Baillie (Stroud).

National and Regional Meetings

There has been a plethora of national and regional meetings held virtually throughout the Covid-19 pandemic to support the valiant efforts of all the NHS Trusts in the region. Amongst others, these have included:

- MH/LDA (Mental Health/Learning Difficulties and Autism) Covid-19 Response webinar for Trust CEOs;
- SW Regional Chief Executive meetings, chaired by Elizabeth O'Mahony;
- SW MH (Mental Health) CEO's meetings, chaired by Anne Forbes; and
- Phase 3 Mental Health Planning process meeting, chaired by Claire Murdoch (National SRO for Mental Health).

I attended the **Virtual Regional Roadshow - South West** meeting, chaired by Elizabeth O'Mahony, on 23rd July. Simon Stevens (NHS Chief Executive), Amanda Pritchard (NHS Chief Operating Officer), Julian Kelly (NHS Chief Financial Officer) and Prerana Issar (NHS Chief People Officer) also participated in the meeting. The call allowed a discussion on the priorities around restoration of services and the continued impact of Covid-19, and provided further detail on the NHS People Plan.

2.0 TRUST STRATEGY UPDATE

We continue to develop the Trust's Strategy following the wide engagement on this work undertaken prior to Covid. The Board will receive an update from the Director of Strategy and Partnership and discuss our next steps in Part 2. Meanwhile a paper is provided to this meeting to confirm our **Trust short-term priorities**.

3.0 NHS PEOPLE PLAN AND PEOPLE PROMISE

"We are the NHS: People Plan for 2020/21" was published on 30th July. This is an absolutely key strategy for the NHS. Director of Human Resources and Workforce will update on the plan and the Trust's response later in this meeting.

4.0 TEAM CHANGES

Sian Thomas, Deputy Chief Operating Officer, is leaving the Trust at the end of October for her new role as Deputy Chief Operating Officer at the Royal Wolverhampton NHS Trust. Sian has been with the former Gloucestershire Care Service (GCS) since June 2016 and prior to that worked within 2gether. She was appointed Deputy COO for GHC from inception of the new Trust and was appointed into the key role of Accountable Emergency Officer for the Covid pandemic in March. She has been instrumental in leading the Trust's initial response to managing the pandemic and subsequently the recovery of our services. On behalf of the Board, I would like to put on record our sincere thanks to Sian for all her work within the Trust and wish her well in her new post.

With Sian's departure John Campbell, COO is aiming to build more resilience into a revised operational structure. This will include moving to a **two Deputy COO model**, **enhancing leadership within the Children's and Young People's service**

directorate, given the significant amount of transformation within this area, and retaining the revised community service configuration, introduced during Covid, that has worked effectively.

An interim DCOO to replace Sian is currently being recruited to this critical post.

David Smith is completing his temporary contract with GCS at the end of September. Dave joined GCS as Director of Workforce in January 2018 having served in a similar role at GHFT for over eight years. In the summer of 2018 he became Transition Director overseeing a significant component of our merger to form GHC. He has continued this programme, extended due to the impact of Covid-19, and also led the system-wide workforce "Bronze Cell" as part of the ICS Covid response programme. Dave has been a close colleague to me and is widely respected across the system and will be much missed.

Michael Richardson, Deputy Director of Nursing, left the Trust in August for his new role as Deputy Director of Nursing for Bristol, North Somerset and South Gloucestershire CCG. Michael has worked in Gloucestershire for 12 years and joined Gloucestershire Care Services eight years ago. He has been Deputy Director of Nursing for five years and Director of Infection Prevention and Control for three years. His service to the county and the Trust, as well as his prime role during the Covid pandemic, mean we will miss him hugely, however we wish him well in his new role.

Matthew Edwards, Deputy Director of Quality and Workforce Transformation, is also leaving our organisation. Matt will be joining the team at Oxford Health NHS Foundation Trust as Director of Clinical Workforce Transformation. This is a great opportunity for Matt to work for a larger NHS provider and utilise and expand his many skills in delivering creative workforce solutions across a range of services and from a range of sources.

Matt has worked in Gloucestershire for 8 years. Within ²gether he was Associate Director of Quality, Assurance and Transformation. Matt made significant contributions to the planning and delivery of our successful merger and supported the organisation through two comprehensive CQC inspections. He also led the agency management work, delivering significant financial savings for ²gether, and carried this forward into GHC.

Hannah Williams has taken over from Michael Richardson as the Trust's new **Deputy Director of Nursing and Quality**. On behalf of the Board, I would like to congratulate Hannah on her appointment and welcome her to the Trust. Hannah is well known to many already, through her role with Gloucestershire Clinical Commissioning Group as Senior Nurse Manager, Quality and Community and she too has been heavily involved in our Covid response.

Hannah is a registered nurse (adult) and qualified District Nurse. Having initially trained as a nurse in Bristol and Edinburgh, Hannah gained acute hospital experience across neurology, acquired brain injury and stroke. She then gained a

wealth of experience across out of hospital settings within the NHS, independent and charitable sector, in particular palliative care and District Nursing.

5.0 EU EXIT UPDATE

The Trust continues to keep up to date with the latest Brexit updates as we move ever closer to the end of the Brexit transition period. **John Campbell, Chief Operating Officer, will be the Senior Responsible Officer for the EU Exit for GHC** as it is crucial that this work is fully co-ordinated with the Covid response and winter planning.

Given that agreement on the terms of the future relationship does not seem imminent, the NHS Confederation has advised that it is likely the NHS will soon need to undertake preparations for potential no-deal style disruption.

The NHS Confederation released a member briefing last month, 'Approaching the end of the Brexit transition: practical implications for the NHS', that aims to clarify the issues for the NHS and lay out what organisations need to start to consider for the end of the year.

Further clarity was provided this week from the government on what will be in place to support the health sector from 'day 1' after Brexit transition. The UK's Medicines and Healthcare products Regulatory Agency (MHRA) on 1 September published a host of guidance for industry and organisations on how to operate from 1 January 2021, including on licensing of medicines and devices, clinical trials, exporting active substances for medicines, importing medicines and investigational medicinal products, pharmacovigilance procedures and new IT systems.

The Association for British Pharmaceutical Industry, which represents pharmaceutical companies preparing for the end of the Brexit transition period, responded to the MHRA guidance saying that companies welcome the important detail included in this guidance which will support them in planning. However, they also asked for further guidance and detail on some areas to do with regulatory controls and the trade in medicines across the EU-UK and GB-NI borders.

On the question of implementing the Northern Ireland Protocol, which is also due to be complete by the end of the year, the NHS Confederation and Northern Ireland Confederation for Health and Social Care recently published a briefing to highlight the considerations it raises for health and social care services on both sides of the border, and what it means in terms of change for the health sector.

In addition to the regulation and movement of medical supplies across the borders, a second key 'day 1' issue after transition for patients is what happens to our rights to access health and care services while living, travelling or working in the EU. The Brexit Health Alliance recently looked at the issue through a series of case studies to explore what citizens' rights are from 1 January 2021 onwards.

With all this talk of what health in the future post-Brexit Britain will look like, many in the health sector are asking where we should go from here. The Reform think tank

this week published a collection of views on the future of regulation discussing steps the UK should take to deliver a dynamic and responsive regulatory system for medicines and medical devices post-Brexit. Authors include Dr Richard Simcock, Consultant Clinical Oncologist, Brighton and Sussex University Hospitals NHS Trust, and George Freeman MP, former Parliamentary Under-Secretary of State for Life Sciences.

The Executive, led by John, will continue to monitor guidance from NHS England and NHS Improvement to inform the Trust's preparations for 'deal', 'light deal' or 'no deal' scenarios.

6.0 SECURITY SERVICES IN GHFT

The **GHC security team** has recently completed a successful scoping exercise at Gloucestershire Hospitals NHS Foundation Trust and is providing leadership to the service there. This has been well received by colleagues in our sister trust and we are hoping to continue working with Gloucestershire Management Services (GMS) to continue with this collaborative way of working.

7.0 CONCLUSION AND RECOMMENDATIONS

The Board is asked to **NOTE** the report and the assurance provided.

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 08

REPORT TO: **Trust Board – 30 September 2020**

PRESENTED BY: Chief Executive Officer

AUTHOR: Paul Roberts, Chief Executive Officer

SUBJECT: **ORGANISATIONAL PRIORITIES UNTIL 31ST MARCH 2021**

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

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

The purpose of this report is to

Update the Board and members of the public on the proposed organisational priorities until 31st March 2021.

Recommendations and decisions required

The Board is asked to confirm its support for the approach described in section 3 and the priorities set out in the table.

Executive summary

This paper sets out the proposed priorities for the Trust until the end of the 2020/21 financial year, which were agreed by the Board at an informal meeting on 11th August 2020.

An update on framing the strategic programme post-merger and capacity in the context of Covid is provided. The Board discussed and agreed a realistic set of 23 priorities for the Trust to pursue over the next six months; these are set out within the body of the report.

Risks associated with meeting the Trust's values
Any risks are referenced in the report

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

Where has this issue been discussed before?
N/A

Appendices:	Report attached

Report authorised by:	**Title:**
Paul Roberts	Chief Executive Officer

ORGANISATIONAL PRIORITIES UNTIL 31ST MARCH 2021

1.0 BACKGROUND

In August 2017, when the Boards of 2gether and Gloucestershire Care Services (GCS) agreed a "**Strategic Intent**" to merge, a framework to oversee this work was adopted comprising three elements known as the three "T"s:

- **Transaction**
- **Transition**
- **Transformation**

By 26th September 2019, when the two Boards met as separate entities for the last time, the first "T" – Transaction was largely compete (it successfully completed five days later on 1st October), there remained however a great deal to complete on the second "T" - Transition and the emergent new Trust had not developed and adopted a strategy to encompass the third "T" –Transformation. Therefore the two Boards agreed a set of **5 short-term high-level priorities** to cover the first six months following the formation of GHC, they were:

- **Consolidation of the merger**
- **Development of a Trust Strategic Framework**
- **Transfer of the Herefordshire mental health and learning disability services**
- **Building blocks of organisational transformation**
- **Progress on the "system" and "place" agenda**

A great deal of progress was made in pursuing these priorities, notably, most outstanding elements of our merger have now been completed with a few remaining that were deliberately postponed and the transfer of the Herefordshire services was completed on time.

Progress was also made on the other priorities however the last two months of 2019/20 was largely taken up by Phase 1 of our Covid-19 response and this has continued over the last eight months with Phase 2 and now Phase 3 recovery. This overwhelming focus has inevitably delayed the progress of the Trust on completing the other priorities and objectives described above.

2.0 CONTINUING BOARD DISCUSSIONS ON ORGANISATIONAL PRIORITIES

In June the Board resumed active discussion of the next steps in developing and delivering the Trust's long term strategy and agreeing further short-term priorities for the organisation. Clearly this has taken place acknowledging that the continued presence of the Coronavirus and the significant challenges it presents provide a backdrop for this work. At the Board Seminar on 24th June, the Non-Executive Director meeting on 17th July and the Board meeting on 22nd July there was useful

discussion on the Trust strategy and the need to identify clear short term priorities in the context of Covid.

On 11th August the Board met informally to discuss and agree the priorities for the Trust until the end of 2020/21 financial year. The following section sets out what was agreed.

3.0 PROPOSED ORGANISATIONAL PRIORITIES UNTIL MARCH 2021

Framing the strategic programme post-merger

The Board agreed that now GHC is running as a confident, ambitious integrated organisation the strategic programme would not be defined by the merger. Therefore the strategy would not be focussed on pursuing the third "T" – Transformation *per se.* Clearly, as an ambitious organisation, many of our aims and objectives will be transformative, but they will be so on their own terms. Also whilst the strategy will build on the "proof of concept" projects undertaken during the merger process the Trust will pursue integration as an aim which will deliver benefits to patients in its own right rather than simply on the basis that it is a "benefit of merger".

Capacity

It was acknowledged that the capacity of the organisation and its leadership team continue to be impacted by the exceptional challenges presented by Covid; both recovery and a potential second surge.

In particular the management and organisational arrangements for the Strategy and Partnership Directorate under Angela Potter had not been finalised when the Covid Programme commenced and were only signed off in July at the last Board meeting. This and the temporary redeployment of many relevant colleagues has reduced strategic management and planning capacity further.

The resourcing of the Strategy and Planning function have now been agreed and recruitment to key roles is either underway or has been completed. Other Directors and senior staff have also had, and continue to operate with, Covid related capacity constraints but are now able and keen to focus on pursuing the strategic agenda for the Trust. It is therefore realistic to move ahead with a defined pragmatic number or strategic priorities.

Proposed Priorities

The Board discussed and agreed a realistic set of 23 priorities for the Trust to pursue over the next six months set out in the table below.

These are "development priorities" rather than "maintenance priorities", i.e. objectives where the aim is to pursue genuine change. Clearly there are always

other objectives which also require considerable time and capacity in order to maintain our governance and management systems effectively, these are not described here.

The priorities have been divided into three categories:

- **Foundations** – the basic requirements needed to ensure that the organisation is safe, secure and well-governed
- **Building blocks** – the elements required to support the organisation in achieving excellence and its ambition to be excellent in both "core business" and in delivering more radical transformation
- **Ambitions** – the areas where we want to make real early transformational progress.

The priorities were also grouped according to the four strategic aims of the organisation.

Strategic Aim	Foundations	Building blocks	Ambitions
High quality care	• Further build a strong voice within the ICS • Develop and maintain Covid safe environments	• Develop an effective QI programme • Build sustainable access to digital care platforms	• Develop a focussed academic partnership • Maximising the impact of the MH Investment Standard • Finalise plans for a hospital in the FoD which provides an excellent and future-proof environment • Continued ambitious roll-out of personalised care agenda
Better health	• Develop a process for routine access to good PHM data and information	• Focus on developing relationship with Gloucester and Cheltenham ILPs with	• Participate in PHM programmes in Cheltenham and Gloucester focussed on inequality

		shared priorities which match GHC ambitions • Develop good data and information on access by high risk communities to our services (a Phase 3 requirement)	• Some further targeted ILP activity focussed on inequality in Gloucester linked to Mental Health investments
Great place to work	• Continued development of recruitment and retention approaches • Further development of H&WB support	• A focussed equality, diversity and inclusion programme	• Pilot a more radical approach to distributed leadership (self-managed teams for instance)
Sustainability		• Develop an estates and "assets" enabling strategy • Develop an environmental sustainability strategy and programme	
Generic	• Provide good support for digital technologies • Continue the development of the Trust Strategy and the detailed	• Finalise the digital strategy specifically for GHC	• Targeted "Covid inspired" role out of digital technology

	ambitions and objectives to support it		

4.0 RECOMMENDATION

The Board is asked to confirm its support for the approach described in section 3 and the priorities set out in the table.

AGENDA ITEM: 09

REPORT TO: **Trust Board – 30 September 2020**

PRESENTED BY: Angela Potter, Director of Strategy & Partnerships

AUTHOR: Angela Potter, Director of Strategy & Partnerships

SUBJECT: **INTEGRATED CARE SYSTEM UPDATE**

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

The purpose of this report is to:

This paper provides an update on the activities that are taking place across the Gloucestershire Integrated Care System (ICS).

Recommendations and decisions required

- Trust Board is asked to **note** the contents of this report.

Executive Summary

The Sustainability and Transformation plan is now in its fourth year (from April 2020) and the ICS continues to play a key role in improving the quality of Health and Care by working in a more joined up way as a system.

The ICS has continued to co-ordinate the system wide Recovery Response to the COVID-19 pandemic and to start the activities associated with the system wide winter plan and the phase 3 planning returns. Service change proposals were presented to the Health Overview and Scrutiny Committee on the 15th September 2020.

The Integrated Locality Partnerships have now also re-commenced their activities and started to revisit their priority actions moving forward, taking into account the impact of COVID.

The Mental Health & Well-being Partnership Board has held a multi-agency workshop focused on the impact and learning from COVID

Public Consultations - The Fit For the Future programme work programme continues to progress with a proposed public consultation in the Autumn (subject to usual assurance and governance requirements).

The development of the new hospital in the Forest of Dean also requires a final phase of

consultation on the proposed service models. Whilst this is not tied to the FFTF programme to enable the smooth running of the consultation and maximise the use of the available resources this will run concurrently with the FFTF consultation commencing mid-October

There have been a number of **engagement and survey activities** to continue to understand the impact that the pandemic has had on our population.

Risks associated with meeting the Trust's values
None.

Corporate considerations	
Quality Implications	There have been changes to previous programmes of work in light of COVID-19. This may impact on agreed timelines and delay some changes coming forward which may have an impact on the Trust's programme of change and service delivery and this ultimately may impact on the quality of care to our population.
Resource Implications	None specific to the Trust
Equality Implications	None specific to the Trust

Where has this issue been discussed before?
Regular report to Trust Board.

Appendices:	The One Gloucestershire ICS Lead report **is available in the reading room**

Report authorised by:	**Title:**
Angela Potter	Director of Strategy & Partnerships

INTEGRATED CARE SYSTEM UPDATE

1. INTRODUCTION

This paper provides Board Members with an overview and update on the activities that have been taking place across the Gloucestershire Integrated Care System.

2. PHASE 3 PLANNING – COVID RECOVERY

The Gloucestershire system has made good progress in re-establishing services and promoting access however, there is a recognition that services cannot return to previous operating models for a range of reasons associated with COVID eg. social distancing measures in place at all sites, greater infection control measures which include but are not limited to enhanced cleaning, PPE for staff and patients etc.

The most recent discharge guidance is also being worked through with a focus on ensuring the system can safely support the care home sector and that we have the right levels of community capacity, including monitoring levels of access across primary care. Colleagues in the acute sector are continuing to work through their recovery plans for increasing the capacity and activity in elective and cancer services as well as diagnostics and urgent care.

The system continues to develop its plan to ensure that it can operate at the highest possible capacity whilst continuing to keep staff and patients safe. Additional support is being negotiated with the independent sector where this is deemed appropriate. It has also meant that some service locations have changed and that services may operate on reduced capacity. Both GHC and Gloucester Hospitals Trust have developed phase 3 proposals that have resulted in service change.

The system presented these service changes to the health overview and Scrutiny Committee on the 15th September 2020 and received support to extend these for a further 6 months to prevent any service disruption in the middle of winter. For GHC this incorporated two key service changes;

Minor Injury Unit Changes

Unit	Normal hours	April – Sep hours	Proposed hours (from Sep)	Proposed change
Cirencester	8am – 11pm	8am – 6pm	8am – 8pm	**Increase opening by 2 hours**
Stroud	8am – 11pm	8am – 6pm	8am – 8pm	**Increase opening by 2 hours**
North Cotswolds	8am – 8pm	8am – 6pm	8am – 8pm	**Full opening**
Vale	8am – 8pm	Closed	10am – 6pm	**Re-opening –**

Unit	Normal hours	April – Sep hours	Proposed hours (from Sep)	Proposed change
			(from Oct)	ongoing assessment to reach normal opening hours
Dilke	8am – 11pm	Closed	Closed	**Remain Closed**
Lydney	8am – 11pm	8am – 6pm	8am – 8pm	**Increase opening by 2 hours**
Tewkesbury	8am – 8pm	Closed	8am – 8pm	**Full Opening**

The amendment to opening hours has been considered in conjunction with the need to maintain safe access to these services and whilst a Walk In offer remains an option, we are also expanding the option for on the day bookable appointments either accessed via NHS 111 or by using a clinically staffed telephone advice line, so that we can assess patients before they are directed to an MIIU, or advise them to attend another health care setting.

Patient behaviour is suggesting they are keen to use telephone advice/triage before arriving at a unit, as it reduces waiting, but MIIUs continue to accept walk-ins and have local processes in place to manage the risk.

Due to the design and size of the Dilke MIIU we are unable to open the unit at this time, as it has limited options for social distancing and effective streaming of Covid and non-Covid patients. However as we progress our direct booking offer we will consider this site for bookable appointments only.

Stroke Rehabilitation at The Vale Hospital

Stroke capacity at GHT has been impacted by the need to introduce social distancing measures into their sites. However, we know that stroke is the 4th biggest cause of death and disability therefore keeping the flow and specialist nature of these services was felt to be a system priority. The Trust has been asked to continue to operate the additional 6 beds at the Vale as Stroke Specialist beds for the next 6 months. This has been supported by the HOSC and we are now in the process of working through how we will continue to staff and operate this model of care.

3. INTEGRATED LOCALITY PARTNERSHIPS

Six Integrated Locality Partnerships (ILPs) operated across the whole of Gloucestershire and they are made up of 15 PCNs. All ILP activity has now started to recommence after being stood down throughout COVID with initial meetings starting to be scheduled across September and October. The first action all ILP's are undertaking is a review of their previous priorities and an assessment of the impact of COVID on these moving forward. The following section gives an update if the ILP has met recently.

Locality	Initial Priorities Identified	Scheduled Next Meeting
Cheltenham	• Population health Management • Complex Care at Home • Care Homes Project	7th September
Gloucester	• Obesity • Mental well-being • Self-care and prevention • Complex Care at Home including frailty • Housing	22nd September
Stroud & Berkeley Vale	• Frailty & dementia • Carers • Children & Young People (especially behaviour issues and depression)	17th September
Tewkesbury	Priorities still to be determined	Workshop planned for 6th October – further dates yet to be confirmed
Cotswolds	• Housing and health • Lifestyle and prevention • Social isolation • Child & Young people's development and well-being • Mental well-being • Frailty	15th September
Forest of Dean	• Childhood obesity & mental well-being • Diabetes in children & young people • Frailty • Long Term Conditions linked to unemployment	Tentative date of 21st October

All of the Primary Care Networks are assessing how to take forward the Enhanced Care in Care Homes element of their contract. This requires a strong focus on multi-disciplinary assessment and input from our Integrated Care Teams so we are actively engagement with system partners in terms of how best to achieve this.

Cheltenham ILP – The ILP met on the 7th September 2020.

Cheltenham ILP has been the test site for the development of Population Health Management (PHM) across Gloucestershire. PHM will be one of the key strategic drivers for the system to reduce health inequalities by focusing on stratified segments of the population (by locality) we can then use the data to develop targeted interventions. GHC has been fully engaged in this work from the outset.

The learning from PHM will be taken back the county wide steering group and support the roll out and spread of this work. The next priority ILP locality will be Gloucester City.

The ILP noted that primary care is starting to see a spike in vulnerable people who weren't previously seeking services pre-COVID as they had informal support mechanisms in place which have broken down. This situation is continuing as we move into the next phase of the pandemic.

Stroud & Berkeley Vale ILP – This ILP has held a number of virtual touchpoint meetings since July 2020 and had their first formal session on the 17th September. The ILP continue to focus on their priority areas but also how they could continue the multi-agency work as the pandemic continues. They noted increasing pressures in primary care and in the community sector with the voluntary sector keen to expand their support offer. PCNs are now starting to employ their own physiotherapists and remain in discussion with the Trust over mental health community based practitioners.

The dementia pilot that has been taking place in this ILP has been considered to be very successful in terms of both supporting families and reducing the demand on services. There are ongoing considerations as to how this could be made mainstream.

Cotswolds ILP – The collaboration between our Integrated Community Teams and the GP's has been highlighted as a positive development. They have also been utilising data analysis to target those areas where need is the greatest with isolation and loneliness and those with pre-diabetes and obesity being the greatest users of services. Deeper dives into these groups and the actions that can be taken to help meet their needs differently will be a focus moving forward.

4. FIT FOR THE FUTURE (FFTF)

The work programme continues to progress with a proposed public consultation in Mid-October (subject to usual assurance and governance requirements).

5. FOREST OF DEAN NEW COMMUNITY HOSPITAL

The development of the new hospital in the Forest of Dean also requires a final phase of consultation on the proposed service models. Whilst this is not tied to the FFTF programme, to enable the smooth running of the consultation and maximise the use of the available resources this will run concurrently with the FFTF consultation commencing mid-October.

As such, work is being progressed by Gloucestershire Clinical Commissioning Group to conclude the NHS England/Improvement Stage 2 Assurance process to enable the consultation to commence. We are anticipate that this will happen early October with a presentation of the consultation proposals to Health Overview and Scrutiny Committee (HOSC) later in the month prior to the consultation commencing.

6. WIDER ICS AND PARTNERSHIP UPDATES

Focus on Patient, carer and staff feedback and engagement

During the COVID-19 pandemic ICS Partners and Healthwatch Gloucestershire continued to maintain service user and carer involvement. This has taken place in a

number of ways including via PALS and our own social inclusion team. In addition partner organisations have been running a number of surveys to gain feedback on the impact of COVID including:

- Inclusion Gloucester and Kingfisher Treasure Seekers - focus on understanding the health inequalities that diverse communities face.
- Barnwood Trust conducted a study between April and June 2020 – focus on disabled people and people with mental health challenges. The report titled *Our changing world* has now been published and makes a number of recommendations that the Trust will consider as part of our ongoing recovery and service development.
- Healthwatch Gloucestershire are running a survey until the end of September looking at people's experiences before lockdown, how they are finding accessing services and the impact to their lives since the pandemic

In order to continue to learn from our response to COVID-19 and improve services the ICS has planned further ways to engage with patient, carer, staff and the public to gather their feedback and we will continue to use the feedback to supplement our own internal engagement mechanisms.

Health & Well-Being Board (HWB)

The HWB has launched a group to scope out the development of the system approach to Anchor Institutes (GHC has volunteered to be a member of this).

The 3 main areas of focus were identified as purchasing power (social supply chain), recruitment/training and employment and system leadership. There was a focus on the BAME inequalities along with other vulnerable groups and a need to ensure targeted activities to help address these inequalities. The group has had its first meeting and a work plan will be developed in due course.

The HWB meets on the 22nd September and is receiving an update on the work programme associated with the delivery of the HWB strategy which was signed off In June 2020. The Trust has taken a lead on the mental health and well-being priority within the strategy and will be taking this forward in conjunction with the Mental Health Partnership Board.

Angela Potter
Director of Strategy & Partnerships

with you, for you

Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 11

REPORT TO:	**TRUST BOARD**
PRESENTED BY:	John Campbell, Chief Operating Officer
AUTHORS:	Sarah Birmingham, Associate Director of Operations & Rosemary Neale, Service Director – Adult MH / LD
SUBJECT:	**MENTAL HEALTH DEVELOPMENTS**

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

The purpose of this report is to:

This report provides the Board with an update on a range of mental health developments within the Trust, which we aim to progress, following a period where many have been paused due to the Covid pandemic. It is increasingly recognised that the mental health needs of the population are being impacted by the Covid situation, particularly the level of change creating new societal norms and on-going anxiety in relation to Covid.

A number of these mental health developments are supported by additional funding from the Mental Health Investment Standard (MHIS). This standard was brought in to address funding disparity which favoured physical health services which left mental health services significantly underfunded. The standard requires CCGs to increase investment in mental health services at a faster rate than their overall increase in funding allocation each year.

Recommendations and decisions required

The Board is asked to **note** the report

Executive summary

This report provides a summary of the range of Mental Health developments being progressed by the Trust, a number of which are supported by the MHIS.

Risks associated with meeting the Trust's values
Potential impact on progressing developments in line with the NHS Long Term Plan if there is a further impact on the Trust of the Covid-19 pandemic

Corporate considerations	
Quality Implications	None identified
Resource Implications	Many developments funded through the MHIS and in line with the aims of the NHS Long Term Plan
Equality Implications	Increasing need to focus on addressing health inequalities as part of our developments

Report authorised by:	**Title:**
John Campbell	Chief Operating Officer

Mental Health Developments

1.0 Introduction

This report provides the Board with an update on a range of mental health developments within the Trust, which we aim to progress, following a period where many have been paused due to the Covid pandemic. It is increasingly recognised that the mental health needs of the population are being impacted by the Covid situation, particularly the level of change creating new societal norms and on-going anxiety in relation to Covid.

A number of these mental health developments are supported by additional funding from the Mental Health Investment Standard (MHIS). This standard was brought in to address funding disparity which favoured physical health services which left mental health services significantly underfunded. The standard requires CCGs to increase investment in mental health services at a faster rate than their overall increase in funding allocation each year. The Trust is in discussions with the CCG in relation to funding allocated through the MHIS in light of the financial framework for the second half of 2020/21.

It is important to recognise that whilst we have made significant progress in re-instating our services after the Covid peak in April 2020 as part of our active recovery, there are growing concerns regarding a potential second covid surge and difficult winter. We will closely monitor any potential impact on the delivery of these initiatives

2.0 Mental Health Developments

There have been reduced referrals and contacts across the Trust services since March 2020 and Covid-19. Post lockdown, indicators suggest referral rates look to now be increasing month to month and this is mirrored in national benchmarking.

2.1 Improving Access to Psychological Therapies (IAPT) 'Let's Talk'

Let's Talk has continued to operate business as usual throughout the Covid period by offering video based therapy via Attend Anywhere.

The current access trajectory is being reviewed with the CCG for the rest of financial year as demand had significantly reduced over lockdown period. The current proposal is to achieve 20.54% by year end, assuming integrated LTC can be resumed. Cardiac and COPD pathways are transitioning to digital delivery, which IAPT will co-deliver.

Roll out of courses have also been developed using digital platforms to continue to offer group sessions supporting throughput at Step 2.

The service is currently recruiting to workforce trajectory for the remainder of the financial year with focus on expansion of Psychological Wellbeing Practitioners (Step 2) and High Intensity Therapists (Step 3). We have recruited 7 Psychological Wellbeing Practitioner trainees who started in September. In addition, we are currently recruiting to 5 additional Psychological Wellbeing Practitioners and 15 high Intensity therapists.

Low demand over lockdown provided an opportunity to reduce waiting lists. Only 5% of people are waiting longer than 90 days between 1st to 2nd treatment which is below the national target of 10%.

Waiting times at Step 2 and Step 3 have reduced during Covid.

	6th April 2020	**7th September 2020**
Step 2 waiting	922	404
Step 3 waiting	981	641
Step 2 (over 6 weeks)	479	17
Step 3 (over 6 weeks)	672	313

Recovery rates have been maintained above the national average of 50%: Recovery rate for Q2 is 56% against a 50% national recovery target.

Recovery rates		
June	July	August
55%	56%	56%

2.2 Perinatal Mental Health

Recruitment is progressing for a Clinical Psychology role and Band 6 Mental Health Practitioner role as part of the MHIS to increase team capacity and the scope of interventions within the perinatal health service.

The additional staff will help the team access more women with moderate to severe mental health problems during pregnancy and up to a year postnatal. The funding will also improve the access to specialist perinatal psychological interventions.

Additionally, as part of the Long Term Plan ambitions the team is also beginning to explore offering assessments for Dads and partners. The service is working with Trust leads on peer support workers and as a service they are keen to employ peer supporters as part of ongoing service development.

In addition, the team has recently submitted a bid to be early adopters of a Maternity Mental Health service previously known as maternity outreach clinics. The Long

Term Plan set out the ambition to establish Maternal Mental Health services which will integrate maternity, reproductive health and psychological therapy for women experiencing mental health difficulties directly arising from or related to the maternity experience, in all areas of England by 2023/24.

2.3 Psychiatric Liaison Service

Through the MHIS, funding has enabled the Mental Health Liaison Team to deliver the CORE 24 standard at Gloucestershire Royal Hospital and the aim is to integrate the children's and adult services into an all age model. Separate Mental Health Transformation funding has helped enhance the Mental Health Liaison Team service available at Cheltenham General Hospital (to achieve a 1 hour response time). Investment in Mental Health Liaison has enabled more timely clinical input into complex cases and oversight of patients with co-morbidity including those with substance misuse/ serious mental illness.

2.4 The Complex Emotional Needs Service

MHIS funding, targeted at Gloucester City ILP has been allocated to provide a specialist service for people with complex emotional needs which are not being met by existing services.

A complex needs task and finish group commenced in August 2020. The group aims to develop a co-design service model, providing integrated care across primary, secondary and their sector services. There is wide stakeholder representation, including VCSE, CCG, primary care, expert by experience and GHC representation pan directorates.

Recruitment of a clinical lead is being progressed this month who will also hold operational responsibility for the First Contact service below.

The Gloucestershire High Intensity Network (GHIN) project in conjunction with Gloucestershire Constabulary works with people that have been either subject to Section 136 or who are in contact with the Emergency Department, or the Ambulance Service on more than two occasions in the past month. The Team works with people aged over 18 years old and who present with a complicated history and behaviours that require specialist interventions. The GHIN project funding ends in March 2021 and a Business Case is being developed to continue funding for the service. The GHIN service, if funding continues, requires integration into the Complex Emotional Needs Service pathway.

2.5 Gloucester City First Contact Mental Health Practitioners

This small initiative consists of 1.6 wte Advance Care Practitioners (ACP) working within identified GP surgeries across Gloucester (Hadwen, Quedeley and Gloucester Health Access centre). The ACP's work within the GP surgeries and offer quicker assessment and treatment of mental health conditions which aim to take pressure off primary care and release GP capacity.

Following joint investment through the MHIS and PCN finances, the service is expanding by a further 2 Advanced Care practitioners to work across all Inner City PCN practices from November 2020.

2.6 Young Adults Project (18-25yrs)

This development, in line with the NHS Long Term Plan, and supported by MHIS funding is a partnership between GHC CAMHS and Young Gloucestershire with a strong emphasis on participation. The aim is to address the unmet mental health needs of young adults who do not meet the threshold of statutory Mental Health Services by supporting the counselling services in place at Young Gloucestershire. These typically include (but are not confined to) past trauma or Adverse Childhood Experiences (ACES) that are having an enduring impact on emotional wellbeing being or function. Innovative approaches will be planned and co-produced with young adults that may include group as well as individual work.

2.7 The Gloucestershire Mental Health Trailblazer 4WW Programme

Gloucestershire's MH Trailblazer has 2 elements – a 4WW pilot and the introduction of Mental Health in School Teams (MHSTs).

The 4WW pilot aims to improve accessibility to mental health services, including enhancing delivery through digital transformation and reducing the number of referrals which 'bounce' between agencies. Stakeholder, Children and Young People, and Parent and Carer forums have been established and all have met during August/September with great feedback from attendees. These will continue monthly and items will be taken for comment from task and finish groups.
Waiting times have improved, as of the end of August

Number of CYP awaiting first contact	103
Number of CYP awaiting second contact	54

Through September we are seeing an increase in referrals and the waiting times at mid-September are

Number of CYP awaiting first contact	137
Number of CYP awaiting second contact	67

Using a quality Improvement approach, the next phase of this initiative will be to establish specified Task & Finish Groups to attain key deliverables within a 3 year transformation plan. This will include:

- Remarketing and repositioning of the core CAMHS offer across the system.
- Phased implementation of a Multi-Agency Front Door to improve timeliness and accessibility of local mental health services for children and young people.

- Introduction to and embedding of the THRIVE framework across the system
- Development of needs based pathways to improve access and enable earlier intervention and prevention, seeking to reduce health inequalities.

The THRIVE framework is nationally recognised as an effective basis for service transformation plans for child and adolescent mental health services. The framework is an integrated, person-centred and needs-led approach to delivering mental health services for children, young people and families which conceptualises need in five categories or needs based groups: Thriving, Getting Advice, Getting Help, Getting More Help and Getting Risk Support.

In collaboration with the CGG, GHC host a Digital and Partnership/Inclusion Project Group which using technology aims to enable children and young people, and those supporting them, to easily access personalised mental health and wellbeing advice and help inform appropriate content for future service users. The aims of this work are to:

- Enable children and young people and their families, and professionals in Gloucestershire to have access to the most reliable and relevant information to help support mental health and wellbeing, including scoping out the potential for a patient portal.
- Co-design resources which are accessible and useful with children and young people, empowering them to drive our transformation programme.

The intention is also to recruit a Digital and Partnership Inclusion Lead Practitioner to drive this agenda, including developing a Children and Young People's health based Participation Plan.

In terms of Mental Health in School Teams (MHSTs) we have successfully completed the first year recruitment of 23 staff including Educational Mental Health Practitioners and Senior Mental Health Practitioners. We have established four Mental Health Support Teams who are fully operational across 73 Trailblazer schools in the Gloucester, Cheltenham and Forest of Dean localities.

The teams are working in collaboration with TIC+ and GHLL to provide early intervention for emotional wellbeing of children across the 73 schools using a Whole School Approach.

The MHST impact will be undergoing full evaluation in December 2020 by an external auditor with focus on qualitative and quantitative measures and will be available in the New Year.

2.8 Trevone House

Gloucestershire County Council has now partnered with a private provider, Homes2Inspire, to improve the quality of life for care experienced young people to enable them to remain in Gloucestershire with the support they need. Trevone House will provide semi-independent accommodation, as well as other specialist

services, that will help young people by giving them the support they need as they head into adulthood and build their independence.

The building itself will host semi-independent accommodation for young people aged 16 +, a designated space for day provision and well-being placements for young people with emotional health support providing a place of safety/calm. (Vision and specifications have yet to be developed for day provision and place of safety/calm).

A trauma informed partnership approach will be implemented by Homes2Inspire, operating in an ACES's aware manner.

The first cohorts of young people are expected to join Trevone House from December 2020 onwards.

The key objectives for Trevone House include:

- Provide a multi-agency support in county for care experienced young people
- Support young people stepping down from Tier 4 health beds, thereby improving stability, educational and employment prospect
- Support transition to adulthood
- Enable young people to successfully sustain a tenancy (staying close).

Trevone House is a new and innovative project which will change and test current delivery of services to our most vulnerable young people using a multi-agency partnership approach.

2.9 Review of complex Children and Young People

There have been long standing challenges in Gloucestershire in consistently addressing the needs of children and young people with complex presentations (particularly those with a mental health component) who require additional Social Care support including residential placements. GHC and GCC are jointly keen to tackle patterns of interaction between the organisations which are not conducive to delivering optimal care and as a result may have a negative impact for both the child/young person as well as the staff involved.

The aim of this work is to explore current barriers, gain a deeper understanding of each other's responsibilities and develop new ways of interacting that enable challenging but respectful discussions to reach consensus on the optimal plan for children and young people. The ultimate aim is to hold collective ownership for delivering high quality and responsive care for children and young people, which can be evidenced by Ofsted and CQC inspection findings.

2.10 CAMHS Level 3 Outreach Team

Through the MHIS the CAMHS Outreach Team will be established to provide interventions that are systemic, individualised and more intensive to support earlier discharge from Tier 4 Units where clinically indicated, as well as supporting core CAMHS provision to prevent 136 or Tier 4 admissions, including re-admissions.

2.11 CAMHS CIC Fostering Developments Project (FDT)

The Fostering Developments Team Pilot was set up as a result of an identified need for newly-approved foster carers to have additional and proactive support and training in the psychological needs of children and young people in care, rather than reactive support in a crisis / potential placement breakdown situation. The pilot ran between April 2019 and January 2021 (extended due to COVID), with the aim of to improving the understanding of newly-approved Gloucestershire County Council foster carers of the impact of adverse childhood experiences (ACE'S) on the emotional and relational needs of children in care.
To date:

- 61 sets of newly approved foster carers supported through consultation.
- 95 Individual children in care supported indirectly through consultation.
- 85 foster carers and social workers attended training.
- 87 social workers in regular clinical group supervision.

3.0 Conclusions

The range of developments within mental health, are fully aligned to our aspirations of prevention and early intervention as the main provider of specialist mental health services in Gloucestershire. We deliver many of our services in partnership with other statutory organisations and the Voluntary, Community and Social Enterprise (VCSE) sector.

The Covid pandemic has magnified issues in relation to health inequalities. It will be important as we move forward as a Trust, to understand the role that we can play in tackling issues relating to equality, diversity and inclusion particularly in relation to mental health. This will include how we work with the diverse range of community groups who have played a key role in supporting communities during the pandemic.

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 12.1

REPORT TO:	**Trust Board – 30 September 2020**
PRESENTED BY:	Neil Savage, Director of HR & OD
AUTHORS:	Linda Gabaldoni, Head of OD/Neil Savage, Director of HR/OD
SUBJECT:	**STAFF HEALTH AND WELL-BEING - NATIONAL NHS PEOPLE PULSE SURVEY JULY TO AUGUST 2020 & COVID RISK ASSESSMENTS**

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

The purpose of this report is to:
This report sets out feedback and results from the Trust's voluntary participation in the National NHS People Pulse Survey between the months of July to August 2020. The feedback has been used to suggest recommended priorities going forwards. The report also provides an update on progress with COVID-19 risk assessments and highlights the next actions to continue to improve completion.

Recommendations and decisions required
The Board is asked to:

- **Review** and discuss the feedback and **note** the key actions agreed by the Executive Committee.

Executive summary
Early during the pandemic, the Trust agreed to participate voluntarily in a new nationally provided Health and Well-being Pulse survey. It was considered this would provide the Trust with an off-the-shelf local survey of colleagues' views alongside, importantly, helpful national benchmarking.

The Executives have previously received two update reports on the Pulse Survey feedback and this report to the Board provides an update and longitudinal picture.

The Trust has performed very well in comparison with other organisations, and in the majority of cases, consistently above average. The feedback trend from responses confirms that colleagues rate the Trust higher than the national average in response to the following keys areas:

- colleagues feeling informed
- feeling supported
- feeling able to have a work/life balance
- feeling calm
- feeling motivated
- feeling confident in local leaders

Of note, the most common responses to the question 'What support would make the biggest difference to help you at work?' was 'more updates on changing operations/ways of working' (31.46%) and 'more frequent team huddles/virtual check ins or other ways to maintain team connection ' (30%).

Going forwards – particularly in light of COVID and the new NHS People Plan --, it is important that the Board, the Executives, the Health and Well-being Hub, line managers, Working Well and HR continue to put strong and regular focus on the importance of health and well-being within the organisation.

Finally, there is an update on our progress with COVID-19 risk assessments and highlights the next actions to continue to improve completion.

Risks associated with meeting the Trust's values

The risks of not progressing our health and well-being agenda within the Trust and the wider ICS risks lower resilience, higher sickness and avoidable turnover. It will be difficult to square a message of being the best place to work, without top notch and constantly developing health and well-being offers and support. The risk of not having completed COVID-19 risk assessments for all at risk colleagues present potentially increased personal health risk and liability risks for the Trust. It is important that our leadership supports the plans to improve completion.

Corporate considerations	
Quality Implications	Quality clinical & non-clinical services demand quality health & well-being provision & support on a collective & personal basis.
Resource Implications	At the moment our health & well-being offers have been funded within existing resources alongside successful local & national charitable bids. This needs on-going review.
Equality Implications	Health & well-being offers within the Trust are regularly equality impact assessed to ensure that protected characteristics are not treated unfairly or unequally & that were necessary differentiated approaches are taken to mitigate inequalities.

Where has this issue been discussed before?
Executive Committee July and September 2020

Report authorised by:	**Title:**
Neil Savage	Director of HR & OD

Staff Health and Well-being - National NHS People Pulse Survey July to August 2020 & COVID Risk Assessments

Wave 1 Pulse Survey Response

From a benchmark perspective, a high number of Trust colleagues (343) responded during that time and the rating was as follows:-

- 84% of colleagues felt informed (the same as the national average)
- 73% feel supported (no national comparison available)
- 65% feel able to have a work/life balance (***better*** than the 62% national rate)
- 60% feel calm (***better*** than the 57% national rate)
- 55% feel motivated (***better*** than the 51% national rate)
- 67% feel confident in local leaders (the same as the 67% national rate)

This was one of the highest response rates from those organisations participating in the survey.

Importantly, the most common answer to the question '**What support would make the biggest difference to help you at work?** was '**more frequent team huddles/virtual check ins or other ways to maintain team connection. '**

Wave 2 Pulse Survey Response

Disappointingly only 65 Trust colleagues responded during that time. However, the benchmarking rating remained very positive with the ratings as follows:- .

↑ ↓ = compared to the Trust's Wave 1 response

- 93.8% of colleagues feel informed (the same as the national average)↑
- 80% feel supported (better than national average) ↑
- 70.8% feel able to have a work/life balance (better than 62% nationally) ↑
- 57.8% feel calm (less than national) ↓
- 56.3% feel motivated (better than the 51% national rate) ↑
- 72.3% feel confident in local leaders (better than the 67% national rate) ↑

The most common answer to the question '**What support would make the biggest difference to help you at work?'** was '**more frequent team huddles/virtual check ins or other ways to maintain team connection. ' (35.9%) and more updates on changing operations/ways of working (35.9%)**

The most common answers to '**What one piece of feedback about the NHS response to the coronavirus would you like to share with your senior local or national NHS leadership team?'** was '**Colleagues are overworked / tired / workload too high**' (15.4%) and '**Crisis has been handled well at the local level'** (15.4%)

Wave 3 Pulse Survey Response

There was an improved response rate for this survey over Wave 2, with 134 Trust colleagues responding, with their ratings as follows:-

↑ ↓ = compared to the Trust's Wave 2 response

- 89.6% of colleagues feel informed (***better*** than the national average) ↓
- 71.6% feel supported (***better*** than the national average) ↓
- 70.1% feel able to have a work/life balance (***better*** than national average) ↓
- 64.9% feel calm (***better*** than national average) ↑
- 61.2% feel motivated (***better*** than national average) ↑
- 66.4% feel confident in local leaders (***better*** than national average) ↓

Interestingly, in answer to the question **'I have found the national H&W support valuable' – 64% of people said 'wellbeing apps'**

In answer to the question **'I have found the local H&W support valuable' – 42% of people said '1:1 support'** and **39.1% said 'group support'**

Again, the most common answer to the question '**What support would make the biggest difference to help you at work?'** was '**more frequent team huddles/virtual check-ins or other ways to maintain team connection. '(39.8%) and more updates on changing operations/ways of working (28.6%).**

The most common answers to '**What one piece of feedback about the NHS response to the coronavirus would you like to share with your senior local or national NHS leadership team?'** was **'Improve safety guidelines/improve guidance enforcement'** (23.8%) and '**Communications need improvement'** (19%)

Wave 4 Survey Response

Again, there was an improved response rate for this survey, with 212 Trust colleagues participating and providing the following ratings:-

↑ ↓ = compared to the Trust's response in Wave 3

- 89.2% of colleagues feel informed (higher than the national average) ↓
- 75% feel supported (above national average) ↑
- 73.1% feel able to have a work/life balance (above national average) ↑
- 65.2% feel calm (higher than national average) ↑
- 55.5% feel motivated (higher than national average) ↓
- 70.3% feel confident in local leaders (above national average) ↑

In answer to the question **'I have found the national H&W support valuable' – 52.9% of people said 'wellbeing apps'** and **35.3% said 'staff support'**

In answer to the question **'I have found the local H&W support valuable' – 57% of people said '1:1 support'** and **37.7% said 'group support'**

Again, the most common answer to the question '**What support would make the biggest difference to help you at work?'** was **'more updates on changing**

operations/ways of working' (31.46%) and 'more frequent team huddles/virtual check ins or other ways to maintain team connection ' (30%)

The most common answers to '**What one piece of feedback about the NHS response to the coronavirus would you like to share with your senior local or national NHS leadership team?'** was '**Communications need improvement'** (18%) and **'Improve safety guidelines/improve guidance enforcement'** (17%) and **'lack of PPE/ lack of appropriate guidance on PPE'** (15%)

Wave 5 Survey Response

Detailed graphs and infographics for the Wave 5 and earlier Wave responses are included in the appendix to this report. Notably in this most recent Wave, the majority of internal Trust ratings have scored lower than the previous Wave, but consistently remain better than the national averages. This is believed to reflect colleagues' thoughts and emotions with the end of summer holidays, schools returning and facing the reality of Winter and a second surge.

↑ ↓ = compared to the Trust's response in Wave 4

- 84.2% of colleagues feel informed (better than the national average) ↓
- 84.2% feel supported (better than national average) ↑
- 68.4% feel able to have a work/life balance (better than national average) ↓
- 57.9% feel calm (better than national average) ↓
- 52.65% feel motivated (better than national average) ↓
- 78.9% feel confident in local leaders (better than national average) ↑

31.6% of colleagues reported not needing additional health and well-being support.

Again, the most common answer to the question '**What support would make the biggest difference to help you at work?'** was '**more frequent team huddles/virtual check-ins or other ways to maintain team connection ' (31.6%) and 'more updates on changing operations/ways of working' (26.3%)**

Summary Pulse Highlights

The trend for the responses to the following questions is that the Trust is better than the national average in response to:

- colleagues feeling informed
- feeling supported
- feeling able to have a work/life balance
- feeling calm
- feeling motivated
- feeling confident in local leaders

COVID-19 Risk Assessment Update

The Trust continues to make good progress in uptake of its comprehensive COVID-19 risk assessment arrangements. This has been a sizeable project and needs sustained and continued focus.

The **first focus** through May and June 2020 was on ensuring that **Black and Minority Ethnic (BAME) colleagues** were assessed and fully supported to mitigate the higher risks from COVID. A risk assessment tool with algorithm and record of the assessment, based on national advice, was developed by Working Well colleagues, tested with senior colleagues and rolled out for BAME colleagues and continues to be used for new BAME appointees.

The **second key focus** of activity through July and August 2020 has then been on risk assessing and supporting those **"shielding" colleagues** identified as higher risk from COVID-19 via Public Health England's list i.e. those with underlying conditions, and planning for their return or continued support to work from home.

The **third focus** of activity through July, August and September 2020 has been to supplement this by focussing on rolling out COVID risk assessments for more latterly identified **other higher risk colleagues**. These include All Males and White Europeans who are 60 years of age or over. This has been more challenging that the previous two focus areas due to much anecdotal feedback from colleagues, that "the horse has already bolted," alongside the holiday period for managers and staff over the July, August and September period. However, plans are in place for continued work to ensure higher uptake and compliance with a proposal to request completion of the outstanding risk assessments of these colleagues by the 11th October 2020. Additional general communications, Senior Leadership Network briefing and individual emails to colleagues are planned.

Finally, the **fourth focus** has been on offering an on-line risk assessment tool for **all colleagues** irrespective of their background, age or situation.

As of 11th September 2020, the completion of risk assessments was as follows:-

Staff Category	Percentage Completion
BAME	99%
All other at risk combined	67%
- Shielding	100%
- Males	44%
- White Europeans 60 or over	73%
- All 60 or over	71%
Proportion of total staff assessed*	30%

***NB Not all Trusts are offering a risk assessment tool to all colleagues.**

Future Actions

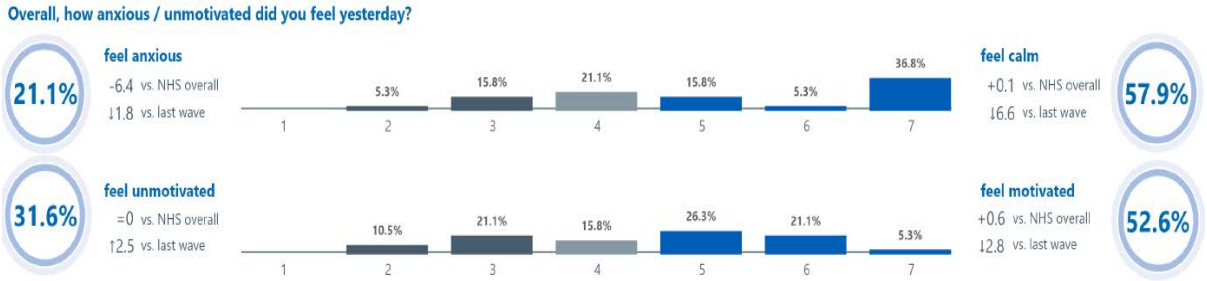
Actions and areas for improvement agreed by the Executive Committee on 22nd September 2020 are as follows:-

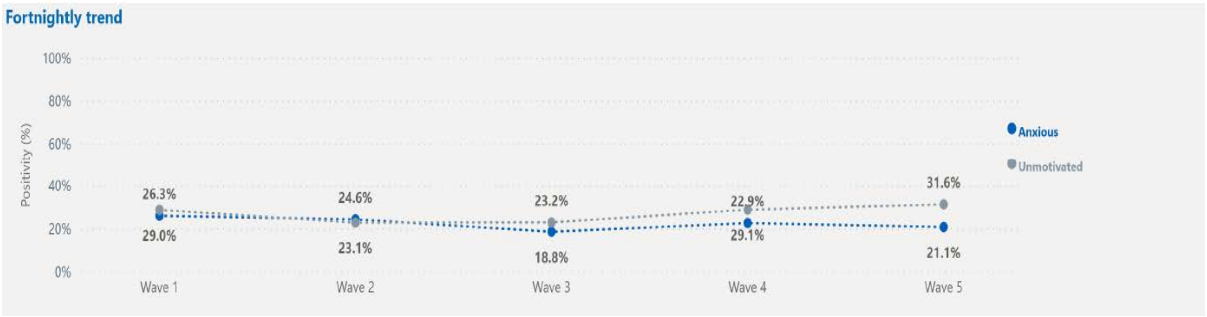
- **More frequent team huddles/virtual check-ins or other ways to maintain team connection**
  Action: - All Executives and Communications to continue to remind line managers of the importance of this through 121s, Senior Leadership Network and Indie-to-go. NB. already covered in the home working guidance and the rebuilding and reflection sessions. Timescale: immediate. Responsibility: All Executive Directors and Communication team

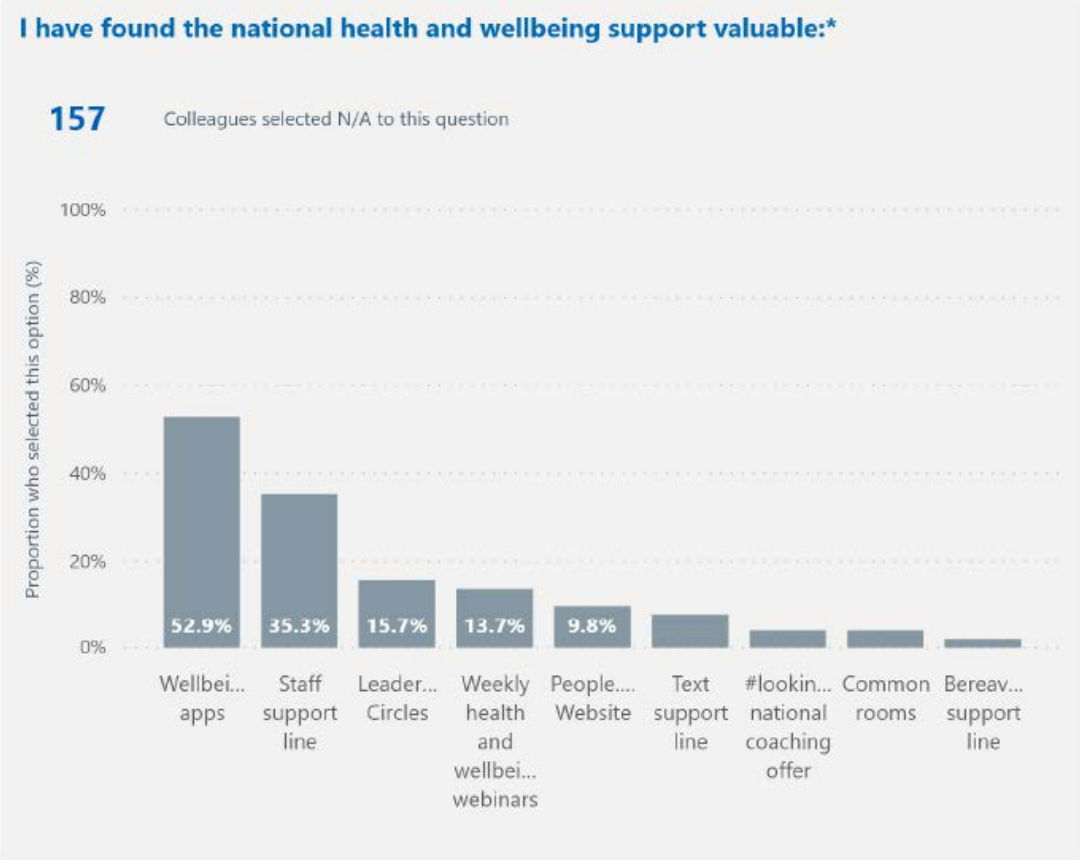
- **More updates on changing operations/ways of working**
  Action:- Feedback to Operations team and Executives' teams, for additional update provision and for teams generally to more widely adopt frequent general briefings and service updates. Timescale: immediate. Responsibility: All Executive Directors and Communication team
- **Communications need improvement**
  Action:- Executives and Senior Leaders to continue with the regular updates and reinforce role of line manager in keeping the team informed. Timescale: immediate Responsibility: All Executive Directors and Communication team
- **Improve safety guidelines/improve guidance enforcement**
  Actions:- Feedback to Executives, in particular the Director of Quality and Medical Director, supported by communications for consideration of additional options and actions. Timescale: September / early October. Responsibility: Director of Quality and Medical Director, supported by Communications.
- **Perceived lack of PPE/ lack of appropriate guidance on PPE**
  Action:- Feedback to Executives. Director of Quality, Operations, Stock and Communication colleagues to consider action Timescale: September. Responsibility: Director of Quality with Chief Operating Officer.
- **Colleagues feel overworked/tired/workload too high**
  Action:- Continue to keep high health and well-being focus and ensure appraisals/1:1s are carried out to support colleagues to prioritise and take regular breaks and that appropriate signposting is done for assistance. Timescale: immediate. Responsibility: All Executive Directors and Senior Leaders.
- **Greater clarity on the personal financial guidance available to employees**
  Action:- Salary Finance launch will be well published to Senior Leadership Network and usual comms routes to all colleagues. Inclusion in Corporate Induction. Timescale: September/October. Responsibility: Director of HR and OD.
- **Greater clarity on what travel is / isn't allowed**
  Action:- Provision of additional guidance to colleagues. Timescale: September. Responsibilities: Deputy Head of HR and Communications team.
- **Greater flexibility to my working schedule / pattern**
  Action:- Feed into flexible working, flexible retire and return policy and guidance review. Timescale: September / October. Responsibilities: Deputy Head of HR and Staff Side.
- **More details about wellbeing/mental health service**
  Action:- Health & Well-being Hub to further review the intranet pages and content of newsletter. Timescale: September / October. Responsibilities: Head of Organisation Development and Communications team.
- **Higher COVID-19 risk assessment completion**
  Action:- Request completion of the outstanding risk assessments of these colleagues by the 11th October 2020. Additional general communications, Senior Leadership Network briefing and individual emails to colleagues. Timescale: September/October. Responsibility: Director of HR and OD with Service Director Working Well and Communications team.

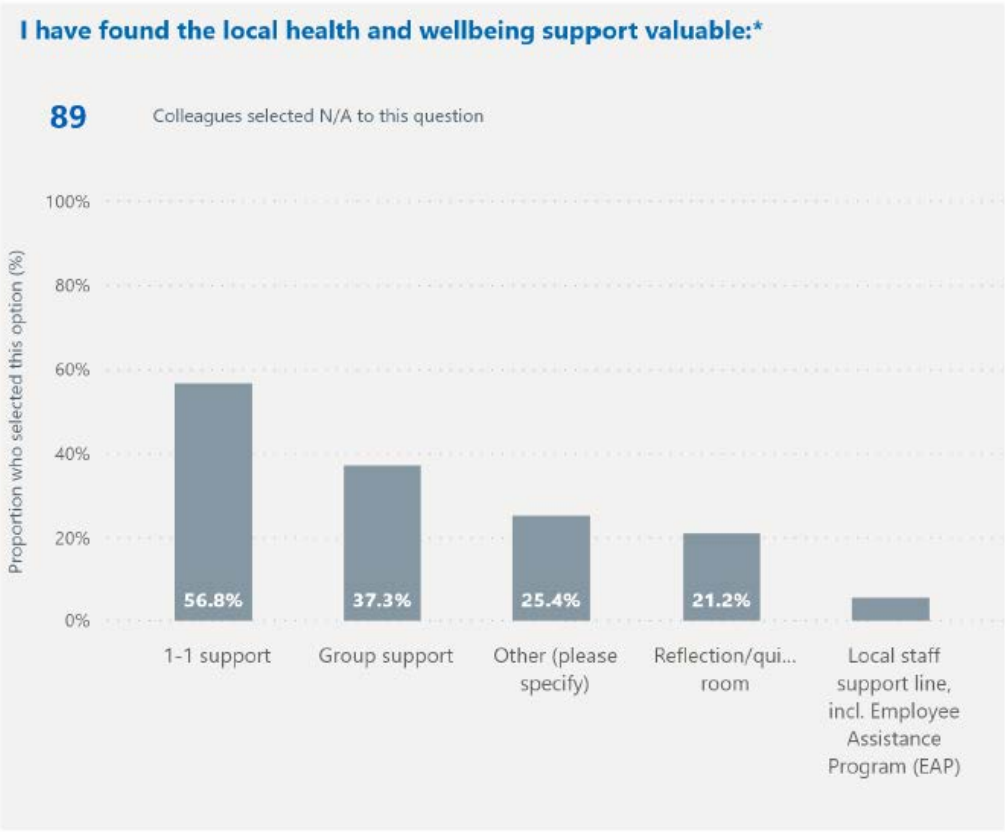
Appendix

Graphs and infographics for Wave 5

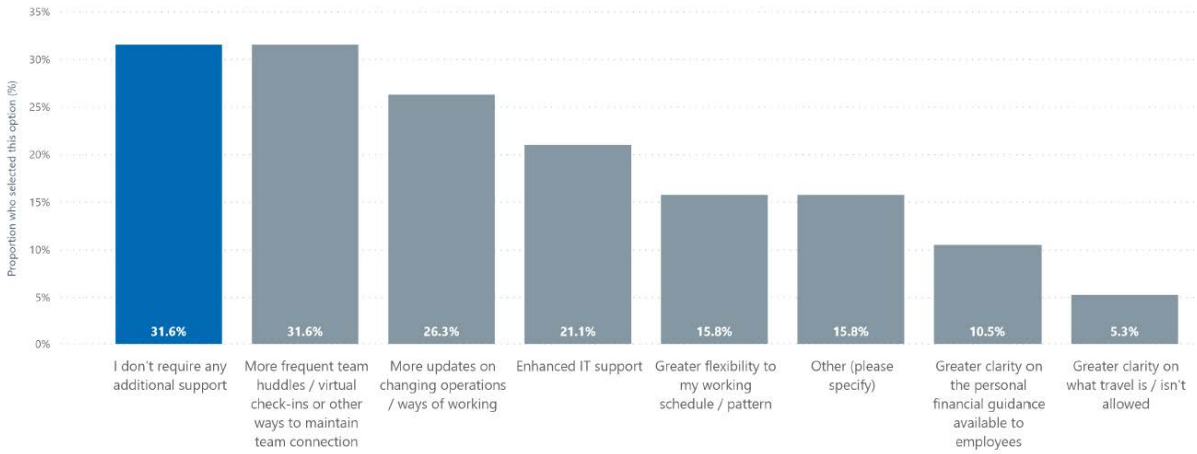





I have found the national health and wellbeing support valuable:*
157
Colleagues selected N/A to this question
Proportion who selected this option (%)
100%
80%
60%
40%
20%
0%
52.9%
35.3%
15.7%
13.7%
9.8%
Wellbei... apps
Staff support line
Leader... Circles
Weekly health and wellbei... webinars
People.... Website
Text support line
#lookin... national coaching offer
Common rooms
Bereav... support line


I have found the local health and wellbeing support valuable:*
89
Colleagues selected N/A to this question
Proportion who selected this option (%)
100%
80%
60%
40%
20%
0%
56.8%
37.3%
25.4%
21.2%
1-1 support
Group support
Other (please specify)
Reflection/qui... room
Local staff support line, incl. Employee Assistance Program (EAP)

At this time, what support would make the biggest difference to help you at work?



Colleague feedback on coronavirus support

Click here to see demographic breakdowns

Wave: Wave 5 | Region: All | Trust: Gloucestershire

Group	Question	Positivity (%)	vs. NHS overall	vs. last wave
Colleague feedback	I feel confident in the approach that my local NHS leaders are taking to manage the impact of the coronavirus	78.9%	+13.9	↑9
	In the current environment, I feel able to balance my work and my personal life in a way that works	68.4%	+4.9	↓3.8
	My organisation is keeping me informed about the impact of the coronavirus on my working life and safety	84.2%	+2.9	↓4.2
	My organisation is proactively supporting my health and wellbeing in the current environment	84.2%	+18.2	↑10.1
Colleague mood	Overall, how anxious did you feel yesterday?	57.9%	+0.1	↓6.6
	Overall, how motivated did you feel yesterday?	52.6%	+0.6	↓2.8
Practical support	Details about any wellbeing / mental health services		-15.9	↓12.8
	Enhanced IT support	21.1%	-1.8	↓5
	Greater clarity on the personal financial guidance available to employees	10.5%	+4.2	↑5.8
	Greater clarity on what travel is / isn't allowed	5.3%	-1.3	↓0.4
	Greater flexibility to my working schedule / pattern	15.8%	-11.2	↓12.6
	I don't require any additional support	31.6%	+7.6	↑5.5
	More frequent team huddles / virtual check-ins or other ways to maintain team connection	31.6%	+0.9	↑2.2
	More updates on changing operations / ways of working	26.3%	-4	↓5
	Other (please specify)	15.8%	-1.2	↑6.3

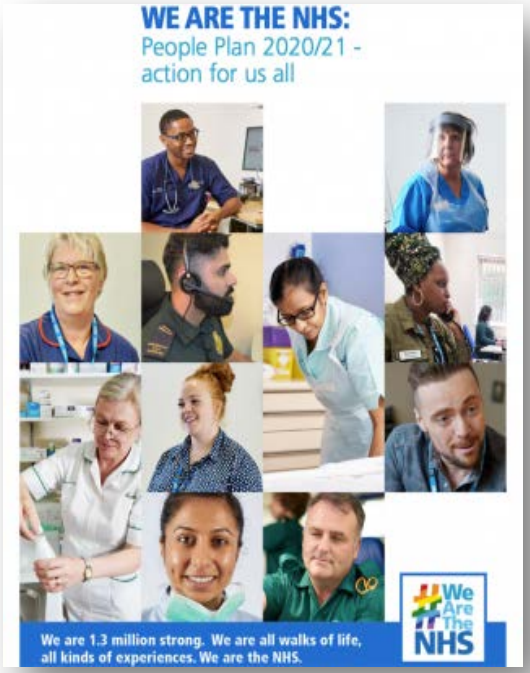
AGENDA ITEM: 12.2

Gloucestershire Health and Care
NHS Foundation Trust

NHS People Plan & Promise

We are the NHS: action for us all

Briefing for the Board of Directors



Key document links include:

- We are the NHS: action for us all (Full document)
- We are the NHS: action for us all (Easy Read)
- The NHS People Promise (Full document)
- The NHS People Promise (Easy Read)
- The NHS People Promise (A4)

Introduction to the People Plan

Gloucestershire Health and Care
NHS Foundation Trust

We are the NHS: action for us all - published end of July 2020 by **NHS England/NHS Improvement** & **Health Education England.** Sets out what NHS staff can expect from their leaders, their employers & each other and focuses on how during 2020/2021 we must be:-

1. **Responding to new challenges and opportunities**
2. **Looking after our people**
3. **Belonging in the NHS**
4. **New ways of working and delivering care**
5. **Growing for the future**
6. **Supporting our NHS people for the long term**

Funding commitments are made within the plan, but some **workforce growth aspirations** outlined in the plan and the government's manifesto, require discussion & are outside the Plan's scope.

Context & Background

The Plan builds on previous interim NHS plans and the central themes of :

- More staff
- Working differently
- A compassionate & inclusive culture

It also includes a brand new "Our People Promise" which sets out national ambitions for what people working in the NHS will ideally say about it **by 2024**.

People Plan - Commitments

The plan sets out practical actions that employers & ICSs should take, as well as the actions that NHSEI, HEE will take. It focuses on these 4 main themes:

1. **Looking after our people** – with quality health & wellbeing support for everyone

2. **Belonging in the NHS** – with a focus on removing discrimination that some staff face

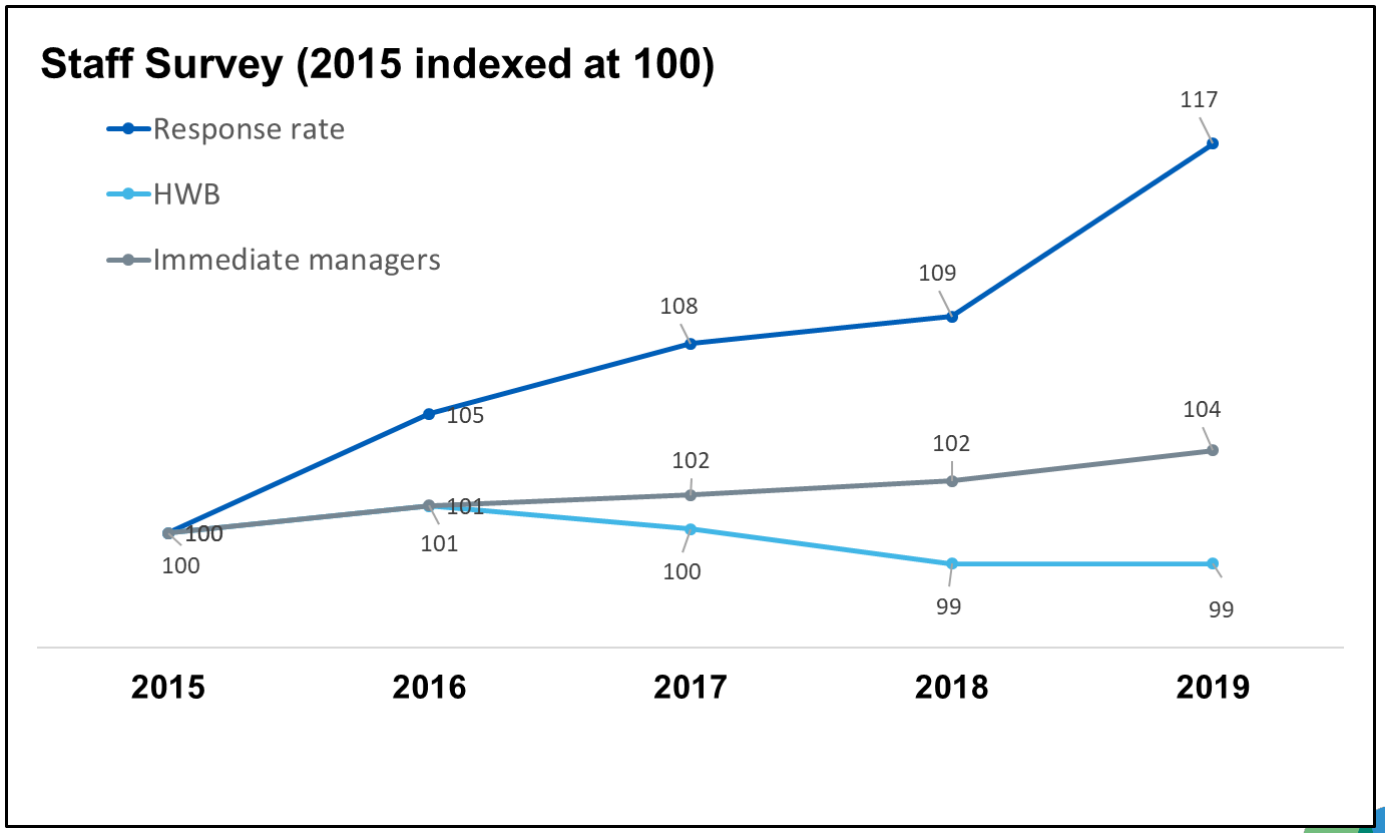
3. **New ways of working** – capturing innovation, new roles, digital enablement etc.

4. **Growing for the future** – how we recruit, train & keep our people, welcoming back colleagues who want to return too

NHS Staff Health & Well-being

Gloucestershire Health and Care
NHS Foundation Trust

While COVID-19 has focussed the attention and action on this, it is against a backdrop of static NHS staff rating of health and well-being.



Our People Promise

Gloucestershire Health and Care
NHS Foundation Trust

The new NHS **People Promise** is central to the Plan.

This aims to embed a consistent & enduring offer to the NHS workforce. From next year, 2021, the annual NHS Staff Survey will align with it.

It sets out a **Promise** to everyone who works in the NHS.

This will help make the NHS a better place to work by ensuring staff are:

- **Safe and healthy**
- **Physically and mentally well**
- **Able to work flexibly**

Key People Promise Commitments

Safe and healthy

- ✓ *Infection risk, PPE, flu vaccination*
- ✓ *Risk assessments for vulnerable staff*
- ✓ *Rest and respite*
- ✓ *Civility and respect toolkit*

Physically and mentally well

- ✓ *Wellbeing guardian (e.g., NED)*
- ✓ *Health and wellbeing conversations*
- ✓ *Mental Health (Resilience) Hubs*
- ✓ *Support for people through sickness*

Able to work flexibly

- ✓ *'Flexibility by default'*
- ✓ *Role modelling from the top*
- ✓ *Extending e-rostering*
- ✓ *Supporting staff who are also carers*

More On The People Promise

Gloucestershire Health and Care
NHS Foundation Trust

The following video includes what a range of staff across the NHS in England think of the Promise.

https://youtu.be/I_Tk5IX7rCs

The Ask For Systems & Trusts

Gloucestershire Health and Care
NHS Foundation Trust

- List of asks for systems & employers to be delivered during 2020-21. [23 actions on **Health & Well-being**, 11 on **Flexible Working**, 6 on **Equality & Diversity**, 15 on **Culture & Leadership**, 6 on **New Ways of Delivering Care**, 16 on **Growing the Workforce**, 9 on **Recruitment,** 10 on **Retention**, & 5 on **Recruitment & Deployment across Systems**]

- Each ICS to develop its own local People Plan, to be reviewed by **regional and system level People Boards**

- Employers encouraged to devise their **own local People Plan**. This comes at a great time for our new Trust Strategy and the creation of our “Best People Strategy”.

- **Metrics** will be developed in “late September 2020” with the intention to track progress using the **NHS Oversight Framework**

Systems Working Together

The new plan makes clear the national intention to see a significantly increased role for **ICS / STP systems** to work as teams with their constituent parts, & for Health Education England, to use data to understand workforce & service requirements & support the attraction, deployment, development and retention of staff within systems.

But …further national work continues *in relation to this, metrics/KPIs & a second plan is expected later in the year.*

Equality, Diversity & Inclusion (EDI)

Gloucestershire Health and Care
NHS Foundation Trust

The Trust has pre-existing general and specific equalities duties and obligations. These have been further added to with EDI requirements from:

- the Long Term Plan
- recent Public Health England recommendations
- the NHS People Plan and Our People Promise

As a result there are a number of additional asks for NHS providers on EDI for the workforce. Delivering the requirements will be a significant ask and resource commitment.

Our emerging strategy puts EDI at its heart, so, following receipt of a paper and job description, Executive Committee in September, Executives have agreed to the creation of a new **Equality, Diversity & Inclusion lead role** within the Trust. The Board is now asked to support this.

The aim is to offer the post initially as a secondment or fixed term, to drive forward agenda both within the Trust and more widely with ICS and Regional partners.

EDI continued

Gloucestershire Health and Care
NHS Foundation Trust

The new **Equality, Diversity & Inclusion lead role** will provide significant focus and resource for progressing equalities and inclusion matters through the range of avenues such as:-

- NHS People Plan & Our People Promise response
- the Workforce Race Equality Scheme
- the Workforce Disability Equality Scheme
- Gender Pay Gap
- Alongside related input on progressing recruitment, related community engagement, leadership development, retention, and support to development our Diversity Network and sub groups

GHC's Approach To People Plan

Gloucestershire Health and Care
NHS Foundation Trust

- Sharing the plan with Executives, Board, Leaders & Staff Side
- Colleague Engagement & discussion sessions
- Contribution to the One Gloucestershire ICS People Plan
- Creation of our "Best People Strategy" & action plan
- …reporting on updates through Resources Committee

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

THANK YOU

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

AGENDA ITEM: 13

REPORT TO: **Trust Board – 30 September 2020**

PRESENTED BY: Sian Thomas, Deputy Chief Operating Officer

AUTHOR: Sian Thomas, Deputy Chief Operating Officer

SUBJECT: **COVID ACTIVE RECOVERY UPDATE**

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

The purpose of this report is to

Provide assurance to the Board on the work the Trust is undertaking in responding to Covid and the active recovery programme.

Recommendations and decisions required

The Board is asked to:

- **Note** the update and work to date

Executive summary

This item provides an update on the Trust's active recovery work, including progress to date with service and operational recovery. Key points of learning have been highlighted alongside some of the successes and achievements.

Risks associated with meeting the Trust's values

A Covid specific risk register is being maintained, with the key strategic risk(s) raised on the corporate risk register.

Corporate considerations	
Quality Implications	Maintaining quality care has been at the forefront out our response to Covid.
Resource Implications	Our Covid response has required the redeployment of significant numbers of staff. Some equipment and facilities spend has been required, this has been attributed to a specific budget code.
Equality Implications	Ensuring incident management responses do not

	disproportionately affect certain groups has been a key principle of our work.

Where has this issue been discussed before?
Weekly discussions held at Executive Team Meeting and Covid Programme Board

Appendices:	Covid Active Recovery presentation.

Report authorised by: John Campbell	**Title:** Chief Operating Officer

with you, for you

Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 13.1

Covid update
Active Recovery, Sept 2020

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

Recovery check ins

- Held sessions with each operational directorate with a range of colleagues from Quality, BI, HR, Facilities, Finance, IT
- Presented by SDs and Deputies
- Great feedback from attendees

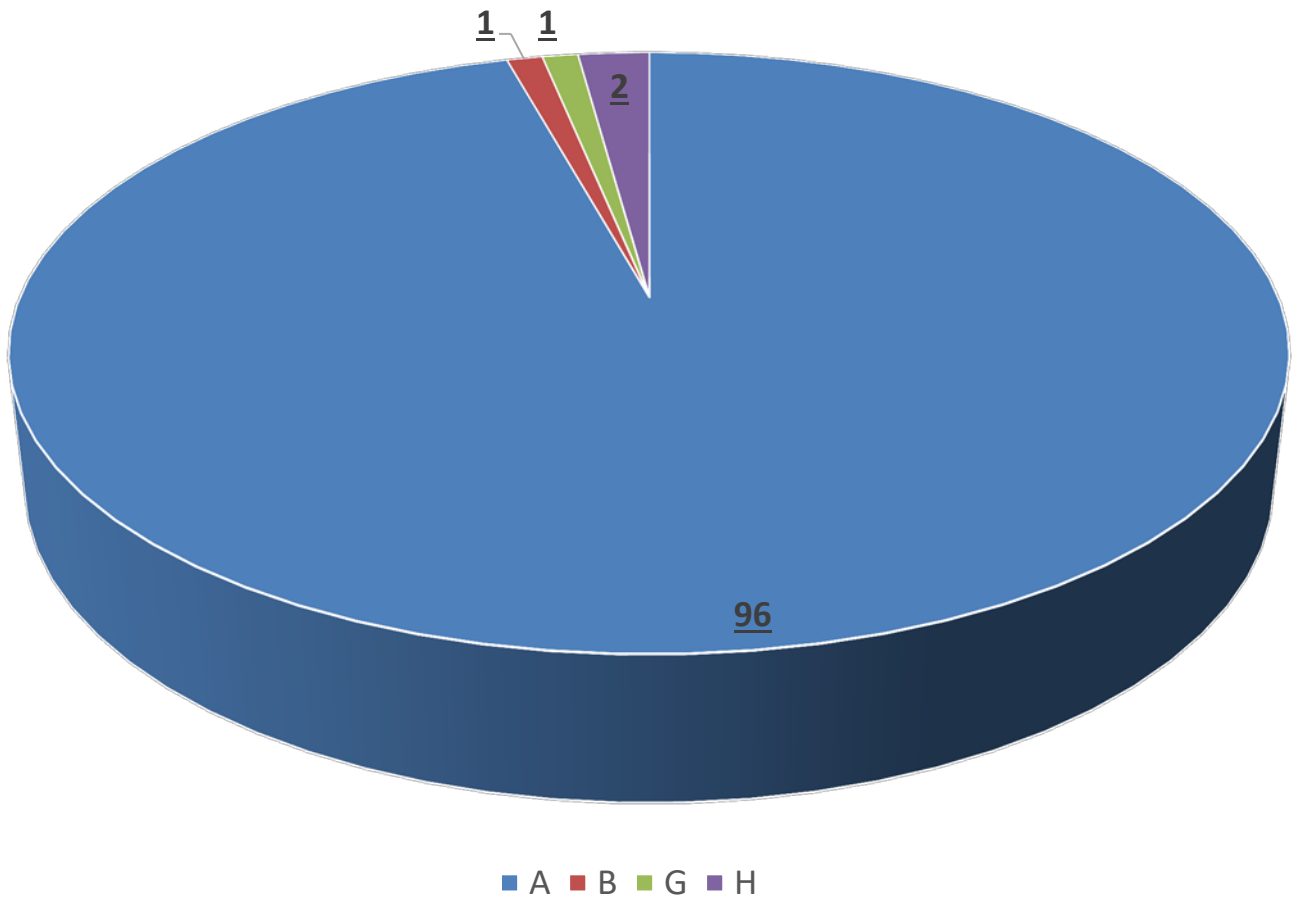
UCASS
AC (MH & LD)
AC (PH)
Hospitals
CYP

Excellent presentation and update and really appreciated colleagues taking the time to update.

Topics Covered:

- Successes to highlight
- Messages from partners and service users
- Learning to highlight
- Help you need with recovery (BI reports, estates, corporate, digital)
- Patient/Quality concerns
- New risks

Service Recovery State (%)



Recovery code key

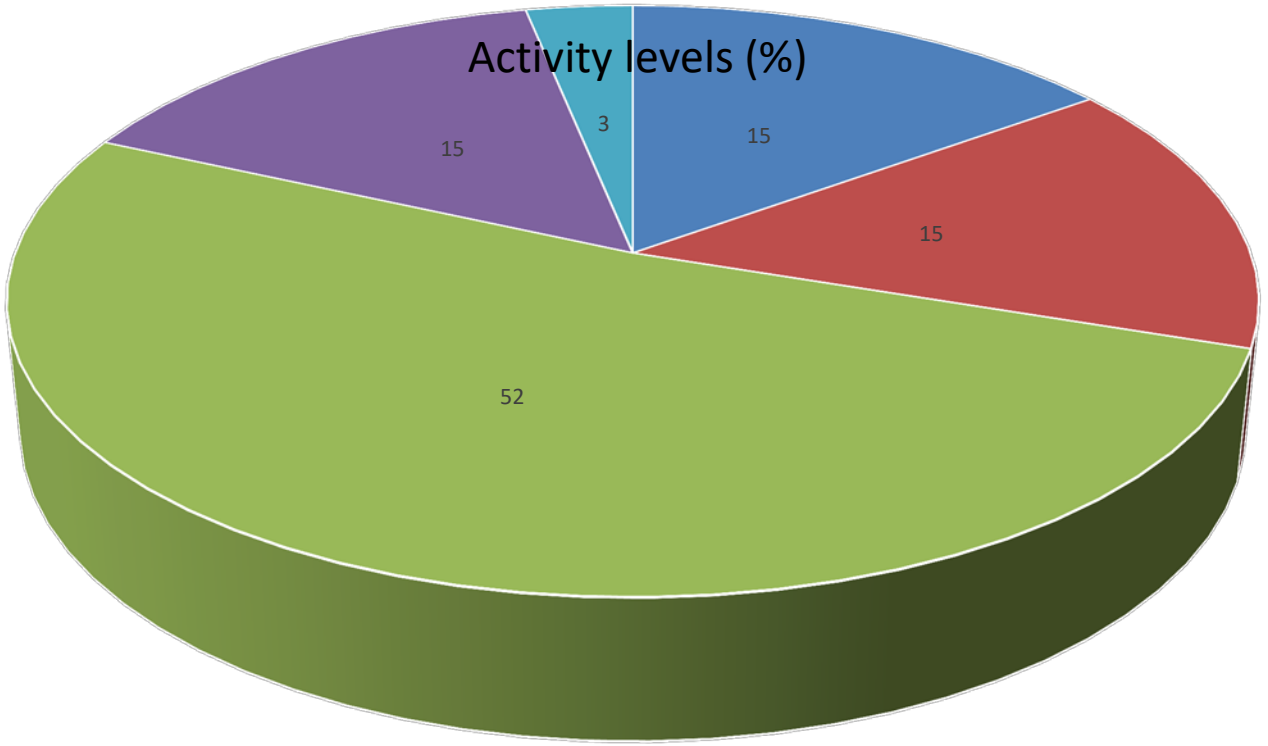
A	Open to all normal referrals
B	Reduced service offer: reduced sites/hours but delivering normal care
C	Reduced service offer: urgent/complex referrals only
D	Reduced service offer: accepting referrals, triage & advice but not care delivery
E	Closed to new referrals but supported priority patients
F	Closed and alternative service put in place
G	Full Closure
H	Partial opening

Service Recovery State

Gloucestershire Health and Care
NHS Foundation Trust

Recovery Code	Service	Current offer	Reason for status	Forward plans
Reduced service offer: reduced sites/hours but delivering normal care	MIIU	**Open 8am – 8pm 7/7** North Cots, Ciren, Stroud, Lydney & Tewks **Opening in Oct** Vale **Remaining closed** Dilke	Reduced hours at sites to ensure resilient staffing offer Closure at Dilke due to estates limitations to be Covid secure	Current model agreed at HOSC until 31/03/21
Full Closure	Live well feel better	No offer A small (2 staff) service supporting service users with lived experience of Long Term Conditions (PH) to volunteer to lead expert patient groups	Due to risk of Covid to client group, plus limits on group work plus lack of resilience in staff model this has not been re-opened	In dialogue about future of service
Partial opening	Dental – special care & high street	Service is delivering in line with NHSE requirements to focus on urgent cases only	NHSE requirements	Special care is clearing waitlist and will fully open from 1st Oct High street has been asked by NHSE to support an access centre model for the foreseeable

Summary stats



58% of services do not have a waiting list

77% of services are 'Green' on their recovery plans

Gloucestershire Health and Care NHS Foundation Trust

Successes to highlight

- ✓ Team working (enthusiasm, strength, togetherness)
- ✓ New triage processes in a range of services – speeding access, correct signposting, reducing travel, reducing risk
- ✓ Speeding up ideas/innovations
- ✓ Use of staff bubbles
- ✓ Use of clinically shielding staff to undertake range of non- F2F roles
- ✓ Development of novel treatment approaches
- ✓ Successful repatriation of colleagues

Messages from partners and service users

Gloucestershire Health and Care NHS Foundation Trust

Overwhelmingly positive

- FFT & compliments
- Helped system flow
- Positively responded to range of requests
- Lots of positives re. digital
  - Speeding access to service
  - reducing travel
  - no waiting

Some areas to think about

- Concerns about referrals being rejected
- Lack of understanding of pace of change
- Understanding about each others interdependencies
- Limits to digital offer
  - Group work
  - therapeutic relationship

Learning to highlight

Services and teams had very different experiences & roles

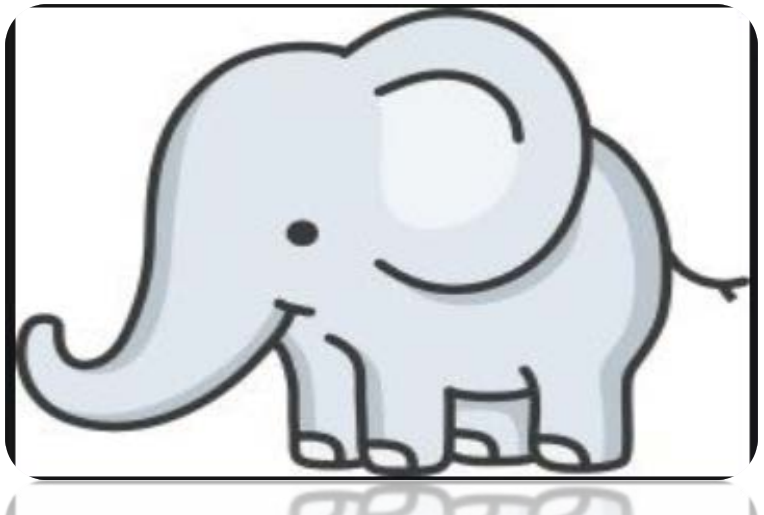
When responding to an incident we need to think about functions/interventions within a service

Therapy colleagues were redeployed into a range of services and positive benefit felt for rehab, MDT and LoS

Training/guidelines on how best to use digital is needed…it makes a difference

Perception referrals are now more complex/higher acuity

We had some challenges pre-Covid……we've identified new challenges due to Covid……we have to decide on our priorities and take small bites of the elephant



Covid Services

Testing team

- Leadership team recruited
- Interviewing for deliver team this week

Stock team

- Leadership team recruited

Covid Secure

– All sites inspected

- Undertaking unannounced site visits
- Group therapy guidance issued
- Some areas more challenging

AGENDA ITEM: 14

REPORT TO:	**Trust Board – 30th September 2020**
PRESENTED BY:	John Trevains, Director of Nursing, Therapies & Quality
AUTHOR:	John Trevains, Director of Nursing, Therapies & Quality
SUBJECT:	**QUALITY DASHBOARD – AUGUST 2020 DATA**

This report is provided for:

Decision | Endorsement | Assurance ☑ | Information

The purpose of this report is to

To provide the Trust Board with a summary assurance update on progress and achievement of quality priorities and indicators across physical health, mental health and learning disability services.

Recommendations and decisions required

The Committee is asked to:

- **Discuss, note** and **receive** the August 2020 Quality Dashboard

Executive summary

This report provides an overview of the Trust's quality activities for August 2020. This report will be produced monthly for Board, Quality Committee and Operational Governance Forum for assurance.

Quality issues for priority development

- Work is required to understand in more detail the reduction in the number of calls received into Single Point of Clinical Access (SPCA). It is possible this is as a result of altered system flow but this needs to be clarified and any impact on patients understood.
- The number of bed days for adult mental health inappropriate out of area placements has risen in the month of August. The reasons for this and impact on patients' needs to be fully understood and monitored.
- The data associated with the cardio-metabolic assessment and treatment for people with psychosis is currently not available. Further work will be undertaken in month with the business intelligence team to re-establish reporting.
- The Quality directorate will work with Children's Services to understand the recovery of a universal antenatal service to ensure that those identified as most at risk are being proactively managed.

Quality issues showing positive improvement

- No healthcare associated Covid-19 infections attributable to the Trust's care for the third month in a row
- Referral to treatment times for physical health services identified within the Quality Dashboard have all exceeded the required thresholds for the first time this year.
- The quality directorate have progressed plans to deliver the "Civility & Patient Safety" programme and the "Embedding learning following investigations project" are making good progress,

Are Our Services Caring?

Good assurance is available that demonstrates GHC services continue to be delivered in a caring way. 93% of respondents to the FFT would recommend Trust services. The Patient and Carer Experience Team have developed new ways of working in light of a Covid-19 secure environment with a further roll out of online platforms planned in Q3.

Are Our Services Safe?

Incident reporting rates have now returned to pre Covid-19 levels, and the proportion of reported moderate harm and above, and low/no harm incidents are comparable to the 2019/20-year end outturn. The prevention, identification and management of pressure ulcers, complex wounds and improving colleagues' tissue viability skills and knowledge remains a priority. As planned, an improvement framework is nearing completion. The Trust is fully assured on current and future supply of all PPE stock items via local and national supply routes. There is good assurance that safe staffing levels have been maintained throughout the month in our inpatient services, and that there has been successful recruitment of newly qualified nurses at both Wotton Lawn and Charlton Lane Hospitals.

Are Our Services Effective?

Good assurance is available that clinical service environments remain Covid-19 secure with a continuing Covid-19 acquired infection rate of zero. Early Intervention Services have met the required threshold for the second consecutive month, providing assurance regarding the effectiveness of service recovery plans. The deep dive regarding the ASC/ADHD Service demonstrates how the service has responded to the pandemic, and the effectiveness and benefit of virtual consultations for most service users. Work is ongoing regarding recovery of Trust services and winter planning.

Are Our Services Responsive?

The board is asked to note the improvement in referral to treatment times across the identified Integrated Care Teams. Paediatric Physiotherapy, Occupational Therapy and Speech and Language Therapy all met the required thresholds in August for the first time during 2020/21.

Are our Services Well Led?

Senior Trust Quality leads continue to visit services and engage with colleagues to listen and promote quality of care and patient safety. Feedback from colleagues

suggests this approach is both welcomed and valued. A structured program of visits is now being developed for the next 12 months.
The Health and Well-being pages of the intranet continue to provide a single point of access for support under 6 domains: physical health, mental health, lifestyle, supporting colleagues, speaking up, and staff benefits.

Dashboard Development
Future iterations of the Quality Dashboard will incorporate the Non-Executive Directors Complaints audit report and summary detail of Non-Executive Director quality visits.

Risks associated with meeting the Trust's values

Specific initiatives that are not being achieved are highlighted in the Dashboard.

Corporate considerations	
Quality Implications	By the setting and monitoring of quality targets, the quality of the service we provide will improve
Resource Implications	Improving and maintaining quality is core trust business.
Equality Implications	No issues identified within this report

Where has this issue been discussed before?
Trust Board on a monthly basis

Appendices:	See attached dashboard

Report authorised by: John Trevains	**Title:** Director of Nursing, Therapies & Quality

with you, for you

Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 14.1

Quality Dashboard 2020/21

Physical Health, Mental Health & Learning Disability Services

Data covering August 2020

Executive Summary

Gloucestershire Health and Care NHS Foundation Trust

This Quality Dashboard reports quality-focussed performance, activity, and developments regarding key quality measures and priorities for 2020/21 and highlights data and performance by exception. This data includes national and local contractual requirements. With regard to defined contractual or nationally-mandated quality related KPIs, the dashboard is only reporting on indicators not met. Certain data sets contained within this report are also reported via the Trust Resources Committee, they are included in this report where it has been identified as having an impact on quality matters. Feedback on the content of this report is most welcome and should be directed to John Trevains, Director of Nursing, Therapies & Quality.

Are Our Services Caring?

The Patient and Carer Experience Team practice and process has resumed following the 'pause' on the national complaints process. Whilst concerns raised dropped by 50% this month, complaint activity is slowly increasing, and the inclusion of additional indicators within the dashboard from July 2020 provides greater focus on the performance of this team. The rate of acknowledging complaint letters within the required timescale dropped to 86% this month due to 1 late response but the team have increased caseload management oversight to ensure timelines remain on track. Response rates to the Friends & Family Test dropped this month but there is a planned wider roll-out of the online platform to compensate for the current need to prohibit paper-based feedback forms for the purpose of infection prevention and control. It is, however, reassuring that despite the diminished return rate, 93% of respondents would recommend Trust services.

Are Our Services Safe?

Incident reporting rates have now returned to pre Covid-19 levels, and the proportion of reported moderate harm and above, and low/no harm incidents are comparable to the 2019/20 year end outturn. One SIRI related to the death of an inpatient at Wotton Lawn Hospital, appropriate review and action has been taken to refresh the programme of work associated with ligature points. The prevention, identification and management of pressure ulcers, complex wounds and improving colleagues' tissue viability skills and knowledge remains a priority. As planned, an improvement framework is nearing completion. Following a medication incident within an independent sector environment the process for reporting to the responsible commissioner has been strengthened.

Are Our Services Effective?

Bed occupancy in physical health inpatient services continues to be lower than comparable historical levels as a direct consequence of lower than normal activity levels across the wider system and alternative discharge pathways being used. Clinical environments remain Covid-19 secure with a continuing Covid-19 acquired infection rate of zero. There were no Covid-19 deaths reported during the month. IAPT recovery rates have positively achieved the required threshold for the third consecutive month. Early Intervention Services have met the required threshold for the second consecutive month, providing assurance regarding the effectiveness of service recovery plans. The deep dive regarding the ASC/ADHD Service demonstrates how the service has responded to the pandemic, and the effectiveness and benefit of virtual consultations for most service users. The deep dive also highlights that not all assessments can be carried out virtually and some assessments will continue to be delayed until face to face consultations can safely resume.

Are Our Services Responsive?

Referral to treatment times across the identified Integrated Care Teams and paediatric physiotherapy, occupational therapy and speech and language therapy all met the required thresholds this month for the first time during 2020/21. The rate of performance in relation to timely Care Programme Approach (CPA) reviews is noted to have experienced minor fluctuations over the past four months and has not met the threshold of compliance during this period. It is important to note that the restrictions imposed by Covid-19 in terms of face to face contact have limited some opportunities for full CPA review. It is anticipated that achievement of this indicator will remain challenging whilst recovery plans are embedded and in keeping with current local and national Covid-19 restrictions. This will be monitored closely and discussions with operational colleagues to discuss effectiveness of recovery will take place during September/October.

Are our Services Well Led?

Senior Trust Quality leads continue to visit services and engage with colleagues to listen and promote quality of care and patient safety. The quality directorate have progressed plans to deliver the "Civility & Patient Safety" programme and the "Embedding learning following investigations project" are making good progress. Both statutory and mandatory training compliance and appraisal compliance have remained at 85% and 76% respectively this month. It is anticipated that compliance will improve further over the coming months as a result of the Trust's continuing programmes of recovery. There will be continued emphasis on the need for appraisal completion over the coming months, including the re-introduction of appraisal training. Sickness absence has remained consistent over the last 4 month period but continues to remain 1.14% above the Trust target of 4.00%. There is assurance that safe staffing levels have been maintained throughout the month in our inpatient services (noting challenges in specific ward and community team areas) and that there has been successful recruitment of newly qualified nurses at both Wotton Lawn and Charlton Lane Hospitals.

Quality Dashboard

NHS
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COVID-19 (Whole Trust data, reporting nationally mandated Covid-19 focused safety and activity information)

No		Reporting Level	Threshold	2019/20 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2020/21 YTD	R A	Exception Report?	Benchmarking Report
1	No of C-19 Patient Deaths reported to CPNS	N-R			30	7	1	0	0								38			N/A
2	Total number of deaths reported as C-19 related (C-19 not primary cause of death)	L-R			64	17	2	1	0								84			
3	No of Patients tested at least once *	N-R			202	234	259	295	472								1462			N/A
4	No of Patients tested C-19 positive or were admitted already positive *	N-R			120	65	6	1	2								194			N/A
5	No of Patients discharged from hospital post C-19	N-R			33	60	21	4	1								119			N/A
6	Community onset (Positive specimen <2 days after admission to the Trust)	N-R					0	0	0								0			N/A
7	Hospital onset (nosocomial) indeterminate healthcare associated (Positive specimen date 3-7 days after admission to the Trust)	N-R					0	0	0								0			N/A
8	Hospital onset (nosocomial) probable healthcare associated (Positive specimen 8-14 days after admission to the Trust)	N-R					0	0	0								0			N/A
9	Hospital onset (nosocomial) Definite healthcare associated (Positive specimen date 15 or more days after admission to the Trust	N-R					0	0	0								0			N/A
10	No of Staff Tested	N-R			276	521	104	57	204								958			N/A
11	No of Staff with confirmed C-19	L-R			85	38	0	0	0								123			N/A
12	No of Staff Self-Isolating	L-R			597	174	63	39	43											N/A
13	No Staff returning to work post Self-Isolating.	L-R			333	118	25	10	28											N/A

Additional Information

Patient Reporting

The table above shows that the number of Covid-19 patient deaths (primary cause of death) continues to reduce month on month since April 2020, with no deaths reported during August 2020. The age range for deaths reported to CPNS was 70-98 years. The information is shown by hospital site / community team in the graph opposite.

Patient Testing

As planned the Business Intelligence system now reports whole Trust data. The numbers of patients tested in month increased in August with the number of positive results remaining low.

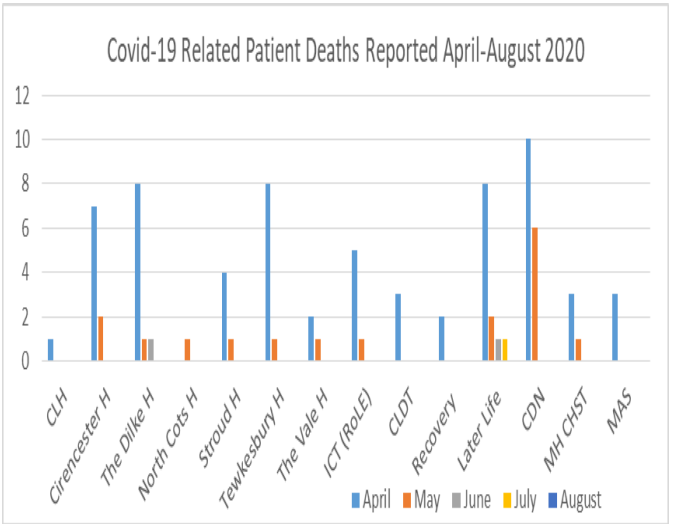
Staff Testing

GHC Staff testing is well established within the pillar one mechanism. The number of system Health and Social Care staff tested in August increased by 258. The number of GHC staff testing positive remains at zero for the third consecutive month. Numbers of staff self-isolating are increasing in light of uptick in cases through August. Trust testing services returned to a 7 day service in September 2020 and therefore numbers are expected to increase significantly.

Infection Prevention and Control - COVID 19

The Trust is required to report any healthcare associated COVID-19 infections (nosocomial infections) attributable to our care. A root cause analysis is required for each infection which is coordinated by the Infection Prevention and Control Team, discussed at the Trust's Infection Control Team meeting and the ICS Bronze System (IPC) Cell.

There have been no nosocomial (health care acquired) infections to report during August.



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

COVID-19 - KEEPING STAFF SAFE – (Are services well led?)

Personal Protective Equipment (PPE)

At the current time, there are no concerns regarding stock levels of any PPE item. The Trust is fully assured on future supply of all stock items via local and national supply routes.

The 'controlled pull model' for key PPE product lines continues to work well. The Team completes a 'pick list' each week and submit via the Covid-19 Logistics, Finance and Supplies Cell.

Updated guidance from Public Health England (PHE) was circulated on the afternoon of 21st August. The main change has been to terminology; previously termed green patient/zone will now be referred to as 'low risk', previously amber patient/zone will now be referred to as 'medium risk' and previously red patient/ zone will now be referred to as 'high risk'.

The PPE required for medium and high risk patients has not changed but some departments are now classified as medium risk areas (for example outpatients). Within mental health inpatient areas, even if a patient tests negative and has no symptoms they will be classified as a medium risk as they interact communally within the ward and many patients have leave away from the hospital.

The National New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG) was asked to give an opinion on whether chest compressions and defibrillation should be considered to be aerosol generating procedures (AGPs). Based on this evidence review, PHE will not be adding chest compressions to the list of AGPs. The guidance states that healthcare organisations may choose to advise their clinical staff to wear FFP3 respirators when performing chest compressions, however it is strongly advised that there is no potential delay in delivering this life saving intervention. The Trust position therefore remains in line with guidance: immediately commence chest compressions whilst wearing a fluid-resistant surgical mask (FRSM) until relieved by colleagues who have donned full PPE, including an FFP3 mask.

The Trust has agreed a model of sustainable delivery of Covid-19 related work streams and recruitment has been successful to the Covid-19 Service Director and Deputy Service Director. Adverts for the remaining team roles went live on NHS Jobs on 27th August, with interviews commencing on 8th September 2020.

FFP3 fit-testing

Reporting compiled by the Training Team on 28/08/20 showed that 713 colleagues have been successfully fit-tested.

Fit-testing rates have reduced due to a combination of fit-testers being recalled to substantive roles and annual leave. The fit-testing work stream will move to the Covid-19 Directorate management team in September, following which a sustainable programme will be agreed and implemented.

The FFP3 Fit-testing project group continues to hold regular virtual meetings to monitor progress of the programme. The first choice mask remains the Cardinal RFP3FV and good supplies of this model continue to be received on the deliveries. The second preference is the GVS F31000 and we are assured by the Covid-19 South West Incident Co-ordination Centre that a good supply of this mask is available. Usage of both types of mask is monitored daily by the Central Stock Management Team.

A new model of FFP3 mask has been introduced to the Trust: the 3M 9330+ model. Fit-testers will introduce this mask to the list of options when Fit-testing.

Quality Dashboard

NHS
Gloucestershire Health and Care
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CQC DOMAIN - ARE SERVICES CARING? (Patient and Carer Experience - PCET)

No		Reporting Level	Threshold	2019/20 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2020/21 YTD	R / A / G	Exception Report?	Benchmarking Report
	Number of Friends and Family Test Responses Received	N - T			Suspended			699	496								1195			
	% of respondents indicating a positive experience of our services	N - R	95%	88%	Suspended			93%	93%								93%			
	Number of Compliments	L - R		2,938	228	58	166	74	67								593			
	Number of Complaints	N - R		117	5	6	1	4	7								23			
	Number of Concerns	L - R		620	31	24	44	60	31								190			
	Number of open complaints (not all opened within month)							27	35											
	Number of re-opened complaints (not all opened within month)							5	4											
	Percentage of complaints acknowledged within 3 working days							100%	86%											
	Number of complaints for which the team are agreeing investigation issues with complainant							7	10											
	Number of complaints awaiting investigation							2	1											
	Number of complaints under investigation							6	9											
	Number of investigations on hold							0	0											
	Number of Final Response Letters being drafted							12	12											
	Number of Final Response Letters awaiting Exec sign-off							0	0											
	Concerns escalated to a formal complaint							2	1											
	Current external reviews							3	3											

In addition to the above GHC data, the Patient and Carer Experience Team (PCET) are managing 5 complaints relating to services delivered in Herefordshire by ²gether NHS Foundation Trust.

*In-month threshold (i.e. March)

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

RAG Key: R – Red, A – Amber, G - Green

Additional information – Patient and Carer Experience (PCET)

Recent activity

- Seven complaints were received in August 2020, which is a 30% reduction from the monthly average during 2019/20 (n= approx. 10 complaints per month in 2019/20).
- Numbers of compliments received this month are 72% lower than the average number of compliments received per month in 2019/20 (n= approx. 245 compliments per month in 2019/20). It is believed that this reduction is due to the suspension of PALS visits to inpatient settings and community hubs due to infection prevention and control measures as a result of Covid-19. PCET will now access the Alcove tablets used by POhWER for Independent Mental Health Advocacy work on the wards. PALS have been allocated system access and will arrange virtual PALS visits to the wards. The PALS visits enable patients to raise concerns directly with PCET and issues can often be resolved quickly and effectively. It will also increase our compliments and FFT response rates as PALS officers are able to ask patients for their feedback via this route.
- The number of concerns reported in August 2020 is lower than the monthly average number of concerns reported in the last financial year (n=approx. 52 concerns per month in 2019/20).
- The low number of concerns escalated to complaints and low number of reopened complaints suggests that people are broadly satisfied with our complaints process.
- Of the seven complaints received, one was not acknowledged within our three day timeframe resulting in the 86% response rate. In order to prevent a recurrence additional caseload monitoring has been introduced.
- The three complaints for external review are with the Parliamentary and Health Service Ombudsman (PHSO): one has been referred by the complainant but we have not received any contact from PHSO, one is under investigation by the PHSO, and the third is being reviewed by PHSO pending a decision on whether to investigate..
- Friends and Family Test (FFT) electronic and SMS messages (email and text) were reinstated on 1st July 2020. The use of paper FFT remains suspended due to Covid-19 infection prevention and control measures, impacting significantly on response rates..
- PCET is in the process of liaising with Operational colleagues and IT to develop the inclusion of FFT at the end of Attend Anywhere consultations.
- The PCET have reinstated the NED quarterly audit of complaints
- For further quality assurance, our internal audit of complaints is being undertaken by Pricewaterhouse Coopers in Q3 and includes complaints between March to August 2020.

You said, we did

A parent took her baby to the GP with concerns about his neck and was referred to Paediatric Physiotherapy Service. She had a telephone consultation but was very worried that without a physical examination and correct physiotherapy advice, her son could develop disabilities that would affect him for life.

A further telephone call was arranged with a senior Physiotherapist. Reassurance was offered and the complainant was advised that face to face appointments are available if a clinician is concerned that a virtual appointment is insufficient.

Out of hours District Nurses:
Patient called to offer thanks and praise to the District Nurses for coming to attend to his care following a recent discharge from hospital. He was very grateful for the help.

Community Dementia Nurses:
Telephone call received from the son of a patient to let the team know that she had passed away and he wanted to thank everyone for the wonderful work and care given to his mum.

Quality Dashboard

Gloucestershire Health and Care
NHS Foundation Trust

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

		Reporting Level	Threshold	2019/20 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2020/21 YTD	R / A / G	Exception Report?	Benchmarking Report
	Number of Never Events	N - T	0	1	0	0	0	0	0								0			N/A
	Number of Serious Incidents Requiring Investigation (SIRI)	N - R		49	4	3	3	6	2								16			N/A
	Number of Serious Incidents Requiring Investigation (SIRI) where Medication errors caused serious harm	N - R		0	0	0	0	0	0								0			N/A
	Number of Serious Incidents Requiring Investigation (SIRI) regarding falls lead to fractures	N - R		6	0	1	0	1	0								2			N/A
	Number of Serious Incidents Requiring Investigation (SIRI) regarding pressure ulcers	N - R		5	0	0	1	0	0								1			N/A
	Number of Serious Incidents Requiring Investigation (SIRI) regarding suspected suicides	N - R		18	2	0	0	4	2								6			N/A
	Number of Serious Incidents Requiring Investigation (SIRI) regarding self harm or attempted suicide	N - R		6	3	1	1	0	0								5			N/A
	Number of Serious Incidents Requiring Investigation (SIRI) regarding mental health homicides	N - R		1	0	0	0	0	0								0			N/A
	Total number of Patient Safety Incidents reported	L - R		12,109	690	866	1001	1047	1141								4745			N/A
	% incidents resulting in low or no harm	L - R		94.71%	90.50%	92.50%	93.11%	94.56%	94.65%								93%			N/A
	% incidents resulting in moderate harm, severe harm or death	L - R		5.29%	9.50%	7.50%	6.89%	5.44%	5.35%								7%			N/A
	% falls incidents resulting in moderate, severe harm or death	L - R		2.24%	0.96%	3.13%	2.04%	3.16%	2.44%								2%			N/A
	% medication errors resulting in moderate, severe harm or death	L - R		0.61%	6.06%	0.00%	0.00%	1.85%	1.82%								2%			N/A
	Embedding Learning meetings taking place to review the outputs of completed SIRI reports and consider practice implications.	L - R		N/A	0	0	0	0	0								0			N/A

*In-month threshold (i.e. March)

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

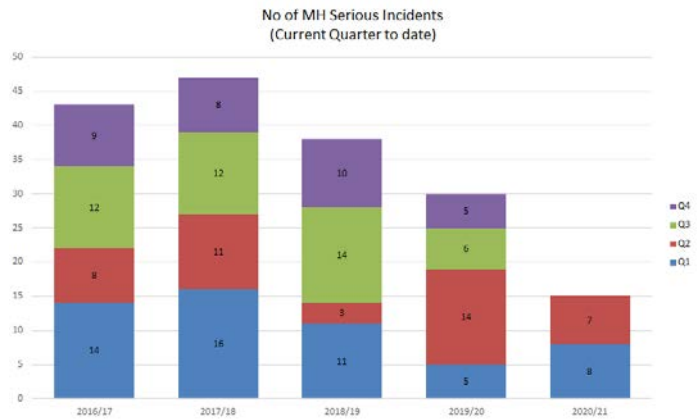
RAG Key: R – Red, A – Amber, G - Green

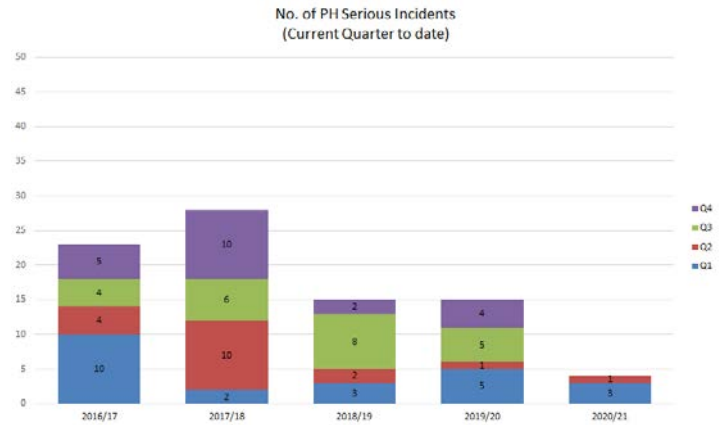
ARE SERVICES SAFE? – ADDITIONAL NARRATIVE INFORMATION

Two SIRIs were declared in August 2020, both within mental health services. One incident occurred with the South Crisis Team with a fatal self harm incident; the other was an inpatient suspected suicide at Wotton Lawn Hospital involving a ligature. All incidents were escalated in line with SIRI reporting requirements. An oversight in reporting had occurred in July whereby an incident (an inpatient fall within a physical health community hospital) was not added to STEIS in a timely way, this has since been corrected and the July data amended to reflect the omission.

The Patient Safety Team continue to monitor both regional and national trends in terms of suicide rates and will analyse and report significant departures from benchmarking trends.

The tables below demonstrate SIRI reporting over the past 5 years.





Five SIRI final reports and three accompanying 'incidents on a page' were completed during August 2020. The two remaining 'incidents on a page' are in progress and will be disseminated upon completion. A Covid-19 recovery plan has been shared with senior managers and commissioners. There were 19 active SIRIs of which nine received an extension to the submission date, agreed with commissioners due to the complexity of 3 of the SIRIs and also the impact of Covid-19 redeployments from the Patient Safety Team. Progress is on track for these reports to be submitted as agreed by the end of September.

Regarding all patient safety incidents:

- The total number of patient safety incidents has continued to increase month on month from April (689) to August (1141). This was expected as services reopened.
- The percentage of patient safety incidents meeting moderate, severe and death thresholds continue to decrease month on month from April (9.58%) to August (5.35%). This may be a consequence of services that are now reopening having a lower risk profile for moderate, severe harm and death incidents than critical services that continued to operate during the earlier phase of the COVID-19 pandemic
- Percentage of falls resulting in moderate and above levels of harm decreased from July (3.16%) to August (2.44%). There were 2 moderate and below harm patient falls in August.
- Percentage of medication errors resulting in above moderate levels of harm decreased from July (1.85%) to August (1.82%). One medication error was reported as moderate harm in August 2020 however this was later regraded to No Harm by the incident handler when reviewing the incident. This referred to an under-dosing of prescribed lithium within an independent sector environment.
- To note, there have been some minor adjustments to data provided in the months prior to July 2020 due to ongoing incident review and approval processes. These adjustments did not substantially change the percentages reported against different levels of harm.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

CQC DOMAIN - ARE SERVICES SAFE? Physical Health Focus

		Reporting Level	Threshold	2019/20 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2020/21 YTD	RAG	Exception Report?	Benchmarking Report
	VTE Risk Assessment - % of inpatients with assessment completed	N - T	95%	97.3%	94.6%	93.4%	96.2%	100.0%	96.5%								96.0%	G		
	Safety Thermometer - % Harm Free	N - R L - C	95%	93.2%														N/A		
	Safety Thermometer - % Harm Free (New Harms only)	L - I	98%	97.8%														N/A		
	Total number of developed or worsened pressure ulcers	L - R	61	784	62	76	82	63	63								283	R		
	Total number of Category 1 & 2 Acquired pressure ulcers	L - R	56	737	54	68	70	59	58								309	R		
	Number of Category 3 Acquired pressure ulcers	L - R	0	46	4	6	8	3	4								25	R		
	Number of Category 4 Acquired pressure ulcers	L - R	0	8	4	2	4	1	1								12	R		

Additional information

Safety Thermometer

Reporting remains suspended due to Covid-19 in agreement with commissioners. A discussion is scheduled at the September Gloucestershire CCG Clinical Quality Review Group to review reinstating the process or agree satisfactory alternatives

Pressure Ulcers

As planned, an improvement framework for Tissue Viability is nearing completion. Pressure ulcers are one of the three tissue viability priorities for the Trust.

The national awareness day for **#StopThePressure** is on the 19th November 2020 and GHC will be building on the previous work of the Trust's legacy organisations to continue to raise the profile and awareness of this quality priority.

A Quality improvement project has commenced in Charlton Lane Hospital to improve the recognition, treatment and reporting of pressure ulcers. Targeted education and learning from pressure ulcer incidents is underway across Gloucester Integrated Care Teams.

Each category 3, 4, unstageable, and suspected deep tissue injury is reviewed by the Patient Safety Team. The review process includes consideration as to whether an RCA, panel review or SIRI investigation is needed according to level of harm sustained. The learning from incident investigations and any emerging themes have been used to inform the Trust Tissue Viability improvement framework that has been developed.

VTE Risk Assessment

The percentage of inpatients with VTE Risk Assessment completed in Community Hospitals has continued to exceed the 95% target in August for the third consecutive month. Focussed work within Mental Health inpatient settings is being scoped following two incidents that highlighted improvement was required when completing VTE assessments and subsequent care planning.

*In-month threshold (i.e. March)

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

RAG Key: R – Red, A – Amber, G - Green

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

CQC DOMAIN - ARE SERVICES EFFECTIVE? (Whole Trust data)

		Reporting Level	Threshold	2019/20 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2020/21 YTD	RAG	Exception Report?	Benchmarking Report
Community Hospitals																				
	Bed Occupancy - Community Hospitals	L - C	92%	94.4%	76.1%	69.8%	83.3%	88.3%	86%								80.7%	R		90.4%
Mental Health Services																				
	Early Intervention in psychosis EIP: people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral	N - T	60%	63.4%	50.0%	66.7%	57.1%	85.7%	87.5%								69.4%	G		
	Ensure that cardio-metabolic assessment & treatment for people with psychosis is delivered routinely in the following service areas:																			
	Inpatient Wards	N - T	90%	80%																
	GRiP	N - T	90%	85%																
	Community	N - T	75%	78%																
	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	N - T	50%	50.1%	37.5%	44.4%	54.5%	56.5%	55.7%								49.7%	A		
	Admissions to adult facilities of patients under 16 years old.	N - R		2	0	0	0	0	0								0	N/A		
	Inappropriate out-of area placements for adult mental health services	N - R	average bed days	19	30	14	11	17	31								21	N/A		
Children's Services - Immunisations				2019/20 Academic Year	Academic Year 2019/20					Academic Year 2020/21										
	HPV Immunisation coverage for girls aged 12/13 years old (1st Immunisation)	N - T	85%*	89.5%	79.7%	Focus on Immunisation Programme provided in July Dashboard											79.7%	R		
Childrens Services - National Childhod Measurement Programme				2019/20 Academic Year	Academic Year 2019/20					Academic Year 2020/21										
	Percentage of children in Reception Year with height and weight recorded	N - T	70%*	97.7%	66.4%	68.0%	67.9%	69.7%	69.7%	Programme commences in November 2020							68%	R		
	Percentage of children in Year 6 with height and weight recorded	N - T	70%*	97.2%	66.1%	70.0%	69.8%	73.9%	73.9%	Programme commences in November 2020							70%	G		

CQC DOMAIN - ARE SERVICES EFFECTIVE

Additional Information

Bed Occupancy
Bed occupancy in physical health inpatient services continues to be lower than comparable historical levels as a direct consequence of lower than normal activity levels across the wider system and alternative discharge pathways being used, in particular those short terms discharge to assess placements within two reablement units. The Trust has a robust process in place to ensure that all inpatient settings are Covid-19 secure to protect colleagues and patients. The impact of this can be evidenced through the number of healthcare associated Covid-19 infections attributable to the Trusts care which remains at zero

Mental Health
IAPT recovery rates have achieved the required threshold for the third consecutive month.

Monthly and year to date data for Early Intervention in Psychosis (EIP) service was updated within the dashboard last month. EIP has met the required threshold for the second consecutive month and the service remains in active recovery .

CQC DOMAIN - ARE SERVICES EFFECTIVE

A focus on flu

Workforce flu vaccination planning

Public Health England has not set an uptake target for workforce flu vaccinations for 2020/21 however the ambition is to offer the flu vaccination to 100% of the frontline workforce.

In 2019/20 the Trust achieved an 86% uptake of flu vaccinations by frontline colleagues; the aim for 2020/21 is to exceed this rate.

In order to achieve this a review has been undertaken of the success and challenges encountered during the 2019/20 program. A dedicated working group has been set up with representation from colleagues across whole Trust services with meetings commencing in June 2020 on a monthly basis that have increased to weekly frequency from September 2020.

The working group has developed a strategy to progress the ambition of vaccinating all frontline colleagues that includes the following:

GHC flu vaccination program updates:
A dedicated flu team has been formed with representatives from a number of directorates, staff groups and regular meetings have commenced.
44 Peer Vaccinators have volunteered from a variety of Trust services and have been fully trained to support the roll out of the vaccination program.
An on-line booking system has been developed and is due to go live on Wednesday 23rd September 2020
The Trust has ordered 6,000 vaccines for GHC Staff in order to offer vaccines to all substantive and bank frontline colleagues. The first 1000 vaccines arrived on 16th September 2020 and these will be used by Working Well to vaccinate all staff who were or are shielding (i.e. those staff at highest risk) the remaining vaccines will be issued to Peer Vaccinators to commence the wider roll out of the program.
The Director of Nursing, Therapies and Quality has been assigned as the Board champion for the Trust flu campaign.
Weekly feedback on percentage uptake for staff groups will be circulated to the Flu Team from mid-October and copied to identified Executive Directors. Performance at directorate and service level will be extracted to identify poor take up areas.
A communication strategy has been developed that includes: • Publishing the rationale and facts for the flu vaccination programme -sponsored by senior clinical leaders and trades unions • Information shared at September 2020 Team Talks. • PHE Flu letter due to be sent to all staff week commencing 21st September 2020. • Mobile vaccination schedule to be published electronically, on social media and on paper. • Flu vaccination programme due to be publicised on screensavers, posters and social media throughout the Trust • Daily communications re available flu appointments. • Successes to be celebrated with weekly updates facilitated by Trust Communications Team

CQC DOMAIN - ARE SERVICES EFFECTIVE

A focus on flu

Vulnerable patient planning

All GHC inpatients who are eligible for a flu vaccination (in line with NHSE criteria) will be offered a seasonal flu vaccination whilst under the care of GHC.

In order to achieve this the following actions are in progress:

- Supplies of vaccine have been ordered from pharmacy providers and supporting paperwork has been drafted.
- Steps to check if patients have already received a flu vaccine within the wider health care system stem will be taken to reduce the risk of any patient receiving more than one seasonal flu vaccination.

Primary care support requirements

Community nursing teams will as in previous years vaccinate eligible patients identified on their case load.

In addition, this year community nursing teams will identify through the GP practices, carers of patients on the caseload and/or household contacts who are shielding who require home vaccination. These vaccinations will then be undertaken by the team.

CQC DOMAIN - ARE SERVICES EFFECTIVE?

Focus on: Autism Spectrum Conditions (ASC) Diagnostic Service and Attention Deficit with Hyperactivity Disorder (ADHD) Service

Performance

Due to the Covid -19 pandemic both the ASC and ADHD Services suspended, with clinical staff redeployed to a variety of roles within the Trust.. With the agreement of the CCG, all referrals into the service were suspended until further notice as these services were considered non-essential at this this time. Every individual on the caseload was sent a letter advising of the service suspension and providing information which included additional advice and guidance. This was followed up by a letter 3-4 months later, advising of the service re-opening.

In July 2020 colleagues began to be released from their redeployed posts in order to resume both the ASC and ADHD services, with full repatriation of colleagues to substantive roles by the beginning of September 2020. The services officially reopened in September 2020 with the services now accepting referrals as per usual business.
All assessments and consultations are being performed using the virtual platform of Attend Anywhere (AA) or by telephone. Where prescriptions need to be provided (ADHD), these are sent directly to service users' home addresses or their chosen pharmacy using recorded delivery methods. Alternatively, in exceptional circumstances, the situation is individually risk assessed and the service user attends The Pavilion. They are seen with the clinician wearing PPE as per Trust guidance. Where blood pressure and cardiac checks are required (ADHD) the service user is directed to the GP to have this completed. In exceptional circumstances, this is individually risk assessed and completed at The Pavilion with the use of PPE.

Procedures were put in place for guiding service users through the process of accessing the virtual platforms. Once the referrals were re-opened those who had been waiting the longest were contacted and were initially assessed via telephone/video, with further appointments made.

Two Consultant Psychiatrists returned to offer weekly diagnostic slots from September 2020. Four Learning Disability Consultants for ASC and one Learning Disability Consultant for ADHD have not returned as assessments are required to be undertaken in a face to face environment rather than virtually. As soon as face to face assessments can safely resume, this part of the service will recommence. The four Learning Disability Consultants for ASC were providing the service with ½ day per week on a rotational basis, so the impact of this is a reduction in assessment capacity of 1 assessment per week.

ADHD
Wait List Progress

	May 2020	02/7/20	06/7/20	13/7/20	20/7/20	27/7/20	03/8/20	10/8/20	07/9/20	14/9/20
ADHD 'Triage' Wait List	6	1	3	6	7	15	19	20	1	5
ADHD 'Initial Asst Wait List*	114	111	95	79	72	69	66	65	92	93
ADHD Asst Wait List **	103	110	121	132	135	135	137	141	140	142
ADHD Medication wait List ***	32	31	30	18	15	13	14	11	11	9
Not currently assigned to wait List ****	36	34	29	39	43	43	45	43	35	30
TOTAL	291	287	279	274	272	275	281	280	279	279

ASC
Wait List Progress

	May 2020	06/07/20	13/07/20	20/07/20	27/7/20	03/08/20	10/08/20	07/09/20	14/09/20
ASC 'Triage'	10	11	15	17	18	25	21	31	28
ASC Post Triage	8	8	8	8	8	8	2	1	1
ASC Pre –Initial Asst	47	47	47	48	48	48	24	9	11
ASC Initial Asst	106	106	106	106	106	106	125	133	133
ASC Asst	106	106	106	106	106	105	104	99	98
ASC SALT Asst	1	1	1	1	1	1	1	1	1
ASC Treatment/ therapy	18	18	18	18	16	17	18	23	20
Grand Total	295	296	301	304	302	309	294	297	292

Although there was a suspension to the referrals coming into the service, the waiting lists were already lengthy. With the reopening of referrals to the service, limited clinician time and the further loss of some consultant time the waiting times are expected to grow. To mitigate this, the service has implemented screening/triage clinics with the purpose of preventing inappropriate referrals being added to the waiting lists and lengthening them further. The service is are holding weekly reporting meetings to review progress with the waiting lists and identify any priorities. Additionally, they are developing further links with Primary Care and MHICT and joining the MHICT weekly meetings to allow time to discuss referrals with a view to reducing inappropriate referrals. Progress against this will be reported at future Quality Committee meetings.

CQC DOMAIN - ARE SERVICES EFFECTIVE?

Focus on – ASC and ADHD Service

Risks

Limited clinician capacity is resulting in increased waiting times. Referrals have increased since re opening in September.

Both the ASC and ADHD specialist clinicians have had to adapt and develop what was already a complex diagnostic assessment, to cater for the use of a virtual platform. This has taken great effort in order to allow for the non-verbal element of the assessment and to take into consideration the complex needs of this client group, along with the reasonable adjustments required. Due to the change in working environments and virtual appointments, administration tasks have greatly increased which will contribute to wait times.

Assurance

All assessments and consultations are completed via a virtual platform or by telephone.

Improved links have been established with our Primary Care/MHICT and wider GHC colleagues in order to offer an “advisory” service to provide education regarding the referral pathway and to offer time for colleagues to discuss any queries regarding referrals. This will allow joined up working to promote appropriate referrals coming into the team and the ability to signpost colleagues to more appropriate services at an earlier opportunity.

Celebrating Success

In the response to the pandemic the Clinical Specialists have shown resilience in a difficult and pressured time. They were flexible and dynamic at a time of global concern. The team have remained positive and continue to provide the best possible service under difficult circumstances. The team sickness rate has been below average and all colleagues have adapted to accommodate rapid changes in service delivery.

Colleagues have developed new ways of working; completing diagnostic assessments, administration and providing post-diagnostic groups in a way that would have previously been considered the impossible for this client group. Despite encountering hurdles, colleagues have continued to provide care and support to this client group and their families and carers.

Going forward, the use of virtual platforms and telephone consultations will allow the service to deliver these diagnostic assessments in a more efficient manner.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

CQC DOMAIN - ARE SERVICES RESPONSIVE?

Minor Injury and Illness Units

		Reporting Level	Threshold	2019/20 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2020/21 YTD	RAG	Exception Report?	Benchmarking Report Feb Figure
	Time to initial assessment for patients arriving by ambulance (95th percentile)	N - T	<15 m	00:14	00:17	00:11	00.13	00:17	0.15								00:14	R		
Referral to Treatment physical health																				
	Podiatry - % treated within 8 Weeks	L - C	95%	73.6%	92.9%	97.2	100%	94.2%	97.7%								96.%	G		
	ICT Physiotherapy - % treated within 8 Weeks	L - C	95%	79.8%	65.1%	57.9%	84.4%	93.6%	97.5%								75.2%	R		
	ICT Occupational Therapy Services - % treated within 8 Weeks	L - C	95%	83.5%	79.4%	62.5%	93.6%	94.9%	98.4%								82.6%	R		
	Paediatric Speech and Language Therapy - % treated within 8 Weeks	L - C	95%	88.5%	60.2%	68.8%	95.3%	99.3%	100%								80.9%	R		
	Paediatric Physiotherapy - % treated within 8 Weeks	L - C	95%	84.5%	72.2%	98.8%	95.2%	99.0%	98.6%								91.3%	R		
	Paediatric Occupational Therapy - % treated within 8 Weeks	L - C	95%	95.4%	92.9%	97.2%	96.2%	99.02%	98.7%								96.3 %	G		
	Single Point of Clinical Access (SPCA) Calls Offered (received)	L - R	3,279	35939	1787	1731	1774	1712	1,702								8706	R		
Mental Health Services																				
	CPA Review within 12 Months	N - T	95%	96.9%	86.9%	86.7%	87.2%	86.3%	88.3%								86.7%	R		
	Admissions to hospital gate kept by CRHTT	N - T	95%	100.0%	96.8%	94.8%	100%	100%	100%								97.9%	G		

Additional information

MIIUs

- The Dilke and Vale MIIUs remain closed as part of the Covid-19 response. Due to the increased level of demand as a consequence of the relaxation of lockdown measures and an increase in injury being seeing at CGH and GRH, Tewkesbury MIIU re-opened on 25/08/20 from 10am-6pm, with this due to increase to 8am-8pm from September (this aligns the 5 units' opening times).
- The Vale will reopen in October from 10am-6pm as currently a full staffing model for this site cannot be assured. The Dilke will remain closed as the clinical space makes it unsuitable for a walk-in model and there is an aim for the MIIU to be opened for pre-booked appointments later in the financial year.
- The MIIU team continue to provide telephone advice for those patients that call first to ensure the right clinical pathway is accessed as soon as possible. This approach has already shown a positive impact on flow within the MIIUs. Increasing bookable appointments through 111 has also improved flow and work is currently underway to improve the take up of this offer. It is understood that more work needs to be done in the 111 service to direct more patients into MIIUs from this provider.

ICTs

ICT therapies activity captured by the KPI definition has still not returned to pre-Covid-19 levels. August saw a month on month step up in referrals to both Physiotherapy and OT, but these are still 25% and 20% down on August 2019 referral numbers. Despite this, new referrals exceeded new cases seen in the month so the number of people waiting for an appointment has risen for the first time since the pandemic. Therapy teams continue to prioritise referrals on the basis of clinical need with 86.9% of people seen by ICT Physiotherapy and 86.8% of people seen by ICT OT in August having waited for 2 weeks or less.

The ICT KPIs pre-date the establishment of these multi-disciplinary teams and do not take account of the work undertaken by our therapists in the ICT referral centres

- If physiotherapy work within the ICT referral centres is combined with the ICT physiotherapy KPI data, then the percentage of people seen within 8 weeks is 98.9% for August.
- If occupational therapy work within the ICT referral centres is combined with the ICT occupational therapy KPI data, then the percentage of people seen within 8 weeks is 99.3% for August.
- This combined data provides a helpful reflection of the experiences of overall contact with the ICTs.

Mental health

- The rate of performance in relation to timely CPA reviews is noted to have experienced minor fluctuations over the past four months and has not met the threshold of compliance during this time period. It is important to note that the restrictions posed by Covid-19 in terms of face to face contact have limited some opportunities for full CPA review. It is anticipated that this indicator will remain challenging to achieve whilst recovery plans are embedded in keeping with current local and national Covid-19 restrictions.
- CRHTT has achieved 100% compliance with gatekeeping admissions to hospital for the third consecutive month this year, the deviation noted in May is largely due to the Trusts actions to reconfiguring services in response to Covid-19.

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

*In-month threshold (i.e. March)

RAG Key: R – Red, A – Amber, G - Green

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

Additional KPIs Physical Health

		Reporting Level	Threshold	2019/20 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2020/21 YTD	RAG	Exception Report?	Benchmarking Report Feb Figure
	Proportion of eligible children who receive vision screens at or around school entry.		70%*	N/A	60.4%	60.4%	60.4%	61.5%	61.5%								60.6%	R		
	Number of Antenatal visits carried out		92	944	46	42	35	24	24								171	R		
	Percentage of live births that receive a face to face NBV (New Birth Visit) within 7- 14 days by a Health Visitor		95%	91.5%	42.9%	30.6%	58.7%	75.7%	82.5%								58.1%	R		
	Percentage of children who received a 6-8 weeks review.		95%	94.1%	12.2%	44.4%	71.8%	76.3%	86%								61.9%	R		
	Percentage of children who received a 9-12 month review by the time they turned 12 months.		95%	84.8%	80.3%	75.2%	67.1%	70.8%	64%								72.3%	A		
	Percentage of children who received a 12 month review by the time they turned 15 months.		95%	90.2%	89.4%	86.2%	89.2%	87.5%	82.2%								87.2%	A		
	Percentage of children who received a 2-2.5 year review by 2.5 years.		95%	83.5%	81.9%	85.3%	81.7%	73.9%	61.1%								76.8%	A		
	Percentage of infants being totally or partially breastfed at 6-8wks(breastfeeding prevalence).		58%	54.9%	56.7%	56.2%	58.2%	58.2%	49%								56.1%	A		
	Chlamydia Screening of Gloucestershire residents aged 15-24 (minimum positivity rate)		3108	1929	895	676	844	963	1233								3378			
	Number of Positive Screens		169	1329	53	40	50	57	73								275			
	Average Number of Community Hospital Beds Open		196	195.4	173.3	168.8	155.8	162.5	177.7								167.62	R		
	Average Number of Community Hospital Beds Closed		0	1.1	19.2	27.2	40.2	33.5	18.3								28.3	R		

Additional Information

The reduction in numbers of antenatal visits has plateaued throughout August due to the partial suspension plan and continued pausing of the antenatal groups; there remains some public apprehension about home visits. Joint working with Gloucestershire Hospitals NHS FT continues to promote virtual antenatal group sessions for families, and a targeted approach is being adopted.
The vision screening programme was suspended when lockdown occurred on 23/03/20 as it is a school-based programme, a catch up programme will commence in September once schools have returned and are allowing access to school nursing staff.
The universal antenatal service is currently suspended but the Health Visitor (HV) and Midwifery services are currently developing a virtual offer. In addition the midwifery notification of antenatal is being reviewed as not all are notified to the HV service. The 24 visits delivered were all targeted based on vulnerability risk factors.
NBV – the dashboard data is limited to face to face activity, if telephone and virtual activity is included the percentage would increase to: 92.1 %. In addition 9 babies remain in Neonatal ICU
6-8 week – the dashboard data is limited to face to face activity; if telephone and virtual activity is included the percentage would increase to: 95.9%
9-12 month – 99 contacts declined the offer and 60 contacts requested a patient delay until face to face activity resumes. This is currently awaiting increased Covid-19 secure environments in order to deliver clinics safely.
12-15 month – 71 contacts declined the offer, 5 contacts requested a delay until face to face activity can resume.
2-2.5 years – 147 contacts declined the offer, 11 contacts requested delays until face to face activity resumes, 5 contacts had no access visits
Breastfeeding - review identified that some data in relation to this area was not being accurately recorded. This has been addressed within the service to ensure data accurately reflects activity.
The service is actively increasing the number of Covid-19 secure clinics to meet service user preference, as the decline in reviews is due to the increased requests for face to face appointments in clinic settings, rather than home visits. A system wide Better Births meeting was held in mid-August to review integrated practice between midwifery and health visiting.

Chlamydia screening: The increase in numbers of tests carried out in August is most likely due to the continued easing of social distancing and lockdown restrictions, it is noted that positivity rates increased this month.

*In-month threshold (i.e. March)

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

RAG Key: R – Red, A – Amber, G - Green

Quality Dashboard

Gloucestershire Health and Care
NHS Foundation Trust

CQC DOMAIN - ARE SERVICES WELL LED?

		Reporting Level	Threshold	2019/20 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2020/21 YTD	RAG	Exception Report?	Benchmarking Report
	Staff Friends and Family Test - Percentage of staff who would recommend the Trust as a place of work	N - R L - T	61%																	
	Staff Friends and Family Test - Percentage of staff who would recommend the Trust as a place to receive treatment	N - R L - T	67%																	
	Mandatory Training	L - I	90%	89.14%	88.8%	88.7%		85%	85%											
	% of Staff with completed Personal Development Reviews (Appraisal)	L - I	90%	80.38%	72.7%	69.9%	65.4%	76%	76%								72%	R		
	Sickness absence average % rolling rate - 12 months	L - I	<4%	4.72%	4.9%	5.0%	5.2%	5.21%	5.14%								5.09%	R		
	SUS+ (Secondary Uses Service) Data Quality Validity - Available in arrears	N-R	96.30%																	

Additional information

Mandatory training, appraisal and absence

The pause on statutory/mandatory training was lifted in July 2020. Although service recovery plans include a focus on meeting target thresholds, this is taking some time given the pressure on services and colleagues' annual leave. Social distancing requirements have posed challenges with room availability for the recommencement of face to face training, although it is anticipated that some key venues will be available from October 2020. The focus will be on the provision of face to face physical intervention and resuscitation training. Subject matter experts are still in the process of converting their training to online options to respond to this challenge. The main focus for training compliance continues to be Information Governance training; this is due to the need to declare alignment with the NHS's Data Security and Protection Toolkit (DSPT) training compliance target in September 2020. Training compliance is likely to remain below target until the new Trust training system, due for implementation in September 2020, is fully embedded.

Appraisal compliance has remained static at 76% for this month. It is anticipated that compliance will improve further over the coming months as a result of the Trust's continuing programmes of recovery, with colleagues returning from annual leave. There will be continued emphasis on the need for appraisal completion over the coming months, including the re-introduction of appraisal training.

Sickness absence has remained consistent over the last 4 month period but continues to remain above the Trust target of 4.00%.

Staff Health and Wellbeing

The Health and Well-being pages of the intranet continue to provide a single point of access for support under 6 domains: physical health, mental health, lifestyle, supporting colleagues, speaking up, and staff benefits.

Recent work and support available during August 2020 includes;

- Offers for staff communicated via emails, intranet, face to face contacts, and leaflet dropping; curating self-care materials including apps; collating and distributing gifts and donations
- Team based psychological support, team facilitation skills programme, and individual support (i.e. Working Well, Let's Talk, Psychology and specific input for shielding staff)
- Freedom to Speak Up support included as a health and wellbeing offer continued with a relaunch of the work in confidence system.
- Thank you letters for children and colleagues, supporting a 'thank you day' for all colleagues
- Water Bottle distribution by Board and Hub colleagues, supported by health and well-being information (during August).
- Feedback from national and local surveys to supporting further development, ensuring colleagues have a voice.
- Hub approved charitable fund bids to further support the development, quick wins and longer term i.e. 3 days for OH extra counselling; NHS Elect mindfulness/reflection programme
- Promoting health and well-being through creativity (e.g. GHC colleagues photography competition) and shared experiences (e.g. blogs by colleagues)
- Encouraging wider participation and feedback by extending Health and Wellbeing core group to include a variety of clinical and operational colleagues.

Gloucestershire Health and Care NHS Foundation Trust

CQC DOMAIN - ARE SERVICES WELL LED?

Safe Staffing Mental Health Inpatient – Aug 2020

	Code 1		Code 2		Code 3		Code 4		Code 5	
Ward Name	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions
Dean	42.5	4	0	0	0	0	10	1	0	0
Abbey	240	32	7.5	1	0	0	0	0	0	0
Priory	280	37	42.5	4	0	0	0	0	0	0
Kingsholm	67.5	9	0	0	0	0	0	0	0	0
Montpellier	45	6	10	1	0	0	0	0	0	0
Greyfriars	420	49	0	0	0	0	0	0	0	0
Willow	7.5	1	22.5	3	0	0	0	0	0	0
Chestnut	37.5	5	7.5	1	0	0	0	0	0	0
Mulberry	22.5	3	0	0	0	0	0	0	0	0
Laurel	0	0	0	0	0	0	0	0	0	0
Honeybourne	0	0	0	0	0	0	0	0	0	0
Berkeley House	0	0	15	1	0	0	0	0	0	0
Total In Hours/Exceptions	1162.5	146	105	11	0	0	10	1	0	0

Definitions of Exceptions:

Code 1 = Min staff numbers met – skill mix non-compliant but met needs of patients

Code 2 = Min staff numbers not complaint but met needs of patients e.g. low bed occupancy ,patients on leave

Code 3 = Min staff numbers met – skill mix non-compliant and did not meet needs of patients

Code 4 = Min staff numbers not compliant did not meet needs of patients

Code 5= Other

The Code 4 exception was due to an agency staff member not arriving for the shift.

MENTAL HEALTH & LD						
Ward	**Average Fill Rate**	**In-Post**	**Bank**	**Agency**	**Vacancies**	**Sickness**
Dean Ward	114.14%	94.82%	13.15%	10.36%	13.15%	10.36%
Abbey Ward	110.65%	69.92%	32.52%	9.29%	32.52%	9.29%
Priory Ward	106.94%	86.06%	25.90%	2.36%	25.90%	2.36%
Kingsholm Ward	104.89%	89.63%	10.38%	8.04%	10.37%	8.04%
Montpellier	99.97%	94.76%	9.30%	4.11%	9.29%	4.11%
PICU Greyfriars Ward	138.98%	82.92%	2.97%	6.13%	2.97%	6.13%
Willow Ward	100.00%	93.84%	-1.96%	5.97%	-1.96%	5.97%
Chestnut Ward	105.91%	93.39%	10.75%	0.91%	10.74%	0.91%
Mulberry Ward	117.90%	96.77%	6.81%	11.03%	6.81%	11.03%
Laurel House	109.14%	88.44%	25.29%	6.97%	25.29%	6.97%
Honeybourne Unit	100.00%	102.58%	0.00%	0.00%	8.54%	9.99%
Berkeley House	111.06%	91.96%	22.13%	2.35%	22.13%	2.35%
Totals (August 2020)	**109.97%**	**90.42%**	**13.10%**	**5.63%**	**13.81%**	**6.46%**
Previous Month Totals	108.23%	86.19%	15.08%	6.96%	13.81%	5.69%

Mental Health and Learning Disability Inpatients

There are mitigations to note in reference to the gaps in the in-post percentages:

- Wotton Lawn is currently running at 23.70 WTE vacancies. There is a cohort of 8 newly qualified nursing staff joining Wotton Lawn in September 2020. Therefore, the net vacancy rate for Wotton Lawn will be 15.70 WTE. Charlton Lane is currently running at 3.8 WTE vacancies. There is a cohort of 3 newly qualified nursing staff joining Charlton Lane in September 2020. Therefore, the net vacancy rate for Charlton Lane will be 0.8 WTE. This is a positive development and reflects recruitment work undertaken earlier this year with student nurses. However further attention is required to maintain required staffing in these areas
- There are currently 8 x 12wk agency contracts in place in Wotton Lawn.
- An agency Guaranteed Volume Contract is in place in Wotton Lawn delivering 28 shifts per week. Work is currently underway to increase this contract by 100% at Wotton Lawn to meet current demand. An equivalent guaranteed volume contract is being developed to include Charlton Lane and work is underway to establish demand. This contract promotes improved continuity of care as these staff undertake RiO and clinical risk training so they can undertake the full clinical role, including being the nurse in charge.

CQC DOMAIN - ARE SERVICES WELL LED?

Safe Staffing Physical Health – Aug 2020

Physical Health

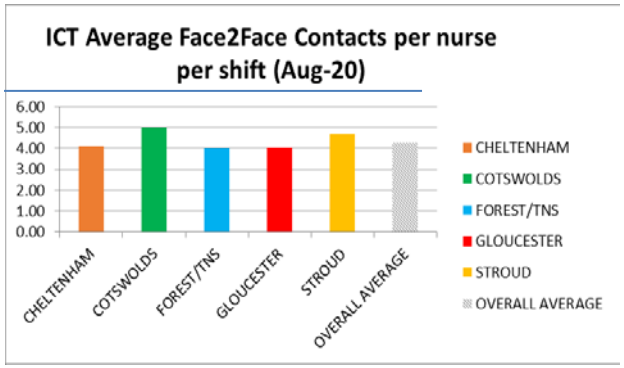
The Trust continues to work to homogenise safe staffing reporting methods across the new organisation. However the Trust is able to report good levels of staffing maintained in inpatient areas set against agreed safe staffing levels. The table below shows that average fill rates in August 2020 were 103.15%, which is similar to July 2020 where average fill rates were 105.44%. A detailed piece of work will be undertaken to enable the reporting of physical health exceptions as currently delivered in Mental Health/Learning Disability services.

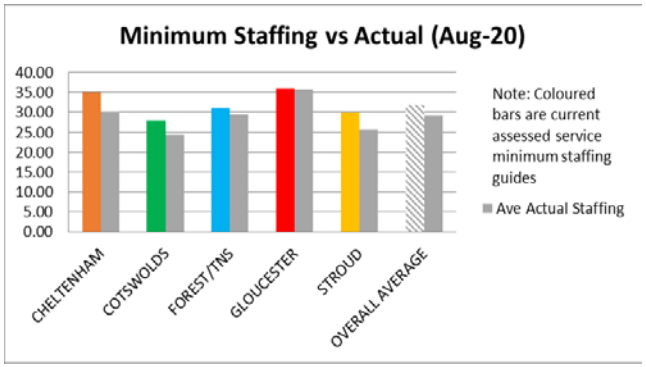
In response to current staffing levels for District Nursing, feedback from internal and system wide colleagues and opportunities for new ways of working within a primary care network environment will be explored by a task and finish group that has been established. This is sponsored by the Director of Nursing, Quality and Therapies and progress will be reported to Quality Committee via the Quality Assurance Group.

PHYSICAL HEALTH						
Ward	**Average Fill Rate**	**In-Post (RGN & HCA)**	**Bank**	**Agency**	**Vacancies**	**Sickness**
Coln (Cirencester)	111.09%	83.53%	6.49%	4.32%	6.48%	4.32%
Windrush (Cirencester)	101.21%	82.41%	14.56%	7.01%	14.56%	7.01%
Jubilee (Stroud)	118.47%	77.98%	26.00%	6.26%	26.00%	6.26%
Cashes Green (Stroud)	94.18%	93.65%	23.88%	6.41%	23.96%	6.43%
Abbey View (Tewkesbury)	101.88%	90.30%	2.46%	7.46%	2.46%	7.45%
North Cotswolds	93.18%	103.35%	0.00%	0.00%	12.20%	5.40%
The Dilke	94.35%	92.26%	34.15%	4.89%	34.21%	4.90%
Lydney	118.45%	88.49%	-4.89%	2.68%	-4.89%	2.68%
Peak View (Vale)	95.57%	89.40%	14.68%	2.43%	14.68%	2.43%
Totals (August 2020)	**103.15%**	**89.81%**	**13.04%**	**4.61%**	**14.41%**	**5.21%**
Previous Month Totals	105.44%	85.59%	15.33%	4.52%	14.41%	5.71%

CQC DOMAIN - ARE SERVICES WELL LED?

Effective Staffing Review - July 2020 – Development data providing focus on ICT (District Nursing teams) activity and staffing levels





- The number of redeployed staff as of 01/08/2020 was 8, however by w/c 10/08/2020 all 8 had been repatriated. This is evident through the actual staffing levels which are on average 29.11 shifts per day compared to the minimum of 32 shifts per day. As all staff have now been repatriated, normalised data (post Covid-19) is expected for the month of September 2020 and will be reported in October 2020.

- The average face to face contacts per nurse per shift is an average taken across the skill mix. The average number during Aug 2020 is 4.29 compared to 6.27 in July 2020. During July there were still redeployed staff working in the teams.
- Phone contact with service users is currently utilised as a method of contact which is not included in these figures.

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AGENDA ITEM: 15

REPORT TO:	**Trust Board – 30th September 2020**
PRESENTED BY:	Sandra Betney, Director of Finance
AUTHOR:	Stephen Andrews, Deputy Director of Finance
SUBJECT:	**FINANCE REPORT FOR PERIOD ENDING 31ST AUGUST 2020**

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

The purpose of this report is to
Provide an update of the financial position of the Trust.

Recommendations and decisions required

The Board is asked to:

- **Note** the month 5 position
- **Approve** the use of £110k merger savings to fund the strengthening of the Operations Directorate
- **Approve** the use of £57k merger savings to fund a new Equality, Diversity and Inclusion Lead

Executive summary

- There is a Covid interim financial framework for the NHS in place for April to September.
- A revised financial framework will be put in place for October to March.
- The Trust's position at month 5 is break even. All Trusts are required to show a break even position by NHSI.
- To reach a break even position the Trust has requested a retrospective top-up of £1.484m for Apr to August. £1.072m of this has been approved by NHSI for April to July.
- To support the creation of a Service Director post in CYPs the Trust is proposing to invest £110k of merger savings in the Operations directorate.
- The cash balance at month 5 is £71.453m.
- Capital expenditure is £0.978m at month 5. The Trust has a capital plan for 20/21 of £10.045m.
- The revised recurring Cost Improvement Plan (CIP) target for the merged

Trust is £4.352m and the amount delivered to date is £3.277m. • The Trust has spent £1.790m on Covid related revenue costs between April and August.

Risks associated with meeting the Trust's values Risks identified within the paper.	
Corporate considerations	
Quality Implications	None identified
Resource Implications	As set out in the paper
Equality Implications	None identified

Where has this issue been discussed before?

Appendices:	Finance Report

Report authorised by:	**Title:**
Sandra Betney	Director of Finance

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AGENDA ITEM 15.1

Finance Report Month 5

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

Gloucestershire Health & Care Overview

Gloucestershire Health and Care
NHS Foundation Trust

- The Covid interim financial framework for the NHS in place since April to September, from October a number of adjustments to the financial framework are being introduced. Block contract payments will continue.
- Gloucestershire ICS has been given an overall funding envelope that it collectively has to manage.
- Trusts have to complete activity, finance and performance plans for the remainder of 20/21
- The Trust has been notified it will receive £1.072m of retrospective true up funding relating to April to July, and has calculated a further £412k for August in order to break even
- This will bring the total retrospective true up payments to £1.484m
- The Trust has £700k reduction in NCA income as we have been instructed not to invoice
- The Trust has recorded Covid related expenditure of £1.790m for April to August
- The adjusted recurrent Cost Improvement Plan target for the Trust following the extension of the interim planning guidance is now £4.352m. The CIP removed so far is £3.277m
- 20/21 Capital plan was approved at £9.945m, with an additional £100k for critical backlog maintenance. Spend to month 5 is £978k, Capital Management Group is monitoring forecast outturn
- Agency cost forecast is £4.832m which is £1.4m lower than 2019/20. No Agency ceiling has been issued by NHSI for 20/21
- Cash at the end of month 5 is £71.5m due to the Trust receiving September's block contract payment early
- To strengthen the capacity of the Operations directorate and support the transformation agenda that formed an integral part of the merger it is proposed to utilise merger savings of £110k to support the creation of a Service Director post in Children and Young People's Services.
- A new Equality, Diversity and Inclusion Lead is also proposed to be funded from the merger reserve at £57k. After these two posts are funded there will be £189k left in the reserve.

GHC Income and Expenditure

Gloucestershire Health and Care
NHS Foundation Trust

The performance at Month 5 is above the planned deficit of £0.210m at break even in line with NHSI policy. The Trust has requested £1,484k of true-ups over five months.

	GHC	GHC Month 5			
Statement of comprehensive income £000	2019/20	2020/21			
	Actual	NHS I Interim plan	Budget	Actual	Variance
Operating income from patient care activities	187,601	95,945	87,370	90,031	2,661
Other operating income exc PSF	9,642	4,125	3,780	2,664	(1,116)
True up income		0	0	1,484	1,484
Provider sustainability fund (PSF) income	2,042	0	0	0	0
Employee expenses	(142,521)	(67,515)	(67,340)	(68,556)	(1,216)
Operating expenses excluding employee expenses	(55,456)	(25,780)	(22,350)	(24,127)	(1,777)
PDC dividends payable/refundable	(2,351)	(1,655)	(1,675)	(1,550)	125
Other gains / losses	222	25	5	10	5
Surplus/(deficit) before impairments & transfers	**(821)**	**5,145**	**(210)**	**(44)**	**166**
impairments	3,489	0	0	0	0
Remove capital donations/grants I&E impact	56	0	0	44	44
Surplus/(deficit) inc PSF	**2,724**	**5,145**	**(210)**	**0**	**210**

Note . The variance compares ‘Budget’ against ‘Actual’

GHC Balance Sheet

Gloucestershire Health and Care
NHS Foundation Trust

STATEMENT OF FINANCIAL POSITION (all figures £000)		GHC 2019/20	GHC Month 5 2020/21 Year to Date		
		Actual	Budget	Actual	Variance
Non-current assets	Intangible assets	2,023	2,283	1,307	(976)
	Property, plant and equipment: other	115,916	121,248	111,524	(9,724)
	Total non-current assets	**117,939**	**123,531**	**112,831**	**(10,700)**
Current assets	Inventories	288	245	283	38
	NHS receivables	11,017	8,456	5,427	(3,029)
	Non-NHS receivables	8,973	5,723	11,672	5,949
	Cash and cash equivalents:	26,619	28,469	71,453	42,984
	Property held for sale	0	500	0	(500)
	Total current assets	**46,897**	**43,393**	**88,835**	**45,442**
Current liabilities	Trade and other payables: capital	(2,143)	(1,784)	(776)	1,008
	Trade and other payables: non-capital	(5,580)	(10,551)	(12,284)	(1,733)
	Borrowings	(76)	(104)	(164)	(60)
	Provisions	(371)	(604)	(544)	60
	Other liabilities: deferred income including contract liabilities	(16,655)	(1,482)	(45,047)	(43,565)
	Total current liabilities	**(24,825)**	**(14,525)**	**(58,816)**	**(44,291)**
Non-current liabilities	Borrowings	(1,773)	(8,338)	(1,377)	6,961
	Provisions	(3,491)	(451)	(3,725)	(3,274)
	Total net assets employed	**134,747**	**143,610**	**137,748**	**(5,862)**
Taxpayers Equity	Public dividend capital	127,526	125,181	120,611	(4,571)
	Revaluation reserve	6,566	7,098	7,204	106
	Other reserves	(1,241)	(1,241)	(1,241)	(0)
	Income and expenditure reserve	1,896	12,572	11,175	(1,397)
	Total taxpayers' and others' equity	**134,747**	**143,610**	**137,748**	**(5,862)**

Note. £32m deferred income. September income received in August

Cash Flow Summary

Gloucestershire Health and Care
NHS Foundation Trust

Statement of Cash Flow £000	YEAR END 19/20		ACTUAL YTD 20/21	
Cash and cash equivalents at start of period		**33,553**		**37,720**
Cash flows from operating activities				
Operating surplus/(deficit)	1,308		1,540	
Add back: Depreciation on donated assets	0		44	
Adjusted Operating surplus/(deficit) per I&E	**1,308**		**1,584**	
Add back: Depreciation on owned assets	4,944		3,554	
Add back: Impairment	3,489		0	
(Increase)/Decrease in inventories	(38)		0	
(Increase)/Decrease in trade & other receivables	(3,516)		3,810	
Increase/(Decrease) in provisions	2,485		184	
Increase/(Decrease) in trade and other payables	2,580		18,067	
Increase/(Decrease) in other liabilities	(863)		7,633	
Net cash generated from / (used in) operations		**10,389**		**34,832**
Cash flows from investing activities				
Interest received	206		1	
Purchase of property, plant and equipment	(4,835)		(979)	
Sale of Property	560		0	
Net cash generated used in investing activities		**(4,069)**		**(978)**
Cash flows from financing activities				
PDC Dividend Received	570		0	
PDC Dividend (Paid)	(2,565)		0	
Finance Lease Rental Payments	(158)		(120)	
		(2,153)		**(120)**
Cash and cash equivalents at end of period		**37,720**		**71,454**

Gloucestershire Health & Care Covid 1

Gloucestershire Health and Care NHS Foundation Trust

- No Covid related capital costs were identified in 19/20.
- Urgent Covid related capital costs have been incurred in 20/21 and a request for funding was put forward for national sign-off which has now been approved (£137k).
- The Trust has submitted further capital proposals under phase 2 of the NHS recovery plan totalling £3.745m.
- Covid related revenue costs of £1,790k have been identified for April to August 2020.

For periods up to and including 31/08/2020 (M1-5)	Pay TOTAL	Non Pay M5	Comments (M5)
Expand NHS Workforce - Medical / Nursing / AHPs / Healthcare Scientists / Other	**260,519.00**	0.00	Includes Nurse Trainees, Medical and some admin
Sick pay at full pay (all staff types)	**28,636.00**		
COVID-19 virus testing (NHS laboratories)	**42,625.00**	**19,066.00**	Includes serology. Review of staffing costs M1-5 (lower).
Remote management of patients	**0.00**	**51,816.00**	
Plans to release bed capacity	**0.00**	**34,502.00**	
Existing workforce additional shifts	**104,033.00**		Additional historic re-deployed costs recognised in M5.
Decontamination	**0.00**	**142,454.00**	Includes all portakabins as showers, some might be storage now
Backfill for higher sickness absence	**788,737.00**		Incl YTD agreed domestic agency staff
Remote working for non patient activites	**0.00**	**52,480.00**	
National procurement areas	**0.00**	**192,963.00**	Includes Hotel, expenses, travel as well as earlier purchases of PPE
Other	**0.00**	**72,370.00**	
	1,224,550.00	**565,651.00**	**1,790,201.00**

Gloucestershire Health & Care Covid 2

Gloucestershire Health and Care NHS Foundation Trust

- The Trust has completed a forecast for Covid related revenue costs in 20/21.
- The Covid related revenue cost forecast is £3.453m for 20/21.
- Recurring costs are £1.068m in a full year.
- The forecast split by scheme is as follows;

COVID FORECAST 20/21				21/22
Covid Scheme	**Recurring**	**Non Recurring**	**Total**	**Recurring**
	£	£	£	£
Infrastructure	172,816	0	172,816	296,258
Virus Testing	139,160	103,400	242,560	238,566
Stock Control	179,865	0	179,865	308,337
IT	150,000	96,903	246,903	225,000
Additional Clinicial Staffing	0	1,368,934	1,368,934	0
Additional Support Staffing	0	186,000	186,000	0
Vale Stroke Ward	0	176,059	176,059	0
Buildings	0	61,518	61,518	0
Decontamination	0	305,374	305,374	0
Procurement	0	419,541	419,541	0
Other	0	92,952	92,952	0
Total of Schemes	**641,841**	**2,810,680**	**3,452,521**	**1,068,161**

Capital – Five year Plan

Gloucestershire Health and Care
NHS Foundation Trust

Capital 5 year Plan	Original Plan	Revised Plan	Actuals to date	Plan	Plan	Plan	Plan	
£000s	2020/21	2020/21	2020/21	2021/22	2022/23	2023/24	2024/25	Total
Land and Buildings								
Buildings	4,259	3,383	406	3,202	4,500	2,500	1,000	14,585
Backlog Maintenance	1,393	1,563	63	1,371	1,050	1,050	250	5,284
Urgent Care	475	200	0	275		0		475
Covid	0	138	86	0				138
Cirencester Scheme						5,000		5,000
Medical Equipment	1,220	587	23	1,059	730	730	3,330	6,436
IT								
IT Device and software upgrade	600	1,270	209	0	600	600	600	3,070
IT Infrastructure	1,498	2,705	128	132	1,400	1,300	1,300	6,837
Sub Total	**9,445**	**9,845**	**915**	**6,039**	**8,280**	**11,180**	**6,480**	**41,824**
Forest of Dean	500	200	62	6,500	6,300		0	13,000
Total	**9,945**	**10,045**	**978**	**12,539**	**14,580**	**11,180**	**6,480**	**54,824**
Disposals				(3,260)		(1,500)		(4,760)
Donation - Cirencester Scheme						**(5,000)**		(5,000)
	9,945	**10,045**	**978**	**9,279**	**14,580**	**4,680**	**6,480**	**45,064**

Forest of Dean - £900k spent in 2018/19 and 19/20. Brings total planned spend to £13.9m.
Additional £100k added to plan in 20/21 for backlog maintenance from Critical Infrastructure Risk funding

The Capital Management Group have reviewed all schemes for any result of a covid related slow start to the year and concluded that the forecast outturn is still deliverable.

Risks

Gloucestershire Health and Care
NHS Foundation Trust

Risks to delivery of the 2020/21 position are as set out below:

Gloucestershire Health & Care Risks	20/21 Risks	Made up of: Recurring	Made up of: Non Recurring	Likelihood	Impact	RISK SCORE
Unidentified Differential CIP schemes	169	169	0	2	2	4
Interim finance might lead to loss of ability to deliver agreed developments	1,291	0	1,291	4	3	12
	2,537	**833**	**1,704**			

Single Operating Framework Ratings

Current FT Financial Risk Rating - Single Oversight Framework
Use Of Resource

Finance and use of resources rating Metric	2019/20 Actual	20/21 Plan	20/21 Actual YTD	20/21 Forecast
Capital service cover rating	1	1	1	1
Liquidity rating	1	1	1	1
I&E margin rating	1	1	1	1
I&E margin: distance from financial plan	1	1	1	1
Agency rating*	4	1	1	1
Risk ratings after overrides	3	1	1	1

* Assuming no adjustment to existing agency ceiling

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AGENDA ITEM: 16

REPORT TO:	**Trust Board – 30th September 2020**
PRESENTED BY:	Sandra Betney, Director of Finance
AUTHOR:	Chris Woon, Associate Director of Business Intelligence
SUBJECT:	**COMBINED PERFORMANCE DASHBOARD AUGUST 2020 (MONTH 5)**

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

The purpose of this report is to
This performance dashboard report provides a high level view of key performance indicators (KPIs) in exception across the organisation.

To offer reader clarity, the visualisation is separated into the following reporting sections;

- Mental Health & Learning Disabilities National Requirements (NHSI & DoH)
- Mental Health & Learning Disabilities Local Contract (including Social Care)
- Physical Health National Requirements
- Physical Health Local Requirements

Performance covers the period to the end of August (month 5 of the 2020/21 contract period). This report aligns to the organisational response to Covid-19 and associated recovery of services. Data validation and associated indicator narrative has improved, but it is recognised that exception narrative could be a stronger focal point during the period (rather than retrospectively), particularly within Finance & Performance (F&P) operational meetings. Discussions continue on how this can be improved with operational and corporate stakeholders and this is overseen though the Business Intelligence Management Group (BIMG).

Where possible, it has been highlighted within the indicator narrative where **Covid-19** may have contributed to in-period data quality, narrative and/ or performance.

Where performance is not compliant, operational service leads are prioritising appropriately to address issues. Service led Covid-19 recovery plans will schedule recovery trajectories, more fully account for 2020/21 performance indicators in exception and provide legacy Service Recovery Action Plans (SRAP) updates.

Recommendations and decisions required
The Board is asked to:

- **Note** the aligned Performance Dashboard Report for August 2020/21.

- **Acknowledge** the impact of **Covid-19** (management and recovery) on operational performance and where relevant reduced activity across teams.
- **Note** the report as a **significant level of assurance** that our contract and regulatory performance measures are being met or that appropriate service recovery action plans are being developed to address areas requiring improvement - in line with the C19 Recovery Programme.

Executive summary

The Board's attention is requested to review the 10 **mental health** key performance thresholds listed in the dashboard (with associated narrative) that were not met for August 2020. It is of note that all indicators have been in exception within the last 12 months. 3.21(Transition) is included purely for data quality reference.

In addition, attention is drawn to the 20 **physical health** performance thresholds listed in the dashboard (with associated narrative) that were not met for August 2020. Within these, 12 are within CYPS and 3 within wheelchair services. In addition there are 4 workforce indicators within the physical health section that now apply to all GHC services. It is of note that all of these indicators have been in exception within the last 12 months. It is further noted that there are addition physical health indicators outside of threshold but are within normal, expected variation, have a proxy threshold, are formally suspended or have a confirmed data quality issue that is administrative only and is being resolved.

Note on 3.21: CYPS Transition to the Recovery Service within 4 weeks; Although not in exception, there were 3 non-compliant records reported in July due to data entry errors. These have not yet been corrected on the clinical system. No response has been received from the CYP service and the Recovery service has now been approached directly for further response

Risks associated with meeting the Trust's values

Where appropriate and in response to significant and wide reaching performance issues (such as Eating Disorders, Podiatry, IAPT, Children's or Wheelchair Services); operational services should have Service Recovery Action Plans (SRAP) in place which outlines appropriate risk and mitigation.

Corporate considerations	
Quality Implications	The information provided in this report can be an indicator into the quality of care patients and service users receive. Where services are not meeting performance thresholds this may also indicate an impact on the quality of the service/ care provided.
Resource Implications	The Business Intelligence Service provides the support to operational services to ensure the robust review of performance data and co-ordination of the combined performance dashboard and its narrative.
Equality Implications	Equality information is monitored within BI reporting.

Where has this issue been discussed before?	BIMG 17/09/2020

Report authorised by: Sandra Betney	**Title:** Director of Finance

Performance Dashboard Report & BI Update

Aligned for the period to the end August 2020 (month 5)

This performance dashboard provides a high level view of Key Performance Indicators (KPIs) *in exception* across the organisation for the period. Highlighted indicators are underperforming against their threshold or are outside normal variation control limits that warrant senior oversight. Additionally, confirmed data quality issues that are being imminently resolved will inform any escalation decision. A full list of all indicators (in exception or otherwise) are available within the dynamic version of this Tableau report.

Where performance is not compliant, operational service leads are prioritising appropriately to address issues. Additionally, a Covid-19 Recovery Programme will schedule service specific recovery trajectories, more fully account for 2020/21 performance indicators in exception and where appropriate, provide legacy Service Recovery Action Plans (SRAP) updates.

In spite of unplanned Covid-19 BI demands and increasing recovery activity, Business Intelligence services have continued to deliver key infrastructure development tasks to date and ensured the continuity of business critical reports during the pandemic. The following tasks have been completed since the last update;

- The development of business critical operational performance reports within Tableau
- Availability of following data sources to reporting anaylists; Datix, Safety Thermometer, Safer Staffing, Imms Reporting, Lillie (sexual Health)
- Physical Health SystmOne and Mental Health RiO aligned system hierarchy (for merged reporting)
- Initial data validation processing of Incident (Datix), Workforce (ESR) and Finance (Integra) data.
- Winter & 2nd C19 surge planning
- Service level recovery engagement and planning
- Finalisation of C19 Exec Dashboard (*PPE stock control outstanding*)
- Finance (Centros) data extract into data warehouse

The following tasks continue to be 'in the development pipeline';

- Key financial reporting to support the new General Ledger (GL) (Oct 2020/21).
- Dashboard visualisation capability further developed to include; threshold figures in place of variances, benchmarking observation, SRAP alerts and data quality alerts (Q3 2020/21).
- C19 Programme Management Board Dashboard developmentn (Q3 2020/21)
- Final legacy GCS reports migrated to Tableau (Q3 2020/21)
- Complete data sources replication for complimentary systems (Q3 2020/21)
- Supplementary system sources brought into BI reporting (Datix, Service Experience, Q4 2020/21)
- Existing data source adjustments (to support data quality monitoring and historic activity) in new environment (Q4 2020/21).
- Internal service specification review, considering Commissioner led contractual KPI review (Q4 2020/21)
- Data source replication (prioritisation for ESR, Integra and Datix) (Q4 2020, dependant on GL and ESR progress)
- Integrated Business Intelligence Performance Dashboard (Q4 2020/21) for Board/ Resources Committee (incorporating full BI stack).
- Birtie decommissioning (Q4 2020/21)

PLEASE NOTE THAT THE DELIVERY OF THIS BI DEVELOPMENT TIMETABLE CONTINUES TO BE RESPONSIVE TO THE DEMANDS ON CURRENT CORPORATE/ OPERATIONAL BAU & ADHOC (e.g. C19) REPORTING.

Performance Dashboard: *Mental Health & Learning Disability - National Requirements (NHSI & DOH)*

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Mental Health - National Requirements Gloucestershire

		August	YTD	
1.04	Care Programme Approach - formal review within12 months	87.3% -7.7%	88.4% -6.6%	

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

1.04: CPA Approach – Formal review within 12 months
This indicator is non-compliant for August at 87.3% (124 non-compliant records) against a 95% threshold with the majority of cases within the Recovery Service (65), AOT Service (24) and EI service (8).

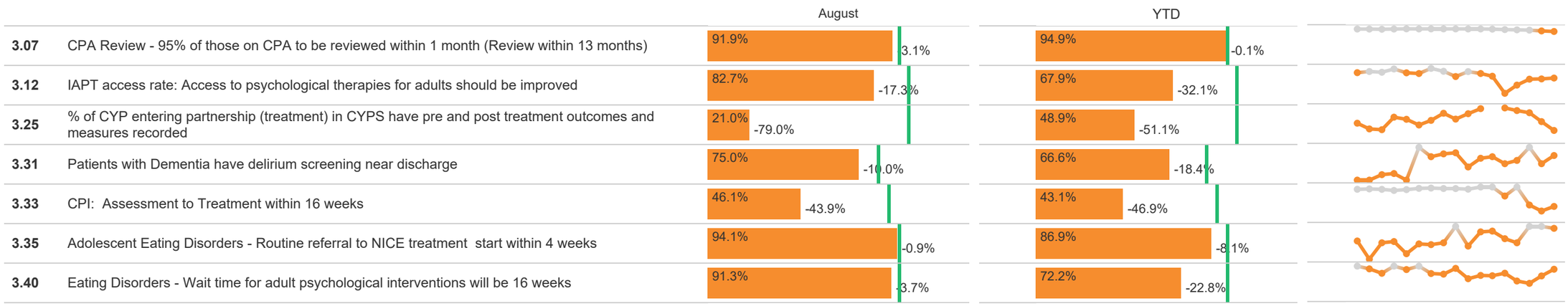
The Adult community teams are now in active recovery post-**Covid** and re-engaging with clinical caseloads. CPA reviews have been scheduled from August onwards, with the aim to achieve compliance by the end of Quarter 2 (September).

The EI service has been concentrating on Priority 1 clients as part of **Covid planning** and as part of recovery planning were hoping to achieve compliance earlier, however are now seeking to return to compliance by the end of October. The service have issued reminders to staff during the month, highlighting areas of concern and are currently proactively working through business intelligence exception reports to monitor and improve compliance going forward.

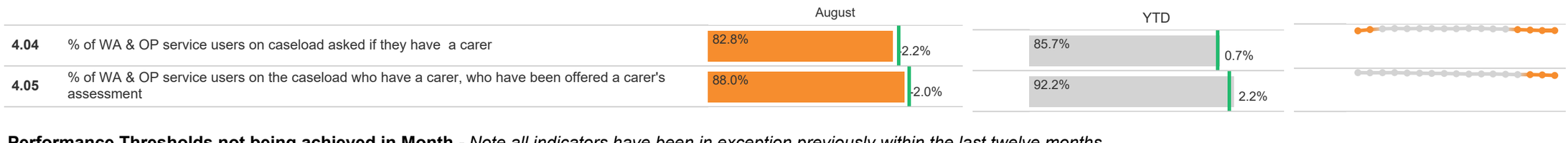
Performance Dashboard: *Mental Health & Learning Disability - Local Contract (Including Social Care)*

KPI Breakdown

Mental Health & Learning Disabilty - Local Contract



Mental Health & Learning Disability - Social Care



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

3.07: CPA Review: 95% of those on CPA to be reviewed within 1 month (Review within 13 months)
Performance for August is at 91.9% against a 95% threshold. This indicator is a subset of 1.04 and of those non-compliant records there were 78 where the CPA review is not recorded as having taken place within 13 months. Of these, 41 were with the Recovery service, 17 with the AOT Service and 4 with the EI service.

The Adult community teams are now in active recovery and re-engaging with clinical caseloads. CPA reviews are being scheduled from August onwards, with the aim to achieve compliance by the end of Quarter 2.

The EI service has been concentrating on Priority 1 clients as part of **Covid planning** and as part of recovery planning were hoping to achieve compliance earlier, however are now seeking to return to compliance by the end of October. The service have issued reminders to staff during the month, highlighting areas of concern and are currently proactively working through business intelligence exception reports to monitor and improve compliance going forward.

3.12: IAPT Access rate
August monthly compliance is 83% of expected numbers based on the trajectory agreed with Gloucestershire prior to the **COVID-19 outbreak**.

Referral rates are increasing and therefore access rates (those that enter treatment) are also expected to increase in September and October. Internal modelling is taking place to inform discussions with commissioners as to what is achievable for the remainder of financial year.

3.25: CYPs entering partnership have pre and post treatment outcomes and measures recorded
Compliance has been affected by the currently delivery of services virtually by “Attend Anywhere” and the fact that outcomes are currently collected using paper returns. The service is now reliant on families returning the forms rather than collection during an attendance. This is causing both a reduction in the number returned and delays in receiving and entering the data.

The service is monitoring this closely and is sending reminders. They are also looking at other virtual collection solutions.

3.31: Patients with Dementia have delirium screening near discharge
There were 2 non-compliant cases in August where screening did not take place near discharge. Both patients were on an acute ward, not the Dementia ward, and had a primary diagnosis of psychosis. The ward manager will be highlighting, in MDT meetings, the need to be clear on whether there is also a diagnosis of Dementia recorded.

3.33: CPI Assessment to Treatment within 16 weeks
There were 7 non-compliant cases in August. These clients were assessed before the service closed at the end of March due to **COVID-19.** They remained under the care of recovery service during this time and have now engaged with the CPI service for the start of treatment. One patient is waiting for face to face therapy which is currently not on offer.

Non-compliance is expected to continue over the next few months as patients begin to engage for treatment and the service are able to offer more intervention types.

3.35 Adolescent Eating Disorders: Routine referral to NICE treatment within 4 weeks
There was 1 non-compliant case in August. The client was seen 8 days post referral for assessment, placed on the CBT waiting list and treatment began 6 -7 weeks after referral. There are fewer staff with skills to provide CBT and therefore when this treatment is clinically indicated the wait is longer than for the majority of cases where FBT can begin at the first appointment.

3.40: Eating Disorders: Wait time for Adult psychological interventions will be 16 weeks
There were two non-compliant cases in August.

One client commenced CBT treatment within 20 weeks of assessment. Due to the expected longer wait a further check-in assessment was given 9 weeks after assessment.

The second client was offered treatment between 16 and 17 weeks after assessment but did not engage. The client was then in prison and treatment via telephone offered but due to prison restrictions not permitted. CBT treatment commenced once the client was released from prison which was 34-35 weeks after assessment.

4.04: % of WA & OP service users on the caseload asked if they have a carer
This indicator is non-compliant for August at 82.8% (910 non-compliant records) against an 85% threshold with the majority of cases within the Older People's services (Managing Memory Together: 334, OP Community Services: 204) and Recovery Service (150).

4.05: % of WA & OP service users on the caseload who have a carer who have been offered a carer's assessment
Performance is reported at 88.0% for August with 201 service users reported with carers who have not been offered a carer's assessment. The majority of cases are within the Older People services (Managing Memory Together: 68, OP Community Services: 60) and Recovery Service (40).

Commentary for 4.04 and 4.05
In response to **COVID-19** the services dealing with patients with dementia have adopted a more crisis level response. Memory Assessment services were closed down and staff redeployed to both priority 1 services and Later Life teams.

Staff are beginning to return to pre-Covid posts based on the capacity for reallocation of caseloads and work has begun on processing referrals, and re-engaging with clients which should improve compliance. However, these groups of patients are vulnerable and shielding is leading to a reduction in the number of routine contacts at which this information is captured.

The Adult community teams are now in active recovery and re-engaging with clinical caseloads which will improve compliance.

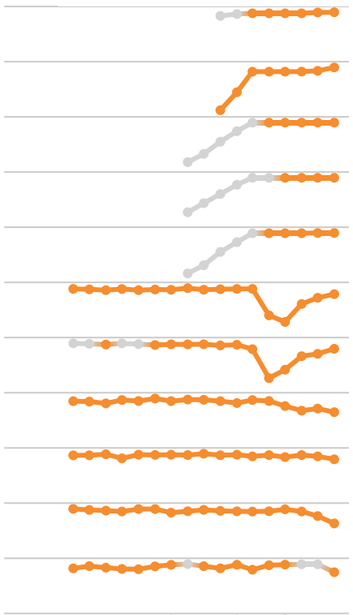
Performance Dashboard: *Physical Health - National Requirements*

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Physical Health - National Requirements

		August	YTD
31a	HPV Immunisation coverage for girls aged 12/13 years old - Immunisation 2	85.6% -14.4%	84.4% -4.6%
31b	HPV Immunisation coverage for girls aged 12/13 years old - Immunisation 1	84.3% -15.7%	79.0% -10.0%
31c	Percentage of children in Reception Year with height and weight recorded	69.7% -30.3%	69.7% -18.3%
31d	Percentage of children in Year 6 with height and weight recorded	73.8% -26.2%	73.8% -14.2%
82	% of eligible children who receive vision screens at or around school entry.	61.8% -38.2%	61.6% -26.4%
84	% of live births that receive a face to face New Birth Visit within 7- 14 days by a Health Visitor	82.4% -12.6%	60.1% -34.9%
85	% of children who received a 6-8 weeks review	86.0% -9.0%	63.1% -31.9%
86	% of children who received a 9-12 month review by the time they turned 12 months	64.4% -30.6%	72.3% -22.7%
87	% of children who received a 12 month review by the time they turned 15 months	82.1% -12.9%	87.1% -7.9%
88	% of children who received a 2-2.5 year review by 2.5 years	61.1% -33.9%	77.3% -17.7%
91	% of infants being totally or partially breastfed at 6-8wks(breastfeeding prevalence)	49.0% -9.0%	55.9% -2.1%
92	% of mothers who are still breastfeeding at 8 weeks who were breastfeeding at 2 weeks	77.6% 2.4%	80.7% 0.7%



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

31a: HPV Immunisation coverage for girls aged 12/13 years old - Immunisation 2
The service resumed the HPV immunisations programme at the beginning of July 2020 to facilitate the completion of outstanding HPV 1 and 2 doses for the 2019/20 academic year.
The cumulative position for HPV 1st dose is now 85.7% compared to an internal trajectory of 90%.

HPV immunisation performance is compared to an increasing trajectory each month up to a target of 90% at the end of the programme at the close of the academic year in August.

31b: HPV Immunisation coverage for girls aged 12/13 years old - Immunisation 1
The service resumed the HPV immunisations programme at the beginning of July 2020 to facilitate the completion of outstanding HPV 1 and 2 doses for the 2019/20 academic year.
The cumulative position for in August 2020 is 84.4% compared to internal trajectory of 90%.

HPV immunisation performance is compared to an increasing trajectory each month up to a target of 90% at the end of the programme at the close of the academic year in August.

Additional commentary for 31a and 31b
The team aims to catch up on children that were absent, unwell or did not respond at the original school based sessions. The school sessions that were cancelled due to Covid-19 and who have not had their HPV 1 year 8 first dose will be caught up in September and will have both doses (HPV 1 & 2) in year 9.

31c: Percentage of children in Reception Year with height and weight recorded
The 2019/20 National Childhood Measurement Programme (NCMP) was suspended due the Covid-19 outbreak. Trust has now submitted all NCMP measurements for the 2019/20 academic year that were recorded before the school closures on March 23 according to Public Health England (PHE) guidelines.

The position for 2019/20 academic year was finalised on 5th August 2020 and performance is behind the internal trajectory (69.7% compared to trajectory of 95%). 4,610 children were measured out of a cohort of 6,610. 48 out of 246 schools were not measured as a result of the Covid-19 outbreak.

31d: Percentage of children in Year 6 with height and weight recorded
The 2019/20 National Childhood Measurement Programme (NCMP) was suspended due the Covid-19 outbreak. Trust has now submitted all NCMP measurements for the 2019/20 academic year that were recorded before the school closures on March 23 according to Public Health England (PHE) guidelines.

The cumulative position for 2019/20 academic year was finalised on 5th August 2020 and is behind the internal trajectory (73.9% compared to trajectory of 95%). 4,871 children were measured out of a

cohort of 6,595. 48 out of 246 schools were not measured as a result of the Covid-19 outbreak.

Additional commentary for 31c and 31d
Public Health England (PHE) does not expect that local authorities will resume NCMP measurements for the current school year, even when schools reopen. For the 2019/20 school year, there will therefore not be an expectation that local authorities meet the minimum participation rates (as set out in the NCMP operational guidance 2019). The service, in accordance with PHE guidance, is working towards restarting the programme in January 2021.

82: Proportion of eligible children who receive vision screens at or around school entry
The 2019/20 Vision Screening Programme was suspended due to the Covid-19 outbreak.
The cumulative position in August is unchanged and remains behind the internal trajectory (61.5% compared to trajectory 95%). No vision screens have taken place since schools were closed in March. The service has commenced a catch up programme for the Vision Screening programme in September 2020. This is for children who will be in Year 1 in September who were not screened in the academic year 2019-20 when they would have been in Reception year. The service intend for this short catch up period to be finalised in October.

84: Percentage of live births that receive a face to face NBV (New Birth Visit) within 7- 14 days by a Health Visitor
The target (95%) was not achieved in August 2020 (82.5%). 409 out of 496 visits were completed within the timeframe. This is as a result of COVID-19 outbreak with visits cancelled by parents, health advice was therefore offered over the phone.
All families of children in this cohort have received an offer of a visit either by telephone, video (attend anywhere) and/or face to face.

There has been a further increase in the number of parents agreeing to a home visit in August compared to the past 3 months and performance is starting to improve.

85: Percentage of children who received a 6-8 weeks review
The target (95%) was not achieved in August 2020 (86%). 443 out of 515 reviews were completed within the timeframe. Performance continue to improve compared to previous three months, however, this continues to be below target mainly as a result of the Covid-19 pandemic where visits have been cancelled by parents. Families of children in this cohort have received an offer of a visit either by telephone, video (attend anywhere) and/or face to face as part of the recovery plan.

In recent weeks, the numbers of parents who had declined a home visit for the NBV have been more receptive to wanting the HV to see them in the home when the baby is 6 weeks old, hence the significant increase in contacts in August in comparison to the previous 3 months.

For those parents that have declined a home visit for both the NBV and 6 week review, their names have been collated so that a FHNA can be undertaken F2F as part of the Recovery plan

86: Percentage of children who received a 9-12 month review by the time they turned 12 months.
The target (95%) was missed in August 2020 (64.4%). 324 out of 503 reviews were completed within the timeframe. All families of children in this cohort have received an offer of a visit and are being seen as part of the service recovery plan. Families of children in this cohort have received an offer of a visit either by telephone, video (attend anywhere) and/or face to face as part of the recovery plan.

87: Percentage of children who received a 12 month review by the time they turned 15 months.
The target (95%) was missed in August 2020 (82.2%). 410 out of 499 reviews were completed within the timeframe. Families of children in this cohort have received an offer of a visit either by telephone, video (attend anywhere) and/or face to face as part of the recovery plan.

88: Percentage of children who received a 2-2.5 year review by 2.5 years.
The target (95%) was missed in August 2020 (61.1%). 294 out of 481 reviews were completed within the timeframe. Families of children in this cohort have received an offer of a visit either by telephone, video (attend anywhere) and/or face to face as part of the recovery plan.

Additional commentary for 86, 87 and 88
All parents were contacted by phone or via Attend Anywhere (AA). If they agreed to having their developmental assessment via phone or AA this was completed. Parents that requested a F2F visit have been added to a waiting list as part of the Recovery Plan.

As more COVID risk assessments are completed and we have access to clinical space, the service will be able to see more children again F2F and complete catch-up work. Community Nursery Nurses supporting Health Visitors has impacted on the number of ASQs they are able to undertake.
The service is promoting the current service offer on social media and on the GHC Health Visiting website pages. There is also a centralised contact number for the HV teams in each locality and a duty HV to respond to this increased volume of calls that the service is receiving. In August, the service has recruited to Health Visitor, Public Health Nurses and Student Health Visitor vacancies.

91. % of infants being totally or partially breastfed at 6-8wks(breastfeeding prevalence)
The target (58%) was missed in August 2020 (49%). 254 out of 518 infants were being totally or partially breastfed at 6-8 weeks.

92. % of mothers who are still breastfeeding at 8 weeks who were breastfeeding at 2 weeks
The target (80%) was missed in August 2020 (77.6%). 250 out of 322 mothers were still breastfeeding at 8 weeks who were breastfeeding at 2 weeks.

Additional Commentary for 91 & 92
Due to the pandemic, there has been a ceasing of F2F community breastfeeding support groups and some families have chosen to have contacts from the HV team via telephone or virtual platforms. Peer support helps mothers to sustain breastfeeding for longer.

An action plan, in collaboration with the Infant Feeding Specialist Health Visitor to offer further support is underway.

Performance Dashboard: *Physical Health - Local Requirements*

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Physical Health - Local Requirements

		August	YTD	
28	Bed Occupancy - Community Hospitals	86.0% -6.0%	80.6% -11.4%	
40	Adult Speech and Language Therapy - % treated within 8 Weeks	91.3% -3.7%	93.4% -1.6%	
47	Bone Health Service - % treated within 8 Weeks	0.0% -95.0%	0.0% -95.0%	
59	Stroke ESD - Proportion of patients discharged within 6 weeks	85.0% -10.0%	92.9% -2.1%	
67	Wheelchair Service: Adults: New referrals assessed within 8 weeks	66.6% -23.4%	72.7% -17.3%	
68	Wheelchair Service: Adults: Priority referrals seen within 5 working days	66.6% -28.4%	66.6% -28.4%	
69	Wheelchair Service: Under 18s: New referrals assessed within 8 weeks	50.0% -40.0%	66.6% -23.4%	
77	Mandatory Training	86.7% -3.3%	86.8% -3.9%	
78	% of Staff with completed Personal Development Reviews (Appraisal)	60.0% -30.0%	63.9% -27.9%	
78a	% of Staff with completed Personal Development Reviews (Appraisal) Active Assignments Only	64.9% -25.1%	68.0% -23.8%	
79	Sickness absence average % rolling rate - 12 months	5.0% -1.0%	5.0% -1.0%	
95	Average Number of Community Hospital Beds Open	90.3% -9.7%	85.2% -14.8%	

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

28: Bed Occupancy - Community Hospitals
*Bed Occupancy in Community Hospitals has shown a continued reduction and is now below SPC chart lower control limit based on 2018/19. Performance in August was 86%, below the threshold of 92%. August was noted to be lower than July of 88.3% due to more beds becoming available however, the number of occupied beds still increased by 6.5% compared to the previous month . The reduced occupancy is mainly due to reduced demand for Community Hospital beds in the wake of the **<u>Covid-19</u>** outbreak but is showing signs that bed occupancy is returning to normal Levels post easing of **<u>Covid-19</u>** lockdown restrictions.*

40. Adult Speech and Language Therapy - % treated within 8 Weeks
*Performance was 91.3% in August 2020, this is below the threshold of the 95%. 21 out of 23 patients were seen within the 8 week target. Both of the patients that breached had a telephone contact prior to starting treatment which does not currently stop the clock. The service have identified that telephone contacts are clinically significant and part of their new model of working post **<u>Covid</u>**. A review of the methodology with all relevant stakeholders will need to take place before this change takes place.*

47: Bone Health Service - % treated within 8 Weeks
*The service reopened in August 2020 after being closed due to **<u>Covid-19</u>**. Patient contacts in August were largely telephone/ video contact with one Face to Face contact which breached the 8 week target. This patient however had a clinically significant telephone contact in July. The service has indicated that this KPI is currently suspended for the foreseeable future. Formal agreement with the relevant stakeholders is being sought. The service has also highlighted that their model is changing to include telephone contacts in the Referral to Treatment criteria. This development change will be made as soon as it receives confirmation from the service that they have been agreed with relevant stakeholders.*

59. Stroke ESD - Proportion of patients discharged within 6 weeks
*The proportion of patients discharged within 6 weeks was 85% in August 2020 which is below the threshold of 95%. The total number of patients seen was 20, 3 of which were discharged over 6 weeks. Performance is within SPC chart control limits. Due to **<u>Covid-19</u>** restrictions patients are undergoing additional therapy sessions in the absence of home visits, which in turn has impacted on the service's capacity to discharge.*

67. Wheelchair Service: Adults: New referrals assessed within 8 weeks
10 out of 15 (66.6%) of new referrals were assessed within 8 weeks, in August. This is below the target of 90%.

68. Wheelchair Service: Adults: Priority referrals seen within 5 working days
2 out of 3 (66.6%) priority referrals were seen within 5 working days in August. This is below the target of 95%

69. Wheelchair Service: Under 18s: New referrals assessed within 8 weeks
1 out of 2 (50%) assessments was carried out in August which did not meet the 8 weeks target.

Additional Commentary for 67, 68 and 69:
*The wheelchair service recognises that there are performance and data quality issues, which are actively being addressed through its service recovery action plan. As such it is difficult to confidently comment on this data. Work to address performance reporting has resumed now the service has commenced the recovery process following the **Covid-19** response.*

77: Mandatory Training
Performance was 86.7% in August 2020, higher than the previous four months, but continues to be below the target of 92%. There is increasing focus to improve compliance rates across the Trust in the coming months.

78: % of Staff with completed Personal Development Reviews (Appraisal)
Performance in August was 60% compared to a target of 95%. There is increasing focus to improve compliance rates across the Trust in the coming months.

78a: % of Staff with completed Personal Development Reviews (Appraisal) Active Assignments Only.
Performance in August was 64.9% compared to a target of 95%. There is increasing focus to improve compliance rates across the Trust in the coming months.

79: Sickness absence average % rolling rate - 12 months
Performance is 5.1% compared to a threshold of 4% for the rolling 12 months. Performance is outside of SPC chart normal variation based on 2018/19 data.

Additional Commentary for 77, 78, 78a and 79
These figures show GHC totals rather than split between former 2G and GCS Trusts.

95: Average Number of Community Hospital Beds Open
*The average number of beds open in Community Hospitals in August was 178 (compared to usual bed stock of 196 beds) and is below SPC Chart lower control limits. This is due to reduced demand for Community Hospital beds combined with a reduced bed stock in the wake of the **Covid-19** outbreak, but it appears more beds are now being open compared to the past three months. See also KPI no. 28.*

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AGENDA ITEM: 17

REPORT TO:	**Trust Board – 30th September 2020**
PRESENTED BY:	John Trevains, Director of Nursing, Therapies', Quality & Infection Control
AUTHOR:	Laura Bucknell, Chief Pharmacist
SUBJECT:	**FLU VACCINATION PROGRAMME 20/21**

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

The purpose of this report is to:

- Inform the Board of the role of Gloucestershire Health and Care in the operational delivery of seasonal flu vaccination
- Meet the requirements of the 2nd Flu Letter (5th August 2020) regarding the GHC self-assessment against the NHS England healthcare worker flu vaccination, best practice management checklist

Recommendations and decisions required

The Board is asked to:

- **Note** the content of this paper
- **Endorse** the GHC completed self-assessment checklist

Executive summary

Delivery of a comprehensive flu vaccination programme is essential to protect patients and staff and to support the resilience of the health and social care system. It is identified that delivery of the flu programme this year will be challenging as a result of the pressures and challenges of COVID-19.

GHC are actively involved in a number of work stream to support the flu vaccination programme for 20/21. These work streams are detailed in this paper.

Risks associated with meeting the Trust's values
No risks identified

Corporate considerations	
Quality Implications	Failure to deliver this programme would have significant impact on quality of care inclusive of patient safety matters
Resource Implications	Resources required for this programme are within existing budgets
Equality Implications	No equality implications have been identified

Where has this issue been discussed before?
Quality Committee

Appendices:	Appendix 1 - GHC Healthcare Worker Flu Vaccination Best Practice Management Checklist

Report authorised by: John Trevains	**Title:** Director of Nursing, Therapies, Quality & Infection Control

FLU VACCINATION PROGRAMME 20-21

1.0 INTRODUCTION

1.1 Flu vaccination is one of the most effective interventions available to reduce pressure on the health and social care system this winter. Planning for delivery of flu vaccination will be challenging this year due to the additional pressures and challenges of COVID-19 however it is more important than ever to deliver a comprehensive flu vaccination programme

1.2 Two annual flu letters have been published, to date, this year, detailing the requirements of this national flu immunisation programme for 20-21.

1.3 The national flu vaccination programme is essential to protecting vulnerable people and supporting the resilience of the health and care system. To support the maximum uptake of flu vaccination across Gloucestershire, the Gloucestershire Integrated Care System (ICS) has developed a seasonal flu group. GHC is actively engaged in the Operational Subgroup of this group which has an operational focus on the arrangements and delivery of seasonal flu vaccinations across the system to improve uptake.

1.0 GHC ACTIONS

1.1 GHC are involved in a number of the operational work streams

- Vaccination of frontline health care workers employed/engaged by GHC
- Vaccination of GHC inpatients
- Vaccination of school age children
- Vaccination of patients on the community nursing caseload, to include carers and shielding household contacts of patients on the case load
- Support the extension of the national flu vaccination programme to include adults aged 50-64 if directed to by Public Health England (PHE)

1.2 Vaccination of frontline health care workers

1.2.1 For 20-21, 100% of GHC frontline colleagues are to be offered a flu vaccination. There is no national vaccination uptake target for this year but GHC aims to exceed last year's rate of 86% of frontline colleagues having a flu vaccination. In order to achieve this a review has been undertaken of the success and challenges encountered during the 2019/20 program. A dedicated working group has been set up with representation from colleagues across Trust services with meetings commenced in June 2020. The frequency of these meetings have now increased to weekly during the flu season

- NHS England has developed a' Healthcare worker flu vaccination best practice management checklist'. A requirement of the 2nd Annual Flu letter published on 5th August is that:
- Every NHS Trust should completed a self-assessment against this best practice checklist. The GHC completed self-assessment is attached at Appendix 1
- The Trust's completed checklist is to be published in the public board papers at the start of the flu season

1.3 Vaccination of GHC inpatients

- To reflect the need to achieve the maximum uptake of flu vaccination across the system, GHC will be offering a flu vaccination to all inpatient, in an eligible group, during the flu season, in line with the request in the national flu letter.
- The vaccination will be delivered by a trained Peer vaccinator

1.4 Vaccination of school age children

- This program will be delivered by the GHC School Age Immunisation Service and will deliver vaccination to all primary school age children and year 7 in secondary school
- The team are working closely with schools to ensure an effective model of delivery

1.5 Vaccination of patients on the community nursing caseload

- As in previous years community nursing teams will deliver flu vaccination to eligible patients on the current case load
- In addition, this year, they will also support the vaccination of:
  - carers of patients on the caseload
  - people who are on the NHS shielded list and are a household contact of a patient on the caseload

2.0 RECOMMENDATIONS

2.1 The Board is asked to

- **Note** the content of this paper
- **Endorse** the GHC completed self-assessment checklist

Gloucestershire Health and Care NHS Trust

Healthcare worker flu vaccination best practice management checklist

For public assurance via trust boards by December 2020

A	Committed leadership	Trust self- assessment
A1	Board record commitment to achieving the ambition of vaccinating all frontline healthcare workers	• PHE have not published an uptake target but have stated an ambition of – 'Offer 100%" • This is taken to assume we will offer flu vaccination to all frontline healthcare workers. This is part of the GHC flu plan detailed below which has full organisational commitment • A Trust target has not been agreed but we aim to vaccinate more front line colleagues than last year (2019/20 – 86%) • In addition GHC offer a flu vaccination to non-front line colleagues as we recognise the importance of supporting all colleagues to stay well and protected
A2	Trust has ordered and provided a quadrivalent (QIV) flu vaccine for healthcare workers	• Working Well has ordered 6,000 vaccine doses for GHC staff for the 2020/21 season. • This quantity will allow us to offer to 100% of colleagues(substantive and bank staff) • We have already taken delivery of 1000 QIVe (arrived 16 Sept) and clinics are commencing 22nd September
A3	Board receive an evaluation of the flu programme 2019/20, including data, successes, challenges and lessons learnt	• The flu vaccination programme for 19/20 was the most successful to date • 86% of frontline colleagues had a flu vaccination which

A	Committed leadership	Trust self- assessment
		exceeded the CQUIN target of 80% Reasons for success • Focused small flu team of key Trust Influencers who communicate weekly to decide on actions • Our focus is on 'doing the right thing' not CQUIN target • Use of peer vaccinators • Review poor performing units – concentrating on those where most staff are based and high risk units • Regular communication to colleagues about locations of clinics • Unplanned walk arounds of sites by Peer Vaccinators • Make it easy for staff to tell us if they have had the jab elsewhere (using Smart Survey) • Flexible staff who will go out at a minutes notice • Keeping the workforce informed of flu outbreaks • Flu stories – service users and staff • We managed to secure some additional funding to pay for some additional resource for flu (£15K). **Challenges** • Keeping the message fresh throughout the flu season • Maintaining the momentum • Supporting those unsure/reluctant to get a vaccination • Processing paperwork to get up to date accurate date to feedback to teams
A4	Agree on a board champion for flu campaign	• John Trevains, Director of Nursing, will be the Board champion for the flu campaign

A	Committed leadership	Trust self- assessment
A5	All board members receive flu vaccination and publicise this	• This can be organised over the next few weeks and we would want to publicise this using the Communication Team
A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives	**Flu Team members** ✓ **Alice Higley**, Communications Team ✓ **Alison Curson**, Head of Nursing & Quality ✓ **Alison James/Amanda Horne** (Working Well), ✓ **Angela Willan**, Lead Nurse for Nursing Projects ✓ **Elaine Tingle**, Admin Support, Flu Co-ordinator ✓ **Graeme Skipp** Staff Side Representative ✓ **Holly Smith**, Complex Case Clinical Lead for Demand and Capacity ✓ **Laura Bucknell**, Chief Pharmacist ✓ **Louise Forrester**, Lead Nurse for Infection Control for Mental Health and Learning Disability ✓ **Michelle Shapland**, PA to Head of Nursing & Quality
A7	Flu team to meet regularly from September 2020	• Meetings commenced in June 2020 and are operating monthly up to 30th September and then will move to weekly up to achievement of target.
B	**Communications plan**	
B1	Rationale for the flu vaccination programme and facts to be published – sponsored by senior clinical leaders and trades unions	• Information to be included in Team Talk 14 and 16 Sept. • PHE Flu letter to be sent to all staff week commencing 21 Sept • Flu Page will be hosted on the intranet and will contain myth busting facts, clinical evidence supporting vaccination and Q&A.

A	Committed leadership	Trust self- assessment
		• Weekly updated in Indigo throughout the flu season • Regular use of Trust social media to support the campaign
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper	• Drop-in clinics are not possible within current COVID restrictions • Clinic dates and plan will be published on all available communications • Working well clinics will be by appointment only and will be booked using an online booking system • Appointment times will be 5 mins • The details of Peer vaccinators will be readily available to allow colleagues to contact them directly to arrange for vaccination
B3	Board and senior managers having their vaccinations to be publicised	• This can be organised over the next few weeks and we would want to publicise this using the Communication Team • The Flu Team also want to publicise a range of colleagues having a flu vaccination
B4	Flu vaccination programme and access to vaccination on induction programmes	• Currently there is little face to face induction but this situation will be closely monitored and reviewed regularly
B5	Programme to be publicised on screensavers, posters and social media	• Screensavers, posters and social media will be organised by the Communication Team • Flu letter will go out to all colleagues. This will be sent with a note regarding the booking system which will go live Wed 23 September 2020 • Peer Vaccinators contact details will be publicised with their agreement

A	Committed leadership	Trust self- assessment
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups	• The data will be provided by Elaine Tingle from the Flu Team and the feedback to teams and colleagues issued by the Communication Team
C	**Flexible accessibility**	
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered	• 44 Peer Vaccinators have been trained and are ready to go • This includes at least 1 peer vaccinator in each inpatient unit • Vaccinations will be made available at sites that have suitable storage to allow Peer Vaccinators easy access. • Peer vaccinators will deliver vaccines in a way that suits there day to day role i.e. ad-hoc, planned clinics, individual arrangement with colleagues
C2	Schedule for easy access drop in clinics agreed	• Drop in clinics will not be in place due to Covid-19 • On-line booking system will be in place for working well clinics • Clinics will be held at majority of Trust premises. (8 Flu Nurses available, which is 4 more than last year) • Daily updates will be issued via global email with available appointments.
C3	Schedule for 24 hour mobile vaccinations to be agreed	This is being considered as we have volunteers for evenings and weekends
D	**Incentives**	
D1	Board to agree on incentives and how to publicise this	To be discussed – flu badge has been ordered. No other incentives such as sweets due to COVID

A	Committed leadership	Trust self- assessment
D2	Success to be celebrated weekly	To be discussed – Comms happy to do weekly updates

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AGENDA ITEM: 18

REPORT TO:	**Trust Board 30 September 2020**
PRESENTED BY:	Dr Amjad Uppal, Medical Director
AUTHOR:	Zoë Lewis, Patient Safety Administrator
SUBJECT:	**Learning From Deaths 2020/21 Quarter 1**

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

The purpose of this report is to:

The purpose of this report is to Inform Trust Board of the mortality review process and outcomes during 2020/21 Quarter 1.

It is a regulatory requirement for all NHS Trusts to identify, report, investigate and learn from deaths of patients in their care, as set out in the National Quality Board *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*, published March 2017.

Recommendations and decisions required

The Board is asked to:

- **Note** the contents of this Learning From Deaths report which covers 2020/21 Quarter 1

Executive summary

- The Board is asked to note that this is the first quarter in which Gloucestershire Health and Care NHS Foundation Trust (GHC) will report both mental health and physical health deaths as a combined figure.

- During 2020/21 Q1, there were 276 reported GHC patient deaths, with an unusually high number reported in April due to the Covid-19 pandemic. At time of writing this report, none of the 276 patient deaths are judged to be more likely than not to have been due to problems in the care provided by the Trust.

- An initial analysis of the impact of the Covid-19 pandemic upon the reported death rates of both inpatients and patients open to mental health or learning disability community teams is presented in this paper.

Risks associated with meeting the Trust's values
There are no identified risks associated with learning from deaths associated with the Trusts values.

Corporate considerations	
Quality Implications	Required by National Guidance to support system learning
Resource Implications	Significant time commitment from clinical and administrative staff
Equality Implications	None

Where has this issue been discussed before?
Quality Committee 01/09/20

Appendices:	None

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

LEARNING FROM DEATHS 2020/21 QUARTER 1

1.0 INTRODUCTION

1.1 The purpose of this report is to inform the Board of the mortality review process and outcomes during 2020/21 Quarter 1.

1.2 The Board is asked to note that from this quarter, 2020/21 Q1, Gloucester Health and Care NHS Foundation Trust (GHC) will report both mental health and physical health mortality data in a combined manner.

1.3 MIDAS, the electronic data collection tool use by Gloucestershire Care Services NHS Trust was decommissioned on 31/03/2020 and since 01/04/2020, deaths of community hospital inpatients are now reported in Datix, facilitating the reporting of combined physical health and mental health data.

1.4 The Covid-19 pandemic has impacted upon the reporting rate of both inpatient and community patient deaths. An initial assessment of this impact is presented in this paper.

2.0 OVERVIEW

2.1 During 2020/21 Q1, 276 GHC patients died. This comprised the following number of deaths which occurred in each month of that reporting period:
185 in April;
63 in May;
28 in June.

2.2 At time of writing, 23/08/2020, 12 case record reviews and investigations have been carried out in relation to the 276 deaths included in 2.1. The number of deaths in each month for which a case record review or an investigation was completed was:
10 in April;
Zero in May;
2 in June 2020.

2.3 Numbers in paragraph 2.2 do not include open investigations and case record reviews.

2.4 Zero, representing 0.0% of the patient deaths during the reporting period are judged more likely than not to have been due to problems in the care provided to the patient. In relation to each month, this consisted of:
Zero representing 0.0% for April;
Zero representing 0.0% for May;
Zero representing 0.0% for June.

2.5 The numbers stated in paragraph 2.4 have been estimated using Structured Judgement Review (SJR). For deaths of :

- mental health patients, the RCPsych Mortality Review Tool 2019 is employed;
- LD patients, a similar Trust-developed SJR tool is utilised which pre-dates the RCPsych tool. This approach has been maintained to allow consistency with the Learning Disabilities Premature Mortality Review (LeDeR) programme;
- physical health patients, a SJR tool has been developed by the Trust to robustly assess the standard of care provided to patients that die during an inpatient stay at a community hospital.

2.6 Case record reviews are discussed at Mortality Review Group (MRG) meetings chaired by Deputy Medical Directors / Clinical Directors and the community hospital MRG meetings are also attended by the County Medical Examiner.

2.7 For any deaths meeting Serious Incident or Clinical Incident criteria, a Comprehensive Investigation, including Root Cause Analysis, is carried out.

2.8 At time of writing this report, 16 case record reviews and investigations had been completed for deaths which took place before the start of the reporting period.

2.9 Zero representing 0.0% 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.

2.10 The numbers in paragraph 2.9 have been estimated using either SJR for case reviews or comprehensive investigations, including Root Cause Analysis, for any deaths meeting Serious Incident or Clinical Incident criteria.

3.0 LEARNING

3.1 Impact of Covid-19 pandemic upon investigations and SJRs

3.1.1 Both incident investigations and MRG meetings have been negatively impacted upon during the Covid19 pandemic, with key members of the Patient Safety Team being seconded to other duties. The Trust negotiated with the CCG to be granted extensions to investigations. The seconded members of the Patient Safety Team have now returned to post and investigations have recommenced.

3.1.2 After an initial delay, both LD MRG and MH MRG continued to meet via Microsoft Teams.

3.1.3 The meeting of PH MRG was suspended during the time of the Covid-19 pandemic. Much discussion has taken place in recent weeks and months as to the structure of PH MRG and the loss of the resource to screen all unexpected and 10% of expected inpatient deaths. More recently, a decision has been made to use a trigger system for mortality review, similar to that used by GHFT, to facilitate discussion of appropriate deaths by PH MRG. The new trigger system will go live in Datix on 01/09/2020.

3.1.4 Check-box triggers in Datix that will flag a patient death for discussion by PH MRG are:

- Relative concerns and/or complaints
- Medical examiner concern
- Unexpected death
- Inappropriate admission
- Death occurring within 72 hours of admission (including within 72 hours of readmission to the Emergency Department or acute hospital)
- Death from Covid-19
- Death from hospital-acquired infection, including C-difficile, MRSA bacteraemia.
- Death necessitating referral to Coroner
- Head injuries
- Deaths as a result of trauma, including falls and fractures in the community hospital
- Post-surgery
- Any incident that ward staff wish to be escalated for discussion.

From September 2020, PH MRG will take place immediately after the monthly Community Hospitals Governance Meeting, and it is hoped that this rescheduling, combined with the new mortality review trigger system within Datix, will facilitate deaths being reviewed in a more timely fashion and ultimately aid learning.

3.2 Learning from SJRs and Investigations

3.2.1 Following the suspected suicide of a MHICT patient, the Trust has identified that Service leads will clarify the overlap and interplay between primary care mental health services (IAPT and MHICT Nursing) and secondary care mental health services (often Recovery Teams) to address the perceived gap in service provision.

3.2.2 Where a patient is transferred between mental health teams, especially between the primary/secondary care divide, those teams must have active dialogue, preferably involving the patient, and each be involved in the plan to be followed by the receiving team in line with the host principle in place across the Trust.

3.2.3 All individuals supervising colleagues are reminded of the need to ensure that patients with a pattern of increasing risk should continue to be managed by the supervisee, whether trainee or non-training grade.

3.2.4 Community Service Managers must ensure their staff are appropriately supported during the delivery of bad news, often following a fatality, and ensure a formal debrief is offered in conjunction with other teams/services associated with the patient's care.

3.2.5 Following an unexpected death (suspected overdose/self-poisoning) on Abbey Ward, Wotton Lawn Hospital, staff should be reminded that clinicians can still engage in conversation with family members to hear their concerns without breaching patient confidentiality, even if no consent to share information has been given.

3.2.6 Risk assessment is a dynamic process. Staff members are to be reminded that:

- All risk incidents and events should be documented in the appropriate section of the risk assessment within a timeframe that is reasonably practicable.
- Factors increasing risk (aggravating factors) should all be clearly documented in the relevant section of the risk assessment. These should include actuarial factors, clinical factors and protective factors as per Trust policy. Factors decreasing risk (mitigating factors), including factors that protect against suicide, should also be thoroughly documented.
- All risk management plans should be clearly documented in the formal risk assessment document.

- The Risk History tool should be used by all who have interventions with a patient, including in-patient unit staff.

3.2.7 Consideration should be given to highlighting how online pro-suicide resources can impact on the risk to vulnerable individuals.

3.2.8 The MH MRG has recognised the need for a second End of Life room at CLH and recommended the exploration of charities to support the renovation.

3.2.9 The MH MRG recommended a review of nurse handovers regarding palliative care patients to ensure that all the relevant information and plans are handed over.

3.2.10 LeDeR has recently published its 2019/20 annual report and has identified the following issues and learning themes:

- Delays in the diagnosis and treatment of illness
- Poor care coordination and communication between agencies
- Omissions in the care or the provision of substandard care
- Poor application of the Mental Capacity Act
- Lack of timely referral to specialists in including learning disability services and neurologists.

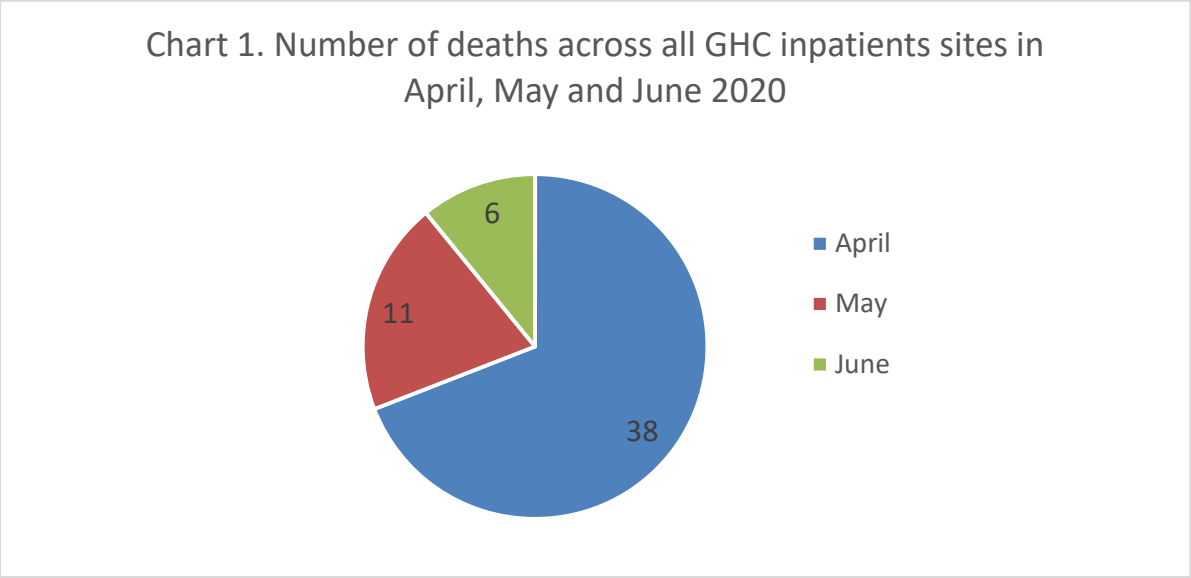
3.2.11 LeDeR has made several recommendations for NHSE and DHSC in terms of policy making. The full LeDeR 2019/20 annual report can be found here: http://www.bristol.ac.uk/sps/leder/resources/annual-reports/

3.2.12 LeDeR have made no specific recommendations regarding the care and treatment provided by GHC during 2019/20.

4.0 IMPACT OF COVID-19 ON REPORTED GHC PATIENT DEATHS

4.1 Impact of Covid-19 on GHC inpatient deaths

4.1.1 During 2020/21 Q1, there were a total of 55 GHC inpatient deaths across all hospital sites, the majority of which took place April 2020. Chart 1 shows the distribution of the 55 deaths across April, May and June 2020.



4.1.2 Of the 55 inpatient deaths in 2020/21 Q1, 37 tested positive for Covid-19 prior to their death. Additionally, there were 2 deaths of inpatients who had tested negative for Covid-19, but whose management remained as per Covid-19, as infection was highly suspected, and there was also 1 death where the patient had initially tested positive for Covid-19 before testing negative prior to their death. There were a further 8 deaths where patients had tested negative for Covid-19. Finally, there were 7 deaths of patients who were not tested for Covid-19 as the infection was not suspected (these deaths occurred before swabbing of patients for Covid-19 as standard was implemented).

4.1.3 Table 1, and Charts 2 and 3, show the breakdown of the 55 inpatient deaths referred to in 4.1.1 by hospital location and whether Covid-19 was:

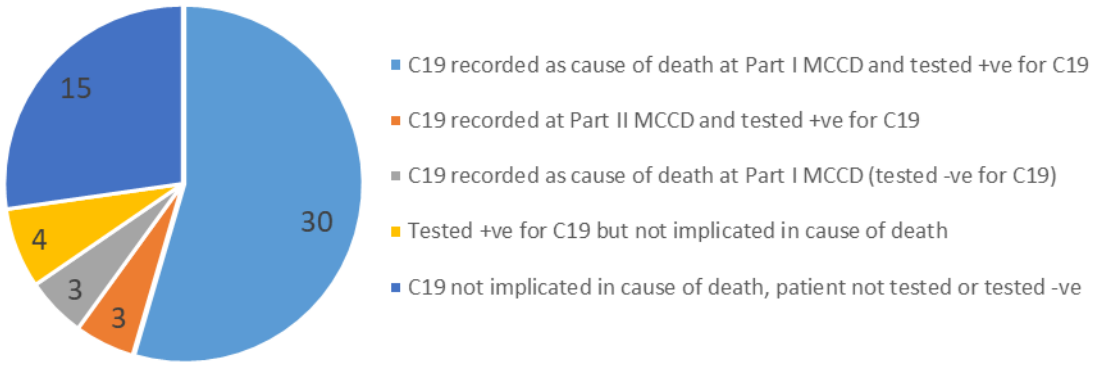
- recorded as the cause of death at Part I of the Medical Certificate Cause of Death (MCCD) and the patient tested positive for Covid-19;
- recorded at Part II of the MCCD, indicating a significant condition that could have hastened death, but is not related to the condition recorded as cause of death at Part I of the MCCD, and the patient tested positive for Covid-19;
- recorded as the cause of death at Part I of the MCCD (patients tested negative for Covid-19);
- not implicated in the cause of death and not recorded on the MCCD, although patient tested positive for Covid-19;

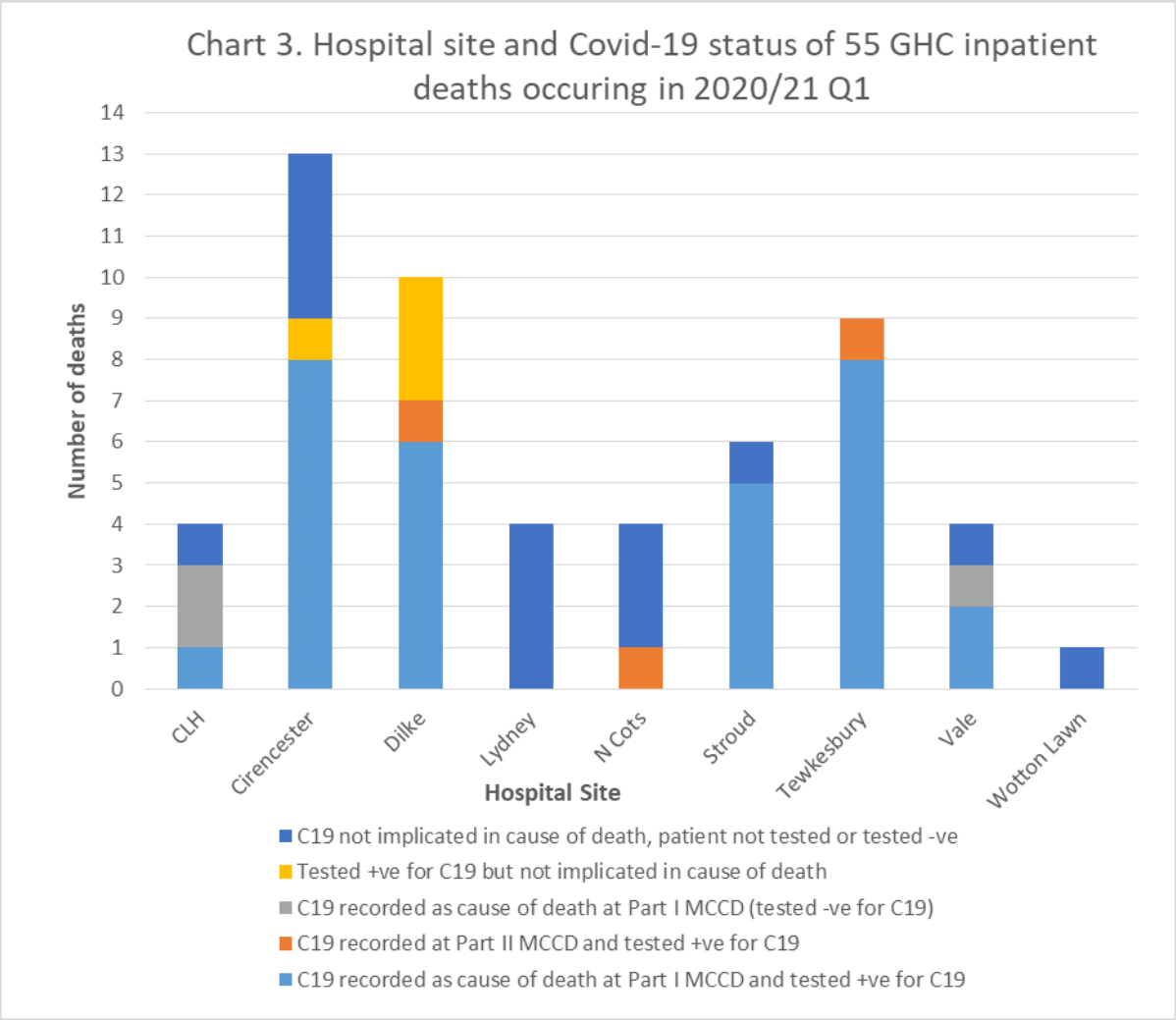
- not implicated in the cause of death and not recorded on the MCCD, the patient received a negative test result or was not tested, as infection was not suspected.

Table 1. Hospital site and Covid-19 status of GHC inpatient deaths which occurred in 2020/21 Q1:

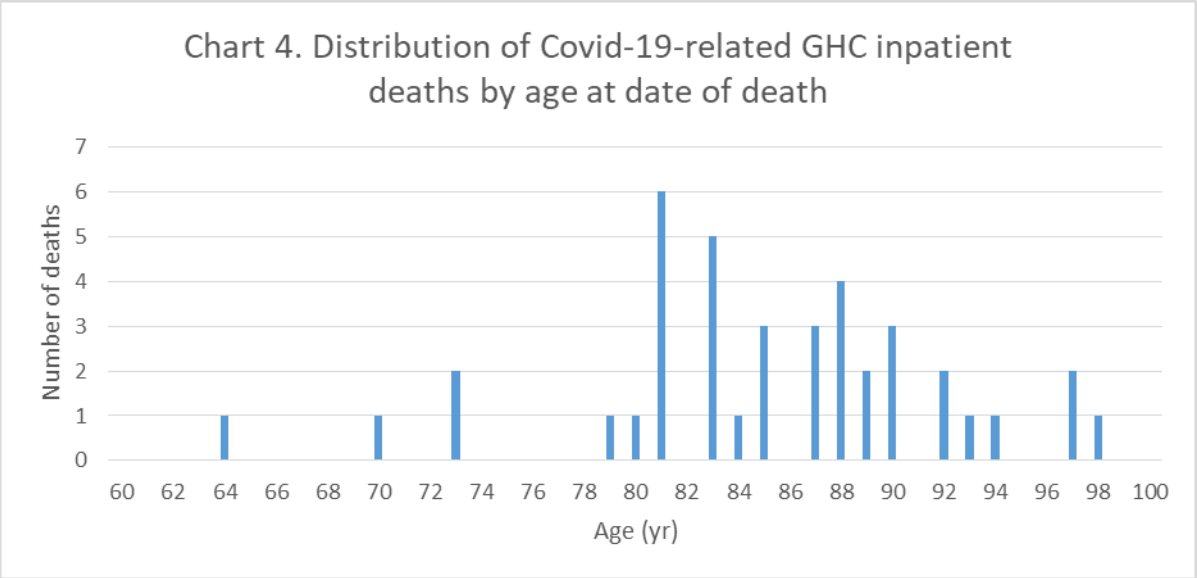
Hospital	C19 recorded as cause of death at Part I MCCD and tested +ve for C19	C19 recorded at Part II MCCD and tested +ve for C19	C19 recorded as cause of death at Part I MCCD (tested -ve for C19)	Tested +ve for C19 but not implicated in cause of death	C19 not implicated in cause of death, patient not tested or tested -ve	Total
CLH	1	0	2	0	1	**4**
Cirencester	8	0	0	1	4	**13**
Dilke	6	1	0	3	0	**10**
Lydney	0	0	0	0	4	**4**
N Cots	0	1	0	0	3	**4**
Stroud	5	0	0	0	1	**6**
Tewkesbury	8	1	0	0	0	**9**
Vale	2	0	1	0	1	**4**
Wotton Lawn	0	0	0	0	1	**1**
Total	**30**	**3**	**3**	**4**	**15**	**55**

Chart 2. Covid-19 status of 55 GHC inpatient deaths occuring in 2020/21 Q1 across all inpatient sites

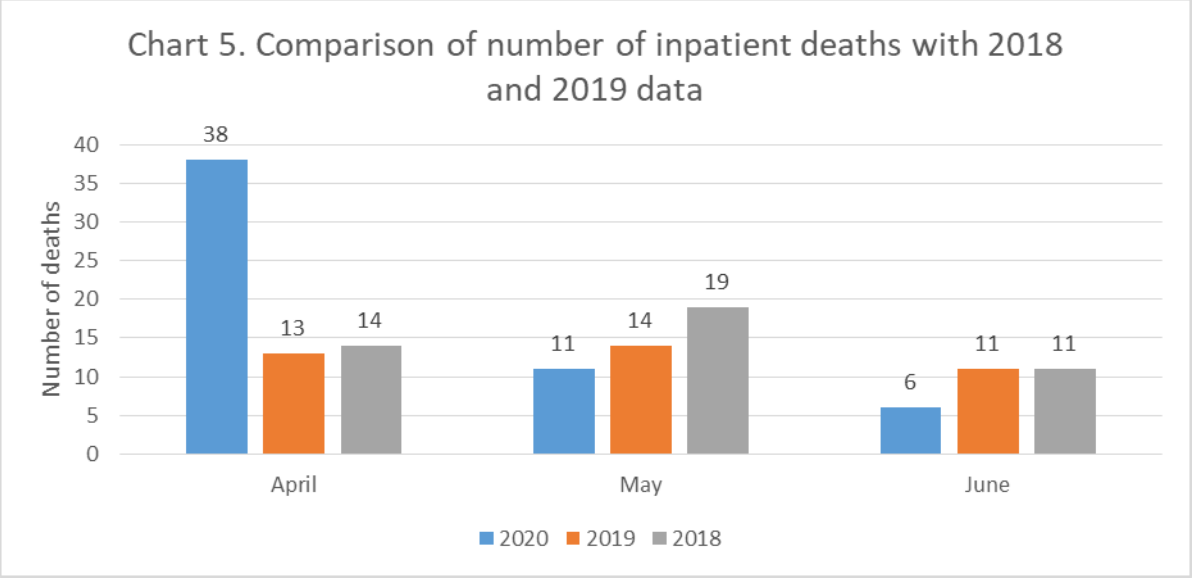




4.1.4 During 2020/21 Q1, there were 40 GHC inpatient deaths where patients had tested positive for Covid-19 prior to their death and/or where Covid-19 was recorded on the MCCD. At date of death, the ages of these patients ranged from 64 to 98 years of age. Chart 4 shows the distribution in age of the 40 GHC inpatients deaths described above.



4.1.5 During 2020/21 Q1, there were a total of 55 GHC inpatient deaths across all GHC hospital sites. During the same time frame in 2019 and 2018, there were 38 and 44 inpatient deaths (excluding Sis), respectively. Chart 5 shows this comparison broken down by number of deaths per month.



4.1.6 Chart 5 shows that after the initial peak in April 2020, the number of inpatient deaths occurring in May and June has decreased to below that of the previous two years' reporting rates. During April 2020, there were 38 inpatient deaths which represents a 2.9 and 2.7 fold increase on the number of inpatient deaths reported during April in 2019 and 2018, respectively.

4.1.7 The Trust's Datix system was rapidly configured to capture the required dataset for onward national reporting of all Covid-19 related deaths to the

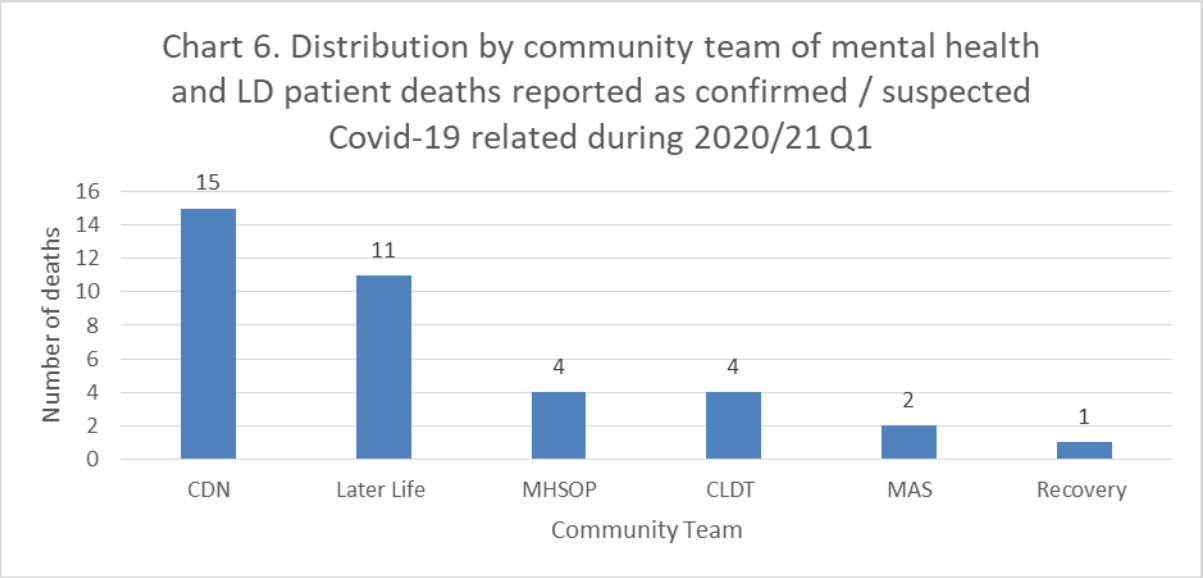
Covid-19 Patient Notification System (CPNS). During 2020/21 Q1, a total of 38 deaths met the criteria for reporting to CPNS. As the pandemic progressed, the criteria for reporting Covid-19-related deaths and the dataset required was updated several times by CPNS. The Trust Datix system has likewise been updated at each step to capture the requested data.

4.1.8 Two deaths which occurred in early April 2020 at Charlton Lane Hospital where Covid-19 was recorded on the MCCD, but where the patients tested negative for the infection, were not reported to CPNS,. At that point in time, the deaths did not meet the reporting criteria, due to the patients not having a positive Covid-19 test result. Subsequently, CPNS have amended the reporting criteria to include all deaths where Covid-19 is recorded on the MCCD with or without a positive test result, however, CPNS have decided not to retrospectively collect such data for deaths which occurred before the reporting criteria was changed.

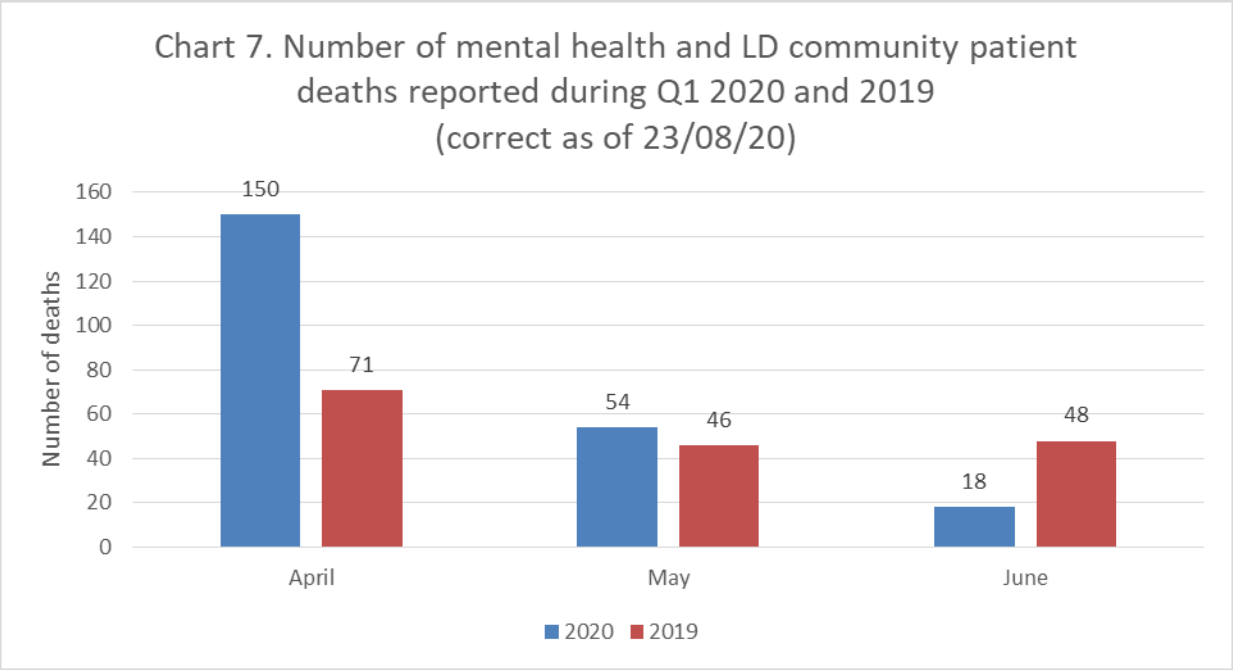
4.1.9 Onward reporting to CPNS has been facilitated by the Patient Safety Team. 30 inpatient deaths were reported to CPNS in April, 7 in May and 1 in June 2020.

4.2 Impact of Covid-19 on GHC mental health and learning disability community patient death reporting

4.2.1 All deaths of patients open to community mental health and LD caseloads are reported on the Trust's Datix system. During 2020/21 Q1, there were 37 community mental health and LD patient deaths reported as being either confirmed or suspected to be Covid-19 related. Chart 6 shows the distribution of the 37 patient deaths across the mental health and LD community teams.

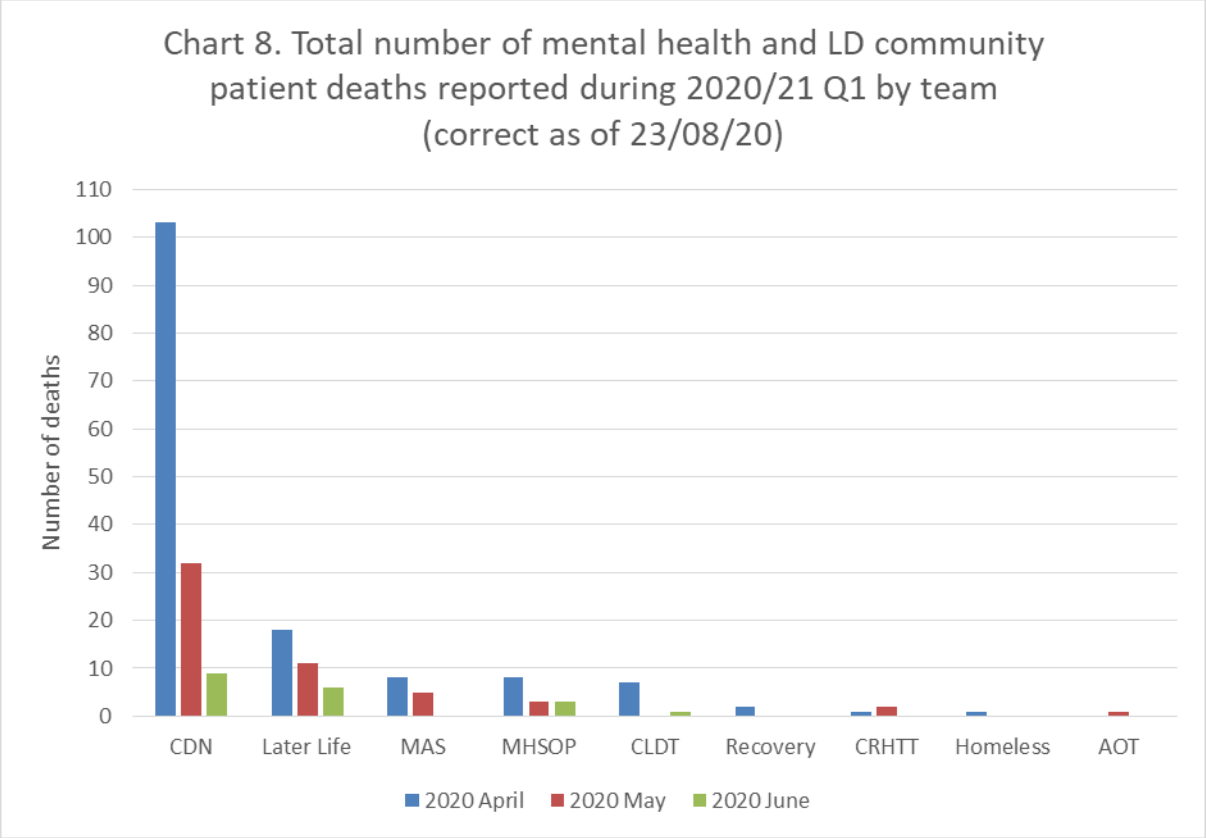


4.2.2 In most cases, reporters of deaths on Datix are not aware of the patient's cause of death, therefore, when trying to gauge the impact of the Covid-19 pandemic upon the number of deaths of patients who were open to mental health and LD community caseloads at the time of their death, it is helpful to look at the total number of deaths that have been reported during Q1 2020/21 and compare this with the same timeframe last year. At time of writing, 23/08/2020, 221 community mental health and LD patient deaths had been reported. Chart 7 shows the number of mental health and LD community patient deaths reported by month during 2020/21 Q1 compared to 2019/20 Q1.



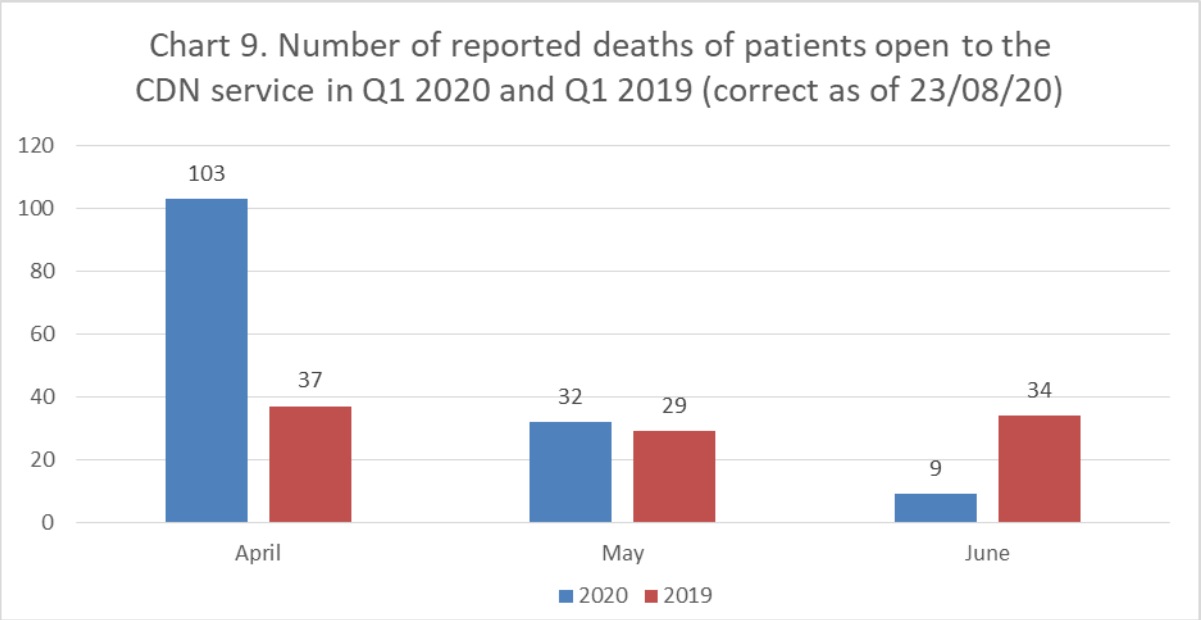
4.2.3 It is important to note that deaths from Q1 of this year will continue to be reported for months to come, which is especially relevant to the Community Dementia Nurse service, where many patients are seen annually for dementia medication review, hence the relatively low number of deaths reported in June 2020 at time of writing. From Chart 7, it is already clear to see the impact upon the number of deaths in the community during the peak of the pandemic in April 2020.

4.2.4 Chart 8 shows the how the total number of reported mental health and LD community patient deaths during 2020/21 Q1 are distributed across the community teams.



4.3 Impact of Covid-19 upon deaths reported amongst dementia patients open to the Community Dementia Nurse (CDN) service

4.3.1 Chart 9 shows that an unusually high number of deaths of dementia patients, who were open to the CDN service for annual review of dementia medication, have been reported during April this year, compared to the number of deaths reported for this patient group in April 2019.



4.3.2 Typically, deaths of patients open to the CDN service can be reported up to many months after the date of death, sometimes up to when the next annual medication review is scheduled, therefore we can anticipate that the number of deaths reported in April 2020 amongst this cohort of patients is likely to increase still further.

4.3.3 A review will be undertaken to analyse whether Covid-19 was recorded on these patients' MCCDs. These data can be difficult to obtain, but we will endeavour to obtain at least a sample to give an indication as to whether we can attribute Covid-19 to the unusually high number of deaths reported amongst this patient group in April 2020.

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 19

REPORT TO:	**Trust Board – 30 September 2020**
PRESENTED BY:	Dr Amjad Uppal, Medical Director
AUTHOR:	Dr Abbasi/Dr Sally Morgan – Guardian of Safe Working Hours
SUBJECT:	**GUARDIAN OF SAFE WORKING HOURS Q4 & Q1 REPORTS**

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

The purpose of this report is to:

It was agreed in the 2016 national negotiations that all NHS Trusts employing trainees (junior doctors) were required to appoint a 'Guardian of Safe Working Hours' in order to work with junior doctors to ensure safe working practices during their training.

As part of that agreement, the Guardian of Safe Working Hours is required to provide quarterly reports to the Trust Board for assurance and information. This is a national template that is used.

Further information about role and requirements can be seen under point 1 – Introduction/Context.

Reports are provided for Q4 2019/2020 and Q1 2020/2021

Recommendations and decisions required

The Board is asked to **note**:

1. The report from the Guardian of Safe Working Hours.
2. Ongoing issues are being addressed.
3. The historical open reports will be closed following agreement between trainees, the Guardian and DME.

Executive summary

- The exception reporting process is part of the new Juniors Doctors Contract to enable them to raise and resolve issues with their working hours and training.

- The Guardian's Quarterly report summarises all exception reports, work schedule reviews and rota gaps, to provide assurance on compliance with safe working hours by both the employer and doctors in approved training programs, and will be considered by CQC, GMC, and NHS employers as key data during reviews.

- The purpose of the report is to give assurance to the Quality Committee and Board that the doctors in training are safely rostered and their working hours are complaint with the TCS.

Risks associated with meeting the Trust's values

- Providing suitable and safe training placements for junior doctors is essential for the Trust in terms of reputation and developing workforce.
- This data is monitored by CQC and HEE.

Corporate considerations	
Quality Implications	✓
Resource Implications	✓
Equality Implications	✓

Where has this issue been discussed before?
Trust Quality Committee on 1st Sept 2020

Appendices:	Appendix 1 – Q4 Report for 19/20 Appendix 2 – Q1 Report for 20/21

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

GUARDIAN OF SAFE WORKING

1.0 INTRODUCTION / CONTEXT

1.1 The safety of patients is of paramount importance for the NHS and staff fatigue is a hazard both to patients and the staff. The 2016 national contract for junior doctors encourages stronger safeguards to prevent doctors working excessive hours. It was agreed during negotiations with the BMA that a 'Guardian of Safe Working Hours' will be appointed in all NHS Trusts employing trainees (junior doctors) to ensure safe working practice.

1.2 The role of 'Guardian of Safe Working Hours' is independent of the Trust management structure, with the primary aim to represent and resolve issues related to working hours for the junior doctors employed by it. The Guardian will ensure that issues of compliance with safe working hours are addressed, as they arise, with the doctor and/or employer, as appropriate; and will provide assurance to the Trust Quality Committee and Board or equivalent body that doctors' working hours are safe.

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

1.4 The Trust has invested in relevant software to help monitor the 'Exception Reports' in line with national guidance and the system is relatively well established in the Trust now.

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

2.0 REPORTS

These reports are made using the nationally agreed template. Please refer to the specific report for details on the exception reports made and actions taken.

2.1 Q4 report for 19/20 – no exception reports made

2.2 Q1 report for 20/21 – 6 exception reports made

2.3 The difference in number of trainees between these two reports is because of the transfer of Herefordshire services to Worcestershire.

3.0 Appointment of Guardian of Safe Working Hours

Dr Abbasi left the Trust and his role as Guardian of Safe Working Hours in June 2020. Following an internal recruitment process, Dr Sally Morgan was appointed in to the role of Guardian of Safe Working Hours with effect from July 2020.

AGENDA ITEM: 19.1

Quarterly Report on Safe Working Hours Data		
Reporting Time Period:		January 2020-March 2020
Trust Name:		Gloucestershire Health & Care NHS Foundation Trust
Guardian of Safe Working Hours Name:		Nader Abbasi
GOSW Email Address:		nader.abbasi@ghc.nhs.uk
No.of doctors/dentists in training (total)		40 (31 Gloucestershire and 9 Herefordshire)
No.of doctors/dentists in training on the 2016 contract TCS (total)		40
No. of lead employer trainees on the 2016 contract at your Trust		
Amount of time available in job plan for Guardian to do the role		1PA
Admin support provided to the Guardian (if any)		
Amount of job-planned time for educational supervisors		

	Exception reports													Work Schedule Reviews												Fines by department	
Specialities/Site	No. GP Trainees		No. Foundation Yesars		No.at CT Level		No.at ST3+ Level		No. given TOIL or payment				No. that are on-going	No. GP Trainees		No. Foundation Yesars		No.at CT Level		No.at ST3+ Level		No. given TOIL or payment			No. that are on-going	No.of fines levied	Values of fines levied
	Raised	Closed	Raised	Closed	Raised	Closed	Raised	Closed	TOIL	TOIL	Payment	Please		Raised	Closed	Raised	Closed	Raised	Closed	Raised	Closed	TOIL	Payment	Please			
Gloucestershire	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
Hereford	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

*If you have any additional comments, issues arising or concerns then please fully detail in the section below

AGENDA ITEM: 19.2

Quarterly Report on Safe Working Hours Data		
Reporting Time Period:		April 2020-June 2020
Trust Name:		Gloucestershire Health & Care NHS Foundation Trust
Guardian of Safe Working Hours Name:		Nader Abbasi
GOSW Email Address:		nader.abbasi@ghc.nhs.uk
No.of doctors/dentists in training (total)		28
No.of doctors/dentists in training on the 2016 contract TCS (total)		28
No. of lead employer trainees on the 2016 contract at your Trust		
Amount of time available in job plan for Guardian to do the role		1PA
Admin support provided to the Guardian (if any)		
Amount of job-planned time for educational supervisors		

Exception reports														Work Schedule Reviews												Fines by department	
Specialities/Site	No. GP Trainees		No. Foundation Yesars		No.at CT Level		No.at ST3+ Level		No. given TOIL or payment				No. that are on-going	No. GP Trainees		No. Foundation Yesars		No.at CT Level		No.at ST3+ Level		No. given TOIL or payment			No. that are on-going	No.of fines levied	Values of fines levied
	Raised	Closed	Raised	Closed	Raised	Closed	Raised	Closed	TOIL	TOIL	Payment	Please		Raised	Closed	Raised	Closed	Raised	Closed	Raised	Closed	TOIL	Payment	Please			
Gloucestershire	0	0	0	0	5	5	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5	0	0	1	0	0

*If you have any additional comments, issues arising or concerns then please fully detail in the section below

We had 6 exception reports during this quadrant(April, May, June), five by core trainees and one by an advance trainee. These trainees who developed these reports managed to have their initual review meetings with their supervisor within normal time plan. All the reports were outcomed as Compensation: Time off in lieu and five of the trainees agreed with the outcome and closed the reportas. One trainee although had the initial meeting and outcome but report hasn't been closed by trainee yet and hasn't raised concern with the Guardian regarding outcome either. It seems to be due to unprecedented time of COVID-19 rather than an actual disagreement. We have contacted the trainee and informed them of situation, hopefully report will be closed soon or be raised to be resolved with the help of Guardian. During these period there were two on call shifts that were covered by agency doctors and also there are 6 trainees who are not able to complete their on-calls as normal. In general it seems Trust had managed well through the current situation with appropriate support for trainees which in turn would provide a safe service for our patients.

AUDIT AND ASSURANCE COMMITTEE SUMMARY REPORT

DATE OF MEETING 06 AUGUST 2020

COMMITTEE GOVERNANCE	• Committee Chair – Marcia Gallagher, Non-Executive Director • Attendance (membership) – 100% • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

INTERNAL AUDIT

The Committee received the Internal Audit Progress Report 2020/21 informing the Committee of the progress since the previous meeting.

It was noted that both the Estates and Facilities audit work and the Cost Improvement Programme audit work were overdue. The Committee received assurance that out of the three outstanding actions for Estates and Facilities, two had now been completed. The outstanding action related to *routine look back on historical data.* This had been delayed due to Covid 19 activities, but was expected to be closed within the upcoming weeks. In relation to the overdue actions for the CIP; all four actions were expected to be completed by the end of August.

EXTERNAL AUDIT

KPMG shared the External Audit Progress Report and Technical Update with the Committee and confirmed that the annual accounts had been signed off within the deadlines. KPMG reported that the audit of the Charity Accounts would be completed before December 2020.

COUNTER FRAUD, BRIBERY AND CORRUPTION

The Committee received the Counter Fraud, Bribery and Corruption report, which included the Final Annual Report of activity undertaken by the Trust and Gloucestershire NHS Counter Fraud Service in 2019/20. A benchmarking analysis of the Self-Review Tool (SRT) was also included. There were no active investigations currently relating to the Trust and it was noted that the Committee Chair continued to have regular meetings with Counter Fraud colleagues.

FINANCE COMPLIANCE REPORT

The Committee received the Compliance Report which provided an update on actions that had been taken under delegated powers. The report noted that the debt relating to GHFT had been significantly reduced. The remaining £900k was expected to be paid soon.

The Committee received assurance that the bad debt relating to Gloucestershire County Council was due to the complex nature of the invoices and Covid. The 91+ days recorded in the report only related to one outstanding invoice. The invoices would be finalised week commencing 10th August and progressed.

REVIEW OF EXTERNAL AUDITOR EFFECTIVENESS

KMPG, the Trust's external auditors were not present for this item

The Committee received and reviewed the External Auditor Assessment 2020 which included a summary of the results from the questionnaire which was circulated to the members of the Audit and Assurance Committee. A satisfactory outcome was noted.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary.

DATE OF NEXT MEETING	**5 November 2020**

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 20.1

REPORT TO:	**TRUST BOARD – 30 September 2020**
PRESENTED BY:	Lavinia Rowsell – Head of Corporate Governance and Trust Secretary
AUTHOR:	Lavinia Rowsell – Head of Corporate Governance and Trust Secretary
SUBJECT:	**AUDIT AND ASSURANCE ANNUAL REPORT 01 October 2019 – 31 March 2020**

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

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

The purpose of this report is to

Consider the draft annual report of the Audit And Assurance Committee to the Trust Public Board being held on the 30 September 2020.

Recommendations and decisions required

The Board is asked to **consider** the Committee's Annual Report 2019/20.

Executive summary

The Committee's terms of reference require that: "*The Audit and Assurance Committee will update each routine Board meeting on its activity, highlighting decisions made, issues being progressed and concerns requiring further consideration or decision by the Board*".

"*The Committee will report to the Board annually on its work in support of the Annual Governance Statement*."

This year this process has been delayed as the Committee in its current format has only been in place since the merger with Gloucestershire Care Services NHS Trust on 1st October 2019. The Annual Governance Statement reflected the operation of

the Committee through review of the Committee Reports and Papers provided to the Board. The attached report provides an overview of the Committee's work in the last financial year, from 1 October 2019 to 31 March 2020 in sections which reflect the headings in the Committee's terms of reference. The report also provides an overview of the work of the Committee in overseeing internal control mechanisms in the Trust as reflected in the Annual Governance Statement. No issues have been highlighted as areas of concern. The Committee has operated in line with its terms of reference to meet the functions delegated to it by the Board. It is recommended that future reports will be presented to the Committee at its early May meeting in order to align with the annual reporting timescales.

Risks associated with meeting the Trust's values
Failure to identify and mitigate corporate and strategic risks may adversely affect the Trust's strategic goals of engagement, quality and sustainability.

Corporate considerations	
Quality Implications	Effective management of risk provides assurance that patient services are being delivered safely.
Resource Implications	None other than those identified in the report.
Equality Implications	None other than those identified in the report.

Where has this issue been discussed before?
N/A

Report authorised by:	**Title:**
Marcia Gallagher Sandra Betney	Non-Executive Director Director of Finance 21 July 2020

Gloucestershire Health and Care NHS Foundation Trust

AUDIT AND ASSURANCE COMMITTEE ANNUAL REPORT

1st October 2019 – 31 March 2020

1.0 INTRODUCTION

1.1 The Audit and Assurance Committee was established in its current form under Board delegation from 1 October 2019 in line with the governance arrangements agreed and set in place from the date of the merger of the Trust with Gloucestershire Care Services NHS Trust. Its terms of reference are informed by good practice and Audit and Assurance Committee guidance within the NHS sector and other sectors.

1.2 All Non-Executive Directors are members of the Committee, with the exception of the Trust Chair. This membership enables the Committee to triangulate information and assurance received at other Board Committees, each of which is chaired by a member of the Audit and Assurance Committee.

1.3 A number of officers are in regular attendance in accordance with the Committee's Terms of Reference. These include the Director of Finance (or a delegated alternate), the Head of Governance and Trust Secretary (or a delegated alternate), Internal and External Auditors, and the Local Counter Fraud Specialist. Other Directors and Managers attended at the request of the Committee, for example where further information is required on follow up actions following issues being raised through an Internal Audit. After each meeting of the Committee, the Audit and Assurance Committee Chair provides a summary report of the Committee's deliberations and decisions to the next Board meeting.

1.4 The Committee met 2 times during the period 1 October 2019 to 31 March 2020, and has discharged its responsibilities for scrutinising the risks and controls which affect all aspects of the Trust's business through self-assessment and review, and by requesting assurances from Trust Officers. Each meeting was quorate.

1.5 Attendance by members at the Committee during the period was as follows:

Non-Executive Directors	Nov 19	Feb 20
Marcia Gallagher(Chair)	Y	Y
Graham Russell	Y	Y
Jan Marriott	Y	Y
Duncan Sutherland	N	N
Sumita Hutchison[1]	N	N
Maria Bond	Y	Y

All members receive papers and have the opportunity to raise any concerns with the Chair even where they do not attend.

1.6 The following were in attendance at the Committee during the period with their attendance dependent on issues to be discussed.

- Director of Finance
- Deputy Director of Finance
- Head of Counter Fraud and/or Team members (receives papers and can raise any concerns with the Chair or Director of Finance if not attending.
- Members of the Trust Secretariat
- Internal Audit
- External Audit
- Members of the Management Team for specific items

2.0 PRINCIPAL REVIEW AREAS

2.1 This annual report is divided into five sections, reflecting the five key duties of the Committee as set out in its terms of reference.

2.2 Governance, Risk Management and Internal Control

2.3 The Committee has reviewed relevant disclosure statements, in particular the Annual Governance Statement together with the Head of Internal Audit Opinion, external audit opinion and other appropriate independent assurances. – **CONFIRMED for Financial Year 2019/20.**

2.4 The Head of Internal Audit Opinion was based on the audit work carried out during the year in line with the plan approved by the Committee, and also had regard to the Trust's Board Assurance Framework, Risk Register, and other control mechanisms. This opinion contributed to the Committee's assessment of the effectiveness of the Trust's system of internal control, and to the completion of its Annual Governance Statement. **CONFIRMED for Financial Year 2019/20.**

2.5 The Committee reviewed the Corporate Risk Register and the Board Assurance Framework at regular intervals in order to provide challenge and receive assurance that strategic and corporate risks are being adequately monitored. – **CONFIRMED.**

2.6 The Committee reviewed both the draft and final versions of the Annual Governance Statement which set out the systems and processes for internal control and formed part of the Trust's 2019/20 Annual Report.

2.7 Compliance reports on governance processes including the Register of Directors' Interests, and the Register of Gifts and Hospitality are reviewed annually.

2.8 The Chairs of all Gloucestershire Trusts' Audit and Assurance Committees are able to meet to discuss governance issues around Integrated Care Systems and Sustainability and Transformation Plans for the County and other issues of mutual interest.

2.9 The Committee has reviewed the completeness of the risk management system and the extent to which it is embedded within the organisation. The Committee believes that while adequate systems for risk management are in place, continued management focus is required to ensure that risk management continues to be embedded within the trust, particularly with the coming together of the Risk Management systems of the two trusts at merger and the ongoing redevelopment of the Board Assurance Framework to reflect the new strategic priorities of the organisation.

2.10 Internal Audit

2.11 In completing its work, the Committee places considerable reliance on the work of Internal Auditors. Throughout the year the Committee has worked effectively with internal audit to strengthen the Trust's internal control processes and during the year the Committee:

Reviewed and approved the internal audit plan for 2019/20.

Considered the findings of internal audit in relation to work on the following issues:

- Risk Management
- Business Continuity Management
- Cost Improvement Programme (Phase 2)
- Corporate Governance
- Finance Systems
- Information Governance (DSP toolkit)
- Estate and Facilities - High Risk
- Performance management
- Staff Complaints and Speaking up
- Statutory and mandatory training

2.12 The Estate and Facilities report had been included in the audit programme at management's request. This review was rated as a High Risk, and the Committee sought and received assurance that measures had been put in place to ensure that the recommendations were to be taken forward with timeliness. All other audit reports were classified as either Medium or Low risk. The audits produced a total of 29 findings (covering only period as GHC) (55 last year – full year). There were 11 Low, 16 medium and 2 high risk-rated findings In respect of each of these findings the Committee sought and received assurance on the mitigating actions being taken, following up

outstanding actions as necessary and referring issues to other Committees as appropriate in order for progress with action plans to be monitored.

The Internal Auditors advised that "In light of the COVID-19 outbreak and latest government guidance it was agreed with management that not all of the planned reviews would take place, specifically: ICT and information management; and Recruitment and Retention. This was a result of the reviews being unsuitable to complete remotely as well as management capacity to support in the review and because the timing of the review was no longer appropriate. During the year we were asked to carry out a review of the supplier data transfer, but this project was delayed. Although these reviews have not taken place we felt sufficient work had been undertaken during the year to provide evidence in support of the areas upon which we are required to provide an opinion, although it should be noted that had these other reviews taken place additional findings may have been identified which may have affected our internal audit opinion." These reviews will be taken forward as possible in 2020/21.

2.13 The Committee has been pleased to note during the period continued good performance in terms of the timely completion of management actions arising from Internal Audit Reviews. Tracking of IA recommendations will be reviewed at each meeting.

2.14 External Audit

- The Committee received and noted the final audit in respect of the 2019/20 Financial Accounts and the 2019/20 Quality Report (unaudited), and approved the Financial Accounts and the Quality Report (unaudited) on behalf of the Trust Board.
- The Committee reviewed and agreed the external audit plan for 2019/20.
- The Committee reviewed and commented on the reports prepared by external audit which have kept the Committee apprised of progress against the External Audit Plan.

2.15 Private Meeting with the Auditors

2.16 The Committee Chair met privately with internal and external auditors during the period. No concerns were raised by either auditor, and both gave positive feedback about the reputation of the Trust and the working relationships that had been established.

2.17 Other Assurance Functions

2.18 The Committee has reviewed the findings of other significant assurance functions where appropriate, and has considered any governance implications for the Trust.

2.19 The Committee received regular Counter Fraud updates, and received the Counter Fraud Annual Report for 2019/20 and the Counter Fraud work plans

for 2019/20 and for 2020/21. The agreed planned total of days of counter fraud activity was delivered during 2019/20 across the 4 generic areas of Counter Fraud activity as defined by the NHS Counter Fraud Authority. The areas of activity for 2019/20 were apportioned thus: 40 to 'Strategic Governance' 48 to 'Inform and Involve', 80 to 'Prevent and Deter' and 89 to 'Hold to Account'. The total cost of the Counter Fraud service during 2019/20 was £114,139.

2.20 The NHS CFA self-review tool provides assurance that the Trust is compliant with the NHS CFA's Standards for Providers. To be compliant with NHS Counter Fraud Authority (NHSCFA) requirements, the Annual Report must include the 2020 Self Review Tool (SRT) of organisational compliance with the counter fraud standards within the Standard Contract. However, due to the pressures of COVID-19 activity, the submission date for the SRT was extended to 30 May 2020 which delayed submission to the Committee and an update is awaited. Performance is expected to be in line with previous years.

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2.21 Management

2.22 The Committee has challenged the assurance process when appropriate, and has requested and received assurance from Trust management and various other sources both internally and externally throughout the year.

2.23 The Committee works to an annual plan of scheduled agenda topics. In setting this annual plan, the Committee considers items currently on the Risk Register, items of current interest, and items raised by the auditors and the Executive Team. In addition the Committee follows up risk items previously identified to ensure that it remains informed of progress against previously agreed actions. A rolling programme of actions is maintained and monitored accordingly for all Committee meetings.

2.24 Compliance Reporting

2.25 The Committee received Losses and Special Payments reports at various points through the year, as required by the Trust's Standing Financial Instructions. The Committee sought assurance in each case as to the processes in place to recover these amounts, and prevent recurrence.

2.26 The Committee has regular reports at meetings on waivers over £25k applied in the preceding period. This reporting includes nil returns.

2.27 The Committee reviewed the 2019/20 financial statements and annual report at the May 2020 meeting prior to recommending the final accounts for Accounting Officer signature, in line with authority delegated by the Board.

2.28 The Committee was pleased to note the external audit report which indicated that an unqualified audit opinion was to be given to the accounts, and that the auditors had not identified any significant weaknesses in systems of accounting and financial control.

3.0 OTHER MATTERS

3.1 The Committee will formally review its own effectiveness during the year. Its format and operation has been informed by best practice and no issues have been identified to date.

3.2 The Committee compiled an Annual Report on its activities which will be considered by the Board.

3.3 The Committee will review its terms of reference during the year.

4.0 CONCLUSION

4.1 The Committee's primary contribution to the achievement of the Trust's strategic objectives is to ensure that Governance, Control, Risk Management and Audit systems are sound, reliable, and robust. The work of the Committee in the last financial year, and the triangulation of information and assurance received both at the Audit and Assurance Committee and at other Committees chaired by members of the Audit and Assurance Committee, have enabled the Audit and Assurance Committee to conclude that the Trust's systems are in the main sound, reliable and robust.

Marcia Gallagher
Chair, Audit and Assurance Committee
July 2020

AGENDA ITEM: 21

RESOURCES COMMITTEE SUMMARY REPORT

DATE OF MEETING 5 AUGUST AND 27 AUGUST 2020

COMMITTEE GOVERNANCE	• Committee Chair – Graham Russell, Non-Executive Director • Attendance (membership) – 80% and 50% • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

EXTRAORDINARY COMMITTEE MEETING – 5 AUGUST 2020

An extraordinary meeting of the Resources Committee took place on 5th August to discuss the delivery options for the new Forest of Dean Hospital.

COMMITTEE MEETING – 27 AUGUST 2020

FINANCE REPORT – MONTH 4

The Committee received the Finance Report for month 4. The Trust had requested a retrospective top-up of £1,072m for the period April to July. £726k of this had been approved by NHSI for April to June. This was to ensure that the Trust would reach a break even position. The System as a whole was required to reach a break even position from months 7 to 12.

THIRD PHASE PLANNING UPDATE

The Committee received a report which provided an update on the latest guidance received for the third phase of the NHS Response to Covid-19.

The Trust had received a letter from Sir Simon Stevens and Amanda Pritchard on 31st July 2020 which provided details on the next phase of the Covid response; including:

- Confirmation of the NHS EPRR incident level move from Level 4 to Level 3
- Setting out priorities for the remainder of 2020/21
- Outlining financial arrangements heading into autumn as agreed with Government.

There were a total of 8 urgent actions and 67 priorities. The actions were set out in the report and they were largely focused on the long term plan ambitions and learning from Covid. A key piece of work on equalities and learning was also identified.

The Trust was required to submit the Local People Plan on 21st September. This was supported by Workforce and Business Intelligence colleagues. The People Plan would be submitted to the Trust Board in September.

<u>Operational Work and Priorities</u>

The Committee received a presentation detailing the Covid Recovery Phase 3 Requirements,

focusing on the Operational Work and Priorities. The presentation highlighted that new requirements had been received in the previous week with regards to hospital discharge guidance and IPC and PPE guidance. A concern was raised that the finances for this were currently unknown due to the financial envelope not yet having being received.

Several scenario workshops had been held as a corporate exercise, addressing possible situations which may arise in winter or if there is to be a second surge of Covid.

The Committee discussed both the report and the presentation and focussed on the differing elements of the recovery phase. An item would be included on the agenda for the September Board Meeting for further discussion.

SOUTH WEST ADULT SECURE MENTAL HEALTH PROVIDER COLLABORATIVE

The Committee received an update on the South West Adult Secure Mental Health Provider Collaborative, noting that the New Care Models Programme was initially introduced in April 2017. The New Care Models Programme would focus on local systems working together through provider collaborates looking at specialised services; which include Children and Adolescent Tier 4 services, Learning Disability, Eating Disorders and Perinatal services.

The decision had been made (following recommendations) that the South West would lead for Adult services and that Thames Valley would lead for Children's services. This was agreed due to where the best pathways were provided to patients.

The Committee was informed that the intention was for the South West Adult Secure Mental Health Services Collaborative to now go 'live' from the 1st October. A Board decision would be required and as such a report would be prepared for the Trust Board in September.

BUSINESS DEVELOPMENT REPORT

The Committee received the Business Development Report providing the Committee with an update on the Trust's business development activities and potential opportunities to strengthen existing income streams and to generate new ones.

HR POLICIES, COVID WORKFORCE RESPONSE & KPIS

The Committee was informed that the Trust's Recruitment Policy and Disputes Policy had been updated.

Training within the Trust had recommenced on 6th July, however face to face courses were being reintroduced on a phased basis due to Covid restrictions.

The Committee received an update on the workforce KPIs, including turnover rates.

The Committee noted the report and expressed thanks to the Director of HR and the wider HR Team for their hard work and efforts over the past few months.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary.

DATE OF NEXT MEETING	**22 October 2020**

AGENDA ITEM: 22

QUALITY COMMITTEE SUMMARY REPORT

01 SEPTEMBER 2020

COMMITTEE GOVERNANCE	• Committee Chair – Maria Bond, Non-Executive director • Attendance (membership) – 86% • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

SIRI (SERIOUS INCIDENTS REQUIRING INVESTIGATION) UPDATE

The Committee received the SIRI update for the period June/July 2020. There had been three SIRIs declared in June and six declared in July. The number of SIRIs had reduced in August, with two SIRIs declared; which bought the quarterly average to the normal expected level. The Committee was informed that comparative data showed a drop in incidents reported of 15.2% against the drop in patient contacts which was 16.6%.

QUALITATIVE AND QUANTITATIVE RISK AUDIT REPORT

The Committee received the Qualitative and Quantitative Risk Audit Report which formed part of the Trust's clinical audit programme. Findings from the audit were shared with colleagues, reported through the Trust's operational and corporate governance systems and fed into the Trust's Learning and Assurance Framework to ensure a continuous cycle of improvement and development. This report was noted.

QUALITY DASHBOARD REPORT

The Committee discussed, received and noted the Quality Dashboard Report for July 2020, drawing attention to those areas requiring further development, and those quality issues showing positive improvement.

There was an ongoing challenge surrounding wound care matters. There was a good level of reporting and visibility on wound care issues, but the area was a focus for improvement. There would be further reporting to the Quality Committee on wound care and enhanced deep dives would be brought to the Committee on pressure ulcers, leg ulcers and tissue viability. Prevention of falls across the services was another area for ongoing development identified.

The Committee was informed of the work that had been done by the Quality Directorate in promoting the new project across the Trust '*Civility Saves Lives'* programme. The principle was that if staff were encouraged and helped to communicate politely – better patient outcomes would be achieved. This would be adopted as the patient safety programme for the remainder of the year.

The Committee Chair thanked John Trevains and his team for the report which kept improving every month and was an extremely helpful addition which provided good commentary and excellent assurance on quality issues. The Team was asked to consider

how the dashboard could be developed further to incorporate more outcomes based quality measures.

ASSESSMENT AND CARE MANAGEMENT AUDIT REPORT

The Committee received the Assessment and Care Management Audit Report. The report provided the Committee with the outcome of an audit, measuring compliance against the Trust's Assessment and Care Management Policy carried out in July 2020. The report considered both Qualitative and Quantitative data and looked at the wider aspects of the records from an Assessment and Care Management perspective. It was noted that compliance rates remained static.

The Committee discussed elements within the report particularly surrounding data quality. Compliance with qualitative data was good, however, quantitative compliance was low. This continued to relate to data being recorded in the incorrect place on the clinical record. A Task and Finish Group would be set up and facilitated by quality colleagues in partnership with operational governance leads to devise and agree on an action plan to address this, with a timeframe anticipated of 1st April 2021 to undertake this piece of work.

CLINICAL AUDIT PROGRAMME OVERSIGHT REPORT

The Committee received the Clinical Audit Programme Oversight Report. The team had reviewed what was achievable for the remainder of the year on a risk basis. The initial review had reduced to 150 audits. Of the 150 audits, 53% were underway and 39% were not due to be undertaken at present. 8% of the audits had been completed. The Clinical Audit team would be reviewing how to stream line the audits and the work would be lined up with governance forums.

ETHICS GROUP TERMS OF REFERENCE

The Committee approved the change of the Ethics Group Terms of Reference to reflect that the Ethics Group would report to the Quality Committee.

QUALITY ASSURANCE GROUP SUMMARY REPORT

The Committee noted the contents of the summary reports for the Quality Assurance Group which took place 24th July and 21st August 2020. Once again the Committee noted the huge amount of work taking place at the QAG and the excellent assurance that this report provided back to the Quality Committee. Continued high levels of attendance were also noted and welcomed.

COMPLAINTS ANNUAL REPORT

The Committee received and noted the Complaints Annual Report. The numbers of complaints received in 2019/20 was the same as in the previous year. The numbers of complaints received were low in comparison to the amount of patient contacts received.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary.

DATE OF NEXT MEETING	**3 November 2020**

AGENDA ITEM: 24

GLOUCESTERSHIRE HEALTH AND CARE NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS MEETING

Wednesday, 17 June 2020

held via Microsoft Teams

Confirmed MINUTES

PRESENT:

Ingrid Barker (Chair)	Vic Godding	Alison Feher
Katie Clark	Bren McInerney	Anneka Newman
Brian Robinson	Anne Roberts	Mervyn Dawe
Said Hansdot	Jenny Hincks	Karen Bennett
Faisal Khan	Jo Smith	Nic Matthews
Katherine Stratton		

IN ATTENDANCE: Steve Alvis, Associate Non-Executive Director
Sandra Betney, Deputy Chief Executive/Director of Finance
Maria Bond, Non-Executive Director
Steve Brittan, Associate Non-Executive Director
Marcia Gallagher, Non-Executive Director
Anna Hilditch, Assistant Trust Secretary
Sumita Hutchison, Non-Executive Director
Jan Marriott, Non-Executive Director
Lavinia Rowsell, Head of Corporate Governance
Kate Nelmes, Head of Communications
Graham Russell, Non-Executive Director (Deputy Chair)
Neil Savage, Director of Organisational Development
Gillian Steels, Trust Secretary Advisor
John Trevains, Director of Nursing, Quality and Therapies
Dr Amjad Uppal, Medical Director

1. WELCOMES AND APOLOGIES

1.1 Apologies were received from June Hennell and Stephen McDonnell. Paul Roberts, Chief Executive had also sent his apologies for this meeting.

1.2 Ingrid Barker welcomed everyone to the meeting. Governors were introduced to Steve Brittan, Associate Non-Executive Director who had been appointed to the Trust Board from 18th May.

1.3 The Council noted that this would be Vic Godding's final meeting, as he would be coming to the end of his second term as a Public Governor for Cheltenham on 31 July. Ingrid Barker expressed her thanks to Vic for his commitment, enthusiasm and huge contribution over the past 6 years.

1.4 The Council of Governors were asked to note that Lawrence Fielder, Appointed Governor for Gloucestershire CCG had resigned from general practice and had therefore been required to stand down as the CCGs Governor representative from 1 May. Ingrid Barker advised that she had written to the CCG seeking a further nomination; however, it was possible that it could take up to 6 months in the current challenging times to find a replacement. The CCG said that they would nominate a lay member in the interim.

2. MINUTES OF THE PREVIOUS MEETING

2.1 The minutes from the previous meeting held on 19 March were agreed as a correct record.

3. MATTERS ARISING AND ACTION POINTS

3.1 The actions from the previous meeting were either complete, on-going or included on this meeting's Agenda.

3.2 Mervyn Dawe said that he had previously requested a report to be shared with Governors focussing on Out of County Placements. He said that he fully understood that other business had taken precedent over the past few months and simply asked that his request be kept on the record for a future time as he was still keen to receive the information.

ACTION: Briefing for Governors on Out of County Placements to be prepared and presented at a future meeting

4. CHIEF EXECUTIVE'S REPORT

4.1 Sandra Betney, Deputy Chief Executive presented a verbal report to the Council, separated out under a number of key headings.

Coronavirus update

4.2 The Governors received an update on progress with recovery from Covid arrangements. All services and teams were being asked to reflect on their own service recovery, and were attending Recovery Clinics set up to review plans and service models. These recovery plans, which included key risks and staffing data, were then received by the Executive Committee for approval, at which point services could then move into active recovery. Sandra Betney advised that 50% of services were now in active recovery, which was a staged plan for them to work towards. It was hoped that all services would have moved into the active recovery phase by the beginning of July.

4.3 Sandra Betney informed the Governors that communication would be going out around the Minor Injury Units (MIIUs). Due to Covid, the Trust had made the decision to temporarily close some of the units, with others having their operational hours reduced. She said that the plan was to continue with these temporary arrangements whilst the Trust looked to manage its active

recovery. It was noted that there could be a move to more of a booked appointment arrangement, rather than walk-ins so the Trust could manage patient flows in line with social distancing guidelines. Brian Robinson said that MIIUs were a sensitive point as they offered people in more rural areas access to services. Ingrid Barker agreed that there was a need to manage the sensitivities around the communication, however, it was noted that current demand for minor injuries units was very low.

4.4 It was noted that there was good capacity within community hospital inpatient services and improving capacity in mental health inpatient services, so a positive picture across the Trust.

4.5 In terms of Learning from Covid, Sandra Betney advised that the Trust had a Future State programme in place and some lessons learned exercises had already been carried out to get vital feedback from colleagues such as online surveys, drop in sessions and posters. GHC was also feeding in to the ICS Recovery Group, where discussions would be taking place around system wide learning.

4.6 Bren McInerney noted that there was good capacity within services currently but suggested that the Trust needed to do more to communicate with and encourage people to start using these services again. Sandra Betney said that work was taking place to review the Trust's waiting lists for some services and communication with primary care colleagues was ongoing to ensure that there was a clear and consistent message sent out about how we are managing new referrals.

4.7 Sandra Betney said that the Trust was carrying out its recovery process in a planned and measured way. There was a need to focus on those services with high demand, as well as working with partner organisations to look at joint recovery as many of the Trust's services linked in as part of the wider care pathway.

Strategy

4.8 The Council noted that the Trust had reviewed its Strategic Framework at the March Board and had planned to carry out a wider programme of engagement. Sadly this had been delayed due to Covid. However, Sandra Betney advised that work on this would recommence shortly and information would be shared with Governors. It was noted that the Board would be holding a series of seminars over the coming months focussing on strategy.

Integrated Care System (ICS) Update

4.9 The Council of Governors noted that the Gloucestershire Health Overview and Scrutiny Committee Meetings had been postponed due to Covid but it was hoped that this would be reinstated in July. Engagement on Fit for the Future and the Forest of Dean Hospital could then recommence as it had not been possible in the interim to carry out the level of engagement desired. Brian Robinson said that he welcomed the return of Scrutiny as this would ensure that the necessary level of due diligence was being carried out on key service developments and changes.

Black and Minority Ethnic Community and the Impact of Covid

4.10 Sandra Betney advised that discussions had been taking place internally about how the Trust responds to the current focus on equality, in particular Black Lives Matter. The Chief Executive had written two blog posts on the subject, and had announced that focus group meetings were being set up for Trust colleagues to discuss this in more detail. A Diversity Network was also being launched, to be chaired by Sumita Hutchison, which would be outcome and action focussed.

4.11 In terms of the differential impact of Covid on BAME communities, Neil Savage said that GHC had written to all affected staff members and developed local risk assessment guidance, with the Trust's Working Well (Occupational Health) Team supporting people in doing this. The Trust has redeployed staff accordingly. He offered assurance that there were robust processes in place to manage this position and any concerns that may arise would be closely monitored.

4.12 Nic Matthews said that he welcomed the setting up of the Diversity Network and focus groups for staff and suggested that it would be helpful if the Trust could ensure that its organisational policies were updated to be reflective of the outcome of these important discussions.

Other

4.13 Bren McInerney expressed his thanks to the Executive Team, Non-Executive Directors and Trust colleagues for all of the work carried out to manage Covid whilst at the same time maintaining safe and quality services. Ingrid Barker also gave a massive thanks to the Executives and Trust teams, who had worked incredibly hard. She said that the Trust would be looking to find a way to recognise and celebrate that contribution at a future date.

4.14 The Governors noted that a Senior Leadership Network meeting had taken place the previous week and presentations were received from a range of staff sharing their own personal experiences of Covid which had been powerful.

5. REPORT FROM THE NOMINATIONS AND REMUNERATION COMMITTEE

5.1 Mervyn Dawe, Public Governor and Committee Member presented this report to the Council, summarising the key business conducted at the meeting of the Nominations and Remuneration Committee held on 9 June.

5.2 The Committee had received the outcome of the Trust Chair appraisal. Mervyn Dawe said that the Committee was pleased to receive and note the very positive appraisal report for Ingrid Barker, acknowledging that the past year had been complex and challenging with a merger and Covid-19 to steer through. Ingrid was seen as a compassionate, approachable and responsive Chair dedicated to those people served by the Trust, with a strong commitment to partnership and system wide working.

5.3 The Committee also received the positive outcome from the Non-Executive Director appraisals, which were completed for Marcia Gallagher, Duncan Sutherland, Graham Russell, Maria Bond, Sumita Hutchinson and Jan Marriott. All six appraised NEDs had made valuable contributions to the Trust and were performing well at Board, as Committee Chairs and across their broader roles. It was noted that there were no performance issues to be raised. The diverse range of skills, experience and backgrounds within the NED pool was seen as very valuable.

5.4 Mervyn Dawe said that the Committee had discussed the response rate to both the NED and Chair appraisals from Governors, which he had already raised with Governors in the earlier pre-meeting. Only 9 responses were received, however, it was felt that this was understandable given the number of vacant posts and newly appointed Governors who would not have been in a position to contribute on this occasion. Governors would be encouraged to contribute next year and a framework for Governors to use to provide their feedback would also be considered.

5.5 The Committee had received and noted a report setting out the recruitment process and subsequent appointment of Steve Brittan as an Associate Non-Executive Director with effect from 18 May 2020.

5.6 As the Council had already been made aware, the Trust's interim Lead Governor had sadly resigned from his position as a Public Governor for the Forest. The Council asked that their thanks and good wishes to Simon Smith be formally recorded. Since that time, discussions had taken place amongst Governors and a proposal for a new Interim Lead Governor and deputy was put forward. Mervyn Dawe said that the Governor pre-meeting had received and approved the proposal that Faisal Khan be appointed as interim Lead Governor, with Mervyn Dawe as deputy, interim roles that would continue until the end of December 2020. Ingrid Barker thanked both Mervyn and Faisal for putting themselves forward for this important role.

5.7 The Council of Governors was asked to endorse the appointment of June Hennell as a member of the Nominations and Remuneration Committee. Further appointments to the Committee would be required and the process for this would be carried out in line with the Governor Review and Refresh work. June's appointment was approved.

6. ANNUAL REPORT AND ACCOUNTS 2019/20

6.1 Lavinia Rowsell informed the Council that the Trust's Audit and Assurance Committee had met earlier in the day and had approved the Annual Report and Accounts. It was very pleasing to note that this had received a clean audit opinion.

6.2 Due to Covid, the timeline for producing the annual report and accounts had been delayed, which therefore meant that the Trust had made the decision to postpone its AGM originally planned for July, until later in September. Lavinia Rowsell advised that the Council would formally receive the Annual Report

and Accounts at its September meeting; however, final copies would be circulated for information well in advance of this. Lavinia said that she would be happy to arrange a training session for interested Governors on the Annual Report and Accounts, which could be carried out via MS Teams. Interest in participating in such a session was expressed, and it was agreed that a date would be sought and circulated out to Governors.

ACTION: Training session for Governors on the Annual Report and Accounts, to be carried out via MS Teams to be set up and a date circulated to Governors

6.3 Bren McInerney said that the Trust's AGM would historically have information stands and stalls for people to visit which was always seen as an excellent networking opportunity. He appreciated that this may not be possible at the current time but suggested that there were opportunities that could be embraced and asked that this be considered as part of the planning for the event.

7. STAFF SURVEY RESULTS AND ACTION PLAN - PRESENTATION

7.1 Neil Savage presented this item to the Council of Governors, which provided a summary of the 2019 Annual Staff Survey results published in February 2020.

7.2 The national office required the Trust to compete two separate surveys – one for the former 2gether NHSFT (2g) and another the former Gloucestershire Care Services NHST (GCS). The survey was completed between October and November 2019. All staff in post on 1st September 2019 were invited to take part in the confidential online survey. The results of the survey were reported to the March 2020 Board.

7.3 Overall, Neil Savage advised that the report demonstrated a performance to be proud of given the context of the merger. In terms of headlines, the following areas were highlighted:

- GCS services show some marked and sustained improvements
- 2G services largely maintained position with a few exceptions and remained in top half of MH/LD Trusts
- GCS, 3rd best Community Trust for colleagues recommending the Trust as a place to receive care
- 2G, 4th best MH/LD Trust for colleagues recommending Trust both as (A) a place to receive care and (B) an organisation to work for
- 2G 6/11 Themes above benchmark cluster average
- GCS 8/11 Themes improved
- Staff engagement rating for GCS improved to 7.1, the highest score in 5 years, while 2G remained at 7.2, in top half of MH/LD Trusts

7.4 The Council noted that both Trusts had the lowest response rates for 5 years – with 36% for GCS and 33% for 2g. Neil Savage said that this was disappointing; however, given the amount of engagement and other surveys

being carried out regularly by Trust colleagues during the period, it was not necessarily surprising that a low response had been received on this occasion. Once confirmation was received that the staff survey would be carried out this year, the Trust would then work with the Communications Team and Trust colleagues to encourage engagement with the survey.

7.5 Nic Matthews, also a Staffside representative, said that it had been challenging to engage with staff over the past few months so agreed that looking at different options of connecting with people could improve the uptake.

7.6 A full report had been produced summarising the staff survey results and the actions being taken, which would be presented to the Trust's Resources Committee. Neil Savage agreed that this report be shared with Governors after the Committee meeting, and also offered to meet with Governors to review the report in more detail.

ACTION: Report on Staff Survey Results and actions, being presented to the Resources Committee, to be shared with Governors once approved by the Committee.

ACTION: Session for Governors to meet with Neil Savage to drill down further into the staff survey results to be arranged.

8. GOVERNOR MEMBERSHIP AND ELECTION UPDATE

8.1 Lavinia Rowsell presented this report which provided an update on the current membership of the Council of Governors, an overview of vacant Governor positions, and details for the forthcoming Governor elections. This report and the timeline for elections was noted.

9. GOVERNOR REVIEW AND REFRESH UPDATE

9.1 Work was ongoing to support the Council of Governors' development to reflect its revised remit as the Council of Governors for a Trust which now has a remit in physical health as well as mental health services and a Trust which is committed to transforming the way it meets the needs of its communities. As an integral part of the Trust's governance it is important that the Council of Governors is informed by best practice in its operation and best use is made of the Council and the time given by the governors to support continuing good governance.

9.2 Following agreement at the March Council meeting, two workstreams to the Review and Refresh work were proposed, one focussing on Membership and the other on the Constitution and Governance. Short life working groups would be set up over the next 4-6 weeks, with two meetings of each group planned. The groups would be chaired by Ingrid Barker, with one or two Non-Executive Directors also in attendance, reflecting the interrelation between the Board and the Council. Lavinia Rowsell invited Governors to volunteer to

participate on the groups, noting that it would be helpful to have two public and two staff governors on each group.

ACTION: Governors to nominate themselves to sit on the Review and Refresh working groups

10. CHAIR'S REPORT

10.1 Ingrid Barker provided a verbal report of her activity over the past few months. A full written report would be produced for presentation at the Trust Board meeting in July, which would also be shared with Governors. Ingrid continued to actively engage with national networks, participating in both the recent Chairs forums and NHS Providers Forum. Close links had continued with local partners to keep in touch during Covid and ensure that people remained up to date on key developments despite the lack of face to face meetings. Work was being carried out to looking at reinstating service visits with Non-Executive Directors and how this could be done given the current social distancing guidelines. Governors were presented with the updated NED portfolios for information following the recent appointment of Steve Brittan.

10.2 Ingrid Barker said that she hoped Governors felt that they were being kept up to date via the fortnightly e-newsletter. Governors agreed that this newsletter was extremely informative and welcomed.

11. GOVERNOR ACTIVITY UPDATES

11.1 Anne Roberts said that a large number of Trust colleagues were now working from home, and she talked about the challenges but also the positive and "human" aspects of working from home and using MS Teams for meetings. She said that it was important to recognise this. Katie Clark agreed, adding that people were using more creative methods of working and there were opportunities to be taken from this.

11.2 Jo Smith said that she had been taking time to make regular contact with vulnerable friends and family.

11.3 Jenny Hincks informed the Council that is was national Carers Week and she had been engaging with lots of other carers and seeing how the last few months had been for them. She said that many carers were shielding themselves and had found the last few months especially difficult. The immense role played by carers was acknowledged.

12. ANY OTHER BUSINESS

12.1 There was no other business.

13. DATE OF NEXT MEETING

13.1 The next meeting would take place on Wednesday, 16 September at 2.00pm.

COUNCIL OF GOVERNORS
ACTIONS

Item	Action	Lead	Progress
17 June 2020			
3.2	Briefing for Governors on Out of County Placements to be prepared and presented at a future meeting	John Trevains	**Scheduled** A briefing paper is scheduled for presentation at the November 2020 Council meeting.
6.2	Training session for Governors on the Annual Report and Accounts, to be carried out via MS Teams to be set up and a date circulated to Governors	Anna Hilditch	**Complete** Marcia Gallagher and Sandra Betney to lead a session on 2nd Sept at 10.30am
7.6	Share the report on Staff Survey Results and actions, being presented to the Resources Committee, with Governors once approved by the Committee	Anna Hilditch	**Complete** Report circulated on 2 July to Governors, along with an invitation to attend a session to discuss the Staff Survey in more detail
7.6	Offer a date and time for interested Governors to meet with Neil Savage to drill down further into the staff survey results	Anna Hilditch / Neil Savage	**Complete** Session to take place on 15th July at 10-11am
9.2	Governors to nominate themselves to sit on the Review and Refresh working groups – Membership and Constitution/Governance	Anna Hilditch	**Complete** Two sessions set up and dates circulated to Governors to express an interest in participating.

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

TRUST BOARD
Public
Forest Green Rovers Football Club
The New Lawn Stadium, Another Way, Nailsworth, GL6 0FG
Wednesday, 29 January 2020
Start: 10:00 - Finish: 14:00

AGENDA

Time	Agenda Item	Title	Purpose		Presenter
Opening Business					
10:00	01/0120	Apologies for absence and quorum	Note	Verbal	Chair
10:00	02/0120	Declarations of interest	Note	Verbal	Chair
10:05	03/0120	Compassionate Stroud	Note	Verbal	Katja Baczko
10:35	04/0120	Minutes of the meeting held on 28 November 2019	Approve	Paper	Chair
10:40	05/0120	Matters arising and action log	Note	Paper	Chair
10:50	06/0120	Questions from the public	Note	Paper	Chair
10:55	07/0120	Report from the Chair	Note	Paper	Chair
11:05	08/0120	Report from the Chief Executive Officer and Executive Team	Note	Paper	CEO
Strategic Issues					
11:10	09/0120	Developing our strategy	Note	Paper	Director of Strategy and Partnerships
11:20	10/0120	System wide update • Fit for the Future • One Gloucestershire ICS Lead Report	Note	Verbal Paper Paper	Chief Executive Officer
11:40	11/0120	Sustainable workforce	Note	Paper	Director HR and OD
11:50	12/0120	Future delivery of Mental Health and Learning Disability Services in Herefordshire	Note	Paper	Managing Director for Herefordshire
12:00	13/0120	Our merger - PME update	Note	Paper	Director of Finance
Performance And Patient Experience					
12:20	14/0120	Summary quality report	Note	Paper	Director of Nursing, Therapies and Quality
12:30	15/0120	Learning from deaths Q2	Note	Paper	Medical Director
12:40	16/0120	Guardian of safe working report Q2	Note	Paper	Medical Director

Time	Agenda Item	Title	Purpose		Presenter
12:45	17/0120	CQC Community Mental Health Patient Survey Results	Note	Paper	Director of Nursing Therapies & Quality
12:55	18/0120	Performance report/dashboard	Note	Paper	Director of Finance
13:10	19/0120	Finance report – Month 9	Note	Paper	Director of Finance
Governance					
13:20	20/0120	Terms of reference: Appointments and Terms of Service Committee	Approve	Paper	Trust Secretary
Items for Information					
13:25	21/0120	Resources Committee Summary 19th December 2019	Note	Paper	Committee Chair
13:30	22/0120	Quality Committee Summary 5th December 2019 and 9th January 2020	Note	Paper	Committee Chair
13:35	23/0120	Nomination and Remuneration Committee Summary - 9th January 2020	Note	Paper	Trust Secretary
13:38	24/0120	Minutes of Council of Governors meeting held on the 14th November 2019	Note	Paper	Chair
13:40	25/0120	Use of Trust seal	Note	Paper	Trust Secretary
Closing Business					
13:45	26/0120	Any other business	Note	Verbal	Chair
	27/0120	Date of next meeting Wednesday, 25th March 2020 Highnam Community Centre, to include AGM (for GCS)	Note	Verbal	All

AGENDA ITEM 04/0120

UNCONFIRMED MINUTES of the Trust Board
PUBLIC
held on **Thursday, 28 November 2019**
at the Friendship Café, Painswick Road, Gloucester, GL4 6PR

PRESENT:
Ingrid Barker, Trust Chair
Paul Roberts, Chief Executive
Sandra Betney, Director of Finance
Maria Bond, Non-Executive Director
John Campbell, Chief Operating Officer
Marcia Gallagher, Non-Executive Director
Sumita Hutchison, Non-Executive Director
Angela Potter, Director of Strategy and Partnerships
Neil Savage, Director of HR & Organisational Development
John Trevains, Director of Nursing, Therapies and Quality
Dr Amjad Uppal, Medical Director
Helen Goodey, Director of Locality Development and Primary Care
Sue Mead, Non-Executive Director
Graham Russell, Non-Executive Director
Duncan Sutherland, Non-Executive Director
Jan Marriott, Non-Executive Director

IN ATTENDANCE:
Kate Nelmes, Head of Communications
Michael Richardson, Deputy Director of Nursing
Simon Crews, Interim Trust Secretary
Lauren Edwards, Trust Advisor Speech and Language Therapy
Frankie Havens – Service User Support
Andy Telford, Deputy Director Adult Mental Health (Community)
Alex - Service User
Rose Burn, Treasure Seekers
Jan Burn, Treasure Seekers
Sue Massey - Trailblazers
Hilary Bowen
Said Hansdot, Governor Gloucester
Lavinia Rowsell, Head of Corporate Governance/Trust Secretary

APOLOGIES:
Colin Merker, Managing Director for Herefordshire
Jane Melton, Director of Therapies

1.0 CHAIR'S WELCOME

1.1 The Chair thanked the Friendship Café for hosting today's meeting recognising that the facility sat at the heart of the community that we serve. The next Board

meeting will be held at Forest Green Rovers FC. Board meetings would be held in community settings in the future.

1.2 This was the first Board meeting since the merger of the two organisations and the exciting and challenging agenda for the organisation can only be achieved with the support of the people we serve and the staff that work for the Trust. The Chair outlined the extensive engagement work that had been undertaken leading up to the merger, involving, inter alia, voluntary organisations, staff groups and other organisations the Trust has relationships with.

2.0 DECLARATIONS OF INTEREST

2.1 The Chair informed the meeting that she was now a Trustee of the GP Educational Trust.

2.2 Duncan Sutherland identified his appointment as Chairman of the Integrated Alliance Board for Herefordshire

3.0 SERVICE USER STORY

3.1 Alex attended the meeting to tell the Board her story concerning the services she had received during her long association with the Trust's services. The story took the shape of a question and answer session.

3.2 Alex had suffered symptoms from a young age and she referred in her answers to the impact on her life and how risks had been managed and reduced.

3.3 Alex identified concerns with the Recovery Team service where she felt the level of support needed was lacking. She did not wish to make any comment concerning the Crisis Service. Her most recent contact with services had been much better, staff had been made aware of her needs and she particularly appreciated the service she had received from the Kingfisher Treasure Seekers substance misuse team. There had been improvements in the service she had received more recently from the Recovery Team and with support from Psychology services.

The safety net provided by 'Treasure Seekers' had been very well received and the importance of personal contact and her ability to talk to individuals when in crisis was very helpful. She expressed concerns at the long wait for support from some services and that there were differences in the quality of service received depending on the point of contact. She said that she would benefit from 24 hours access to 'Treasure Seekers'. A comparison was made with the 24 hour service available in Bristol.

3.4 A representative from 'Treasure Seekers' was complimentary concerning the support and willingness to try new approaches from the Trust's substance misuse services. Andy Telford emphasised links with the third sector which paid real dividends and drew attention to the higher funding levels for the Bristol service which made comparisons difficult.

3.5 Alex was invited to become an "expert and experience user" to support the Trust in learning from service users experiences.

3.6 John Campbell, Chief Operating Officer [COO] referred to the support provided by the CCG and it was agreed that this should be acknowledged by the Chair on behalf of the Board.

3.7 Alex and the staff who had attended the meeting to support her were thanked for their informative and frank presentation.

3.8 **Agreed: Chair to acknowledge support received from the CCG**

4.0 MINUTES OF THE MEETINGS HELD ON 26TH SEPTEMBER 2019

4.1 The 2G & GCS minutes taken at the Trust Board meeting held on 26th September 2019 were accepted as a true and accurate record.

5.0 MATTERS ARISING AND ACTION LIST

5.1 Items identified on the action tracker had now been completed.

6.0 CHAIR'S REPORT

6.1 The Chair introduced Sue Mead who had been appointed as an Associated NED as previously agreed by the Board. This position will provide continuity and knowledge from the previous Gloucestershire Care Services Trust.

6.2 Appended to the Chair's report were details of the NEDs roles. It was noted that Duncan Sutherland's role on the Mental Health Legislation and Scrutiny Committee should be added pending the appointment of the GP NED.

6.3 A recent appointment to the position of Chair of the Integrated Care System had been made, but could not be announced due to the pre-election period.

6.4 An excellent Better Care Together event had recently been held.

6.5 Time had been spent at the Summerfield Charitable Trust where a better understanding of their work had been obtained. This is a charitable organisation who will be visiting our services in the future.

6.6 The Chair reported on the recent meeting of Governors to undertake a review and refresh exercise concerning their future work and engagement.

6.7 **Agreed: The Chairs report was received and noted.**

7.0 CHIEF EXECUTIVE'S REPORT

7.1 The CEO referred to his report which could in the main be taken as read.

7.2 He welcomed Sue Mead Associate NED to her new role.

7.3 In relation to the Corporate Governance function, the CEO asked Board members to recognise the extent of staff turnover and to make allowances in connection with the work of this department until normal staffing levels were in place. He welcomed Lavinia Rowsell who would be commencing duties early January.

7.4 The CEO referred to a number of underused Trust properties in Gloucester which he had approached the City Council about concerning a better use for these assets. A task and finish group was being established. Angela Potter, Director of Strategy and Partnerships [DoS&P] will be the lead Executive with Graham Russell and Duncan Sutherland representing the NEDs.

7.5 The Senior Leadership Network continues to operate. Chair and NEDs are welcome to attend. Events would be moving to bi-monthly from April. After taking soundings from the group and executive colleagues and in recognition of the increasing engagement of external agencies, consideration is being given as to how we may better strengthen engagement.

7.6 The CEO highlighted the importance of research, referring to the continued work being undertaken within the organisation.

7.7 The CEO was working on formalising links with universities where closer engagement would be important.

7.8 The national election period had constrained the Trust's ability to say more publically about the progress with Fit for the Future and arrangements for Herefordshire services.

7.9 In connection with strategic responsibilities it was confirmed that John Campbell, COO is responsible for emergency planning within the Trust.

7.10 In answer to Duncan Sutherland the CEO confirmed that he had spoken to colleagues concerning the future of Herefordshire Governors and their future involvement within Herefordshire. A solution was imminent.

7.11 **Agreed: The Chief Executive report was received and noted.**

8.0 QUESTIONS FROM THE PUBLIC

8.1 Within the papers there was a written response to a question raised by the public; however, this person had felt that the question he had put to us differed from the one recorded in our papers. Neil Savage, Director of HR & Organisational Development [DoHR&OD] agreed to make contact and clarify the exact questions.

8.2 Agreed: The DoHR&OD to provide a further response

9.0 SERVICE EXPERIENCE QUARTERLY REPORT

9.1 John Trevains, Director of Nursing, Therapies and Quality [DoNTQ] confirmed there were two reports due to the merger of the two organisations. Work was underway to integrate these reports in the future.

9.2 Two service user experience teams had been relocated and he provided further insight into the headlines included within the full report.

9.3 Effort was being placed on responding to complaints more speedily and taking lessons from complaints - an area where improvement was needed.

9.4 In answer to a question from Jan Marriott it was confirmed that whether an issue was a formal complaint or a concern was identified with the person concerned. There was Trust wide guidance on this matter. In addition confirmation was given that a process was being put in place to ensure lessons were learned from service quality visits and that appropriate action would be subsequently taken. In addition reports would be received by the Executive Team.

9.5 Marcia Gallagher drew attention to the large number of complaints linked to poor communication and asked whether the new organisation could tackle this. John Trevains, DoNTQ confirmed the commitment of the team to improving this problem and sharing learning and referred to consumer experience initiatives in certain areas which had shown benefits.

9.6 John Campbell, COO had recently attended an event which had highlighted the importance of professional staff hearing from users of their experiences. A focus should be on changing the relationship between professionals and users and carers. In response to a challenge to provide timeframes around implementation and improvement, the DoQ confirmed that a previous process had recommenced and he would be reporting progress in future quality reports to the Board.

9.7 **Agreed: The Service Experience Quarterly report was received and noted.**

10.0 QUALITY REPORT

10.1 John Trevains, DoNTQ invited his deputy Michael Richardson, Deputy Director of Nursing [DDoN] to introduce the attached reports. Due to the merger of two organisations there were two reports included. Work has taken place with service commissioners in order to support a more helpful end of year presentation.

10.2 Good progress was reported following the merger, by bringing together expertise from both organisations. The indicators within the report were highlighted and where dips in performance were evident a deep dive exercise was underway.

10.3 It was proposed to undertake a more granular approach to pressure ulcer detail and consideration is currently underway as to how best to present this. There had been a recent programme of displays within the Trust to focus on ulcer pressure management.

10.4 Clarification on waiting times for minor injuries was requested. The CEO confirmed that there had been successful recruitment to hopefully ease the problem, however, this was an issue for the Trust and we will be reviewing how we manage minor injuries pressures. It was agreed that an update report would be presented by John Campbell, COO at the Board's next meeting.

10.5 Sue Mead recommended a more forensic analysis of the issues surrounding ulcers. She believed the Quality Committee would benefit from this. She highlighted a distinction between acquired and unavoidable ulcers.

10.6 Delays in the reporting cycle and areas where the Trust is below trajectory needed urgent attention. The Executive was asked whether there was confidence that there would be greater momentum in these areas. Michael Richardson, DDoN reported that in connection with falls following a meeting with the head of community hospitals, greater assurance had been provided. Bedside recording had caused a level of inaccuracy.

10.7 In relationship to assessments for medication there are two separate assessments, one more immediate, and the other within 24 hours. Investigation into this matter had shown there to be recording anomalies.

10.8 Sue Mead drew attention to the benefit of benchmarking to aid understanding variations. She requested effort be placed on more detailed benchmarking, comparing our performance with peers.

10.9 Maria Bond confirmed that a deep dive presentation had provided significant information concerning pressure ulcer management.

10.10 Graham Russell drew attention to a newer event involving the extraction of an incorrect tooth. He believed this had happened on a previous occasion. This was reported to be mainly due to human error, but had led to an improvement in systems.

10.11 It was noted that oral health promotion was regarded as very good in connection with Learning Disability services. Jan Marriott questioned whether this would be commissioned in the future. John Trevains, DoNTQ confirmed that work locally was being undertaken to establish services that were important for service users, and that nationally oral health was seen as a priority. Neil Savage, DoHR&OD confirmed that a paper was to be presented to the next Work Force Group meeting in connection with promotion and training. Louise Moss confirmed that NHS England had made an approach to fund the commencement of an oral health programme. In connection with the extraction it was confirmed that this also involved a system partner.

10.12 Referring to paper item 10.1 concerning Mental Health and Learning Disability services, the quality measures on pages 15 & 16 showed a mixed picture. Discharge planning could be seen as an area of significant concern. Focused work in some service areas had demonstrated improvements and this work was to be revisited.

10.13 People feeling involved in their care was below target and work is already commencing with the relevant teams.

10.14 Restraint is receiving attention and new approaches are being reviewed in Learning Disability Services. A new appointee has experience in reducing restraint. A question was raised concerning whether it was capacity or perception that is involved in assessments and was this tested at the Quality Committee. John Trevains, DoNTQ explained there were four components and on one we are 10% below target. Work was on-going, but the figure demonstrated more work was needed. The Patient Experience Team was engaged on this matter.

10.15 The Chair noted that there was a marked difference in discharge performance between wards. She hoped that this would be picked up and given attention.

10.16 John Campbell, COO referred to suicide data pointing out that work was needed across the Integrated Care System as this matter was wider than this Trust's services. It was questioned whether the incident review process involved the criminal justice system and if there was an interface with our services. Marcia Gallagher wished to liaise with the DoQ outside the meeting concerning this, however, the DoQ confirmed there were good working relations and that he would have a more detailed look at the case in question.

10.17 **Agreed: An update report to be presented by the COO to the next meeting, on management of minor injuries**

Subject to the above agreed action the report was received and noted.

11.0 AUDIT OF COMPLAINTS

11.1 Maria Bond referred to the report. A greater focus was still needed on capturing learning from complaints and embedding this within the organisation. Standardisation of responses and styles would also be helpful. It had become apparent to her the very difficult situations that our staff face on a daily basis.

11.2 It was agreed that the DoQ would report back on the issue of more standardised complaint responses at the next Board meeting.

11.3 It was important to ensure that the random selection of complaints for scrutiny was across the complete Trust.

11.4 **Agreed: The DoQ would report back on the issue of more standardised complaint responses at the next Board meeting.**

Subject to the above agreed action the report was received and noted.

12.0 PERFORMANCE REPORT

12.1 Sandra Betney, Director of Finance [DoF] explained that there would be a move towards exception reporting with greater statistical analysis instead of the current traffic light reporting. The system would be more automated, but also involve engagement with services.

12.2 An interactive display is planned for the Resources Committee and other Board members were welcome to attend. It will allow drill down for more detail and will give a more detailed picture of what is happening at ground level.

12.3 Duncan Sutherland suggested it would be more helpful for numbers to be included in addition to percentages. The DoF confirmed that this was recognised and that feedback would be sought from the users. There was a timetable to more to a more consistent approach and review of KPIs. This would include a review of which KPIs should be included in reporting. This Board would need to agree the levels of reporting and whether more granular detail is done for other committees. The timetable demonstrated the timing for the receipt of information. This report aims to show the critical information that needs to be viewed. The COO confirmed that work was taking place with commissioners on the formulation of KPIs.

12.4 A question from Maria Bond concerned the Trail Blazer project and that the Trust was aiming for an 18 week target for March end. The target would be met by end of December, however, workforce gaps needed to be understood and addressed and this was being looked at. The CEO asked JT to make the paper available to members.

12.5 Neil Savage, DoHR&OD reminded Board members of the importance of fully understanding the impact that newly commissioned services has on our own resources. John Campbell, COO supported this view as new service introductions do impact on the delivery of our own core services and this needs to be fully understood and recognised by service commissioners.

12.6 Sue Mead drew attention to waiting times for Therapy Services. This is a long standing problem which needed examination. Long waits do matter. Continuity and learning from staff turnover and recruitment is important as is working practises.

12.7 Graham Russell referred to the school nursing team in Cirencester who had recently indicated to him that a large amount of their time is spent on safe-guarding issues. He had also heard that family support services were struggling and using locums and that the problems were caused by constant change of social workers preventing the building of relationships with clients. He referred to the high exclusion rates in schools and questioned whether incorrect assumptions were being made that strong support services would be available.

12.8 Members discussed the current pressure that the Trust is placed under in dealing with young service users where provision to meet needs is not always available. This was not an area that this Trust could solve alone, but we should work with partners and support them in this very important area. A strategic solution was needed. The CEO felt that this was an area that needed greater focus by the ICS.

12.9 John Campbell, COO was asked to provide details on the timescale for the strategy on children's services.

12.10 **Agreed: COO to provide details on the timescale for the strategy on children's services**

Subject to the above action the Board received and noted the report.

13.0 FINANCE REPORT

13.1 Sandra Betney, DoF explained that the Trust was required to produce a final set of accounts for the part year that Gloucestershire Care Services [GCS] operated. As a result the report contained two sections.

13.2 The GCS closing position was being reviewed by external audit and would then be referred to the Audit and Assurance Committee in February. In March it would be presented as part of a condensed AGM. Generally the position presented was as expected, but moving forward the Board would need to consider how this element would be reported.

13.3 In respect of the combined report a number of key areas were highlighted including the agency staff overspend and cost improvement programmes (CIP). This year's CIP was considered a low risk, however, posed a significant risk recurrently. The disparity in capital spend between GCS Trust and 2gether Foundation Trust was noted and that good progress was being made with certain capital underspends.

13.4 Duncan Sutherland noted long standing problems in meeting capital targets and hoped that now the two organisations had merged this could be improved. He questioned whether a deep dive exercise would be helpful via the Resources Committee.

13.5 The risks associated with the local health economy were recognised. The DoF confirmed that the 2019/20 position was manageable however; the challenge in reaching this position was significant. Graham Russell wished to thank the DoF and her team. The Board recognised that this had been a tough year.

13.6 Movements in use of agency staff could have a huge impact on the Trust's position. Similarly in connection with the Forest of Dean it is important to make sure there is correct provision both capital and revenue to ensure the facility and services are fit for purpose.

13.7 The CEO confirmed the high level focus on agency staffing confirming that the priority was 'safety first'. The DoHR&OD confirmed that he and the COO will be providing information on this at the next Resources Committee meeting. Marcia Gallagher was aware that the previous 2gether Board had made a conscious choice to employ agency staff to meet IAPT targets. The COO confirmed that this was contributory factor, but that recruitment and retention work had been successful.

13.8 **Agreed: The Board received and noted the report.**

14.0 BOARD ASSURANCE FRAMEWORK

14.1 The Chair introduced the Board Assurance Framework stressing that this was at a very early point of development, but was designed to provide the Board with an outline of the style and direction of travel. Simon Crews, Interim Trust Secretary confirmed that much further work was needed and that the paper provided the

starting point from which a fully developed BAF would emerge. A useful approach might be for the Board to spend development time building the BAF, although the strategic objectives which form the starting point of the BAF had yet to be finalised. The Board and Board Committees would receive further iterations of the BAF. He was asking the Board to agree the style and approach being taken and recommended that the Trust should adhere to the nationally recommended template as far as possible.

14.2 **Agreed: The Board supported the approach taken as outlined.**

15.0 LEARNING LESSONS TO IMPROVE PEOPLE PRACTICES

15.1 Neil Savage, DoHR&OD drew attention to a well published national case involving the suicide of someone following dismissal. The dismissal had been judged unfair. The review recommendations had been widely circulated. The NHSI are funding organisations to help review culture. The recommendations were outlined for the Board along with actions taken and planned.

15.2 Sumita Hutchinson referred to people's individual characteristics, questioning whether some level of predictability could be understood. Consideration was given to supporting people through more training for key staff.

15.3 Duncan Sutherland questioned whether a similar level of oversight could be introduced as is currently involved in the NED review of complaints.

15.4 The Chair questioned whether the Resources Committee could have a focused quarterly session involving the NEDs. The CEO supported NED engagement in this way with escalation where necessary.

15.5 **Agreed: The Chair agreed the matter be given greater consideration at a planned meeting in December involving NEDs**.

16.0 TERMS OF REFERENCE - RESOURCES COMMITTEE

16.1 The Chair reported that the Terms of Reference had been approved by the Board Committee and were now presented to the full Board for adoption.

16.2 **Agreed: The Board approved the Terms of Reference.**

17.0 TERMS OF REFERENCE - AUDIT & ASSURANCE COMMITTEE

17.1 The Chair reported that the Terms of Reference had been approved by the Board Committee and were now presented to the full Board for adoption.

17.2 **Agreed: The Board approved the Terms of Reference.**

18.0 TERMS OF REFERENCE - QUALITY COMMITTEE

18.1 The Chair reported that the Terms of Reference had been approved by the Board Committee and were now presented to the full Board for adoption.

18.2 **Agreed: The Board approved the Terms of Reference.**

19.0 GLOUCESTERSHIRE CARE SERVICES NHS TRUST CHARITIES - TRUSTEES' REPORT AND FINANCIAL STATEMENT FOR YEAR END 31 MARCH 2019

19.1 The financial statement for year-end 31March 2019 as presented was received and approved by the Trust Board.

20.0 STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD OF DIRECTORS

20.1 The Standing Orders which had been subject to only minor adjustment to reflect the new organisation were received and approved by the Trust Board.

21.0 COUNCIL OF GOVERNORS MINUTES - 18TH JUNE 2019

21.1 The minutes of the meeting held on 18th June 2019 were received and noted by the Trust Board.

22.0 2G MENTAL HEALTH LEGISLATION SCRUTINY COMMITTEE – SEPT 2019

22.1 The minutes of the meeting held on 11th September were received and noted by the Trust Board.

23.0 MENTAL HEALTH LEGISLATION SCRUTINY COMMITTEE – NOV 2019

23.1 The Board was made aware of a visit by the CQC to the Mulberry Ward at Charlton Lane.

23.2 The Board was asked to note potential slippage in training connected with Liberty Protection and Safeguarding.

24.0 QUALITY COMMITTEE SUMMARY – OCTOBER & NOVEMBER 2019

24.1 John Trevains, DoNTQ confirmed that there had been two meetings of the Quality Committee on 16th October 2019 & 7th November 2019 and the attached report provided an overview. This report highlighted achievements, how risk is being responded to and where improvements need to be made.

24.2 The pressure that services were working under was highlighted along with the use of agency staffing. There was a desire for a focus to be given to staff wellbeing.

24.3 The report highlighted a range of related service quality aspects and the potential impact across the organisation.

24.4 **Agreed: The Trust Board received and noted the report.**

25.0 AUDIT & ASSURANCE COMMITTEE SUMMARY – NOVEMBER 2019

25.1 The summary report from the Audit and Assurance Board Committee on 6th November 2019 was received and noted.

26.0 RESOURCES COMMITTEE SUMMARY – OCTOBER 2019

26.1 The summary report from the Resources Committee on 24th October 2019 was received and noted.

27.0 ANY OTHER BUSINESS

27.1 There were no further matters of business raised.

28.0 QUESTIONS FROM THE PUBLIC

28.1 There were no questions from the public.

29.0 DATE OF NEXT MEETING

29.1 Wednesday 29th January 2020, at
Forest Green Rovers Football Club, Carol Embrey Suite, The New Lawn Stadium, Another Way, Nailsworth, Gloucestershire, GL6 0FG

Signed: ……..….. **Dated: ……**

Ingrid Barker (Chair)
Gloucestershire Health and Care NHS Foundation Trust

TRUST BOARD: PUBLIC SESSION - Matters Arising Action Log – 29 January 2020

Key to RAG rating:

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

Minute reference (Item No. & Date)	Item	Action Description	Assigned to	Target Completion Date	Progress Update	Status
28 Nov 2019	08.2	Further response to be submitted to the member of public who had raised question.	Director of Human Resources & OD	29 January 2020	On agenda	
28 Nov 2019	10.4	Management of Minor Injuries pressures progress report.	Chief Operating Officer	29 January 2020	On agenda – CEO report	
28 Nov 2019	11.2	Standardised complaint responses for future Board meeting.	Director of Quality	29 January 2020	Update to be provided at meeting	
28 Nov 2019	12.9	Further details to be provided in the timescale for the Children's Services Strategy.	Chief Operating Officer	29 January 2020	Update to be provided at meeting	

AGENDA ITEM: 06/0120

QUESTION FROM A MEMBER OF THE PUBLIC – TRUST BOARD - JANUARY 2020

How does the evaluation report on Workforce Race Equality Standard (WRES), support and enhance the work of the Gloucestershire Health and Care NHS Foundation Trust in implementing the WRES.? How will the Trust evidence that the use of the WRES information has made a meaningful and positive impact to Workforce Race Equality at Gloucestershire Health and Care NHS Foundation Trust?

Trust response:

We have used a number of resources to inform our approach to the Workforce Race Equality Standard (WRES). These have included review of the 2019 "A Model Employer: Increasing black and minority ethnic representation at senior levels across the NHS" - the WRES Leadership Strategy, the Long Term Plan, evaluation of the legacy Trusts' NHS Workforce Race Equality Standard data and reference to the "Evaluation of the NHS Workforce Race Equality Standard". The latter provided an independent report on an initial evaluation of the national data in January 2019.

The Trust has a named Executive responsible for ensuring commitment and momentum, and, the Board as a whole has committed to delivering improvements in equality and diversity through its adoption of a Valuing Difference Leadership strategy and action plan, which includes the roll out of Reciprocal Mentoring across the Trust, the formation of a Valuing Difference Staff Network alongside the annual WRES report and action plan.

The WRES actions are being taken forward operationally by the Workforce Management Group chaired by the Director of HR and OD, and reported via the Resources Committee.

At the end of October 2019, the Trust received from Yvonne Coghill, the national Director - WRES Implementation Team - aspirational targets for our legacy Trusts. These have been initially considered at the November 2019 Workforce Management Group's meeting and will be incorporated into our 2020 action plan. These include 10-year ambition modelling and targets for increased recruitment of BME staff into more senior levels of the workforce. This action plan is expected to be signed off in February with progress being reported via the Workforce Management Group and the Resource Committee.

The Trust will measure progress via delivery of the WRES action plan, how colleagues rate the Trust on the related metrics through the Staff Survey, the BAME representation in senior roles, and the annual WRES report scores.

AGENDA ITEM: 07/0120

REPORT TO: Trust Board – 29 January 2020

AUTHOR: Ingrid Barker, Chair

PRESENTED BY: Ingrid Barker, Chair

SUBJECT: **CHAIR'S REPORT**

Can this subject be discussed at a public Board meeting?	Yes

This report is provided for:

Decision Endorsement **ASSURANCE** **INFORMATION**

PURPOSE OF REPORT

To update the Board and members of the public on my activities and those of the Non-Executive Directors to demonstrate the processes we have in place to inform our scrutiny and challenge of the Executive and support effective Board working.

RECOMMENDATIONS

That the Board note the report and the assurance provided.

EXECUTIVE SUMMARY

Executive Summary

Since the last meeting we have continued to put in place key building blocks for the development of the "new" Board. We have had two Board Development sessions to take forward the development of the new strategic vision and direction of the Trust and work will continue on these in coming months, with co-production embedded into this work.

Another key building block has been our new Head of Corporate Governance, Lavinia Rowsell, taking up her appointment at the start of January 2020. I am delighted to welcome Lavinia to the team and look forward to her contribution as experienced governance professional. The importance of strong governance to support an effective well-led Trust is well recognised and I am sure Lavinia will help us ensure this is in place.

I would also like to thank Kate Atkinson, public governor since 2017; Stephen Wright, public governor since 2019; and Mike Scott, public governor since 2017 who have recently stepped down from the Council of Governors. I'd also like to congratulate our two most recently elected Staff Governors – Karen Bennett and Anne Roberts. Karen

and Anne, along with all of our other Governors (staff and public) play a vital role in holding the non-executive directors of the Trust to account for the performance of the board of directors. We are currently holding another election process for Staff Governors to fill vacancies in the Medical, Dental and Nursing staff class and the Health and Social Care Professions class. We are fortunate to have Simon Smith as our Interim Lead Governor during a period of 'Review and Refresh' for the Council. I am pleased to report that he has agreed to extend his term for a further six months.

My report also includes updates on:

- Working with our system partners
- Working with our colleagues
- National and Regional Meetings attended and any significant issues highlighted

CORPORATE CONSIDERATIONS	
Quality implications:	
Resource implications:	
Equalities implications:	
Risk implications:	

WHICH TRUST VALUES DOES THIS PAPER PROGRESS (P) OR CHALLENGE (C)?			
Working together	**P**	**Always improving**	**P**
Respectful and kind	**P**	**Making a difference**	**P**

CHAIR'S REPORT

1.0 INTRODUCTION AND PURPOSE

This report seeks to provide an update to the Board on the Chair and Non-Executive Directors activities in the following areas:

- Board
- Working with our system partners
- Working with our colleagues
- National and Regional Meetings attended and any significant issues highlighted

2.0 BOARD

2.1 Non-Executive Director Update

The Trust's Constitution allows for there to be a full complement of 7 Non-Executive Directors (NEDs). In addition to this the regulator's Code of Governance requires that "At least half the board of directors, excluding the chairperson, should comprise non-executive directors determined by the board to be independent."

Following our recent recruitment exercise in December, we are pleased to announce the appointment of Dr. Stephen Alvis MBChB (Bristol) 1982, DRCOG, MRCGP (FP Cert**)** as an Associate Non-Executive Director. Dr Alvis was a GP Partner since 1987. He also helps the Primary Care Trust as a Quality and Outcomes Framework Assessor. Dr. Alvis also undertakes surveys on behalf of the Healthcare Accreditation Programme and is a member of the Local Medical Committee Gloucestershire.

This, however, still leaves us with a vacancy for a 7th substantive NED and the Nomination and Remuneration Committee met on the 9th January to consider this and make a recommendation to the Council of Governors.

Their recommendation was put to the Council of Governors at their meeting on 21st January 2020 and received their unanimous support.

The recommendation of the Nomination and Remuneration Committee was that the Trust should proceed immediately to recruit a 7th NED. That having reviewed the skills and experience of the existing Non-Executive Directors, emphasis should be placed on recruiting someone who has a history of business and commercial experience. Following advice from the Director of Human Resources and Organisational Development it was recommended that the Trust should utilise the expertise of a specialist recruitment firm from the national NHS Framework of providers, as this approach has resulted in the highest degree of success historically.

The remuneration for this position will be in line with the approved pay structure for NEDs.

2.2 A Board Seminar was held on 3rd December, which was the first of three sessions scheduled where the Board will be focusing on developing a new strategic vision and direction for the Trust. Two further sessions were held on 15th and 16th January 2020 where we continued to work on developing a strategic framework.

3.0 NATIONAL AND REGIONAL MEETINGS

I attended the NHS Providers Chairs and CEOs meeting on 5th December where we had presentations on Provider Collaboration; an update on the Clinical Review of Access Standards, along with strategic and policy updates.

The Clinical Review of Access Standards is an issue of key interest to Trusts and service users, reflecting an ongoing review of access standards to ensure that they measure what matters most to patients, and clinically. The interim report was published in March 2019, setting out proposals to test new access standards in mental health services, cancer care, elective care and urgent and emergency care, to see whether they can be used safely and improve patient experience and outcomes.

Since then, the NHS nationally has been working to identify and support local teams to test how the different proposals work in the real world. A Clinical Oversight Group is helping guide the programme, as are individual advisory groups for each workstream made up of patient groups, national charities, and clinical representatives. This engagement, and the expertise that people have contributed throughout, has been an important part of this process, and will continue alongside further testing and evaluation. The update was a helpful summary of the current position and consideration of potential future changes to ensure as a Trust we are prepared for changes, and are already able to reflect on patient and clinical key drivers.

I attended the two-day NHS Providers Board Annual Strategy Sessions on 8th and 9th January where we were pleased to welcome Sir Ron Kerr as the new Chair of NHS Providers. Sir Ron's long and distinguished career in health service management, including ten years as one of the country's leading provider chief executives, with experience spanning acute, community and primary care services, as well as mental health and social care, provider, commissioning organisations and sustainability and transformation partnerships means he brings a stimulating and challenging perspective which we will benefit from during his tenure.

These events help to ensure NHS Trusts are working collectively to deliver the Long Term Plan and that time is not spent unnecessarily reinventing wheels when another Trust has been through a detailed process with proven good practice as an outcome.

4.0 WORKING WITH OUR PARTNERS

I have continued my regular meetings with key stakeholders and partners; highlights are as follows:

Along with the CEO, I attended a meeting of the Gloucestershire ICS Board on 12th December. Matters discussed included updates on Clinical Programme Group (CPG) priorities and the NHS Long Term Plan. The next meeting is scheduled to be held on 23rd January and a verbal update will be given at Board.

Following interviews held in November for the ICS Independent Chair, Dame Gill Morgan was successfully appointed and took up her position on 1st January. I held an introductory meeting with her on 9th January. Gill was Chair of NHS Providers until Dec 2019. Following a career as a doctor, Gill was permanent secretary of the Welsh Assembly government, chief executive of the NHS Confederation and chief executive of North and East Devon Health Authority. Gill is a fellow of the Royal College of Physicians and the Faculty of Public Health. This breadth of experience, and her respected national profile, will prove invaluable in supporting the further development of the ICS.

Along with the Director of Strategy and Partnerships (Angela Potter) I attended a regular meeting of the Gloucestershire Health Overview and Scrutiny Committee (HOSC) on 14th January 2020. The meeting considered matters relating to healthcare services across the county, including an update on Fit for the Future. This focused on the engagement exercise that has been undertaken, feedback.

A meeting of the Gloucestershire Health & Wellbeing Board took place on 21st January. The Trust was represented at this meeting by the Chief Operating Officer, John Campbell. Matters discussed included long-term plan update finalisation of the Gloucestershire Health and Wellbeing Strategy and Children's Health and Wellbeing Strategy.

I have been represented at a number of important Herefordshire meetings by Non-Executive Director, Duncan Sutherland, as summarised in the NED activity report later in this paper.

5.0 WORKING WITH THE COMMUNITIES AND PEOPLE WE SERVE

The Trust's excellent series of Better Care Together events have continued including:

4th December 2019 – "Personalisation: with you, for you". This is at the heart of everything that our new Trust aspires to achieve for the people who use our services. To support us and the wider Integrated Care System in further developing our aspirations to deliver truly personalised care, we heard from the internationally acclaimed inspirational speaker Chris Lubbe, who is currently working with NHS England supporting the promotion of personalised care.

These sessions continue to be key to how we develop our organisation as we move forward. We really appreciate the time that our community is giving to support these key activities – we really do need your continuing help to achieve our aims, and events like these will become part of our ongoing co-production processes. I recognise that many people are volunteers and certainly all are juggling a range of responsibilities which makes the level of engagement we are achieving even more remarkable.

Along with the Chief Executive, on 19th December I attended the Annual Carol Service at Tewkesbury Abbey. This was a very enjoyable event arranged by the Gloucestershire Constabulary, the Office of the Police and Crime Commissioner and Gloucestershire Fire & Rescue Service.

On 22nd January, the Chief Executive, Director of Strategy and Partnerships and I were invited to meet with the Leader of the Forest of Dean District Council, along with representatives from the Council where matters discussed included the new Community Hospital.

6.0 ENGAGING WITH OUR TRUST COLLEAGUES

I attended the Hereford Senior Management Network on 9th December where topics discussed included TUPE, Transitional work and governance arrangements and an update on community mental health service development.

I was very pleased to be invited along to the Wotton Lawn Hospital Therapy Department on 17th December as part of the panel judging the best mince pie and Christmas wreaths – a very enjoyable duty!

I visited the Dilke Hospital in Cinderford on Christmas Day to thank colleagues for working. Whilst there I encountered Santa (*Robert Young, Chair of the Dilke League of Friends*) delivering presents to patients.

I attended a meeting of the Mental Health Act Managers Forum at Charlton Lane Centre on 18th December, along with Non-Executive Director Jan Marriott. I and other NEDs have subsequently undertaken training on the Mental Health Act.

Whilst on the Charlton Lane site, Jan Marriott and I were also able to visit the Managing Memory team at the Fritchie Centre joining them for their Christmas lunch.

A Non-Executive Directors meeting took place on the afternoon of 18th December and was held at the Charlton Lane Hospital in Cheltenham. A series of regular meetings have been arranged for this year and all will be held within service venues.

I attended the Trust's Resources Committee on 19th December.

A meeting of the Council of Governors took place on 21st January where we undertook a strategy workshop led by Director of Strategy & Partnerships, Angela Potter, developing the strategic aims for the new organisation.

I continue to have a range of 1:1 sessions with Executive and Non-Executive colleagues as part of my regular activities.

7.0 NED ACTIVITY

Activities undertaken by the Trust's Non-Executive Directors are detailed below:

Graham Russell

- Board Seminar
- Better Care Together Personalisation event
- Meeting with NED Sumita Hutchison and Stroud League of Friends Chair Roma
- Walker
- Senior Leadership Forum
- Clinical Interview panel member
- Non-Executive Directors Meeting
- Resources Committee
- Estates Strategy Meeting
- Meeting with CEO and Trust Secretary
- Nomination and Remuneration Committee
- Board Strategy (2 days)
- Council of Governors
- Mental Health Act training session
- ICS Board

Jan Marriott

- Board Seminar
- Better Care Together Personalisation event
- Mental Health Operational Managers Meeting
- Quality Committee x 2
- Meeting with Interim Lead Governor
- Medical Education Update Mental Health Act
- Meeting with Freedom to Speak Up Guardian
- Mental Health Act Managers Forum
- Managing Memory Xmas Lunch
- Meeting with Sumita Hutchison, Non-Executive Director
- Resources Committee
- Non-Executive Directors Meeting
- Meeting with Head of Corporate Governance
- Consultant Clinical Excellence Awards
- ICS NED/Lay Member meeting
- Board Strategy (two days)

Maria Bond

- Board Seminar
- Better Care Together Personalisation event
- Telephone meetings with Director of Nursing
- Quality Committee x 2
- Visit to Independent Living Centre, Cheltenham
- Council of Governors meeting
- Task and Finish Group
- Board Strategy (two days)

Marcia Gallagher

- Board Seminar
- Better Care Together Personalisation event
- Mental Health Act Hearing Panel
- Autism Partnership Board
- NEDs meeting
- Meetings regarding ongoing complaint
- Meeting with Director of Nursing
- Meetings with Chair and CEO
- ICS NED/Lay Member meeting
- Board Strategy (two days)
- Task and Finish Group
- Council of Governors meeting

Sumita Hutchison

- Board Seminar
- Quality Committee x 2
- Meetings with Director of HR
- Meeting with NED Graham Russell and Stroud League of Friends Chair Roma Walker
- Resources Committee
- Board Strategy (2 days)
- Council of Governors
- Mental Health Act Training
- People Participation meeting

Duncan Sutherland

- Board seminar
- Hereford Senior Management Network x 2
- Meeting with Hereford CCG
- NEDs meeting
- Resources Committee
- Estates Strategy Meeting
- Hereford Health & Well-being Board
- Hereford ICAB
- Board Strategy (two days)

Sue Mead (Associate)

- Quality Committee x 2
- Non-Executive Directors meeting

7.1 Non-Executive Directors' Portfolios as at January 2020 – see table on Page 9.

8.0 Conclusion and Recommendations

The Board is asked to **NOTE** the report and the assurance provided.

NON-EXECUTIVE DIRECTORS' PORTFOLIOS – as at JANUARY 2020

LOCALITY	NON-EXECUTIVE DIRECTOR	CHAMPION	* AUDIT	CHARITABLE FUNDS	MENTAL HEALTH ACT	QUALITY	REMCOM /ATOS	RESOURCES
Tewkesbury	**Dr Stephen Alvis** (Associate)				✔ (Vice-Chair)	✔		
Herefordshire	**Duncan Sutherland**	• Safeguarding			✔		✔	✔
	Sue Mead (Associate)					✔		
Cheltenham	**Jan Marriott**	• FTSU • Learning Disabilities • Learning from Death			✔ (Chair)	✔ (Vice-Chair)	✔	✔
Cotswold	**Maria Bond**	• Emergency Planning	✔ (Vice-Chair)			✔ (Chair)	✔	
Forest	**Marcia Gallagher** (SID)	• Counter-fraud, Security and Procurement	✔ (Chair)	✔ (Vice-Chair)			✔	
Gloucester	**Sumita Hutchison**	• Equality and Diversity • Climate Protection		✔ (Chair)		✔	✔	✔ (Vice-Chair)
Stroud	**Graham Russell** (Vice-Chair)		✔	✔			✔	✔ (Chair)

*All NEDs are members but 3 are nominated as regular attendees

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AGENDA ITEM: 08/0120

REPORT TO: Trust Board – 29 January 2020

AUTHOR: Chief Executive Officer and Executive Team

PRESENTED BY: Paul Roberts, Chief Executive Officer

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

Can this subject be discussed at a public Board meeting?	Yes

This report is provided for:			
Decision	Endorsement	**ASSURANCE**	**INFORMATION**

PURPOSE OF REPORT
To update the Board and members of the public on my activities and those of the Executive Team.

RECOMMENDATIONS
The Board is asked to note the report.

EXECUTIVE SUMMARY
This report is my second since the formal transition from ^{2}gether NHS Foundation Trust and Gloucestershire Care Services NHS Trust to Gloucestershire Health and Care NHS Foundation Trust. We are continuing to move forward with even more concentration on the key driver for the merger – transformation. I am excited to see how with colleagues and service users and their families and carers we can make change our services to better meet their needs – something I know that I and the rest of the Board are passionate about. The Report also updates on:

- CEO Engagement
- Partnership Activities
- National and Regional meetings attended
- Herefordshire Integrated Working Update
- Brexit Preparedness
- Executive Update
- Operational Update

CORPORATE CONSIDERATIONS	
Quality implications:	Any implications are referenced in the report
Resource implications:	Any implications are referenced in the report
Equalities implications:	None identified
Risk implications:	None Identified

WHICH TRUST VALUES DOES THIS PAPER PROGRESS (P) OR CHALLENGE (C)?			
Working together	**P**	Always improving	**P**
Respectful and kind	**P**	Making a difference	**P**

Report authorised by: Chief Executive Officer and Executive Team	**Date:** 21 January 2020

Where has this issue been discussed before?
Workforce Management Group
What wider engagement has there been?
As referenced in the report.

Appendices:	Report attached

CHIEF EXECUTIVE OFFICER AND EXECUTIVE TEAM REPORT

1.0 CHIEF EXECUTIVE ENGAGEMENT

I remain committed to spending a significant proportion of my time vising front-line services and meeting frontline colleagues in a variety of settings in both organisations and continue to be impressed and heartened by the professionalism and commitment of colleagues across the organisations and in the pride that they take in the delivery of, in many cases, outstanding services. You will have seen from headlines in the papers the ongoing pressures which the NHS is responding to. Our Trust continues to play an important role in the Gloucestershire system with colleagues working committedly to meet the needs of our community.

I have continued to attend a range of meetings including:

Council of Governors meetings - these are reported on in the Chair's report and elsewhere in this agenda.

Corporate Induction – I welcomed new colleagues on 6th and 20th January, where I gave the Executive overview. I plan to attend, representing the Board, as many of these sessions as possible in the future as I am keen to demonstrate from day 1 that as an Executive team we are approachable and open to ideas. New starters have fed back positively this approach.

Senior Leadership Workshop – 16th December this was a workshop session which considered our leadership culture and focused on agreeing a response to the Interim People Plan and to implement the vision, values and behaviours of GHC
Linda Gabaldoni, Head of Organisational Development has been key in supporting this work. I was pleased with the energy and enthusiasm displayed at the session – reflecting how central these issues are to the effective operation of the Trust. This session fed into the Board Development Sessions in December and January.

Senior Leadership Network – two meetings have been held on 17th December and 17th January.

These sessions continue to be really helpful opportunities to discuss Trust and county wide issues across the wider Trust leadership.

Last report I updated on the Trust's excellent series of Better Care Together events

- 02 October – Focus on Learning Disabilities (Opportunity, Inclusion and Equality)
- 18 November – Our Joint Intent
- 27 November – Celebrating Community Assets, people, places and partners.

The output of these sessions have been an important element of the strategic sessions held by the Board.

We will continue with these events in coming months and the next will be in February. These are a core part of our commitment to co-production.

I attended the JNCF meetings on 6th December and 7th January. As usual this was an effective meeting with attendees prepared to raise concerns and issues – again a demonstration of the open organisation we are determined to foster.

I hosted a Team Talk session at Stroud Hospital on 13th January. Other members of the Executive cover other venues across the county and we pull together themes from feedback which again help to ensure effective communication across the Trust.
It was also an opportunity to recognise the work of colleagues which continues across the festivities. The way colleagues go the extra mile to make it a special time is much appreciated by service users and their families.

I attended a meeting of the Associate Medical Directors and Clinical Directors on 20th December. These sessions are a helpful way to understand their perspectives and activities.

On 22nd January Tim Gwilliam, Leader of Forest of Dean District Council, invited the Chair, myself and Director of Strategy and Partnerships, to meet with the council's leadership team to discuss progress with the arrangements for the new community hospital.

On 12th December, Bren McInerney invited me to accompany him on two visits. The first was to The Butterfly Garden in Bamfurlong. I was delighted to meet Chris Evans, the inspiring Founder, to hear more about the invaluable work the Butterfly Garden does. It is an educational, therapeutic and recreational scheme, based initially on gardening, but now offering much more. It is a project for people of all ages dealing with disablement of any kind. The second visit was to SkillZone in Tuffley, Gloucester. This is Gloucestershire's only interactive life skills village where people of all ages can learn how to keep themselves safe whether at home or in their community. They offer safety education and bespoke programmes for schools and community groups. Working with the voluntary sector, through projects such as this, helps to enable them to support our community holistically.

2.0 PARTNERSHIP WORKING

I continue to have regular meetings with the CEO of Gloucestershire Hospitals NHS Foundation Trust (GHFT) and the Accountable Officer for Gloucestershire Clinical Commissioning Group (GCCG). I also continue to attend regular meetings of the ICS Board and ICS Executive which are focused on taking forward our joint One Gloucestershire ambitions.

Resilience during this period of particular pressures on the NHS has been an issue of continuing focus, with regular meetings with senior colleagues across the health system to ensure joined up working.

I had an introductory meeting with the newly appointed Chair of the ICS, Dame Gill Morgan, on 7th January. More about Gill is in the Chair's Report.

Fit for the future
As I advised in my last report feedback from this programme had been delayed due to the General Election. We have now updated to the Health Overview and Scrutiny Committee on 14th January 2020 on the outcome of the engagement into Fit for the Future and the engagement for the Forest of Dean Hospital. Full detail of the report is available from their site here HOSC Papers Jan 2020

The focus of the engagement was to:

- test and develop ideas to support our planning for inpatient services in the new hospital;
- find out what's important to local people in accessing consistent urgent (not life threatening) advice, assessment and treatment;
- gather feedback on the range of outpatient and diagnostic services that should be provided in the new hospital;
- understand what's important to local people when accessing services in the new hospital

The feedback is informing our next stages of planning.

As part of my work with the Gloucestershire ICS, I continue to lead on three major strategic works streams including chairing a meeting of the Diagnostics Programme Board on 9th January and the Urgent Care Project Board (part of the Fit for the Future programme) on 17th January.

I was pleased to have a catch up session with Sarah Scott, Director of Public Health, on 6th January. Ensuring the work of the Trust aligns effectively to the public health agenda is important in ensuring that we get best value for the Gloucestershire health pound.

I attended a regular meeting of the Medical Staffing Committee on 3rd January 2020.

3.0 HEREFORDSHIRE INTEGRATED WORKING DEVELOPMENTS

Colin Merker, Managing Director of Herefordshire Mental Health and Learning Disabilities Services and Duncan Sutherland Non-Executive Director continue to be heavily engaged in working with colleagues in Herefordshire and Worcestershire to further develop partnership working. An update on this work is a separate item on the agenda.

Along with Colin Merker, I attended the Hereford Senior Manager Network on 9th December to ensure that staff have the opportunity to be briefed directly and raise concerns.

4.0 NATIONAL AND REGIONAL MEETINGS ATTENDED

I attended the West of England Academic Health Science Network (AHSN) Board meeting on 6th December which provided helpful information on the opportunities and ways we could do things differently.

5.0 EU EXIT

The Trust continues to follow national guidance on this issue and respond to information requests from the Department of Health and Social Care/ NHS England/Improvement.

6.0 EXECUTIVE UPDATE

I wanted to formally update on the current and future arrangements for Deputy Chief Executive. At the moment and until the end of March 2020, Colin Merker and Sandra Betney remain as my two deputies as they have been since I started in 2018, running the two previous Trusts. In April, Sandra will continue as the single Deputy Chief Executive following on from Colin's second attempt to retire!

I am also delighted to congratulate John Campbell, Chief Operating Officer on his selection to participate in the prestigious Aspiring Chief Executive programme**,** run by the Leadership Academy. It was an incredibly competitive process to be elected. and I am delighted that John was successful.

7.0 OPERATIONAL UPDATE

7.1 Review of Hospital Food

You may be aware that TV personality and Chef Prue Leith is conducting a national review of NHS hospital food, having been asked to do so by the Secretary of State for Health, Matt Hancock.

She has been visiting various hospitals and facilities for this work and on 10th January she was with us in Gloucestershire – at Charlton Lane Hospital, in Cheltenham, and the Vale, in Dursley.

The visit went very well and has received coverage on social media as well as from the local BBC – BBC Radio Gloucestershire and BBC Points West.

We are pleased to be able to play a part in this as we appreciate the vital importance of nutrition and hydration in our hospitals, and their impact on patient health, wellbeing and recovery.

7.2 X-Ray Provision Community Sites

In 2018 following significant staffing issues GHFT presented a paper to HOSC to temporarily reduce the opening hours of x-ray at community sites. This meant:

- A reduction in weekday cover at Tewkesbury, Vale, Lydney and North Cotswolds Hospitals
- A reduction in weekend cover at Stroud Hospital
- A change of days across Dilke Hospital

GHFT have continued to actively recruit and use bank, agency or overtime where possible and appropriate in order to offer more hours at community sites. We saw an improvement in opening hours during 2019 and this has continued into 2020; whilst we are not at pre-2018 opening hours it is a significant improvement. The table below shows the pre-2018 opening days in blue and the 2020 opening days in red.

For the most part this is a sustained position with the exception of Tewkesbury and North Cotswolds where one day a week is dependent on additional staff availability and therefore cannot be guaranteed.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Cirencester	Yes/Yes	Yes/Yes	Yes/Yes	Yes/Yes	Yes/Yes	Yes/Yes	Yes/Yes
Stroud	Yes/Yes	Yes/Yes	Yes/Yes	Yes/Yes	Yes/Yes	Yes/**No**	Yes/Yes
Tewkesbury	Yes /**Sometimes**	Yes/Yes	Yes/**No**	Yes/Yes	Yes/Yes	NA	NA
North Cotswolds	Yes /**Sometimes**	Yes /**Sometimes**	Yes /**Sometimes**	Yes /**Sometimes**	Yes/**No**	NA	NA
Lydney	Yes		Yes		Yes	NA	NA
The Vale		Yes			Yes	NA	No/**Yes**

An outstanding concern is the timeliness of x-ray reporting and we continue to meet with colleagues at GHFT to agree joint standards and ways to improve the process.

8.0 Conclusion and Recommendations

The Board is asked to **NOTE** the report and the assurance provided.

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AGENDA ITEM: 09/0120

Report to: Trust Board - 29 January 2020

Author: Angela Potter, Director of Strategy & Partnerships

Presented by: Hazel Braund, Programme Director, Better Care Together

SUBJECT: **DEVELOPING OUR TRUST STRATEGY**

Can this subject be discussed at a public Board meeting?	Yes

This report is provided for:			
Decision	Endorsement	Assurance	**INFORMATION**

PURPOSE OF REPORT

This report outlines the process that the Trust is following to engage colleagues, service users, carers, partners and wider stakeholders in developing the Trust's Strategy for the next five years.

RECOMMENDATIONS

The Board is asked to note and support the ongoing activities and timetable to develop the strategy through conversations and engagement with staff and wider stakeholders

EXECUTIVE SUMMARY

The Board has agreed that the Trust should move forward a process to engage colleagues, service users, carers, partners and wider stakeholders in developing the Trust's priorities for the next 5 years.

The approach taken should be consistent with the Trust's values, in particular its commitment to listening to those who deliver care, who use our services, carers, partners, stakeholders and all those who have an interest in the current and future provision of health and care in Gloucestershire.

Stage one of the engagement process will run from December 2019 to March 2020, when a paper will be taken to the Trust Board sharing a draft Mission, Vision and set of Strategic Aims and priorities that have emerged from the engagement process.

The Trust Board has undertaken 3 development days focused on the future strategy and direction for the Trust. This work has been undertaken in conjunction with the key

elements of Stage One of engagement which are set out in Appendix A. The ongoing co-creation of the strategy will run in parallel with, and be informed by the organisational development plan which includes embedding of the Trust's values, partnership working and co-production.

CORPORATE CONSIDERATIONS	
Quality implications	Consideration of quality implications and service user outcomes is at the heart of the strategy development.
Resource implications:	Resources have been identified to support the engagement process from within the existing teams and from existing budgets. The identification and allocation of any resources investments for the delivery of the strategy will be made through the annual planning process.
Equalities implications:	The Social Inclusion Team is leading engagement with seldom heard and hard to reach groups in our communities. The Strategy will take into account health inequalities across a number of strands.
Risk implications:	None Identified.

WHICH TRUST VALUES DOES THIS PAPER PROGRESS (P) OR CHALLENGE (C)?			
Working together	P	Always improving	P
Respectful and kind	P	Making a difference	P

Report authorised by:	**Date:**
Angela Potter, Director of Strategy & Partnerships	20/01/20

Where has this issue been discussed before?
Board Development & Executive Committee
What wider engagement has there been?
Engagement is ongoing and the paper describes the different elements of this.

Appendices:	Appendix A – Strategy Development Timeline

DEVELOPING THE TRUST'S FIVE YEAR STRATEGY

1.0 INTRODUCTION

Gloucestershire Health and Care NHS FT is a newly created organisation that now needs to set out its longer term direction and ambitions and clearly articulate its mission, vision and strategic aims and priorities.

To date the focus of attention has been on completing the transaction to enable the creation of the new integrated trust with the emphasis on creating a *Transforming Organisation.* The approach has deliberately not emphasised what the organisation needs to strive for or achieve in terms of overarching ambitions and more granular strategic goals and milestones. It is important that these are co-produced and wholly owned by the new Trust Board, our 4,000 colleagues and our patients, service users and stakeholders and therefore can only truly happen once all parties are fully wedded and bound by being part of the single integrated organisation from October 2019.

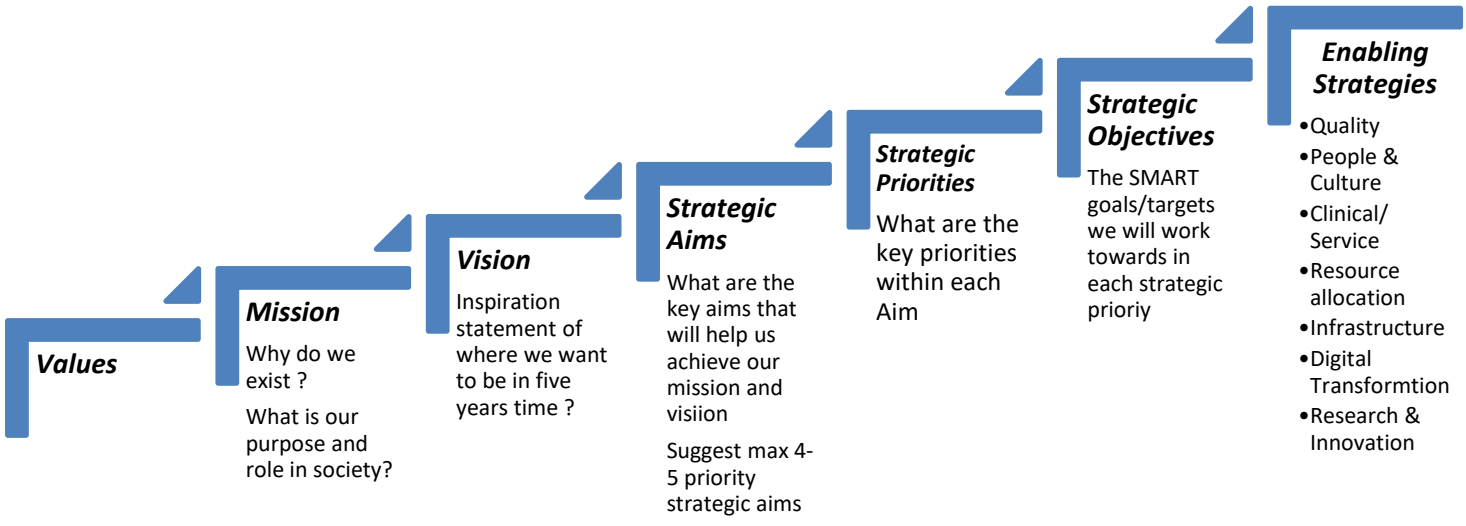
This paper outlines the work required to enable the development of the Strategy and the key success factors that need to be considered.

2.0 STRATEGY DEVELOPMENT PROCESS

Our strategy will build on the values work undertaken to date and the visioning work that the shadow board have already undertaken. In addition, we will adopt best practice guidance, including the Monitor Strategy Development Framework and learn where appropriate from those CQC Outstanding organisations that have well refined and embedded strategic frameworks.

The Trust Board have agreed the following components in terms of the development of the strategy at their development session on the 14/15th January. These are outlined below in Figure 1 below. A previously agreed timetable for strategy development is set out in Appendix 1.

Figure 1 – Strategy Components



The Trust Board has undertaken three development days focused on the future strategy and direction for the Trust. This work has been undertaken in conjunction with the key elements of **Stage One** of engagement which are:

a) Internal engagement (including colleagues, Governors, Members and Experts by Experience):
- On line survey
- Paper survey and collection points available for those for whom on line is not convenient
- Team discussions using resources (presentation and capture sheets) provided by the Strategy & Partnerships team in conjunction with support from the Communications & Engagement team
- Workshops at sites across the Trust
- Senior Leadership Network discussions

b) External engagement:
- Stands at 17 sites across the county for a day or half day
- Workshops and focus groups for Experts by Experience, seldom heard groups and other stakeholder groups
- Discussions and stands at scheduled meetings and events according to needs and wishes of the groups
- Perception Review delivered by external provider to ensure confidentiality and neutrality in reporting, including 20 to 30 in-depth interviews with key partners identified by Trust and on-line survey offered to approximately 200 stakeholders and partners
- Better Care Together conference on 19th February for colleagues, partners, service users, carers, stakeholders to share and discuss emerging priorities.

Stage Two of the engagement process will run from April to the end of June and will be used to test out the priorities identified in the first stage and move forward the next level of detail towards implementation of the strategy.

The ongoing co-creation of the strategy will run in parallel with, and be informed by the organisational development plan which includes embedding of the Trust's values, partnership working and co-production.

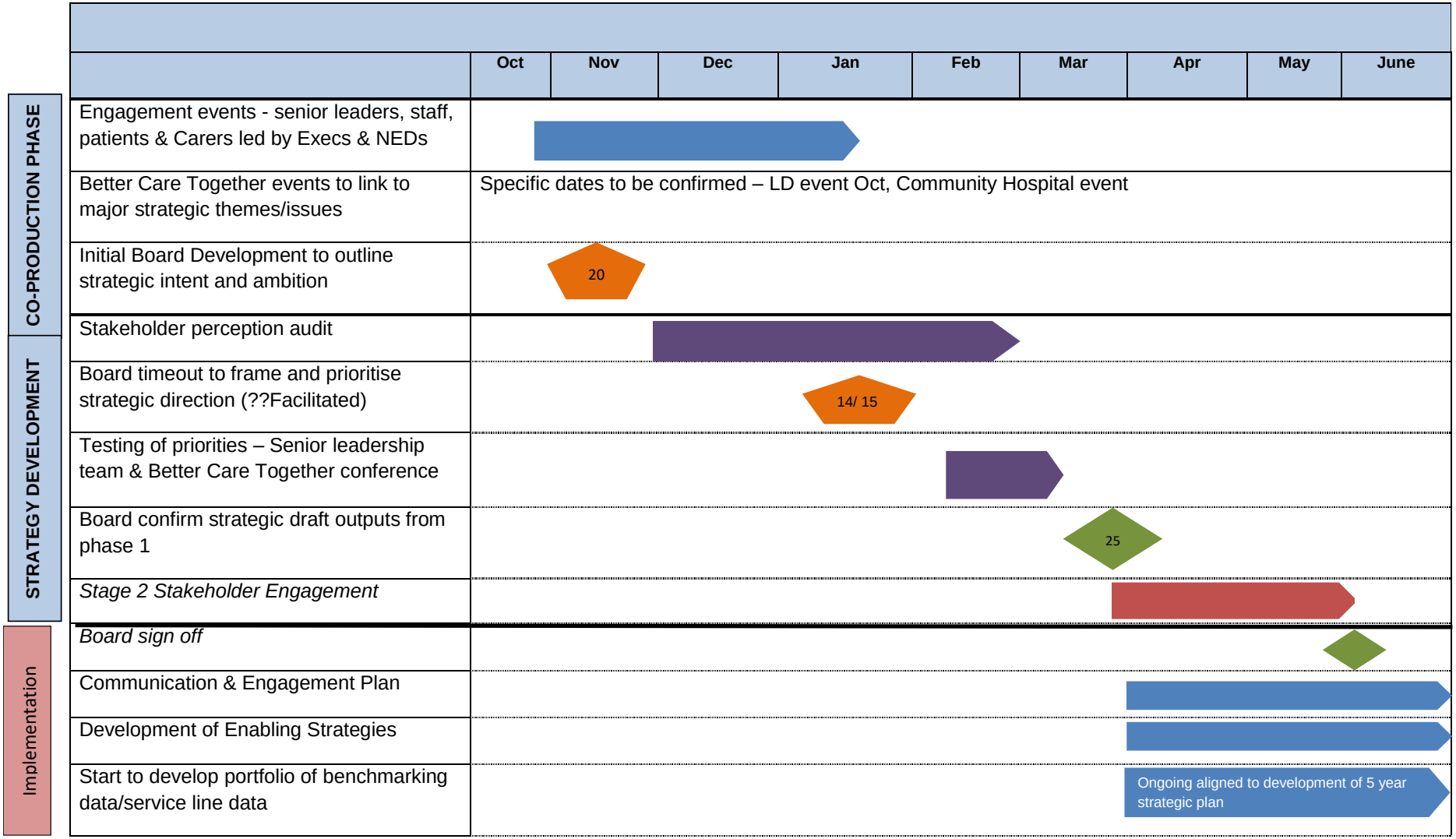
It is important for us to be able to determine and monitor that the emerging strategy will meet the current and future needs of the organisation therefore the following measures of success have been proposed;

- Staff and stakeholders can recognise their voices in the Trust's strategy
- A bold, ambitious and aspirational strategy that has a clear and realistic delivery timetable
- Clearly supports the ongoing development of a *Transforming organisation*
- The strategy is clear and relevant to everyone
- All staff are clear about the part they play in implementing the strategy through clear and measurable actions
- Partners and stakeholders are clear about GHC's role in the system

3.0 Recommendations

The Board is asked to note and support the following;

- The ongoing activities and timetable to develop the strategy through conversations and engagement with staff and wider stakeholders


Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
June
CO-PRODUCTION PHASE
STRATEGY DEVELOPMENT
Implementation
Engagement events - senior leaders, staff, patients & Carers led by Execs & NEDs
Better Care Together events to link to major strategic themes/issues
Specific dates to be confirmed – LD event Oct, Community Hospital event
Initial Board Development to outline strategic intent and ambition
20
Stakeholder perception audit
Board timeout to frame and prioritise strategic direction (??Facilitated)
14/ 15
Testing of priorities – Senior leadership team & Better Care Together conference
Board confirm strategic draft outputs from phase 1
25
Stage 2 Stakeholder Engagement
Board sign off
Communication & Engagement Plan
Development of Enabling Strategies
Start to develop portfolio of benchmarking data/service line data
Ongoing aligned to development of 5 year strategic plan

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AGENDA ITEM: 10/0120

Report to: Trust Board - 29th January 2020

Author: Angela Potter, Director of Strategy & Partnerships

Presented by: Paul Roberts, Chief Executive Officer

SUBJECT: **SYSTEMWIDE UPDATE**

Can this report be discussed at a public Board meeting?	Yes

This report is provided for:

Decision Endorsement Assurance **INFORMATION**

EXECUTIVE SUMMARY

Fit for the Future

Discussions have been underway for some time regarding the timeline associated with the Fit for the Future pre-consultation business case and the Board were aware of the need to build in additional time to take account of purdah due to the General and Local elections.

Four domains are currently included within the Fit for the Future (F4TF) processes – general surgery; image guided interventional surgery; emergency and acute medicine and urgent care in the community. This paper provides an update on the timeline and the associated actions required.

The Trust Board will be asked to approve the Pre-Consultation Business Case prior to submission to NHS England/Improvement (NHSE/I) for stage 2 approval, following which it will be submitted to the Gloucestershire Health Overview Scrutiny Committee (HOSC) – a process to achieve this is currently being agreed.

One Gloucestershire Integrated Care System (ICS) Lead Report

The report attached provides an update to Board members on the progress to date of key programme and projects across Gloucestershire's ICS.

RECOMMEDATIONS

The Board is asked to

- Note the timetable and requirements for approval for the Pre-Consultation Business Case for the Fit for the Future programme.
- Note the ICS Lead report

CORPORATE CONSIDERATIONS	
Quality implications	Fit for the Future is a key delivery vehicle for the integrated care system change programmes and therefore has impact to all key stakeholders across the Gloucestershire Health and Care system.
Resource implications:	
Equalities implications:	An extensive programme of engagement has been completed with the public stakeholders and partners across Gloucestershire.
Risk implications:	

WHICH TRUST VALUES DOES THIS PAPER PROGRESS (P) OR CHALLENGE (C)?			
Working together	**P**	Always improving	**P**
Respectful and kind	**P**	Making a difference	**P**

Report authorised by	**Date**
Angela Potter Director of Strategy and Partnerships	19/01/20

Where has this issue been discussed before?	**Date**
Executive Team Meeting	10/10/19 and 14/01/20

Appendices:	Appendix 1 – Fit for the Future Timeline v7 Appendix 2 – ICS lead report

DEVELOPING THE PRE-CONSULTATION BUSINESS CASE – FIT FOR THE FUTURE

1. Introduction

This paper provides an overview of the next steps associated with the development of the Pre Consultation Business Case (PCBC) for the Fit for the Future (F4TF) across Gloucestershire. A key work stream within this programme is the consideration of urgent care in the community for which the Trust is the main provider of services.

2. Progress to Date

A number of key milestones were delayed as a consequence of the General Election but significant progress continues to be made. An extensive programme of engagement has now been completed with the public, stakeholders and partners across the whole of Gloucestershire and the report from this exercise has now been completed and is available at https://www.onegloucestershire.net/yoursay/fit-for-the-future-output-of-engagement/

The engagement was an opportunity to seek views on the ways services could be organised to get the best urgent advice, support and care across Gloucestershire along with understanding the benefits of having two thriving specialist hospitals in the future in Cheltenham and Gloucester.

A number of key themes were noted from the engagement which include:

- Keep the A&E at Cheltenham Hospital
- Improve NHS 111 services
- Improve access to General Practice
- Ensure community urgent care options provide local, equitable access and are well resources with access to a range of diagnostics
- More joined up ways of working

A number of focused discussions also took place in the Forest of Dean (FoD) which were extended to give people a further opportunity to share their views on the development of the new hospital. Key feedback from the FoD sessions over and above the previous bullet points included;

- The number of beds needs to be clarified and consider fully the demographics and end of life care
- Transport is an issue for urgent care provision, particularly in the south of the Forest and there is a need to improve GP access to support urgent/out of hours care
- The current range of services provided at the Dilke and Lydney should be provided in the new hospital

3. Development of the Pre-Consultation Business Case

The longlisting process for all workstreams and the development of the hurdle criteria has been completed. This has enabled workstreams to develop the medium list of options that are being further develop. Appendix A includes an overview of the up to date timetable with notable key next steps including;

- 4th and 5th February – Solutions Appraisal for workstreams as appropriate to develop the shortlist of options that will move forward into the pre-consultation business case
- Feb – April – Development of the PCBC
- Trust Board's will be required to review and support the PCBC (exact approach to be determined) prior to submission to NHS England in April and the Health Overview and Scrutiny Committee in May for review and support.

One Gloucestershire
Transforming Care, Transforming Communities

FIT FOR THE FUTURE

NHS

Update

Date: Nov 2019

Programme Timeline: Engagement to Consultation

FIT FOR THE FUTURE

General Election (12/12/19)

Local Election (07/05/20)

Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20

Agreement to engage

Public & staff engagement

- FFTF booklet & survey
- Locality bus & stands (x24)
- **Involvement workshops* (x4)**
- **Locality workshops* (x7)**
- **Engagement hearing* (24/10)**
- GHFT Staff walkabouts, Intranet etc.

Engagement report

Solution development

- Emergency & Acute Care
- General Surgery
- Image Guided Surgery
- Community urgent care

Criteria development

- Assessment Criteria
- Long-list to medium-list

Pre-Consultation Business Case

- Integrated Impact Assessment (quality, equality & travel)
- Modelling (activity, workforce, finance)

Assurance

SW Clinical Senate (w/c 31/03/20)

Citizens Jury (20-24/01/20)

NHSE Stage 2 (23/04/20)

HOSC (19/05/20)

Solutions Appraisal (4-5/02/20)

Shortlist

Preferred Option(s)

Preferred Option(s) Approved

Decision making #1

CCG/GHFT/ GHC

CCG/GHFT/ GHC

ICS Board

ICS Board

Public consultation

Decision making #2

One Gloucestershire
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Criteria & Solutions development phase

FIT FOR THE FUTURE

General Election (12/12/19)

Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20

Public & staff engagement

- Emergency & Acute Care
- General Surgery
- Image Guided Surgery
- Community urgent care

31/10 Engagement report

17/10 Criteria Task & finish group #1

Issue guidance for criteria development; develop solutions appraisal process

Criteria development 01/10-05/11

12/11 Criteria Task & finish group #2

Review inputs from engagement report and Workstream groups and propose draft criteria for solutions appraisal

Clinical and non-clinical Workstream groups advise on revisions to draft criteria

Solution development 30/10-13/12

Long List

Clinical Workstream draft Long List

Solutions Appraisal 20/11-23/12

Medium List

Citizens Jury (20-24/01/20)

Solutions Appraisal (4-5/02/20)

Shortlist

Preferred Option(s)

£ Criteria development

High Level £ appraisal

Medium List modelling

Short List/ Option(s) modelling

£ & activity Baseline

Financial model preparations: assumptions, permutations etc.

Criteria development process

- Involvement and locality workshops reviewed Pre Consultation Business Case criteria
- Draft Criteria developed by Task & Finish Group
- Reviewed by:
  - Community Urgent Care Workstream
  - Emergency and Acute Medicine Workstream
  - Image Guided Interventional Surgery Workstream
  - General Surgery Workstream
  - New Models of Care Board including Primary Care
  - Resource Steering Group
- Engagement Report includes involvement and locality workshop feedback
- Criteria to be finalised by Task & Finish Group with recommendation to Programme Development Group and ICS Executives for approval

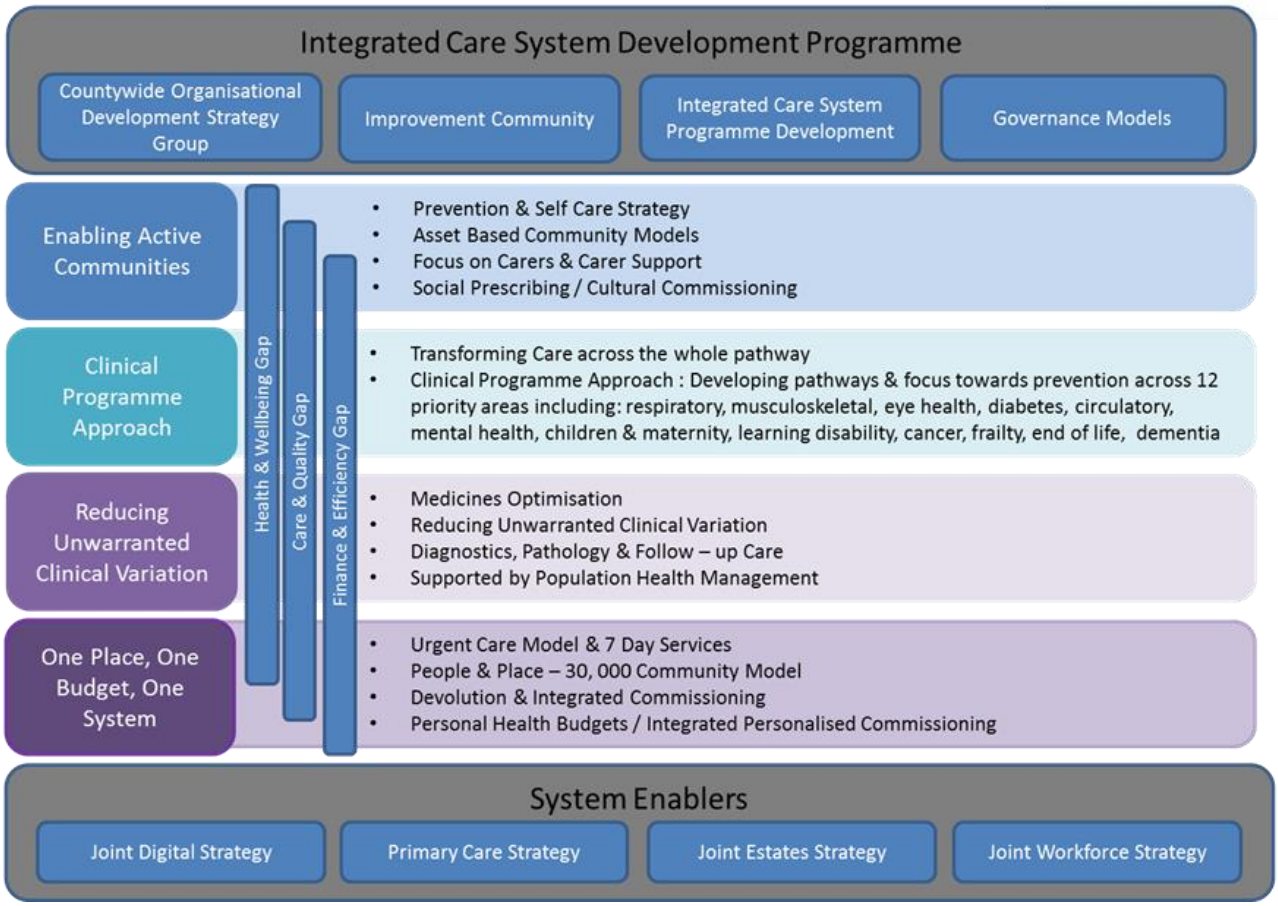
January 2020

One Gloucestershire ICS Lead Report

1. Introduction

The following report provides an update to the CCG Governing Body on the progress of key programme and projects across Gloucestershire's Integrated Care System (ICS) to date.

Gloucestershire's Sustainability & Transformation Plan commenced year three of four in April 2019. Priorities continue to be delivered across the main transformation programmes and we have reviewed the plans as part of our planning work on the One Gloucestershire Long Term Plan. In this report we provide an update on 2019/20 plans and the progress made against the priority delivery programmes and supporting enabling programmes included within the ICS. One of the roles of the ICS is to improve the quality of Health and Care by working in a more joined up way as a system.



Gloucestershire's ICS Plan on a page

2. Enabling Active Communities

The Enabling Active Communities programme looks to build a new sense of personal responsibility and improved independence for health, supporting community capacity and working with the voluntary and community sector.

The development of the Gloucestershire Prevention and Shared Care Plan, led by Public Health, aims to improve health and wellbeing. It recognises that a more efficient approach to preventing ill health is very important. This will improve the health of the population and make an important contribution to the maintenance of sustainability in our ICS.

Key priorities for 2019/20 will align to the refreshed Health & Wellbeing Strategy and are split across the 4 main work streams: supporting pathways, supporting people, supporting places and communities and supporting our workforce.

Supporting Pathways

- The provider of the **Tier 2 Child weight management service** is in the final stage of developing a trial service for Gloucester and Forest of Dean. This includes establishing referral routes and developing ways of testing the programme. Tier 2 services focus on lifestyle changes to support healthy weight.
- **Tier 3 (specialist) Child weight management service** clinics are due to start in January 2020.
- As at the end of November there are now 12 people on the Gloucester Cohort and 8 people on the Cheltenham cohort as part of the **Blue Light Change Resistant** Drinkers project. There was more attendance at the Cheltenham meeting, with colleagues from YMCA, Police, Safe Spaces and Cheltenham Borough Homes.
- **Postpartum contraception -** Delivery of 'contraceptive counselling' continues. The service has achieved a delivery rate of 100%; with 100% of women attending the service accepting contraceptives.

Supporting People

- The **Self-Management - Live Better, Feel Better** has shown positive results for how people manage their conditions and report their progress and concerns to health care staff. The service has managed to reach the right people as planned.
- A project has been developed which focuses on improving the quality of ‘Stop Smoking’ services.

Supporting Places & Communities

The **Community Wellbeing Service (CWS)** continues to make a positive impact to individuals, with 4,314 referrals made since the service began nearly 3 years ago. Of these referrals, 73% of individuals have shown an improvement in their mental health. Staff within Primary Care and the CCG are working closely together to make sure we have staff in the right places.

We Can Move programme:

- Stroud district council have purchased 800 falls sets to train their housing staff. A total of 717 People have now received falls packs via community groups. These will help prevent people

from falling.

- There are currently 155 schools taking part in The Daily Mile. The 'Big Day' campaign registered 133 Gloucestershire primary schools, with a total of 26,380 children taking part. 27 of these schools had never run The Daily Mile before which was a fantastic outcome for this campaign.
- Barton & Tredworth women's steering group have linked to the Friendship Cafe Inspire women's project. Monthly female-only activity sessions and Wednesday Wellbeing Evenings are being planned. They are working with local activity providers to help train individuals.
- The first Active Travel session for staff was held and 2 new Action Learning Groups (young people and disability groups) took place in November. We are looking at how knowledge can be shared on line as well exploring the development of the 'We can move' website.

Strengthening Local Communities

- In the Cotswolds 13 local people have been trained to become Community Dementia Link Workers and in Gloucester City, Monday evening community engagement drop-ins are being run by an active resident. In the area. .

Supporting Workforce

- **Workplace Health and Wellbeing:** The Healthy Lifestyle Service has successfully recruited to the accreditor post. Work is underway to plan an official launch event for the new Gloucestershire accreditation.

3. Clinical Programme Approach

The Clinical Programme Approach has been adopted across our local health care system to make sure services work together to redesign the way care is delivered in Gloucestershire. , By reorganising the way care is delivered and services that deliver this care we can make sure that people get the right care, in the right place, at the right time. During 2019/20 we have identified 4 clinical programmes which will be moved forward more quickly. These are Respiratory, Diabetes, Circulatory and Frailty & Dementia.

Respiratory:

Health Education England funding has been approved to continue education and training in 2019/20 across primary care, community and acute care. This includes developing bespoke training packages including diagnostics, management and preventative support for teams working in Primary Care.

Health Education England funding has been approved to support the education and training approach in 2019/20 across primary care, community and acute care. There are significant opportunities for education across community and hospital teams including Pulmonary Rehabilitation, Leadership and Asthma.

Educational video and podcast resources are being planned and developed for the Forest of Dean.

There has been an agreement to change the description for Home Oxygen Assessment and detailed planning is under way. This change will enable a joined up approach to supported discharge to be embedded across the respiratory specialist team.

Diabetes:

The new National Diabetes Prevention Programme (NDPP) provider ICS Health and Wellbeing is working well and there have been 650 referrals made since August 2019. The CCG is working closely with Primary Care Networks to look at ways to increase referrals onto NDPP and share good practice examples.

The pathway for children with Type 1 diabetes going onto Continuous Glucose Monitor is working with 50 children in receipt of this device. The device will help manage their diabetes and reduce its complications.

The 10 Year Diabetes Strategy has been finalised and has been approved by the Diabetes Clinical Programme Group in November 2019.

The virtual clinics held by the GP Clinical Champion are progressing and working well.

A diabetes integration workshop is taking place with Gloucester City in December 2019 to test the proposed way of working.

The CCG was successful in being awarded £40,500 for using volunteering approaches to appoint a person/s with a lived experience of diabetes to interact with others in community setting to improve health & wellbeing outcomes.

Circulatory:

An evaluation workshop for the Community Stroke Rehab Unit has taken place with a report and action plan to follow

Atrial fibrillation (AF) podcast has been recorded as part of action in Primary Care. All practices are in the process of completing a review of patients prescribed treatment for AF to provide assurance that patients are receiving the correct dose.

We are looking at the journey for patients with chest pain who go to hospital. This involves working with the Urgent Care team to identify ways to reduce emergency admissions for this condition.

Gloucestershire Hospital has commenced a quality improvement project to increase referrals to Cardiac Rehab.

REACH-HF project for home-based rehabilitation for patients with heart failure is on track, with positive feedback from patients so far.

The Nature on Prescription project for people who have had a cardiac event is now on the 2nd intake and referrals are starting to be received for the Forest of Dean as well as Gloucester,

Frailty & Dementia:

At the most recent Frailty Clinical Programme Group, the group agreed the approach to divide people into 4 groups (pre-frail, patients living with mild frailty, patients living with moderate frailty and patients living with severe frailty). The definition of these groups was agreed and the approach to looking at data and defining appropriate interventions was also agreed.

Health Education England funded Young Onset Dementia training which was delivered to Community Dementia Nurses and Dementia Advisors which was well received and outcomes included best practice examples and research.

The Community Dementia Dog project has been extended to 12 months based on positive outcomes from mid-point review. The most effective and beneficial referral source is Social Prescribing and it is hoped that this can be continued. The national Dementia Dog project in Forest of Dean has seen a mix of regular community Dog Days and home based interventions.

Focus on Stroke Early Supported Discharge (ESD)

The following case studies give some insight into the support the early supported discharge team and approach can give to stroke patients.

Mr T

Mr T was seen over a period of 3 years and is now walking independently, managing the stairs and his speech continues to improve. He has the flexibility to self-refer back to Assessment and Rehabilitation Unit as required. Mr T's discharge from the Dean Hospital was expedited by ESD therefore making cost savings and enabling him to get home which benefitted his wellbeing and rehabilitation. The severity/complexity of his stroke required longer term stroke specialist intervention and there was an overall improvement achieved with further rehabilitation. The fact that Mr T could access the Tewkesbury Assessment and Rehabilitation Unit after ESD and the community neuro physio specialist enabled him to achieve his goals of walking independently indoors, making a meal for himself, attending to his own personal care (therefore not being reliant on a package of care) and improve his cognition.

Mr C

Mr C benefitted from 12 weeks with ESD, preventing admission to another rehabilitation facility or needing to go out of county for treatment. Mr C had significant loss of independence with regards to his communication, personal care, mobility and had already had a long stay in hospital, he needed a significant level of input from the Occupational Therapists, Physiotherapist and Speech and Language Team over the 12 week period:

- At 6 weeks he was walking supported with one carer, but it was evident that he was unlikely to be independently mobile in the future. The additional 6 weeks enabled ESD to concentrate on getting him out of the house, exploration of potential interests/hobbies and onward referral for Electrically Powered chair.
- Mr C and his wife needed time to adjust to life after stroke. It was essential that ESD had adequate time to support this beyond the standard 6 weeks of service. At discharge Mr C and his wife felt well supported and that great progress had been made in the 12 weeks, with onward plans established.
- He significantly improved in confidence in his ability to transfer, balance and mobilise with supervision from his wife independently in his home environment.
-

Mr C did not fit into the mild to moderate category of stroke and as such did not meet ESD criteria. However, the team accepted him because it was his best interests to receive stroke specialist input and because there was no other appropriate community service available. Mr C would not have been able to attend outpatient services at 6 weeks as he was still unable to get out of the house, get in a car, and was too fatigued to have managed a session if he had been taken on hospital transport. Providing longer term intervention at home was definitely the most appropriate service for him.

4. Reducing Clinical Variation

The Reducing Clinical Variation programme looks to elevate key issues of clinical variation to ICS level. This will include having conversations with the public around some of the harder priority decisions we will need to make. This includes building on a different approach with primary care, promoting 'Choosing Wisely', thinking about how medicines can be used in a better way to reduce cost and waste, undertaking a review of diagnostic services and working to improve Outpatient services.

Key priorities for 2019/20 are

- We will continue to use the successful Prescribing Improvement Plan (PIP) to ensure that we continue to save money and improve benefits for as much of the year as possible. Actions include working with GP practices via the prescribing support team to identify and record beneficial changes to prescribing activity.
- We will continue to work with Hospital colleagues to consider areas including medication choice and how medicines are supplied so that benefits are shared across the ICS.
- Continue to include Medicines Optimisation topics within the annual Primary Care offer to support primary care colleagues to maximise savings available from prescribing in a better way
- Continue the successful provision of the Clinical Pharmacist team working within many GP practices by recruiting to fill current vacancies.
- Implement a two year programme Medicines Optimisation in Care Homes scheme, specifically in residential homes.
- Develop & improve mechanisms to allow GPs to access specialist opinion/advice and guidance.
- Develop appropriate alternatives to Hospital outpatient services where there are opportunities to manage patients in a less specialist and lower cost setting.
- Support changes to how Outpatient Care in delivered across the ICS Improve how money is spent to commission services through changing and developing relevant policy.
- Referrals to Hospitals will be triaged and managed using improved procedures. A review of diagnostic services across the ICS will be undertaken to support programmes of change.

What we've achieved so far:

- Work within GP practices is progressing towards achievement of the 2019-2020 Prescribing Savings target through the updated Prescribing Improvement Plan and Primary Care agreement which have been combined for the first time this year.
- Our team of Prescribing Support Pharmacists, Prescribing Support Technicians and Clinical Pharmacists are working with their allocated practices and provide support to help achieve prescribing savings for individual practices.
- Ongoing communication with the public around changes to medicines policies including the prescription of over the counter (OTC) medicines. OTC medicines information leaflet, relating to encouraging people to buy their own medications where possible, has been updated.
- Funding from the Primary Care Training Hub has enabled Gloucestershire CCG to run training days for GPs covering how to identify skin lesions and how to take high quality images. Training days were well received with a total of 96 GPs being trained. Further resources to continue to support learning have been provided on the G-care website.
- In Rheumatology the GP practices with high numbers of inappropriate referrals have been identified and agreed a programme of training with GPs in Forest of Dean to improve their knowledge of Rheumatic Disorders.
- Primary care pathology differences was investigated and presented at Reducing Clinical

Variation Board (RCV). The RCV Board agreed that a series of bitesize guides for primary and secondary care would be beneficial.

- The £200 million capital announcement for replacement of old (over 10 year at March 2019) diagnostic equipment resulted in the hospital receiving an allocation of new machines.

5a. One Place, One Budget, One System

New Models of Care & Place Based Model

The One Place, One Budget, One System programme takes a place based approach to resources and ensures we deliver best value. Our community care redesign will ensure responsive community based care is delivered through a transformative ICS approach to health and social care.

The intention is to enable people in Gloucestershire to;

- Be more self-supporting and less dependent on health and social care services,
- Live in healthy communities,
- Benefit from strong networks of community support
- Be able to access high quality care when needed.

New locality or Place led 'Models of Care' trials started in 2016/17. The trials were to 'test and learn' from this process including benefits, challenges and working across organisational boundaries. This led to the formation of 16 locality clusters/ Places across the county.

Key priorities for 2019/20 are

- Senior leaders from health and social care, locally elected government and non-professional representatives are working together to inform and support integration at Primary Care Network (PCN) level. This will help with unlocking issues and sharing responsibility for finding local solutions to deliver ICS priorities and tackling issues which arise for their population which can only be resolved by working together. .
- Clinically-led integration, involving staff and local people in decisions, to support more people in the community and out of hospital.
- Integrated Locality Partnerships (ILP) plan to deliver an approach which concentrates on their population which includes keeping people healthy (prevention) and public health. The agreed priorities will help to improve health and wellbeing for their population.
- Develop how teams made up of different health and social care staff will work together at a PCN level.

What we've achieved so far:

- The Population Health Management Programme across Cheltenham ILP has been well received and has gathered momentum. Each PCN has defined their patient cohort in conjunction with wider community partners.
- A planning event was held for Tewkesbury ILP in December and wider partners have been asked to suggest collective priorities in January and agree them during February. All Remaining ILPs have agreed collective priorities.

South Cotswolds Frailty Service

- Flu' clinic packs have been assembled and Wellbeing Coordinators have dates in their diary to attend the clinics.

- Work continues to look at identifying and supporting people who are at the End of Life. This includes supporting GP practices. Looking at how patients can be supported to call the Frailty Team directly. This will help make sure that resources are used correctly and free up Frailty team time
- Aiming to improve partnership working with Cirencester Community Hospital
- Development of a communications and training plan for the Ambulance Trust, to include Me @ My Best and training on managing frailty in urgent situations is being developed.

5b. One Place, One Budget, One System

Fit For The Future

Our vision for Urgent Care will deliver the right care for patients, when they need it. In order to make this vision a reality and provide safe and sustainable services into the future, we need to consider how to make best use our resources, facilities and beds in hospitals and in the community.

We want to improve arrangements for patients to access timely and senior clinical decision making about their treatment and ensure specialist support is accessed as soon as possible. We propose potentially changing the way some care and support is organised in Gloucestershire to meet changing demands, make best use of our staff, their skills and the money we have.

Regular updates on the Fit for the Future Programme have been shared with HOSC, describing how the programme aims to deliver an integrated urgent care system and hospital centres of excellence to ensure we realise the vision for urgent care.

Our key deliverables for 2019/20 include;

- Continue to develop and refine the "Fit for the Future" strategy focussing upon development of same day urgent care services, Centres of Excellence and Integrated Urgent Care (Clinical Advice and Assessment Service).
- To further develop and deliver plans identified within the Emergency Department attendance (A&E) admission avoidance programme and length of stay management.
- To further develop and deliver plans which look at the journey patients take from the time they are admitted until discharge which will reduce bed occupancy of long stay patients by 25%:
- To further develop and deliver plans identified within the Community Admission Prevention programme.
- To further develop and deliver plans identified within the Find and Prevent programme.

Current progress

The Fit for the Future engagement was on 'pause' during the pre-general election purdah period but is now however, ready to resume conversations.

An independent Citizens' Jury will meet on 20th January to begin its work and look at how specialist hospital services in Gloucestershire could develop in the future. The Jury will sit for five days in public with participants reflecting the county's diverse population.

Jury members will consider feedback from the Fit for the Future public and staff engagement, together with evidence on the need for change across Gloucestershire's two main hospital sites – Cheltenham General and Gloucestershire Royal. They will hear from NHS staff working in the services, from public and patient representatives and from a variety of other speakers on relevant topics.

They will consider, and be asked for their views on, a vision for centres of excellence approach to providing hospital services. This approach reflects the way a number of services are already delivered across the Trust such as stroke, children's services and trauma and orthopaedics, which is serving patients well.

Following a period of advertising, 181 people applied to be a member of the Jury. 18 people were selected and are broadly representative of the people of Gloucestershire in relation to age, gender, education, ethnicity and postcode.

6. Enabling Programmes

Our vision for future Health and Social Care in Gloucestershire is supported by our enabling programmes. These are working to ensure that the ICS has the right capacity and capability to deliver on the clinical priorities which have been identified.

Joint IT Strategy: Local Digital Roadmap

- Cinapsis (an Advice and Guidance system), has now been rolled out to 58 practices across the county. This supports GPs and hospital consultants and other clinical staff communicating to support GPs with advice for patients on a quick turnaround.
- Joining Up Your Information (JUYI) is being viewed 240 times a day on average supporting the sharing of information across our health and care providers.
- 26. 08% of patients are now registered for online primary care digital services.
- A Children's & Young People Mental Health digital bid has been submitted for central support to develop an online portal for young people to manage their appointments, advice, message their therapist and access a moderated group chat

Joint Workforce Strategy

The following 2019/20 Workforce Development Projects have been signed off by Health Education England and therefore supported with funding;

- Advancing Practice,
- Apprenticeship Hub supporting us to continue to provide excellent apprenticeships in health and care roles,
- Support to the clinical programmes (see section 3)
- Primary Care Network (PCN) Health Coaching Skills Training,
- Gloucestershire Improvement Community Programme,
- Outpatients and Upskilling Allied Healthcare Professionals in Ophthalmology Clinics.

The Leadership Programme is progressing well and positive feedback has been received. In terms of cohorts;

- Cohort 3 (Urgent Care) has finished the programme;
- Cohort 4 (Dementia & Frailty) remains ongoing;
- Cohort 5 (CVD & Diabetes) remains ongoing; and
- Cohort 6 (Respiratory & End of Life Care) remains ongoing.

We held our first workshop to look at the whole system impact of the promoted new roles in primary care. This focused around pharmacists and working together as a system to support the best way to deliver these new roles.

Joint Estates Strategy

The ICS Estates Strategy is being developed which brings together updated organisational estates strategies of each partner organisation, as part of the long term plan. An updated Primary Care Infrastructure Plan with plans up to 2026 is being drafted and developed. The South Western Ambulance NHS Foundation Trust strategy for future estate provision will deliver a range of operational sites. These will consist of the development of new Hubs (Make Ready Centres) mainly close to Acute hospitals and supported by a network of Book On locations (staff start and finish shifts) and Spokes

(standby points). Each Hub will be subject to a detailed Business Case for approval by the Trust. The proposal for a new Minchinhampton surgery has been approved.

Primary Care Strategy

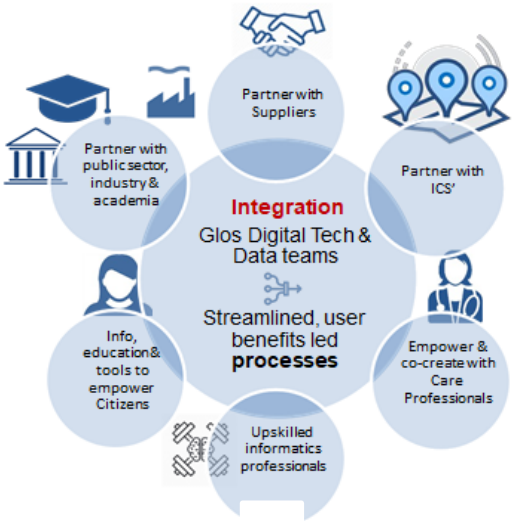
Our first ICS digital primary care priority is to have a main offer for all practices. It will test further digital improvements to establish the benefits for patients and GP practices. At the same time it will keep an eye to the future developments with 111 Online and the NHS App roll out.
The 2019-2024 Primary Care Strategy must demonstrate how the ICS will:

- enable services to remain flexible and sustainable,
- improve integration and partnership working,
- detail priorities and how these will be achieved,
- describe how Primary Care Networks will be the focus as the key enabler to the strategy.

Developing the Primary Care Workforce: A number of schemes are ongoing to help develop and improve the Primary Care Workforce. We have continued the Care Navigation trial with a training provider. Roles Reimbursement scheme is continuing with a Gloucestershire ICS stakeholder workshop for Pharmacy and Medicines Optimisation and this took place on 10 December 2019. There are Three GPs currently on the Health Equalities Fellowships scheme. The Primary Care Workforce website has been developed.

Focus on Digital Technology

Our vision is to work together to deliver digital convergence and collaboration across the ICS and to ensure that digital technology is one of the key drivers facilitating service transformation and sustainability. We will invest in a sustainable and underpinning technical infrastructure to support the delivery of transformational service changes, driven by care professionals and focused on empowering people to take control of their own health and care.



1. **Converge our digital, data and technology platforms, services and teams** to overcome funding, expertise and care co-ordination barriers.
2. **Closer formal linkages with clinical and transformation programmes,** to ensure the right solutions that are most likely to realise the greatest benefits are prioritised.
3. **The ICS governance to make system wide decisions will be refreshed** to increase visibility, co-ordinate investments and speed- up decision making.
4. **Starting to develop our skills in Agile digital delivery and user centred design processes** will increase the value of investments, visibility of progress and velocity.
5. **Developing career pathways and skills development programmes** will increase our expertise, retain more staff and attract new high quality people of high quality.
6. **Care CIOs will be developed and embedded into our delivery processes** to improve the design and adoption of digital services.
7. We can't do this alone, so **need to develop our partnerships with academia, industry, suppliers and other ICS'. Partnerships,** This will focus on raising our expertise levels, sharing effort, cost efficiencies and planning for the future.

So Far….

- The first phase of the new Hospital Electronic Patient Record went live in Gloucester Royal Hospital in December. This started with electronic documentation, tracking boards and a clinical record portal, which also allows access to a Shared Care Records. Time savings for staff as well as improved quality of care are already being evidenced, helped by a high level of engagement from nursing staff in In-patient wards.
- The clinician to clinician messaging pilot, called Cinapsis, has been rolled out to 68 GP practices and the frailty service. This allows GPs to seek specialist advice on patients that may need to be sent to urgent care services and dermatology services. Early feedback on the impacts are positive
- Funding has been awarded to the hospital and mental health services in Gloucestershire to implement Electronic Prescribing and Medicines Administration. This will improve safety and efficiency significantly compared to the paper based mechanisms in place currently.
- 40 new GP websites have gone live, including new capabilities to do online messaging from patients to the practices. A programme of support is being developed for best usage and benefits from increasing usage of digital primary care services.
- A new Gloucestershire Digital Technology professional network has been established called Glos Care Informatics. The Academic Health Science Network has sponsored the first two events and speakers have been lined up for the next two from national and local teams. The group aims to increase the network, skills and knowledge of technology and health care staff in the county. This includes introducing aspiring informaticians to the career pathways and opportunities to learn more.

7. Integrated Care System

As a Wave 2 Integrated Care System we are working towards increased integration to improve health and wellbeing, we believe that by all working better together, in a more joined up way, and using the strengths of individuals, carers and local communities, we will transform the quality of care and support we provide to local people.

The System Development work stream captures the work to develop the overarching ICS programme. The responsibilities of this programme are as follows:

- Provide Programme Direction to the Gloucestershire ICS
- Manage a Communications and Engagement approach on behalf of the ICS, including ensuring the Health and Social Care Act duties regarding significant services changes are met in relationship to the ICS
- Ensure the ICS has a robust resources plan in place that all ICS partners are signed up to and that is aligned to organisational level plans.
- To ensure that the ICS has clear governance and performance management in place to ensure the system can manage and oversee delivery.

Our key achievements made since the last report include;

- Dame Gill Morgan has been appointed as Independent Chair of the One Gloucestershire Integrated Care System (ICS) and has taken up her role in January 2020. Gill has enjoyed a long and distinguished career in the NHS and third sector at national and local level. She has extensive

leadership experience having held a number of senior roles including Chair of the Alzheimer's Society, Chief Executive of the NHS Confederation and Chief Executive of North and East Devon Health Authority. She has also been a Permanent Secretary in the Welsh Government. More recently Gill has been Chair of NHS Providers since 2014, Vice Chair of the Lloyds' Bank Foundation for England and Wales, Commissioner (Vice Chair) for the review of physical and sexual abuse in women suffering multiple disadvantages and is Patron of the Infection Prevention Society. We are excited to welcome her to the One Gloucestershire system.

- One Gloucestershire ICS Web 'Bitesize' Priority Summaries: A useful resource for community partners and health and care professionals these summaries cover everything from active communities to transforming services. The summaries cover what we are doing as a partnership, a case study and highlight our plans going forward. The first 16 summaries have recently been added to the onegloucestershire.net website and provide a 'bitesize' overview of ICS priorities. A further 13 are in production. The summaries can be found at https://www.onegloucestershire.net/
- The third draft of the One Gloucestershire Long Term Plan response has been submitted and the overall shift in compliance was positive. The plan is moving towards finalisation with a plan to publish a public facing guide and the full narrative plan.
- A number of system wide strategies are progressing rapidly including outpatients, digital, primary care, Health & Wellbeing Strategy and the Prevention & Inequalities Framework.

8. Recommendations

This report is provided for information and the Governing Body are invited to note the contents.

Mary Hutton
ICS Lead, One Gloucestershire ICS

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 11/0120

Report to:	Trust Board - 29 January 2020
Authors:	Becca Shute, Assistant to the Chief Operating Officer Alison Wilmott-Miller, Deputy Director of HR Neil Savage, Director of HR and OD, John Campbell, Chief Operating Officer
Presented by:	Neil Savage, Director of HR and OD Sian Thomas, Deputy Chief Operating Officer
SUBJECT	**SUSTAINABLE WORKFORCE UPDATE**

This Report is provided for:

Decision	Endorsement	**ASSURANCE**	**TO NOTE**

EXECUTIVE SUMMARY

This report sets out a summary of the Trust's current approach to a sustainable workforce. The report was requested following a related discussion item at the December 2019 Resources Committee.

The report's purpose is to provide an update and assurance to the Board of Directors around the Trust's strategy and actions, both short and long term, being taken to tackle and mitigate the challenges and risks of a sustainable workforce.

Essentially, the report presents its approach to a sustainable workforce through the following three components:

- **Temporary Staffing** (i.e. Bank and Agency) – looking at the current position, our recent refocus, the alignment of legacy Trust staff and central bank
- **Recruitment** – improving the pipeline
- **Retention** – keeping hold of our people

RECOMMENDATIONS

The Board of Directors is asked to consider this report and to support the outlined strategy.

CORPORATE CONSIDERATIONS	
Quality implications:	A sustainable workforce is an essential component in the Trust's delivery of quality services. Our approach to workforce is critical to safety, effectiveness and experience (both of patients and colleagues). It is also a core enabler or disabler of the three key CQC Domains of "Safe", "Caring" and "Well-led".
Resource implications:	Some 60 to 70% of provider trusts' income is spent on workforce salaries, with a further proportion on temporary staffing. NHS Improvement have set each Trust with an agency staff cap alongside individual caps relating to what trusts can pay agency workers.
Equalities implications:	Equality and diversity are a core element of the Trust's people management practices, policies and procedures, in particular for recruitment, development and retention.
Risk implications:	If the Trust does not keep a keen focus on in its immediate and longer term workforce delivery and wider approach it risks being able to deliver quality services in a sustainable way.

WHICH TRUST VALUES DOES THIS PAPER PROGRESS (P) OR CHALLENGE (C)?			
Working together	**P**	Always improving	**P**
Respectful and kind	**P**	Making a difference	**P**

Report authorised by:	**Date:**
Neil Savage – Director of HR and Organisational Development John Campbell, Chief Operating Officer	20 January 2020

Where in the Trust has this been discussed before?		
Resources Committee	Date	December 2019

What consultation has there been?		
	Date	

Explanation of acronyms used:	GHC - Gloucestershire Health & Care NHS Foundation Trust HEI – Health Education Institutes HEE – Health Education England NMC – Nursing and Midwifery Council HCPC – Health Care Professions Council NHSI/E – NHS Improvement and NHS England ABMG - Agency and Bank Management Group RN – Registered Nurse (RGN and RMN) RMN – Registered Mental Health Nurse RGN – Registered General Nurse PMO – Programme Management Office QSIR - Quality Service Improvement Redesign

SUSTAINABLE WORKFORCE UPDATE

1.0 INTRODUCTION

1.1 Following a workforce discussion item at the Resources Committee in December 2019, it was agreed that a further update report would be taken to the next available meeting of the Board of Directors.

1.2 This report has been produced in partnership by operations and human resources colleagues provides an update and assurances that appropriate action and oversight is in place to address the on-going challenges facing the Trust in relation to a sustainable workforce.

1.3 The Board should also be mindful that the challenges of a sustainable workforce experienced by providers across the NHS for many years is not something that is completely within its scope of control to resolve in view of the complexity and scale of the challenge, alongside the fact that much of the supply pipeline remains the responsibility of external partners such as HEIs and HEE.

1.4 By means of illustration, taking nursing within the wider NHS, there are over 40,000 nursing roles currently unfilled. This represents some 12% of the nursing workforce. A recent Health Foundation report suggests that this could hit 100,000 in a decade. Arguably, to tackle such an endemic challenge, five things need to happen simultaneously across the NHS to bridge the gap in the longer term: -

- Firstly, there needs to be more **local and overseas recruitment**. This presents challenges from the impact from Brexit and the yet to be finalised approach to post-Brexit overseas recruitment and work arrangements
- Secondly, the UK needs to **train more RN** nurses in its HEIs. This presents a double edged sword – with the assistance of additional recruits in the longer term, counterchallenged by providers having to resource the related additional student nurse placements
- Thirdly, providers need to be able to **retain** their current workforce. This needs further enticements, improved colleague experience and improvements in flexible working, alongside more flexible retire and return packages
- Fourthly, HEIs, regulatory bodies such as the NMC and HCPC, and provider need to continue working in partnership to **embed and develop new roles**. While good progress has been made, for example on Nursing Associates, Assistant and Advanced Practitioners, there is still much to do
- Finally, a further **cultural and behavioural shift** is needed to better embrace workforce transformation and different ways of staffing the provision of care. This includes a shift in the digital enablement of the workforce, through better use of e-rostering and e-job planning. It also includes less professionally territorial approaches and competency based role development

1.5 Encouragingly, the government has promised 50,000 more nurses, with 18,500 of these coming from retaining existing nurses, 12,500 new appointments from overseas, 5,000 via nursing apprenticeships and 14,000 through training routes. It has also promised to re-introduce the nursing bursary it previously removed.

1.6 What the Trust is currently doing to tackle the sustainable workforce challenges locally is outlined below and broken down into the following components:

- **Temporary Staffing** (i.e. Bank and Agency) – looking at (a) the current position, (b) our recent refocus, and (c) the alignment of legacy Trust staff and central bank
- **Recruitment** – improving the pipeline
- **Retention** – keeping hold of our people

1.7 Benefits in Temporary Staffing are expected to be realised within 3 to 9 months. Benefits in other aspects highlighted for Recruitment and Retention are longer term and range from realisation within 12 months for example, for improved exit and on-boarding processes, to 12 months for our local RGN pipeline, 12 to 24 months for our local RMN pipeline, circa 36 months for our physiotherapist pipeline and, in the case of more local junior medical supply, 7 years.

2.0 TEMPORARY STAFFING – CURRENT POSITION

2.1 The demand for bank and agency staffing across GHC has continued to rise throughout 2019/20, most notably within mental health and learning disability services.

2.2 This is the cumulative effect of continuous vacancies in Band 5 nursing posts in both mental health and community hospital services due in part to the national workforce challenges, and also an increasing demand on additional staffing to meet complex needs of the patient population, for example, through additional resourcing requirements for 'enhanced levels of observation and engagement'. Recruitment to Health Care Assistants also continues to present challenges in the current competitive employment market within the county.

2.3 In line with the national medical workforce shortages, our medical agency use has continued to increase. There also continues to be a need to utilise agency staff to full fill the requirements of the Improving Access to Psychological Therapies (IAPT) service contract but it is important to note that this is decreasing as part of our planned recruitment and retention strategy.

2.4 Current forecasts indicate an end of year position of £6.231m temporary staffing spend against an NHSI/E ceiling of £4.25m. While this is a similar challenge many NHS providers are facing, it is one that the Trust needs to urgently address.

2.5 This end of year position is expected to result in GHC receiving an Agency Risk Rating from NHSI/E of 3 (1 best, 4 worst) as a result of being >25-50% above the agency spend ceiling. This is not where the Trust would want to be on its ratings.

2.6 It is clear that the range of initiatives in development or early implementation will not reduce the current forecast end of year position.

2.7 It is also important to note that at present, as a result of multiple information systems, for example, two Electronic Staff Record subsets, two finance ledgers, two NHS Jobs accounts, two staff bank/central bank approaches, there are significant limitations in the ability to easily access the depth of information required to gain a comprehensive understanding of the current position and the influencing factors.

2.8 This results in a limited consistent understanding of the vacancy and turnover rate, the average duration of end to end recruitment process, the use of temporary staffing at team and service level across clinical and non-clinical services and presents difficulty collating and centrally monitoring the impact of the range of initiatives in train

to support the achievement of a reduction in agency spend and longer term, a sustainable workforce. Fully integrated reporting will be embedded in Q2 20/21.

2.9 As resources are focused on critical system integration in the short term, reports on workforce information have to be manually produced and combined from separate systems which is highly time consuming at a time when those same colleagues are focussing on a variety of system harmonisation projects. At present, due to these projects, there is a need to limit the information generated to that which is essential for service delivery which challenges the ability to report the wider position.

2.10 Sections 3 and 4 below outlines actions undertaken since December 2019 to ensure a better understanding of the current position is achieved and short term (6-9 months), high impact actions to reduce agency spend are implemented.

3.0 TEMPORARY STAFFING - REFOCUSING TO REDUCE AGENCY SPEND

3.1 It is apparent that in both organisations prior to becoming GHC the initiatives implemented have not resulted in a sustained reduction in agency spend, this has been hampered by limited operational engagement at a strategic level to drive change and limited availability of business intelligence to direct focus.

3.2 This is further compounded by the national workforce gaps and challenges.

3.3 Using this learning and aligned with Quality Improvement principles, a decision was taken to adopt a 'less is more approach' and commence a re- focused Agency and Bank Management Group (ABMG)

3.4 The Chief Operating Officer was asked by the Chief Executive Officer to lead the newly constituted group with enhanced and delivery focus from senior operational and human resources leads, the key priority is to reduce the spend on agency in line with NHSI/E ceiling.

3.5 The group operates as a project board with some members also leading priority work streams.

3.6 The work streams target areas of highest need and opportunity for short term (6 – 9 months) impact on spend reduction and are focused on the following three areas: -.

1. Recruitment processes: -

- QSIR review of end to end recruitment processes will report in February 2020 identifying further ways to shorten processes
- Positive risk taking approach for pre-employment checks to reduce delays in start date has been implemented

2. Service with highest use of agency staffing (Wotton Lawn Hospital)

- Proactive recruitment to achieve and maintain full complement of HCA peripatetic teams
- Addition of Band 2 HCA's to peripatetic teams and staff bank to capitalise on workforce supply
- Continue the use of master vendor contracts and guaranteed supply of RN's and HCA's through framework agencies
- Review and adjust "safe staffing" models to more accurately reflect need

3. Business Intelligence - developing a consistent approach: -

- Identify essential information required at service level
- Map current data gathering and reporting processes across services
- Streamline interim manual reporting process
- Develop consistent reporting for bank and agency usage across staff and central bank

3.7 The inaugural meeting of the ABMG was held in December 2019 and the meetings are scheduled on a fortnightly basis throughout 2020 to ensure focus is maintained and outputs achieved.

3.8 Given the higher level of agency spend on medical staff, the Trust is also piloting Locum's Nest over the next 6 months. Locum's Nest is an established mobile locum app that connects doctors to locum work in providers, whilst cutting out the inefficiencies and expenses of the agency middleperson. For a small supply fee, the Trust benefits from quicker and cheaper advertising of available shifts, that using the more traditional framework agencies. Progress with this will be overseen by ABMG.

4.0 TEMPORARY STAFFING - ALIGNMENT OF STAFF BANK AND CENTRAL BANK

4.1 The merger has provided the opportunity to review the functions of staff bank (MH/LD) and central bank (Physical health) and develop a new future joint model.

4.2 Led by the Head of Organisational Resilience, a program has commenced supported by the PMO, to bring together the two teams and streamline systems and processes and create one internal staff bank.

4.3 It is envisaged that this will enable the following outcomes: -

- Improved streamlining and enhanced recruitment and retention
- Enhanced compliance with training and ensured high quality workforce
- Improved consistency in processes for booking and management of agency staff including approvals for off framework agency.
- Bank staff enabled to work across both physical health and mental health/LD services where appropriate
- Increased efficiency and enhanced working patterns for the staff bank team
- More effective trust-wide reporting of bank and agency usage

4.4 The new combined service will be operational from 1st April 2020.

4.5 In addition to the above service development actions are in place to: -

- Ensure more consistent processes across the two teams to manage the allocation of bank and agency resources with a view to reducing the need for last minute off framework agency requirements
- Agree roles and responsibilities in managing agency contracts and ensuring effective communication with the staff bank team and operational services
- Review the 857 bank-only contract holders to ensure all are active, up to date with training and understand how the bank workforce align with the clinical requirements and translate into shift availability

4.6 The Board is reminded of its previous agreement to continue using off framework agencies in the event that their use is the only way safe staffing can be assured as a result of all other options having been exhausted by the bank.

5.0 RECRUITMENT - IMPROVING THE PIPELINE HEI RELATIONSHIPS

5.1 To tackle the longer term sustainable workforce challenges, GHC has continued to work closely with a number key HEIs alongside HEE to ensure improved pipeline for prioritised professional groups. Our partnerships include amongst others, University of Gloucestershire, University of West of England, University of Bristol, University of Birmingham, University of Worcestershire and the University of Bath.

5.2 Locally, while our wider HEI relationships remain critically important, two specific relationships have been of particular importance. With the University of Gloucestershire, the Trust has supported the development and implementation of local RGN, RMN and Physiotherapy degree courses as well as the Nursing Associate programme. The Trust works with partner organisations and the University through its membership of the Gloucestershire Strategic Workforce Development Partnership Board which is attended by the Director of HR and OD, and the Director of Nursing, Therapies and Quality. While it is early days for all the local programmes, there are good longer term benefits predicted for our local Gloucestershire supply pipeline as a result of these new programmes alongside the RGN programme. Similarly, with University of Worcestershire, the Trust has developed its relationship and supply pipeline of RMNs and Nursing Associates.

5.3 The Trust has significantly increased the number of RMN student placements in the past year by circa 60%. We have also offered RMN student nurse bursary packages with guaranteed jobs on qualification, student practitioner placement packages, and for RGN students, payment of student loan interest payments. These have not had the uptake we would have desired and further work is being done on future offers. While the provision of more student nursing placements is challenging in terms of the requisite extra support, supervision and their supernumerary nature, future growth in numbers are essential to ensure we have a sustainable supply pipeline.

5.4 In addition, as a partner with the University of Worcestershire, the Trust is supporting its development and application to become a future medical school. Through the Three Counties Medical School Partnership Group, we hope to have a very local pipeline to supplement the existing medical student and junior doctor supply routes of Bristol and Birmingham. If successful, the benefits of this will not be experienced for another 7 or 8 years at the earliest.

5.5 Further sustainable workforce benefits are expected from partner HEI's recent developments of higher apprenticeship in health (Assistant Practitioner) and Advanced Clinical Practice programmes (Postgraduate Certificate / Postgraduate Diploma / MSc).

SOCIAL MEDIA AND RECRUITMENT MICROSITE

5.6 All NHS trusts use the national "NHS Jobs" website. While this is now a well-established recruitment pipeline, and a platform which largely removed the need for Trust advertising budgets, it is a one shoe size fits all model. The legacy ²gether Trust previously benefited from both the added recruitment data and from sourcing

recruits through its own recruitment microsite with social media short films and local area benefits and information. A recruitment microsite is being redeveloped for our newly merged Trust and will be relaunched in spring.

5.7 The Trust and its ICS partners are exploring how they can better use the "Proud To Care Gloucestershire" recruitment website and promotion material to create a single brand and Gloucestershire-specific gateway for both health and social care roles.

5.8 Both legacy Trusts have also had some initial successes through the use of targeted social media campaigns, for example, via Facebook. These have translated into appointments and we are now planning wider more regular use of both geographical and profession specific targeted recruitment campaigns.

RECRUITMENT EVENTS

5.9 A planned programme is in place for local and national recruitment events in the first half of 2020. This builds on the successes of HCA events in 2019 and includes a weekend student nursing event, a Job Centre Guildhall event, a Stroud General Hospital physical and mental health recruitment day, and a stand at the Royal College of Psychiatrist's Annual Congress. Further events are being planned for later in the year. The return on investment from each of these will be carefully reviewed to inform future activities. However, the Congress has previously been successful in securing medical appointments.

5.10 The ICS Recruitment Group is exploring options in partnership with the Council's Lead for Disability Employment on available local employment schemes and promotional events to build on our NHS Pledge (Learning Disability Employment Programme pledge).

5.11 With the appointment of a new Recruitment and Retention post in the HR team in February 2020, a plan will be worked up for a systemic local school and college career event and fayre programme in the second half of the year.

RELOCATION EXPENSES

5.12 In September 2019, in advance of the merger, the legacy Trusts agreed a reviewed and refreshed Relocation Expenses Policy. This provides more flexibility for managers and new recruits to access support for moving into the area, including the option of travel expenses in lieu of relocation. Our adverts and recruiting managers now need to ensure they highlight the options to potential candidates.

6.0 RETENTION – KEEPING HOLD OF OUR PEOPLE

6.1 The Trust has just reviewed and refreshed its Flexible Working and Appraisal policies and practices – both of which are critical to retention.

6.2 The new Flexible Working policy provides a clear revised policy and guidance on all the different options that exist to enable colleagues to work flexibly. Additionally, the Trust has identified that it has 258 Special Class Status (SCS) and Mental Health

Officer Status (MHO) clinical colleagues. These are nursing, AHP and medical colleagues who can retire on full pension benefits earlier at the age of 55. Out of this total, 194 colleagues are in the age range of 41 to 55 and have yet to retire, while 64 have already retired and returned or simply continued to work. This is a legacy affecting a smaller number of colleagues who were part of the 1995 Pension Scheme. Some of those identified have already retired and returned to work with flexible packages. Clearly, the Trust needs to maximise its retention of these highly skilled and experienced colleagues, ensuring it does not unnecessarily lose them. To that end, the Trust is now rolling out a new flexible retire and return package. This has been successfully piloted in the legacy ²gether Trust, with, several RMNs and medical consultants returning to work for our services after retirement. This will continue to be a key component of our retention strategy.

6.3 The new Appraisal policy and documentation improves and simplifies the related processes. Alongside this, nursing and AHP services are being encouraged to develop their own local "career opportunity" trees, based on a model shared from Great Ormond Street Hospital. This will be used to pictorially inform both candidates and existing colleagues via the appraisal conversations. A similar "leadership opportunities tree" has been developed and is used to inform leadership development conversations.

6.4 Following on from the learning of being part of the NHSI Retention Cohort, the Trust is implementing two new survey methodologies. One is a new Retention and On-boarding Questionnaire 12 months into a new appointment with the Trust. The other is a revised Exit Questionnaire. These are being launched through February and March and will use electronic systems allowing for ease of current and historic reporting. Both will also offer face-to-face opportunities too. Options are also being scoped for further follow up contact with ex-employees 6 months after they have left.

6.5 This quarter we are also launching a broader colleague benefits package with partners Neyber and Vivup which is intended to support our core employment offer to benefit both recruitment and retention.

7.0 CONCLUSION AND RECOMMENDATIONS

7.1 The Board of Directors is asked to consider this report and to support the outlined strategy which aims to tackle, resolve or mitigate short and long-term workforce challenges.

7.2 Going forwards, Temporary Staffing, Recruitment and Retention, will be key components of the Trust's new "Best People" strategy now in development alongside the wider Trust strategy. It is recommended that regular progress updates are brought back to the Resources Committee, particularly in light of the challenges presented in this paper alongside the forthcoming publication later in January 2020 of the national NHS People Plan.

AGENDA ITEM: 12/0120

REPORT TO: Trust Board – 29 January 2020

AUTHOR: Colin Merker, Managing Director Herefordshire Mental Health and Learning Disability Services

PRESENTED BY: Colin Merker, Managing Director Herefordshire Mental Health and Learning Disability Services

SUBJECT: **FUTURE DELIVERY OF MENTAL HEALTH AND LEARNING DISABILITY SERVICES IN HEREFORDSHIRE**

Can this subject be discussed at a public Board meeting?	Yes

This report is provided for:

Decision Endorsement **ASSURANCE** **INFORMATION**

PURPOSE OF REPORT

The following provides Board colleagues with an update on our work associated with the transfer of Mental Health and Learning Disability Services in Herefordshire to Worcestershire Health and Care NHS Trust by 1st April 2020.

RECOMMENDATIONS

Board colleagues are asked to note the current position

EXECUTIVE SUMMARY/REPORT

Transition programme

The transitional work associated with the transfer of services to Worcestershire Health and Care Trust ('WHCT') continues at pace appropriate to the 31st March deadline and the work remains track. The key areas of focus are:

- Workforce: communication and TUPE arrangements
- Novation or cessation of third party contracts
- Operational management structures
- IT infrastructure and services
- Clinical and non-clinical information services

- Financial arrangements

This is work is led by WHCT as the incoming provider, but it continues to be strongly supported and informed by Gloucestershire Health and Care NHS Foundation Trust (GHC) to ensure that services transfer safely on the 1st April 2020.

There is a formal programme board and project team structure to direct and oversee the specific work streams.

A particular area of focus and of risk in recent weeks has been the Clinical Information Systems work steam, which requires further focus if it is to be completed on time. Whilst WHCT will continue to access the GHC "RiO" Clinical Information System until the end of June 2020, the migration strategy for information between "RiO" to "Care Notes" still needs to be finalised. GHC will continue to support this area of work closely and seek to escalate through the Programme Board if necessary.

CQC Registration and regulation

Helpfully our local CQC liaison team met with WHCT's local CQC liaison team to facilitate the handover of CQC reporting. WHCT and ourselves are supported by different regional teams within the CQC. The meeting provided further assurance to WHCT on a number of challenging issues which GHC has successfully managed in Herefordshire, for instance the environmental concerns about Oak House and the Stonebow Unit single-sex management issues.

Internally John Trevains' team are well advanced with the work required to deregister the services that will transfer to Worcestershire Health and Care NHS Trust.

On 21st January 2020, the outcomes of WHCT's CQC Inspection of late Autumn 2019 were published. Overall the Inspection outcome maintained the "Good" rating achieved by the Trust following their previous inspection in 2018.

The really good news from the inspection was that their CAMHS services have been rated as "Outstanding".

Unfortunately this is balanced with their Adult Community Mental Health Services being rated as "Inadequate". Sarah Dugan, the Chief Executive for WHCT had already shared some concerns about these services with our Herefordshire Senior Leadership Forum and advised that they were fully reflected on the Trust's risk register. GHC colleagues were assured that there is a robust action plan in place to deal with issues related principally to staffing challenges.

Further information in relation to the CQC inspection report outcomes has been shared

with Staff in Herefordshire and with Board members via separate correspondence.

Governor Engagement

The Herefordshire Governors continue to receive invites to, and attend the Herefordshire Senior Leaders Forum so that they are briefed on matters alongside the Herefordshire Senior Leadership Team.

They also attend smaller Governor meetings with Colin Merker and Duncan Sutherland to discuss more detailed issues. Recently the governors met with HealthWatch and WHCT's Director with responsibility for Patient/Service User and Carer involvement, Sue Harris, to discuss:

- The future arrangements for Governors and wider membership
- The continuing engagement of Herefordshire Experts by Experience and volunteers.

A wider engagement day is being planned for late February/early March 2020.

Continuing engagement of colleagues

In addition to appreciation and farewell events being arranged in March 2020 by the CEO and Chair of GHC, in order to ensure staff feel fully welcomed into WHCT, were supporting WHCT in facilitating a series of staff welcome and induction days which are being arranged for the 4th, 9th and 30th March 2020.

The collaborative working arrangements that have been put in place between GHC and WHCT should continue to ensure that staff feel involved, informed and able to influence the process.

CORPORATE CONSIDERATIONS	
Quality implications:	A successful transfer of leadership is required to support the continued successful delivery and development of Mental Health and Learning disability services in Herefordshire. As the transfer of services is progressed, we need to ensure that there is no detrimental impact on either services in Herefordshire or Services within the wider Gloucestershire portfolio of the Trust
Resource implications:	The Herefordshire contract income will cease on the 1st April 2020 and the Trust will need to have resolved issues associated with the removal of corporate contributes by that time.
Equalities implications:	Need to ensure services in Herefordshire are treated equitably until the point of transfer
Risk implications:	Loss of focus in either Herefordshire or Gloucestershire due to transition. Financial planning around cost recovery. Staff moral during transition.

WHICH TRUST VALUES DOES THIS PAPER PROGRESS (P) OR CHALLENGE (C)?			
Working together	**P**	Always improving	**P**
Respectful and kind		Making a difference	**P**

Report authorised by: Colin Merker, Managing Director Herefordshire Mental Health and Learning Disability	**Date:** 22 January 2020

Where has this issue been discussed before?
Board Meeting - November 2019 Executive meetings – ongoing 2019/20
What wider engagement has there been?
Wider engagement continuing with Herefordshire colleagues and Governors through workshops, meetings and 1-1 meetings.

AGENDA ITEM: 13/0120

REPORT TO: Trust Board – 29 January 2020

AUTHOR: Sandra Betney, Director of Finance

PRESENTED BY: Sandra Betney, Director of Finance

SUBJECT: **OUR MERGER – PME UPDATE**

Can this subject be discussed at a public Board meeting?	Yes

This report is provided for:

Decision Endorsement **ASSURANCE** Information

PURPOSE OF REPORT

To update the Board on the work of the Programme Management Executive (PME) in discharging its strategic intent responsibilities with a view to providing a final review to the March Board.

RECOMMENDATIONS

To note the assurance and update provided in this report.

EXECUTIVE SUMMARY

The PME is the executive group which led on delivery of the merger and now on integration of the two antecedent Trusts as part of the Strategic Intent. This update is part of the process of ensuring delivery of the Strategic Intent is safely 'handed-over'.

The Report explains that the Director of Strategy and Partnerships will act as the executive champion and quality improvement lead, that strategic themes will provide guidance to colleagues as to improvement priorities and that progress will be monitored and communicated without stifling innovation (see Appendix 1).

The Board is invited to note that programme delivery largely met and in some areas improved, on the financial assumptions described in the full business case and that the risks and issues have been either closed off or, in very few cases, transferred.

Assurance is provided regarding quality assurance and the meeting of the obligations provided through the various board memoranda. The Board will be required to submit its quality assurance certificate to meet a 1st April 2020 deadline, a draft for approval will be provided to the March Board.

The Board is invited to note that there will be a period of considerable system integration around March and April but that appropriate communications, training and issue management procedures are being put in place.

As part of its monitoring of workforce post-merger, PME confirmed the need to provide renewed focus on leadership and personal development through-out the management layers and to review GHC structures on a dynamic basis.

GHC is developing a 'Thoughts from our Journey' presentation to assist other merging Trusts and the content of the 'what went well' and 'particular challenges' slides is included for information.

PME is assured that it will have fully served its purpose by 1 April, will be submitting a final review to the March Board and be seeking at that point agreement for PME to be stood-down as an executive working group with effect 1 April 2020

CORPORATE CONSIDERATIONS			
Quality implications	N/A		
Resource implications:	N/A		
Equalities implications:	N/A		
Risk implications:	N/A		
WHICH TRUST VALUES DOES THIS PAPER PROGRESS (P) OR CHALLENGE (C)?			
Working together	**P**	Always improving	**P**
Respectful and kind	**P**	Making a difference	**P**

Report authorised by: Sandra Betney, Director of Finance	**Date:** 20 January 2020

Where has this issue been discussed before?
What wider engagement has there been?

Appendices:	Appendix 1: Our Merger – PME Update

AGENDA ITEM: 13/0120

APPENDIX 1

OUR MERGER – PME UPDATE – JANUARY 2020

INTRODUCTION

1. Purpose

To update the GHC Board on the work of the PME in discharging its strategic intent responsibilities, as lead-in for a final review at the March Board. The update reflects the current PME focus which is to provide a stable platform and boost the launch of GHC strategy development and implementation. It takes in the following areas:

- 'Governance'
- Progress and performance
- Finance
- Risks and issues
- Quality assurance
- Obligations and undertakings
- Integration
- Culture, values and workforce

2. Introduction

PME is the executive group which historically reported to the Strategic Intent Leadership Group (SILG) and led on delivery of the transaction to merge the two Trusts and the subsequent workforce, culture and system integration. Learning from other transactions identifies significant risk of momentum being lost after merger, the vision becoming blurred and the organisation reverting to pre-merger behaviours. PME is developing the plan to safely 'hand-over' delivery of the strategic intent to mitigate against this risk.

HANDOVER

3. Governance

The PME membership evolved as need changed and currently comprises the GHC executive chaired by the Director of Finance (Co-Deputy CEO) and provides, in effect, a 'ring fenced' and focussed executive team agenda. Post-PME, responsibility for delivery will remain with the executives, both individually and collectively with coordination through the CEO's routine executive meetings as required. Whilst Quality Improvement will become 'business as usual' it will still need some form of governance and championing if it is to compete with the daily operational pressures. This executive leadership and focus will be provided by the Director of Strategy and Partnerships reporting to the Resources Committee and through the Improving Care Group to the Quality Committee.

4. Progress and Performance

The executives have considered how best to set, measure or report performance and progress, primarily as a means of supporting governance. Options considered ranged from the highly directive performance management system advocated by NHSI to the entirely informal option, maximising on colleagues freedom to innovate. The formal option was discounted as being counter-productive, resource intensive, inhibitive on innovation and not in keeping with Trust co-creating and co-production vision. Whilst there was support for the 'hands off' approach note was taken of the experience at NELFT where it was found that some guidance and prioritisation of colleague initiatives had been of significant benefit. PME executives agreed that whilst GHC should do nothing that threatened to stifle innovation it would be helpful to offer colleagues some support and guidance. The CEO and Director of Strategy and Partnerships have outlined the use of strategic themes to help guide (rather than prescribe) GHC development and this along with the desire to be in a position where success can be communicated, led, to the selection of a light touch option. The Director of Strategy and Partnerships will be the executive responsible for overseeing the collation and presentation of success to the Resources Committee and through the Improving Care Group to the Quality Committee. The steps will be:

- Revise and collate proof of concept initiatives
- Manual collation of project deliverables contained in PMO sponsored projects
- Manual collation of improvements (delivered or intended) indicated in Life QI
- Grouping of initiatives from above steps to help indicate what is of 'bottom-up' interest to help inform strategy development
- Stored as central resource by the Communications Team
- Over-view report prepared by Director of Strategy and Partnerships. Ad-hoc quantification will be provided, if required (though this will not be the default) by the Business Intelligence function.
- Periodic release as communications items and an intranet update.

5. Finance

The £1.3m programme delivery budget approved by the Board in 2017 closes on 31 March 2020. The Board is invited to note:

Non-Recurrent Costs

- **Merger Programme Delivery** The merger programme was delivered at £0.341m under budget, driven mostly by underspends in project coordination and support.
- **Transition Costs** Non recurrent transition costs were £0.136m higher than planned due mainly to additional phase 2 exit costs of £0.254m. The planning assumption had been of no redundancy costs during that stage of restructuring.
- The additional non-recurrent transition costs can be more than offset by the £0.341m underspend in the merger cost budget.

Recurrent Costs and Savings

- The measures taken as a result of the merger are expected to deliver a recurrent saving to GHC of £0.996m
- The forecast recurrent savings anticipated in the FBC were in the order of £1.265m.
- The variation of £0.269m is largely attributable to:
    - decisions taken to provide additional capability to the medical structure (£0.323M)
    - A £0.275m cost pressure brought about by the extension of those IT systems and software operated by GCS which we have subsequently selected to roll out across GHC. We had initially hoped to be able to fund this from savings achieved by bringing IT services in house but will now be funding it from recurrent savings instead.

6. Risks and Issues

The Board will be aware that PME maintained and managed a comprehensive risk and issues register**.** The vast majority of risks have now either failed to materialise or been mitigated to an extent that they can be removed. In those few cases where it is felt a risk to GHC remains these have been passed to and discussed with an appropriate risk owner.

7. Quality Assurance

Changes, improvements and initiatives will be subject to the quality assurance system implemented by the Director of Nursing, Therapies and Quality. Further guidance as to when and how quality and equality impact assessments should be completed has been issued and compliance will be monitored. Quality assurance reports will be submitted to the Quality Committee and will include the impact of any significant change and Quality Improvement activities. The GHC Board is required to submit its post-transaction quality certificate to NHSI within 6 months of merger (ie by 1 April 2020). The version submitted to NHSI on merger will be updated by the Head of Corporate Affairs for approval at the March Board.

8. Obligations and Undertakings

PME has been overseeing completion of those items which arose from the advisory recommendations of Grant Thornton and the NHSI or were undertakings given in the FRP or Quality memorandum. The vast majority of items have subsequently been completed as the reporting procedures and quality systems are put in place. Any residual items will continue to be tracked by the executive team with any risks and issues escalated to the Resources and Quality Committees as required.

9. Final Integration

There are some areas of integration which for technical or procurement reasons won't be completed in this financial year. Whilst their delivery will be the responsibility of the

relevant executive there are areas of dependency which will need continued coordination by the Transition Director until the end of March 2020. There will be a

number of system changes, notably around corporate systems and workforce data (especially ESR) whose effects will be felt by colleagues in the period from mid-March to end of April 2020. There is a risk that this system go-live period will be as impactive, as Day 1, potentially more so. A programme of user familiarisation training, tailored to those that need it, has been developed and a communications and issues management plan similar to that for Day 1 is being put in place. Any residual activity required beyond March will be documented and agreement reached on executive ownership.

10. Culture, Values and Workforce

PME has been monitoring the impact of merger on the workforce through the Pulse Survey and more recently through workforce reporting. It has not established a direct link, though turbulence does seem to be greatest in the corporate services and a deep dive was held into that aspect. As a result it was decided to provide renewed focus on leadership and personal development through-out the management layers and to review GHC structures on a dynamic basis.

11. Lessons Identified

GHC is developing a 'Thoughts from our Journey' presentation to support other Trusts in their mergers. The key lessons are summarised in the tables below:

WHAT WE DID WELL

- A strong case, aligned to national priorities, passionately owned by the Boards and successfully shared with colleagues
- Done by us, not to us and with co-delivery
- Colleagues believed in the cause and were prepared to 'dig deep'
- Cultural alignment started early and with high profile
- A committed and disciplined approach to 'passing the exam'
- Relationship with NHSI regional team
- Integrating early and visibly, no pause or unravelling post-merger
- Minimal redundancies below Board level
- Merging of best practice
- Phasing in before and after merger rather than big bang
- Preparation for Day 1, Month 1, year-end potential trip hazards
- Maintaining an eye on the real prize – transformation not the merger
- Setting out the Transforming Organisation and proving the concept
- Communications and pulse check – an integral part not just a tool

PARTICULAR CHALLENGES

- We might not know yet – but we are ready
- Simultaneously meeting both BAU and Change pressures
- Communications – 'poor signal zones'
- Allowing for co-development
- Overcoming the notion of winners and losers
- Individual uncertainty and concerns
- Quantifying benefits
- A tense wait for last minute Ministerial sign-off!!
- Allowing for recovery and consolidation?

12. PME STAND-DOWN

The PME, individually and collectively is assured that it will have fully served its purpose by 1 April 2020, that the appropriate steps have been taken to ensure that any remaining risks and issues have been properly transferred and that systems are in place to provide the required governance and assurance.

13. RECOMMENDATION:

The GHC Board is invited to note:

- the arrangements made to close or transfer any remaining PME matters and to continue to drive the strategic intent
- that it will be invited to agree at the March Board that PME be stood down as an executive working group with effect 1 Apr 2020 (this report will be updated by way of final review).

AGENDA ITEM: 14/0120

Report to:	Trust Board – 29 January 2020
Author:	John Trevains, Director of Nursing, Therapies and Quality.
Presented by:	John Trevains, Director of Nursing, Therapies and Quality.
SUBJECT:	**QUALITY SUMMARY REPORT – DECEMBER 2019**

Can this subject be discussed at a public Board meeting?	Yes

This report is provided for:

Decision Endorsement **ASSURANCE** **INFORMATION**

PURPOSE OF REPORT

To provide the Board with a summary assurance update on progress and achievement of quality priorities and indicators in both Physical and Mental Health Services.

RECOMMENDATIONS

The Trust Board is asked to discuss, note and receive the December 2019 Quality Summary Report.

EXECUTIVE SUMMARY

This report and attached appendix provides an overview of the Trust's quality activities inclusive of April to December 2019 data. It is a summary report combining information from the two Trusts, prior to merger, reporting systems into a single format for the Board. This report will be produced monthly for Board, Quality Committee and Operational Governance Forum information and assurance.

Historical quality reporting has been maintained to ensure existing quality schedule and contractual arrangements can be reported against for 2019/20. A more detailed Mental Health and Learning Disabilities service quarterly quality update is scheduled to be completed in February in line with previous reporting arrangements.

Physical Health Services

Safety and Patient Experience

- Friends and Family Test response rate increased in December to **10.1%** compared

to **9.7%** in November.

- The proportion of patients indicating 'Likely' or 'Extremely Likely' to recommend our services increased slightly in December to **96.3**% compared to **96.0%** in November (Apr-2017 – Dec-2019 mean **93.49%**).
- Safety Thermometer Harm free score increased in December to **92.5%** compared to **91.9%** in November, target 95%, and remains below the mean **93.75%** (Apr-2017 – Dec-2019).
- Based on new harms only, the Trust achieved harm-free care of **98.1%** in December, compared to **96.9%** in November, target 98%, and above the mean **98.03% (**Apr-2017 – Dec-2019); significantly higher than the national benchmarking average for November of 89.9%. For Board information we are aware that Safety Thermometer reporting may be removed as a national indicator in the 2020/21 national contract.
- No post-48 hour Clostridium Difficile infections in December.
- 4 SIRIs were declared in December and are currently being investigated.

Quality Priorities

- Our acquired pressure ulcer quality metrics continue to make progress and are on trajectory
- Deteriorating patient monitoring has made a significant positive improvement in Q3
- Quarter 3 data for Catheter Management and Wound Care is on track to be reported for the next monthly report
- MUST scores and End of Life Template require additional attention regarding data quality and completion of tool is not at required levels

Quality Dashboard

- The Trust compiles a quality dashboard covering the Community Hospital Inpatient and Minor Injury and Illness Units, updated on a monthly basis and displayed within each of the units. In terms of underperformance we are seeing reduced variance between sites which is an encouraging picture. Work is in progress to reduce this variance.

Mental Health And Learning Disability Services Quality Indicators

Please note a further detailed update for Board will be provided as part of the Q3 Mental Health and Learning Disability Services quality report update. This is scheduled to be compiled in February 2020 when all required data is available and will be presented at March Board.

Positive progress is being made in the delivery and achievement of Trust Quality Indicators

The following indicators are currently being achieved

- Improving personalised discharge

- Care Programme Approach reviews occur for all service users who make the transition from children's to adult services
- User experience survey
- Reducing suicides
- Reducing harm from absconding
- Reducing prone restraint using supine alternative
- Individual restrictive intervention plans - Berkley House

Quality Indicator Areas for improvement

Target 1.1 Improving the physical health care for people with schizophrenia and other serious mental illnesses; Compliance within the inpatient service is at **78%** against a target of **90%.**

- The Audit & Assurance Team will establish an electronic audit which will provide ward/team managers with weekly compliance data and actively promote intervention if required.
- A re launch of the Health & Lifestyle form is planned for February 2020 which will involve ward/team training and posters to be displayed around the Trust.

Target 1.2 Ensuring that people are discharged from hospital with personalised care plans.

48hr follow up is currently showing as 72%, this appears low compared to historical trends and will be subject to additional validation where we expect the score to improve.

Targets 2.1 & 2.4 (Survey questions)

We are non-compliant in some component areas respectively in Q2 & Q3 although cumulative compliance is achieved for year end to date.

This appears to be a consequence of significantly reduced response rates, including a zero return from Herefordshire Services in Q3 following diminishing returns in Q1 and Q2. Recovery actions are in place to seek to improve this for Q4.There is ongoing work to promote the survey during Q4 ahead of the new FFT and a new harmonised physical and mental health patient and carer survey being launched in April 2020.

Corporate Considerations	
Quality implications:	By the setting and monitoring of quality targets, the quality of the service we provide will improve
Resource implications:	Improving and maintaining quality is core trust business.
Equalities implications:	No issues identified within this report
Risk implications:	Specific initiatives that are not being achieved are highlighted in the report

WHICH TRUST VALUES DOES THIS PAPER PROGRESS (P) OR CHALLENGE (C)?			
Working together	**P**	Always improving	**P**
Respectful and kind	**P**	Making a difference	**P**

Report authorised by:	**Date:**
John Trevains, Director of Nursing, Therapies and Quality.	20.01.2020

Where has this issue been discussed before?
Quality Committee December and January. Quality Assurance Group December
What wider engagement has there been?

Appendices:	Full Quality Report

with you, for you

Gloucestershire Health and Care
NHS Foundation Trust

Quality Report

Trust Board - 29th January 2020

Data for December 2019

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

with you, for you

Gloucestershire Health and Care
NHS Foundation Trust

Physical Health Services
(formerly Gloucestershire Care Services NHS Trust)

Data covering April to December 2019

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

Executive Summary

Gloucestershire Health and Care
NHS Foundation Trust

This report contains the Quality measures and Quality priority section from the previous Quality and Performance report. A separate report is produced covering the Performance metrics.

Are Our Services Caring?

- Friends and Family Test response rate increased in December to **10.1%** compared to **9.7%** in November.
- The proportion of patients indicating 'Likely' or 'Extremely Likely' to recommend our services increased slightly in December to **96.3**% compared to **96.0%** in November (Apr-2017 – Dec-2019 mean **93.49%**).

Are Our Services Safe?

- Safety Thermometer Harm free score increased in December to **92.5%** compared to **91.9%** in November, target 95%, and remains below the mean **93.75%** (Apr-2017 – Dec-2019) although this is based on a reducing sample size. Work is in progress to remedy this noting Safety Thermometer may be removed as a national indicator in 2020/21 national contract.
- Based on new harms only, the Trust achieved harm-free care of **98.1%** in December, compared to **96.9%** in November, target 98%, and above the mean **98.03% (**Apr-2017 – Dec-2019); significantly higher than the national benchmarking average for November of 89.9%.
- We had no post-48 hour Clostridium Difficle infections in December.
- 4 SIRIs were declared in December and are currently being investigated, 2 were related to the pregnancy advisory service; 1, wheelchair service and 1, was an acquired pressure ulcer in a community setting

Quality Priorities

Quality Priorities for 2019/20 included in this report are based on a mixture of metrics and audits. Where audits or actions are to be reported on a quarterly basis a RAG rating will be applied and updated during the quarter to provide an update of progress towards completion of audits or actions.

- Our acquired pressure ulcer quality metrics continue to make progress and are on trajectory
- Deteriorating patient monitoring has made a significant positive improvement in Q3
- Quarter 3 data for Catheter Management and Wound Care is on track to be reported for the next monthly report
- MUST scores and End of Life Template require further attention regarding data quality and completion of tool

Quality Dashboard

- The Trust compiles a quality dashboard covering the Community Hospital Inpatient and Minor Injury and Illness Units, updated on a monthly basis and displayed within each of the units. This is featured on page 14 of this report. In terms of underperformance we are seeing reduced variance between sites which is an encouraging picture. Work is in progress to reduce this variance

Quality Dashboard

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Gloucestershire Health and Care
NHS Foundation Trust

CQC DOMAIN - ARE SERVICES CARING?

		Reporting Level	Threshold	2018/19 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2019/20 YTD	RAG	Exception Report?	DQ Rating	Benchmarking Report Nov Figure
1	Friends and Family Test Response Rate	N - T	15%	14.5%	17.7%	19.4%	16.7%	15.1%	11.5%	15.9%	11.0%	9.7%	10.1%				14.1%		No - within SPC limits	G	
2	% of respondents indicating 'extremely likely' or 'likely' to recommend service	N - R L - I	95%	92.7%	93.4%	92.7%	92.7%	92.7%	94.1%	92.6%	92.6%	96.0%	96.3%				93.7%		No - within SPC limits	G	90.7%
3	Number of Compliments	L - R	1,317	1,317	124	104	180	178	132	134	146	151	170				1,319			G	
4	Number of Complaints	N - R	42	42	6	5	6	2	5	3	3	6	2				38			G	
5	Number of Concerns	L - R	485	485	40	32	23	40	34	35	33	20	22				279			G	

CQC DOMAIN - ARE SERVICES SAFE?

		Reporting Level	Threshold	2018/19 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2019/20 YTD	RAG	Exception Report?	DQ Rating	Benchmarking Report Nov Figure
6	Number of Never Events	N - R		0	0	0	0	0	1	0	0	0	0				1			G	
7	Number of Serious Incidents Requiring Investigation (SIRI)	N - R		11	0	2	3	0	0	0	0	2	4				11			G	
8	Number of Serious Incidents Requiring Investigation (SIRI) where Medication errors caused serious harm	N - R		0	0	0	0	0	0	0	0	0	0				0			G	
9	Total number of incidents reported	L - R		4,443	398	410	342	424	371	344	378	383	410				3,460			G	
10	% incidents resulting in low or no harm	L - R		96.4%	97.2%	95.1%	94.4%	95.5%	95.7%	93.9%	93.9%	94.8%	92.9%				94.8%			G	
11	% incidents resulting in moderate harm, severe harm or death	L - R		3.6%	2.8%	4.9%	5.6%	4.5%	4.3%	6.1%	6.1%	5.2%	7.1%				5.2%			G	
12	% falls incidents resulting in moderate, severe harm or death	L - R		1.8%	3.1%	3.1%	2.9%	0.0%	4.9%	0.0%	1.6%	0.0%	1.5%				1.9%			G	
13	% medication errors resulting in moderate, severe harm or death	L - R		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%				0.0%			G	
14	Number of post 48 hour Clostridium Difficile Infections	N - R L - C	1*	15	0	0	1	1	1	5	1	1	0				10	G		G	
15	Number of MRSA bacteraemias	N - R L - C	0	0	0	0	0	0	0	0	0	0	0				0	G		G	
16	Number of MSSA Infections	L - R	0	0	0	0	0	0	0	0	0	0	0				0			G	
17	Number of E.Coli Bloodstream Infections	L - R	0	2	0	0	0	0	0	0	0	0	0				0			G	
18	Safer Staffing Fill Rate - Community Hospitals	N - R		100.2%	102.0%	100.7%	101.3%	99.7%	100.8%	99.7%	102.5%	101.3%	99.7%				100.9%			G	
19	VTE Risk Assessment - % of inpatients with assessment completed	N - T	95%	96.9%	99.5%	98.9%	97.0%	95.5%	96.1%	95.9%	96.5%	99.4%	96.1%				97.2%	G		G	
20	Safety Thermometer - % Harm Free	N - R L - C	95%	93.7%	94.3%	92.6%	93.4%	94.4%	93.5%	92.9%	93.7%	91.9%	92.5%				93.2%	R	Pg. 13	A	
21	Safety Thermometer - % Harm Free (New Harms only)	L - I	98%	98.1%	98.3%	98.1%	98.4%	98.4%	98.5%	97.8%	96.9%	96.9%	98.1%				97.9%	G		A	89.9%
22	Total number of Acquired pressure ulcers	L - R		728	79	63	56	64	60	59	65	60	70				576			G	
23	Total number of grades 1 & 2 Acquired pressure ulcers	L - R		671	74	59	60	59	56	54	64	54	67				547			G	
24	Number of grade 3 Acquired pressure ulcers	L - R		52	5	4	3	4	4	4	1	2	2				29			G	
25	Number of grade 4 Acquired pressure ulcers	L - R		5	0	0	0	1	0	1	0	4	1				7			G	

*In-month threshold (i.e. December)

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

RAG Key: R – Red, A – Amber, G - Green

Quality Priority | Are Service Safe?

1. Medication Incidents

Outcome: Improve learning from "no-harm" and "low-harm" medication incidents to enhance patient safety

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This priority will enable (1) identification and theming of factors contributing/causing low and no harm medication incidents and (2) recommendations to address identified themes

Improve the learning from "no-harm" and "low-harm" incidents		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Actions		Establish a baseline of quality of reporting of harm reported medication incidents using quality audits - Completed, see below.			Quality Improvement working group will establish a training needs analysis on baseline data and agree actions required to improve quality of reporting			Implementation of actions agreed from Qtr. 2			A repeat audit of harm reported medication incidents will be performed to determine if the aims of the outcome have been achieved		
Low/no harm incidents have been investigated and closed by end of each quarter	Target				45%			60%			75%		
	No-harm medication incidents	Baseline: 32%			25%								
	Low-harm medication incidents	Baseline: 29%			57%								
Low/no harm incidents should state the medication involved	Target				91%			95%			100%		
	No-harm medication incidents	Baseline: 87%			85%								
	Target				80%			90%			100%		
	Low-harm medication incidents	Baseline: 71%			57%								
Low/no harm incidents should state the indication for the medication involved	Target				33%			66%			100%		
	No-harm medication incidents	Baseline: 0%			30%								
	Low-harm medication incidents	Baseline: 0%			0%								

Additional information:

Performance
There were 30 medication incidents with Community Physical Health Services responsibility reported in December.
- 2 resulted in low harm
- 28 resulted in no harm

SPC charts show the number of medication incidents, no harm medication incidents and low harm medication incidents to be within control limits (normal variation).

Actions
- Work is progressing with the Education and Learning team to develop medicines training (new starter and 3 yearly) refresher to be hosted on an electronic platform.
- The terms of reference for the new Medication Safety Group are being developed. This group will be focus on the Quality Priority and report to the Medicines Optimisation Group.

2. Mental Capacity Act

Outcome: Improve the usage of mental capacity assessments in our hospital and community settings to ensure that individuals who lack the ability to make decisions are the focus of any decisions made, or actions taken on their behalf

Mental capacity Act and DoLS operational practice
Reference – 559
Rating – 12

The philosophy of the Mental Capacity Act 2005 (MCA) is to ensure that individuals who lack the capacity to make specific decisions are the focus of any decisions, or actions taken, on their behalf. It is a legal requirement to carry out an assessment when a person's capacity is in doubt. MCA needs to become a "business as usual" exercise, to ensure that the Trust is compliant with legislation and to achieve optimum benefits to our patients and families. Metrics will focus on the completion of the MCA2 and Deprivation of Liberty Safeguards (DoLS) assessments for significant decisions.

MCA Metrics		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Has an MCA2 been completed for restrained or restricted patients in our community hospitals? (Baseline from March 2019 audit 11%. Measured from dip test audit mid quarter)	Target	15%			30%			60%			90%		
	Actual	33%			65%			92%			Audit available end March 2020		
Has a deprivation of Liberty Safeguards application been made for all patients who do not have capacity to consent to being restricted or restrained? (Baseline 22% from March 2019 audit)	Target	25%			40%			60%			90%		
	Actual	33%			55%			85%			Audit available end March 2020		

Actions:

- For the Qtr. 3 audit MCA 2s completed needs to be qualified, as 46% of those completed had been saved as final version, while 46% were recorded on SystmOne but were saved for future editing. This continues to be an issue, and the SNSA will feed this back to staff to encourage them to save as final version.
- The quality of the MCA 2 forms completed is variable, but it is encouraging that so far we have surpassed our target number, which indicates staff are confident and skilled in completing them.

3. "Better Conversations" and Personalised Care

Outcome: Develop a programme of personalised care planning to enable patients to manage their long term conditions more effectively

Personalised care is a priority in the Long Term Plan, with a stated objective that it should become "business as usual across the health and care system". In the ICS workforce strategy the vision is to see this facilitated by a health coaching approach, called "Better Conversations". It is noted that both the GCS and 2Gether NHS FT contracts for 2019-20 include a commitment to work with the GCCG to develop "5 core measurable statements for the ICS personalised care programme that define outcomes for patients and success". This programme will directly feed in to this growing body of work.

NHSE have committed to "*consider, develop and test the most appropriate personalised care activity metrics*" including the development of a new Long Term Conditions Patient Recorded Outcomes Measure (PROM).

The Patient Activation Measure (PAM) will be a key tool in these early stages. Patient "activation" describes the knowledge, skills and confidence a person has in managing their own health and care. The concept of patient activation links to all the principles of person-centred care, and enables the delivery of personalised care that supports people to recognise and develop their own strengths and abilities. Services included will be MacMillan Next Steps, Self Management, Diabetes Education, and part of the ICTs (Complex Care at Home and Berkeley Vale ICT where health coaching training has taken place).

Actions completed:

- Attended NHSE/I workshop on evaluation of personalised care.
- Sent 3 people on PAM Trainer training and introduced training in how to use PAM within Integrated Community Teams.

Better Conversations and Personalised Care Measures	Qtr. 1	Qtr.2	Qtr. 3	Qtr. 4
Number of care planning conversations taking place for the identified cohorts	Set by individual teams and based on relevance to patient cohort(s)	This is happening, however more work is required to report from SystmOne	SystmOne reports 7,148 patients with a care plan. Caution is required as definitions are not standard, and some eligible plans are not recorded on SystmOne.	Available end March 2020
Number of patients completing a Patient Activation Measure (PAM) questionnaire	Baseline: 1,500 per annum; target + 30%	Numbers are stable rather than rising but this is attributable to specific difficulties within 2 services and these are now resolved/resolving. Expect to recover lost ground	Trajectory now back on track. First 3 Quarters of 2018/19 = 552 people had PAM score; same period 2019/20 = 926 people had a PAM score	Available end March 2020
Number of patients completing a second PAM	Baseline: 500 per annum; target + 30%	This is increasing in line with target	264 compared to 420 at same point last year (Qtr. 3)	Available end March 2020
The use of PAM data to tailor interventions to further the personalisation agenda	Narrative reporting - commenced June 2019 in Complex Care at Home, MacMillan Next Steps	Progressing well. Embedded in 2 services and embryonic in others	Progressing well. Embedded in 2 services and embryonic in others	Available end March 2020
Delivery of a quarterly qualitative report detailing ongoing developmental activities and examples of good practice, patient stories and shared learning	Linked to quarterly PAM data; most teams dependent upon CCG feed and Qtr. 1 data; delivery expected during Qtr.2	Some case studies produced and shared with system partners as well as internally. Increasing anecdotal evidence of successes but failed thus far to produce "formal" report	Case Study report submitted to Clinical Quality Review Group (14 November 2019).	Available end March 2020

4. Catheter Management

Outcome: Quality Improvement programme to improve management of catheters in community settings

Long term catheters whilst beneficial for some patients are also associated with morbidity. Infections (including sepsis) and other complexities which include anxiety over unpredictability of catheter problems (e.g. sudden blockage), difficulties managing away from home (e.g., taking equipment on holiday), sense of physical restraint, limited clothing choices, interruptions to sleep due to discomfort or pulling, and self-identity issues.

It has been identified that some patients appear to have clinically unnecessary urinary catheters in situ; the above risks and problems can therefore impact on the safety, morbidity and quality of life of these cohorts of patients.

Catheter Management metrics	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4
Reduce the amount of community nursing contacts to patients between planned routine catheter changes to manage catheter associated problems.	Target	95% of baseline	90% of baseline	85% of baseline
	Set targets for use in Qtrs. 2 to 4 Baseline: 3,900 Contacts per quarter (1,300 per month)	5% reduction	Available end January 2020	Available end April 2020
Reduce the number of (clinically unnecessary) urinary catheters inserted in the community setting.	Establish baseline and set targets for use in Qtrs. 2 to 4 Delay due to determining percentage of patients whose first catheter insertions were not on GCS Nurse caseloads, or may have a positive TWOC* outcome	Delayed data capture continuing through October, report available November	Audit available end January 2020	Audit available end April 2020

* TWOC – Trial Without Catheter to determine if clinically indicated.

Actions completed:

- An audit of new catheter requests for October in the ICTs demonstrated:
  - 85% of all (33) new catheter requests received into ICTs in October were found to be clinically relevant and appropriate
  - Of the remaining 15% of people referred in October (5 people) their reasons for catheterisation were: 1 x End of life care – catheter was not inserted / 1 x reduce mobility – was catheterised in GHFT / 1 x post-operative, but not urology surgery – again decision to catheterise was taken outside of GHC / 1 x incontinence + dementia and cancer of the prostate (this may have been inappropriate but insufficient clinical information available to appraise) / 1 x undefined need patient (insufficient assessment information available to appraise)
  - 77% of requests were for male patients with clinical need, of those the majority will go on to have surgical intervention as such they would all be clinically appropriate catheterisations.
- We have now reviewed the draft of the countywide catheter passport and comments returned to lead in GHFT– asserting this needs to be a countywide document under the One Gloucestershire umbrella not branded to GHFT.
- A practice improvement poster is nearly completed by One Gloucestershire based on GHC work undertaken. This will be disseminated to all clinical areas, care homes and care agencies across the county.
- PDSA work is underway for small scale improvement in service areas as follows:
  - Evening & Overnight nursing – production of a standard equipment in the home list and to standardise equipment.
  - Complex Care @ Home – catheter education required for all colleagues as not all nurses in team.
  - Community Hospitals - knowledge on trouble shooting guidance e.g. CAUTI and Trial Without Catheter/retention trouble shooting, focus on untrained education (nothing currently available for HCA's).
  - ICTs – Bowel routine recording on clinical SystmOne template.
- A countywide continence formulary is in the final stages of development between the Continence Specialist Lead, the CCG and the Head of Community Nursing. This will standardise equipment in use, identify best value for money and reduction in unwarranted variation which will help improve practice. This is now appraised by the Trust and agreed. Delays in this moving forward are not of GHCs causing.
- Education offers for bladder and bowel assessment and care are now on ESR.

5. Wound Care

Outcome: Increase the quality of wound assessments and management countywide in order to reduce clinical variation and improve wound healing rates

Gloucestershire Health and Care NHS Foundation Trust

This priority builds on the 2017-2019 CQUIN which was put in place nationally following UK studies that identified inconsistencies in the assessment and management of wounds and the opportunities to improve both efficiency of working and patient outcomes.
There are two principle reasons why wound assessment has been targeted:

1. A need to improve the quality and consistency of care delivered.
2. A need to reduce the cost burden of wounds. Clinical practice and wound outcomes should ultimately improve.

The Trust has been working to improve wound care as per the 2017-19 CQUIN, performance from Qtr. 4 of year 2 of the CQUIN is used below as a baseline for the Quality Improvement.

Wound Care Metrics		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
To increase the number of patients who receive a fully compliant assessment (to the "leading change adding value" clinical assessment domains of the 2017-19 wound assessment CQUIN) on admission to Community Nursing caseloads, Complex Leg wound services, Podiatry Service or Inpatient Settings from baseline.	Target	**30%**						**40%**			**60%** by the end of Year 1 of the QI project. Metrics to be reviewed again if project goes in to Year 2		
	Actual	25.00%						Audit available end January 2020			Audit available end April 2020		
To increase the number of patients who have received a full wound assessment according to the "leading change adding value" Clinical Assessment domains of the 2017-19 wound assessment CQUIN AND whose wounds have healed within 4 weeks.	Target	**60%**						**65%**			**70%**		
	Actual	22.00%						Audit available end January 2020			Audit available end April 2020		

Actions completed:

A revised education offer for all aspects of wound assessment is under development – this includes all areas where wound assessment will be discussed and will be:

- Revised Tissue Viability education offers go live in January.
- We have trialled a new SystmOne wide wound assessment and treatment template for all services – next step is to appraise this to coding and data extract needs (reference costs).
- Working with the CCG on countywide clinical pathways and resources for all areas to aid clinical decision making, this is developing with multiple clinical pathways in development.
- Revised exceptions reporting form issued (on intranet for countywide use).
- Bespoke Tissue Viability education has been offered into Gloucester City ICT to support novice practitioners in wound assessment, this was identified in a number of reported incidents as required learning.
- Compliance to the revised wound formulary (issued April 19) is relatively good, with the exception of barrier cream use, work underway to reduce this and move patients to formulary advised products.
- A picture clinical decision making tool related to the new formulary has been issued service wide and well received.

6. Pressure Ulcers

Outcome: Build on our success of reducing pressure ulcers by working with the NHSI Stop the Pressure Collaborative framework. This will focus on specific community programmes to reduce pressure ulcers

The prevention of pressure ulcers remains one of our top priorities with regards to patient safety. Despite great strides in the past 2 years our aim will be to continue to monitor the number and incidence of pressure ulcers and to continue to drive our reduction plans forward. Metrics for measuring performance therefore are:

1. Pressure ulcers will continue to reduce across our patient facing services where our span of influence can have an impact.
2. Quality improvement methodology continues to target areas of high incidence and as a response to incident reports to understand the issues, current focus on Cotswolds, Cheltenham and Forest hospitals to showcase improvement. The PDSA cycle will report quarterly on these areas and will include a qualitative report.

Plans also include working collaboratively with GHFT and / or care homes where specific incidences or themes demonstrate the potential for system wide learning. Qualitative reporting will also include case studies where pressure ulcers have been managed and healed, following the patient journey and taking in to account other factors such as nutrition and hydration.

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Pressure Ulcers		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Acquired Pressure Ulcers will continue to reduce across patient facing services where our span of influence can have an impact	Target (Number of avoidable acquired pressure ulcers over total pressure ulcers)	**8%** (2018-19 Q4 baseline 8.9%)			**7%**			**6%**			**5%**		
	Actual	8.6%			6.6%			5.9%			Audit available end March 2020		
	Number of acquired and avoidable pressure ulcers	37			24			24					
	Total number of pressure ulcers in audit	430			365			409					

Preventing Pressure Ulcers update:

- The quarterly metrics taken from Datix reports continue to evidence that clinicians are reporting and recognising skin integrity damage at earlier stages in patient's care journey. This is reflected in increased category 1 & 2 Pressure Ulcers and reduced occurrence of avoidable categories 3 & 4. This suggests that the posture and risk management approach to education is improving patient safety.
- Monthly deep dive review into all reported category 3 & 4 ulcers commenced in November.
- Deep dive into the pressure ulcers for Qtr. 3 that are recorded as developed or worsened under our care and categorised as unavoidable will be reviewed for themes and reported to the Quality committee in February/March
- Community Hospitals have completed their quality improvement PDSA cycle across the Forest Community Hospitals and this has rolled out to Tewkesbury and Cirencester hospitals.
- North Cotswolds professional leads in Physiotherapy, Occupational Therapy and Community Nursing have completed 2 workshops focused on risk assessment and posture for AHP's. This approach is a result of the #stopthepressure PDSA results which highlighted training to reduce avoidable harm should focus on holistic assessment and posture management.. Additionally this AHP approach is underway in Cheltenham with cross locality support from North Cotswolds

Risks
(Pressure Ulcers)
Reference – 562 - Rating – 12

Compliance with published standards from NHS Improvement (July 2018) and National Reporting and Learning System (NRLS) (March 2019) have been achieved. Definitions of acquired and inherited have been updated on the Datix incident reporting system. This has completed the outstanding actions from the gap analysis report for the Quality and Performance Committee (July 2018): Pressure ulcer developed or worsened during care by this organisation (previously: *acquired*). Pressure ulcer present before admission to this organisation (previously: *inherited*).

Benchmarking: In the 'Rate of new grade 2,3,4 avoidable pressure ulcers acquired in a Community Hospital setting per 1,000 occupied bed days' the Trust submitted a figure of 0.89 in November. The benchmarking figure is 1.01 for Community Hospital settings.

Gloucestershire Health and Care
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7. Nutrition and Hydration

Outcome: Increase the use of nutrition and hydration assessments in all appropriate settings in order for patient's to be optimally nourished and hydrated

The quality improvement group is adopting a Quality Improvement methodology and the metrics include:

- Patients will have a baseline MUST on admission to wards or clinical caseloads (the maximum time frame is 72 hours for in-patient settings or 2 visits for Integrated Community Teams - ICTs).
- An audit approach to measure performance will be used until more reliable reporting can be assured from SystmOne.
- Qualitative, quarterly reporting will also be included as part of the Quality Improvement approach (using a PDSA methodology). This will focus on reviewing samples of patients where MUST scores have triggered the need for interventions to establish whether patients are being managed appropriately and to a high quality. This will include all aspects of the patient's care such as food charts, supplements, referrals to dieticians and impacts on other aspects of care such as the prevention or healing of pressure ulcers.

Nutrition and Hydration metrics 2019/20 (performance from audit data)						
Service area	Baseline		Q1	Q2	Q3	Q4
ICTs	December 2018 audit 66%	Target	65%	70%	75%	95%
		Actual	66.0%	65.0%	60.0%	Audit end March 2020
Community Hospitals	March 2019 audit 80%	Target	80%	85%	90%	95%
		Actual	91.4%	76.0%	84.0%	Audit end March 2020

Actions completed:

- Electronic audit tool tested in Cirencester Hospital by senior clinicians; reported to be user friendly and time efficient.
- Request and tool sent to each Community Hospital Matron for snapshot data entry for each patient. Some data entries were confused, however these were removed from the sample to ensure they did not adversely affect the sample.
- Qtr. 4 priority is to further review the electronic tool and support clinical colleagues from Community Hospitals with data entry during January.

8. End of Life Care

Our aim will be to embed as "business as usual" with dedicated leadership.

End of Life Care improvements will continue to be reported during 2019/20.

- Percentage of patients on an End of Life template has not increased. Efforts are focussing on our Community teams as Community Hospitals consistently use the template in most cases.

End of life Care	Baseline	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Percentage of Community Hospital inpatients who have End of Life care recorded on SystmOne EoL template	81.0%	81.8%	100.0%	90.9%	83.3%	82.4%	86.7%	75.0%	77.8%	75.0%			
Percentage of all Trust patients who have End of Life care recorded on SystmOne EoL template	48.6%	52.1%	56.6%	55.2%	57.3%	59.2%	60.0%	55.1%	57.6%	48.3%			
Number of patients who have End of Life care recorded on SystmOne EoL template	n/a	76	82	74	82	77	69	75	76	71			
Number of patients who died in the month	n/a	146	145	134	143	130	115	136	132	147			

Actions completed:

- The exemption criteria has now been applied and although the completion rate for the Community Hospitals has improved, The criteria applied is: any unexpected deaths, or deaths within 24 hours of referral/admission, and patients referred to the Physiotherapy and Occupational Therapy services (with the exception of the Palliative Care Occupational Therapists).
- No significant improvement was seen in community nursing with the exemptions applied. A deep dive of al the patient records without EoL template for October has show that there are a number of deaths that should be excluded from the numbers. Unfortunately due to the way that the information is recorded we are unable to exclude these during the reporting processes. For October, out 66 patient record 18 patients died in the acute hospital, 4 in a hospice, 5 died unexpectedly at (no EoL indication in record)a and 13 died in nursing/care home (no EoL indication seen in record)
- ReSPECT launch countywide on 10th October 2019. Document is being used widely across Gloucestershire. Event being held in April to target Nursing/Care homes and GP to complete ReSPECT forms
- National Audit of Care at End of Life (NACEL): completed the collection of data and the audit is now closed. Poor return response rate, only one completed questionnaire received. This is significantly less than the response rate to local bereavement survey.

9. The Deteriorating Patient

Outcome: Continue to train and support front line colleagues to recognise and manage deteriorating patients to ensure that they are managed quickly and effectively

The metrics are:

- All patients admitted onto Trust caseloads (Community and Inpatients) will have their NEWS recorded as a baseline. This will be measured with a snapshot audit which also extracts information about deterioration, recognition of sepsis and appropriate escalation.
- The qualitative data from the snapshot) audits will establish whether rapidly deteriorating patients have been identified and escalated appropriately within the service where their care is being managed (according to the Trust policy action cards).

For some patients this will include looking to assess whether there were any challenges evident to colleagues identifying early enough that the patient was deteriorating and at risk of sepsis and to identify key issues that may be used to develop further measures for improvement. For example, this may be clinical practice such as the frequency of observations once a NEWS has raised above a certain threshold for a patient – or around ensuring the NEWS scale 2 is used is for patients who have COPD with a clinically diagnosed oxygen (O_2) deficit and therefore need prescribed oxygen (O_2) at an lower rate (88-92).

NEWS Recording Targets 2019/20 (performance from audit data)						
Service area	**Baseline**		**Q1**	**Q2**	**Q3**	**Q4**
Community Hospital In-patients	March 2019 audit 89%	Target	89%	91%	93%	95%
		Actual	92%	98%	98%	Audit end March 2020
ICTs	March 2019 audit 33%	Target	33%	40%	50%	60%
		Actual	54%	31%	70%	Audit end March 2020

Actions completed:

- Results for Qtr. 3 snapshot audit results from NEWS in the ICT's show an encouraging improvement.
- Community Hospitals removed from risk register due to their percentage compliance with NEWS assessments.
- Quality Improvement work with Community Nurses took place on December 3rd reviewing data and developed an informative process map and plan to address compliance. A follow up workshop is scheduled for January.
- A review of each locality's results to be shared with operational colleagues and a focus on areas that need support will commence in February/March.

10. Falls Prevention and Management

Our aim will be to embed as "business as usual" with dedicated leadership.

Gloucestershire Health and Care NHS Foundation Trust

The Trust will be participating in a national CQUIN associated with falls and especially with regards to:

- Lying and standing blood pressures
- Rationale for documenting prescribed hypnotic or anxiolytic medications
- Mobility Assessments

Falls Prevention and Management	Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	YTD RAG
Quarterly national CQUIN. Percentage of patients meeting **all three** actions shown individually below:	80%		28.4%			43.8%			49.9%					R
CQUIN element 1: Lying and Standing Blood Pressure recorded on SystmOne at least once	80%	55.6%	51.3%	53.3%	60.8%	60.3%	67.3%	69.9%	63.9%	75.5%				R
CQUIN element 2: No hypnotics, antipsychotics or anxiolytics prescribed **or** rationale for prescribing documented	80%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				G
CQUIN element 2: Mobility assessment completed within 24 hours **or** walking aid provided within 24 hours	80%	41.5%	38.8%	50.3%	72.3%	60.3%	61.9%	67.1%	61.7%	61.2%				R
Mobility assessment completed at any time during inpatient spell	No Target	67.7%	74.5%	85.0%	94.6%	87.2%	85.7%	91.6%	87.5%	85.2%				
% of those assessed where a walking aid was not required	No Target	88.2%	83.7%	87.2%	85.4%	87.0%	88.1%	80.3%	82.5%	70.1%				
Post fall SWARM completed	80%	N/A	78.5%	79.4%	91.0%	90.5%	93.0%	91.8%	88.3%	85.9%				G

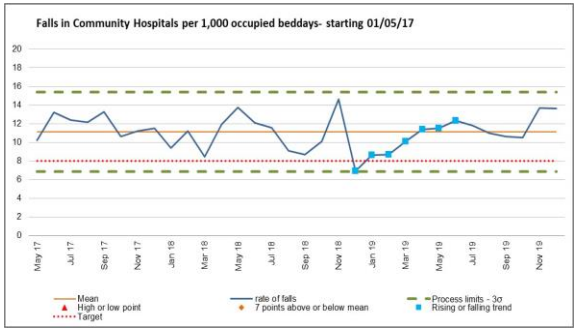
Actions required:

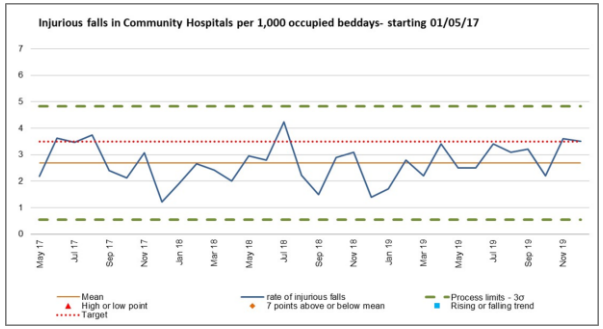
The national CQUIN identifies three key actions that should be completed as part of a comprehensive multidisciplinary falls intervention and result in fewer falls, bringing length of stay improvements and reduced treatment costs. The three key actions which must **all** be completed are:

- Lying and standing blood pressure recorded.
- No hypnotics or anxiolytics prescribed, or rationale documented.
- Mobility assessment completed or walking aid provided within 24 hours.

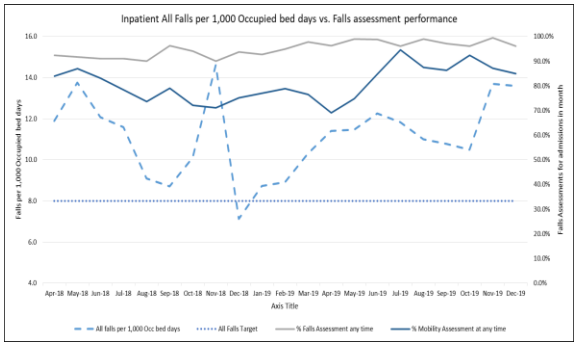
Actions completed:

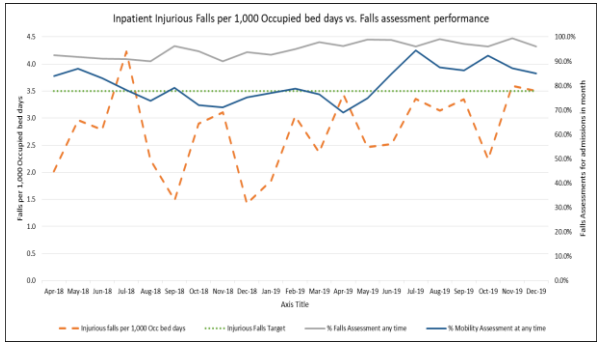
- Reminder to colleagues to ensure lying and standing blood pressure is recorded on SystmOne at least once during their admission (observations are usually recorded on the paper NEWS chart). Added box to SystmOne to enable 'not appropriate' to be selected, e.g. if patient hoisted or unwell/end of life. Suggestion to check that this has been completed before discharging a patient.
- There will be a focussed education programme throughout January to ensure colleagues are fully aware of all the components of and the rationale for the CQUIN – this will include a reminder that the initial mobility assessment must be completed within 6 hours of admission and that this can be completed by any registered professional – does not have to be a physiotherapist.





The SPC charts show all falls and injurious falls to be within control limit.
The internal target of 8 falls per 1,000 occupied bed days is above the mean in November and December 2019 following a low in October 2019 The target was only achieved in December 2018 suggesting this may need to be reviewed.
74.2% of all falls reported in the year to date are **without harm.**





The charts above show how performance in completing Falls and Mobility assessments during admission compare over time with rates of all falls and injurious falls.

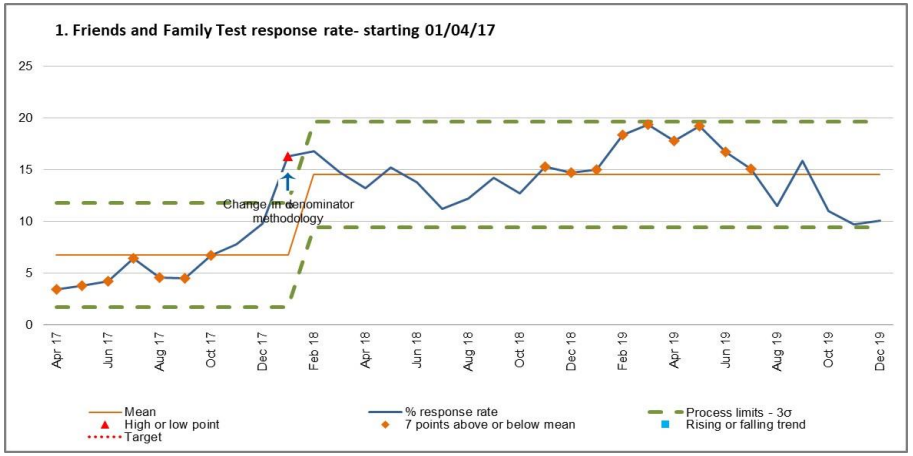
Quality | Are Services Caring?

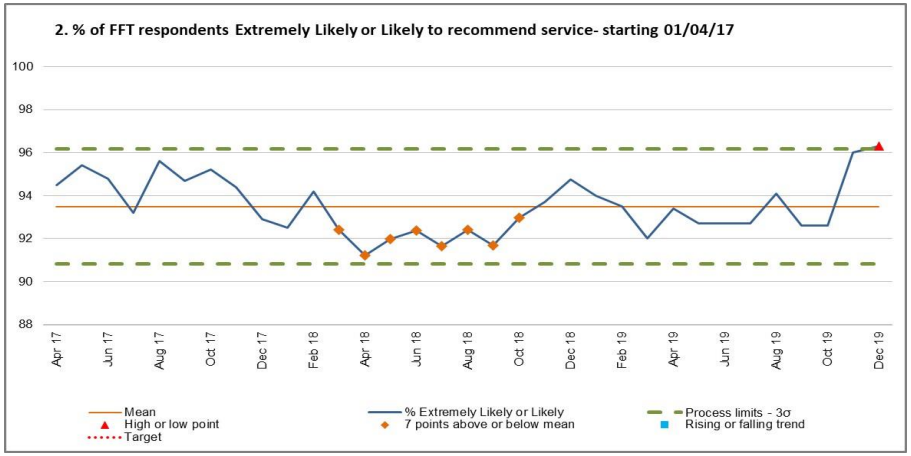
Patient Experience

Gloucestershire Health and Care
NHS Foundation Trust

CQC DOMAIN - ARE SERVICES CARING?

		Reporting Level	Threshold	2018/19 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2019/20 YTD	RAG	Exception Report?	DQ Rating	Benchmarking Report Nov Figure
1	Friends and Family Test Response Rate	N - T	15%	14.5%	17.7%	19.4%	16.7%	15.1%	11.5%	15.9%	11.0%	9.7%	10.1%				14.1%		No - within SPC limits	G	
2	% of respondents indicating 'extremely likely' or 'likely' to recommend service	N - R L - I	95%	92.7%	93.4%	92.7%	92.7%	92.7%	94.1%	92.6%	92.6%	96.0%	96.3%				93.7%		No - within SPC limits	G	90.7%
3	Number of Compliments	L - R	1,317	1,317	124	104	180	178	132	134	146	151	170				1,319			G	
4	Number of Complaints	N - R	42	42	6	5	6	2	5	3	3	6	2				38			G	
5	Number of Concerns	L - R	485	485	40	32	23	40	34	35	33	20	22				279			G	





Additional information related to performance

Friends and Family Test (FFT) response rate SPC chart shows a decrease in response rate since May 2019.

The percentage of FFT respondents recommending our services has been on, or close to the mean for seven months.

What actions have been taken to improve performance?

- The recent decrease in the FFT response rate is mainly due being unable to send the FFT surveys by email and SMS, which has significantly reduced the responses received in a number of services. This was originally down to web issues, however, as part of the recent changes where we have moved over to Office 365, it would now seem that we need an Office 365 mailbox including in the process so that we can send emails out to non GHC domain email addresses. This needs will be resolved by Countywide IT services.

- December satisfaction rate has improved from November (96.0%) at 96.3%, and is above to year to date figure of 93.7%.

Note: there is no formal benchmark for the level of 'extremely likely'/'likely' response to the Friends and Family Test, but the average from NHS Benchmarking Network for December is 90.7%.

SPC charts for Concerns, Complaints and Compliments show the following:
Concerns – Number of Concerns within normal variation.
Complaints – Number of Complaints within normal variation.
Compliments – Number of Compliments within normal variation based on the recalculated mean.

Exception Report | Are Services Safe?

Safety Thermometer

Gloucestershire Health and Care NHS Foundation Trust

CQC DOMAIN - ARE SERVICES SAFE? RAG Key: R – Red, A – Amber, G - Green

		Reporting Level	Threshold	2018/19 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2019/20 YTD	RAG	Exception Report?	DQ Rating	Benchmarking Report Nov Figure
20	Safety Thermometer - % Harm Free	N - R L - C	95%	93.7%	94.3%	92.6%	93.4%	94.4%	93.5%	92.9%	93.7%	91.9%	92.5%				93.2%	R	Pg. 13	A	
21	Safety Thermometer - % Harm Free (New Harms only)	L - I	98%	98.1%	98.3%	98.1%	98.4%	98.4%	98.5%	97.8%	96.9%	96.9%	98.1%				97.9%	G		A	89.9%

Additional information related to performance

- The overall sample number has increased from 445 in November to 519 in December.
- Harm free care (new harms only) is above target at **98.1%** compared to **96.9%** in November.

What actions have been taken to improve performance?

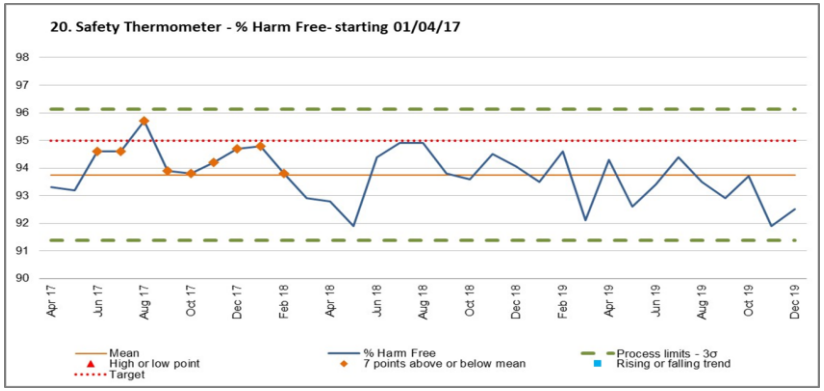
- Quality Improvement projects are being planned or currently underway to build on the success of reducing pressure ulcers over the past year which will align with our quality priorities for 2019-20.

There are three Quality Improvement projects currently in progress:

- North Cotswold ICT community nursing.
- Forest Community Hospitals.
- Alongside AHP's 'Everybody's Business' training on risk assessment & posture management. Project will focus on prevention of pressure ulcers by identifying those at risk across AHP professions. This has previously been highlighted as an issue.

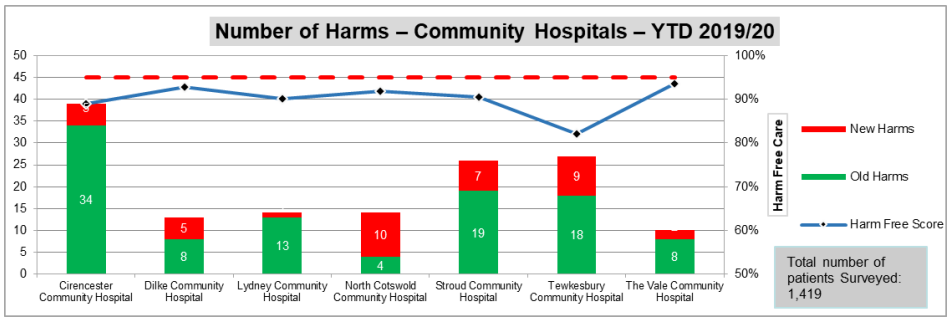
Risks
Pressure Ulcers
Reference – 562, Rating – 12

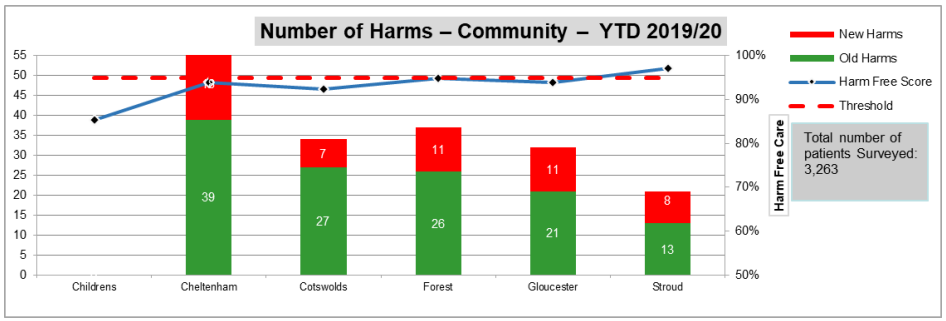
- **Benchmarking:** In the 'Safety Thermometer – Percentage of 'Harm Free Care (New Harms Only)' measure, the Trust submitted a figure of 98.1% in December. The benchmark is 89.9% for November.



Safety Thermometer Harm Free Care within normal variation. However target consistently missed.

SPC Charts have been reviewed for other harms: VTE harms fluctuate above and below the mean – but remain within control limits and are very low numbers. UTI / Catheter harms show a steady reduction over the period. Falls resulting in harm fluctuate above and below the mean – but remain within control limits and are very low numbers.





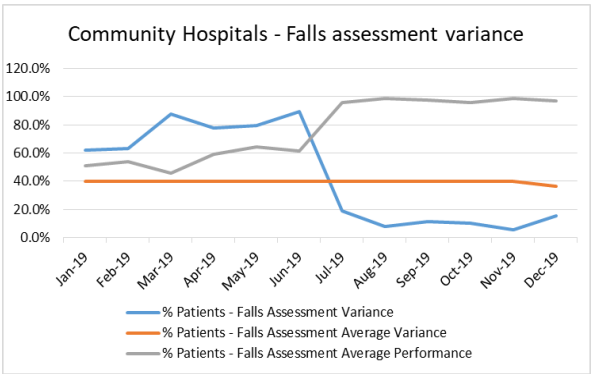
Quality | Are Services Caring?

Quality Dashboards

NHS
Gloucestershire Health and Care
NHS Foundation Trust

Dec-19	Safe	Safe	Safe	Effective	Effective	Effective	Well Led	Well Led	Well Led	Caring	Caring	Caring
CoHos	% Patients - Blood Clot (VTE) Assessment	Pressure Ulcers Developed (Acquired)	% Patients - Falls Assessment	% Unplanned Re-admissions (CoHo 30 Days)	Number of Infections	% Days lost to Delayed Discharges	% Safe Staffing fill rate	% Staff up to date PDR	% Hand Hygiene Compliance	Compliments	Complaints	% in FFT say treated with Dignity & Respect
Trust Average	96.1%	1	96.1%	5.5%	0.0	4.4%						
Cirencester - Coln Ward	100.0%	0	84.6%	3.8%	0	1.9%	97.8%	92.1%	100.0%	7	0	100.0%
Cirencester - Windrush Ward	100.0%	0	100.0%	0.0%	0	0.0%	97.4%	64.5%	100.0%	0	0	100.0%
Dilke - Forest Ward	89.7%	1	96.8%	6.5%	0	14.7%	100.1%	97.5%	100.0%	20	0	100.0%
Lydney	93.3%	1	93.8%	0.0%	0	4.5%	99.6%	82.9%	100.0%	4	0	100.0%
North Cots - Cotswold View Ward	95.0%	0	100.0%	4.5%	0	0.0%	98.5%	82.9%	100.0%	0	0	N/A
Stroud - Cashes Green Ward	95.7%	2	95.7%	17.6%	0	7.8%	98.7%	93.3%	95.0%	1	0	100.0%
Stroud - Jubilee Ward	100.0%	2	100.0%	5.0%	0	6.8%	102.4%	71.4%	95.0%	5	0	100.0%
Tewkesbury - Abbey View Ward	100.0%	2	100.0%	0.0%	0	0.0%	100.2%	57.6%	100.0%	4	0	100.0%
Vale	92.9%	0	100.0%	0.0%	0	3.1%	103.6%	97.4%	95.0%	1	0	60.0%
Winchcombe	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	N/A
MIIUs	% Staff Trained in Resuscitation (Target: 92%)	Average Time to Initial Assessment (Target: 15 min)	% of shifts filled by agency staff	% Patients seen within 4 hours	% Unplanned Reattendances	% Referred on to A&E or GP (Target: 4.4%)	% Who say in the FFT they would recommend our services	% Staff up to date PDR	% Hand Hygiene Compliance	Compliments	Complaints	% in FFT say treated with Dignity & Respect
Trust Average			2.2%	99.5%	1.5%							
Cirencester MIIU	100.0%	10	0.8%	99.8%	1.9%	5.5%	97.4%	82.6%	N/A	1	0	98.0%
Dilke MIIU	100.0%	11	3.3%	97.5%	0.7%	8.5%	N/A	54.6%	100.0%	0	0	N/A
Lydney MIIU	100.0%	11	3.3%	99.7%	1.5%	6.5%	100.0%	88.9%	100.0%	0	0	N/A
NCH MIIU	100.0%	8	0.0%	100.0%	1.5%	3.9%	100.0%	100.0%	100.0%	0	0	N/A
Stroud MIIU	100.0%	13	5.0%	99.3%	1.3%	4.2%	94.8%	93.8%	100.0%	0	0	98.0%
Tewkesbury MIIU	100.0%	9	2.7%	99.8%	1.9%	12.4%	N/A	87.5%	100.0%	0	0	N/A
Vale MIIU	100.0%	9	3.8%	100.0%	1.4%	6.2%	100.0%	100.0%	N/A	0	0	100.0%

The Trust compiles a quality dashboard covering the Community Hospital Inpatient and Minor Injury and Illness Units, updated on a monthly basis (November 2019 data above). The figures are copied onto posters displayed within each of the units. The dashboard includes measures from the Safe, Effective, Well Led and Caring domains.

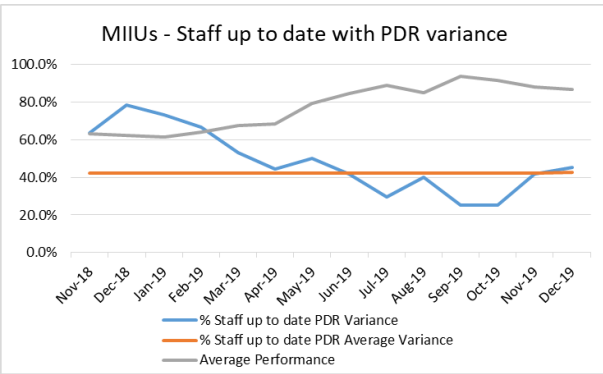


Analysis of the monthly data shows the variance in measures between the different sites over time.

Variance (blue line in the charts) is the monthly difference between the minimum and maximum for a measure across the sites. The red line is the average of this variance over time.
Average performance of the measure across the sites is in grey.

The left hand chart shows how the variance, between wards, of patients having falls assessments has decreased considerably over time while the overall percentage of assessments has increased. Indicating the improvement is across all sites.

The chart on on the right shows that while the variance of staff PDR being up to date has decreased over time, there is still a significant difference in performance between sites.



Physical Health Performance Dashboard

NHS
Gloucestershire Health and Care
NHS Foundation Trust

		Reporting Level	Threshold	2018/19 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2019/20 YTD	RAG	Exception Report?	DQ Rating	Benchmarking Report Nov Figure
CQC DOMAIN - ARE SERVICES EFFECTIVE?																					
Community Hospitals																					
26	Re-admission within 30 days of discharge following a non-elective admission**	N - R		8.2%	9.5%	11.6%	6.9%	9.8%	10.5%	11.4%	8.7%	5.3%	5.5%				8.9%			G	
27	Inpatients - Average Length of Stay	L - R		27.7	30.5	29.9	27.9	30.6	28.6	26.5	29.1	28.8	30.3				29.1			G	24.6
28	Bed Occupancy - Community Hospitals	L - C	92%	93.6%	94.1%	93.4%	95.0%	93.4%	94.6%	92.2%	95.9%	95.6%	96.2%				94.5%	A		A	91.7%
29	% of direct admissions to community hospitals	L - R		19.3%	18.9%	12.6%	10.4%	16.1%	7.7%	20.5%	17.4%	11.2%	7.1%				13.5%			G	
30	Delayed Transfers of Care (average number of patients each month)	L - R		2	2	2	3	3	2	2	2	4	5				3			A	
31	Bed days lost due to delayed discharge as percentage of total beddays	L - R	<3.5%	1.4%	1.5%	1.7%	2.8%	2.1%	2.6%	2.3%	3.6%	5.5%	4.4%				3.0%	G		A	9.6%
Childrens Services - Immunisations				2017/18 Academic Year	Academic Year 2018/19					Academic Year 2019/20											
31a	HPV Immunisation coverage for girls aged 12/13 years old (2nd Immunisation)	N - T	90%*	84.4%	84.5%	84.8%	85.1%	85.2%	86.5%	Programme commences in January 2020							86.5%	A		G	
31b	HPV Immunisation coverage for girls aged 12/13 years old (1st Immunisation)	N - T	90%*	87.7%	87.9%	88.3%	88.7%	88.9%	89.5%	Programme commences in January 2020							89.5%	A		G	
Childrens Services - National Childhod Measurement Programme				2018/19 Academic Year																	
31c	Percentage of children in Reception Year with height and weight recorded	N - T	95%*	97.7%	84.8%	91.2%	96.5%	97.7%	97.7%			14.9%	26.4%				26.4%	G		G	
31d	Percentage of children in Year 6 with height and weight recorded	N - T	95%*	97.2%	89.6%	92.1%	95.9%	97.2%	97.2%			22.6%	35.8%				35.8%	G		G	
CQC DOMAIN - ARE SERVICES RESPONSIVE?																					
Minor Injury and Illness Units																					
32	MIIU % seen and discharged within 4 Hours	N - T	95%	99.0%	99.1%	98.9%	99.5%	98.8%	99.3%	99.2%	99.0%	99.6%	99.5%				99.2%	G		G	
33	MIIU Number of breaches of 4 hour target	L - R		828	59	75	30	95	50	56	59	21	32				477			G	
34	Total time spent in MIIU less than 4 hours (95th percentile)	L - I	<4hrs	02:58	03:07	03:01	02:46	03:06	02:49	03:00	02:41	02:47	03:45				03:00	G		G	
35	MIIU - Time to treatment in department (median)	L - I	<60 m	00:34	00:34	00:35	00:31	00:36	00:24	00:32	00:31	00:30	00:12				00:12	G		G	
36	MIIU - Unplanned re-attendance rate within 7 days	L - C	<5%	0.9%	0.4%	1.5%	1.5%	1.3%	1.1%	1.4%	1.5%	1.1%	1.5%				1.3%	G		G	
37	MIIU - % of patients who left department without being seen	L - C	<5%	3.9%	1.1%	0.8%	0.8%	1.1%	0.7%	1.0%	0.6%	0.5%	0.7%				0.8%	G		A	
38	Time to initial assessment for patients arriving by ambulance (95th percentile)	N - T	<15 m	00:20	00:14	00:12	00:13	00:14	00:13	00:12	00:11	00:12	00:12				00:12	G		A	
39	Trolley waits in the MIU must not be longer than 12 hours	N - T	< 12 hrs	0	0	0	0	0	0	0	0	0	0				0	G		G	
Referral to Treatment																					
40	Adult Speech and Language Therapy - % treated within 8 Weeks	L - C	#	55.8%	69.4%	56.3%	53.6%	63.8%	69.7%	78.1%	81.3%	98.1%	83.5%				73.4%			A	
41	Podiatry - % treated within 8 Weeks	L - C	95%	97.2%	88.8%	81.2%	76.5%	82.1%	75.2%	68.1%	59.8%	71.5%	67.1%				74.5%	R		A	
42	MSKAPS Service - % treated within 8 Weeks	L - C	95%	96.5%	92.4%	87.7%	96.4%	95.1%	90.7%	90.5%	90.3%	94.3%	94.1%				92.8%	A		A	
43	MSK Physiotherapy - % treated within 8 Weeks	L - C	95%	89.7%	80.4%	69.1%	65.6%	64.1%	68.1%	71.2%	75.9%	74.6%	79.5%				72.1%	R		G	
44	ICT Physiotherapy - % treated within 8 Weeks	L - C	95%	82.8%	81.0%	81.9%	79.8%	80.7%	83.1%	72.8%	76.2%	82.8%	86.5%				80.5%	R		A	
45	ICT Occupational Therapy Services - % treated within 8 Weeks	L - C	95%	75.5%	82.6%	83.7%	81.4%	84.6%	85.2%	85.6%	81.9%	88.4%	84.3%				84.2%	R		A	
46	Diabetes Nursing - % treated within 8 Weeks	L - C	95%	93.5%	100.0%	97.2%	97.0%	95.8%	97.6%	96.2%	90.3%	100.0%	95.7%				96.7%	G		A	
47	Bone Health Service - % treated within 8 Weeks	L - C	95%	99.1%	99.4%	99.4%	100.0%	99.5%	100.0%	100.0%	99.4%	99.4%	100.0%				99.7%	G		A	
48	Contraception Service and Sexual Health- % treated within 8 Weeks	L - C	95%	99.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				100.0%			G	
49	HIV Service - % treated within 8 Weeks	L - C	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				100.0%	G		G	
50	Psychosexual Service - % treated within 8 Weeks	L - C	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				100.0%			G	
51	Sexual Health - % of terminations carried out within 9 weeks and 6 days of gestation	L - C	70%	77.6%	78.4%	86.3%	89.0%	87.9%	81.4%	82.1%	81.1%	85.3%	88.1%				84.2%	G		R	
52	Paediatric Speech and Language Therapy - % treated within 8 Weeks	L - C	95%	97.5%	90.9%	90.9%	67.3%	86.9%	97.1%	97.0%	98.8%	95.2%	97.9%				91.1%	R		G	
53	Paediatric Physiotherapy - % treated within 8 Weeks	L - C	95%	91.9%	87.2%	86.5%	90.4%	89.0%	85.8%	72.6%	76.6%	86.4%	92.1%				84.3%	R		G	
54	Paediatric Occupational Therapy - % treated within 8 Weeks	L - C	95%	95.7%	97.9%	91.5%	91.7%	94.2%	97.1%	95.4%	95.9%	97.9%	97.3%				95.4%	A		A	

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RAG Key: R – Red, A – Amber, G - Green

Physical Health Performance Dashboard

NHS
Gloucestershire Health and Care
NHS Foundation Trust

		Reporting Level	Threshold	2018/19 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2019/20 YTD	RAG	Exception Report?	DQ Rating	Benchmarking Report Nov Figure
CQC DOMAIN - ARE SERVICES RESPONSIVE?																					
55	MSKAPS Service - % of referrals referred on to secondary care	L - C	<30%	15.9%	21.1%	20.5%	24.3%	24.5%	20.2%	21.7%	15.0%	11.4%	2.2%				18.3%	G		A	
56	MSKAPS Service - Patients referred to secondary care within 2 days of decision to refer onwards	L - C	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				100.0%	G		A	
58	Stroke ESD - Proportion of new patients assessed within 2 days of notification	L - C	95%	84.3%	100.0%	97.1%	100.0%	89.7%	90.3%	91.3%	94.4%	100.0%	100.0%				95.7%	A		A	
59	Stroke ESD - Proportion of patients discharged within 6 weeks	L - C	95%	97.0%	97.1%	84.6%	100.0%	93.8%	94.4%	93.8%	100.0%	88.9%	100.0%				94.7%	A		A	
60	Social Care ICT - % of Referrals resolved at Referral Centres and closed	L - C		48.8%	45.1%	50.5%	49.2%	47.3%	46.6%	46.3%	45.2%	47.2%	51.2%				47.6%			A	
63	Single Point of Clinical Access (SPCA) Calls Offered (received)	L - R		39,348	2,975	3,045	3,048	3,033	3,007	2,934	3,319	3,234	3,089				27,684			G	
64	SPCA % of calls abandoned	L - C	<5%	1.4%	0.9%	0.5%	0.9%	0.7%	1.1%	0.8%	1.8%	1.7%	1.7%				1.1%	G		G	
65	95% of priority 1 & 2 calls answered within 60 seconds after introductory message finishing	L - C	95%	97.2%	97.9%	98.5%	98.0%	98.1%	97.1%	98.0%	95.4%	95.6%	95.9%				97.2%	G		G	
66	Rapid Response - Number of referrals	L - C	*2,786	3,905	346	318	333	356	329	335	300	326	345				2,988	G		A	
67	Wheelchair Service. Adults: New referrals assessed within 8 weeks	L - C	90%	26.9%	4.5%	23.1%	7.1%	40.9%	35.7%	68.8%	22.4%	15.4%	37.0%				28.9%			R	
68	Wheelchair Service. Adults: Priority Referrals seen within 5 working days	L - C	95%	20.0%	100.0%	0.0%	No priority Assessments	No priority Assessments	0.0%	100.0%	0.0%	7.1%	0.0%				13.5%			R	
69	Wheelchair Service. Under 18s: New referrals assessed within 8 weeks	L - C	90%	35.3%	50.0%	50.0%	50.0%	33.3%	0.0%	33.0%	44.4%	50.0%	100.0%				59.0%			R	
70	Wheelchair Service. Under 18s: Priority Referrals seen within 5 working days	L - C	95%	75.0%	No priority Assessments	No priority Assessments	No priority Assessments	No priority Assessments	No priority Assessments	No priority Assessments	No priority Assessments	0.0%	No priority Assessments				0.0%			R	
71	Wheelchair Service: Under 18s: Equipment delivered within 18 weeks of referral	L - C	92%	31.8%	No Deliveries	100.0%	100.0%	0.0%	0.0%	50.0%	100.0%	33.0%	50.0%				64.3%			R	
72	Percentage of patients waiting less than 6 weeks from referral for a diagnostic test	N - T	>99%	100.0%	100.0%	100.0%	100.0%	100.0%	95.9%	85.9%	98.8%	100.0%	94.0%				96.7%	R		G	
Cancelled operations																					
73	No urgent operation should be cancelled for a second time	N - T	0	0	0	0	0	0	0	0	0	0	0				0	G		G	
74	Number of patients who have had operations cancelled for non-clinical reasons that have not been offered another binding date within 28 days	N - T	0	0	0	0	0	0	0	0	0	0	0				0	G		G	

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Physical Health Performance Dashboard

NHS
Gloucestershire Health and Care
NHS Foundation Trust

CQC DOMAIN - ARE SERVICES WELL LED?

		Reporting Level	Threshold	2018/19 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2019/20 YTD	RAG	Exception Report?	DQ Rating	Benchmarking Report Nov Figure
75	Staff Friends and Family Test - Percentage of staff who would recommend the Trust as a place of work	N - R L - T	61%	58.5%			52.0%			58.0%							55.00%	R		G	
76	Staff Friends and Family Test - Percentage of staff who would recommend the Trust as a place to receive treatment	N - R L - T	67%	84.6%			83.0%			88.0%							85.5%	G		G	
77	Mandatory Training	L - I	90%	85.90%	85.8%	86.62%	86.71%	86.40%	91.08%	90.02%	90.38%	90.12%	90.40%				88.61%	A		A	91.2%
78	% of Staff with completed Personal Development Reviews (Appraisal)	L - I	90%	77.1%	76.42%	77.72%	79.42%	82.22%	82.57%	80.35%	80.63%	80.14%	79.20%				79.85%	R		A	86.9%
78a	% of Staff with completed Personal Development Reviews (Appraisal) Active Assignments Only	L - I	90%	81.4%	81.24%	82.54%	85.35%	87.38%	86.72%	84.91%	85.84%	85.79%	84.82%				84.95%	R		A	
79	Sickness absence average % rolling rate - 12 months	L - I	<4%	4.8%	4.90%	4.87%	4.82%	4.80%	4.76%	4.77%	4.78%	4.76%	4.74%				4.80%	A		A	5.1%
80	SUS+ (Secondary Uses Service) Data Quality Validity - Available in arrears	N-R	96.3%	99.1%	71.00%	74.30%	76.50%	76.60%	76.60%	78.90%	89.60%	T					77.6%	R		R	

Additional KPIs

		Reporting Level	Threshold	2018/19 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2019/20 YTD	RAG	Exception Report?	DQ Rating	Benchmarking Report Nov Figure
81	Mixed Sex accommodation breaches			0	0	0	0	0	0	0	0	0	0				0			G	
82	Proportion of eligible children who receive vision screens at or around school entry.		20%*	98.2%								12.2%	22.4%				22.4%	R		A	
83	Number of AnteNatal visits carried out		N/A	1107	89	82	74	99	93	66	63	59	66				691			G	
84	Percentage of live births that receive a face to face NBV (New Birth Visit) within 7- 14 days by a Health Visitor		95%	88.6%	92.30%	91.40%	89.8%	92.00%	89.8%	91.10%	90.50%	93.60%	90.60%				91.2%	A		A	
85	Percentage of children who received a 6-8 weeks review.		95%	93.37%	96.5%	95.5%	94.20%	96.3%	95.1%	93.20%	94.50%	94.50%	94.70%				94.9%	G		A	
86	Percentage of children who received a 9-12 month review by the time they turned 12 months.		95%	83.4%	83.8%	83.0%	79.9%	85.8%	84.1%	88.4%	83.8%	86.6%	86.2%				84.6%	R		A	
87	Percentage of children who received a 12 month review by the time they turned 15 months.		95%	86.2%	89.4%	89.5%	91.50%	91.00%	90.70%	90.10%	90.60%	89.9%	92.40%				89.8%	R		A	
88	Percentage of children who received a 2-2.5 year review by 2.5 years.		95%	80.2%	86.1%	84.3%	83.2%	81.6%	85.8%	85.9%	79.6%	82.0%	84.4%				83.6%	R		A	
89	Percentage of children who received a 2-2.5 year review using ASQ 3.		95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				100.0%	G		A	
90	Percentage of infants for whom breastfeeding status is recorded at 6-8wk check.		95%	99.2%	98.8%	97.7%	98.8%	99.2%	98.3%	96.5%	98.3%	98.4%	97.7%				98.3%	G		A	
91	Percentage of infants being totally or partially breastfed at 6-8wks(breastfeeding prevalence).		58%	54.5%	53.5%	56.2%	54.6%	52.9%	52.6%	55.9%	57.7%	58.5%	56.1%				55.3%			A	
92	% of mothers who are still breastfeeding at 8 weeks who were breastfeeding at 2 weeks.		80%	81.4%	79.50%	82.6%	81.9%	80.5%	79.80%	81.0%	83.7%	79.90%	81.5%				81.1%	G		A	
93	Chlamydia Screening of Gloucestershire residents aged 15-24 via the Chlamydia Screening Service (minimum positivity rate)		N/A	3108	2044	2432	2314	2009	1908	1908	2094	1621	1266				1955			A	
94	Number of Positive Screens - GCS and Joint responsibility		N/A	2031	113	120	127	119	113	113	124	96	75				1000			A	
95	Average Number of Community Hospital Beds Open		N/A	194.3	195.8	196.0	194.7	195.7	195.4	194.8	195.5	195.5	192.6				195.1			G	
96	Average Number of Community Hospital Beds Closed		N/A	0.6	0.2	0.0	1.3	0.3	0.6	1.4	1.4	0.5	3.1				1.0			G	

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L – C	Locally contracted measure (target/threshold agreed with GCCG)	N – R/L – C	Measure that is treated differently at national and local level, e.g. nationally reported/local target

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with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

Mental Health Services
(formerly 2gether NHS Foundation Trust)

Quality Indicator Data covering April to December 2019

Executive Summary

Gloucestershire Health and Care NHS Foundation Trust

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

Are Our Services Effective?
In 2019/20 we remain 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.

Do We listen And Act on Patient & Carer Feedback?

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

- Were you involved as much as you wanted to be in agreeing the care you will receive? > 84%
- Have you been given information about who to contact outside of office hours if you have a crisis? > 71%
- Have you had help and advice about taking part in activities that are important to you? > 64%
- Have you had help and advice to find support for physical health needs if you have needed it? > 73%

Are Our Services Safe?
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 5 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;
- To ensure that 100% of service users within Berkeley House have a bespoke restrictive intervention care plan tailored to their individual needs;
- Embed the learning from our reported serious incidents:

Targets Not Being Met

1. **Target 1.1 Improving the physical health care for people with schizophrenia and other serious mental illnesses;** Compliance within the inpatient service is at **78%** against a target of **90%.**

- The Audit & Assurance Team will establish an electronic audit which should provide ward/team managers compliance data on a weekly basis and actively promote intervention if required.

- A re launch of the Health & Lifestyle form is planned for February 2020 which will involve ward/team training and posters to be displayed around the Trust. This is to coincide with some minor changes made to the form to increase awareness around national screening programmes, but will also act as a reminder to staff to complete the form fully.

Risks

1. Target 1.2 Ensuring that people are discharged from hospital with personalised care plans. 48hr follow up is currently showing as 72% ,this appears low compared to historical trends and will need validating by the Information Team where we expect the score to improve .

2. Targets 2.1 & 2.4 (Survey questions) were none compliant respectively in Q2 & Q3 although cumulatively compliance is achieved. This appears to be a consequence of significantly reduced response rates, including a zero return from Herefordshire Services in Q3. There is ongoing work to promote the survey during Q4 ahead of the new FFT and harmonised physical and mental health patient and Carer survey being launched in April 2020.

Gloucestershire Health and Care NHS Foundation Trust

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

Within Quarter 3, the Gloucestershire Health and Care NHS Foundation Trust has committed to offer a full cardio metabolic check to all inpatients and all SMI/CPA service users in the community. Our target for compliance remains at;

75% of community patients will receive the health check and will have any associated interventions offered if required.
90% of inpatients will receive the health check and will have any associated interventions offered if required.

An audit continues to establish if the six parameters of the Lester tool are completed, along with the recording of any interventions offered. The Quarter 3 audit shows:

76% of community patients have had these checks and interventions in place.
78% of inpatients have had these checks and interventions in place

We are not currently meeting the inpatient target

Actions completed:

Successful physical health clinics continue to run at Pullman Place and 27a St Owen Street, providing service users in the community access to physical health checks in an environment with staff who are familiar to them. Such is the success of the physical health clinics, a Physical Health nurse has been employed for one day a week to take a lead on developing the clinics further within Pullman Place.

The Trust has purchased nine ECG machines for the community hubs. These will provide the opportunity for routine ECG screening for possible cardiac anomalies for patients who are at an increased cardio metabolic risk, largely due to medication side effects and lifestyle factors. Training for staff to take ECG's has been provided by the Physical Health Facilitator, and refresher training for medics to interpret ECG's will be held internally by the Trust own Medical team.

Alongside this health screening work, Gloucestershire Health and Care NHS Foundation Trust continues to increase access to physical health treatment for service users. The Quality Improvement initiative 'Well Woman Wednesdays' at Wotton Lawn Hospital, where ladies are offered a full range of advice and success to cervical screening in house, has now been expanded to the community Hub. This has enabled service users to access this vital screening in an environment they are familiar with.

The recent Trust merger has offered further opportunities for staff to access community physical health services such as Tissue Viability, Community Diabetes Teams and District Nursing teams. This will enhance the services and opportunities available for service users and improve the knowledge of physical health for our mental health staff.

Actions Planned

- The Audit & Assurance Team will establish an electronic audit which should provide ward/team managers compliance data on a weekly basis and thereby promote timely interventions.
- A re launch of the Health & Lifestyle form is planned for February 2020 which will involve ward/team training and posters to be displayed around the Trust. This is to coincide with some minor changes made to the form to increase awareness around national screening programmes, but will also act as a reminder to staff to complete the form fully.

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Target 1.2 To improve personalised discharge care planning in:
a) Adult inpatient wards and
b) Older people's wards.

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. We have continued with this 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 HEF been completed (LD only
4.Has the Pre-Discharge Planning Form been completed?
5.Have the inpatient care plans been closed within 7 days of discharge?
6.Has the patient been discharged from the bed?
7.Has the Nursing Discharge Summary Letter to Client/GP been sent within 24 hours of discharge?
8.Has the 48 hour follow up been completed?

Outcome:

Overall compliance for the Mental Health Inpatient Units across Gloucestershire and Herefordshire for Q3 was **79%**, compared to **75%** in Q2. This shows an increase of **4%** compliance across the Trust.

Overall compliance for Gloucestershire only for Q3 was **76%** compared to **72%** in Q2; this means that there has been a **4%** increase in compliance.
Overall compliance for Herefordshire only for Q3 was **82%** compared to **78%** in Q2; this means that there has been a **4%** increase in compliance.

During Q3 of 2019-20, there were 80 discharges from Herefordshire, and 158 from Gloucestershire. The total number of discharges from all Mental Health Inpatient Units across the Trust was 238.
We are currently meeting the target

	Criterion	Current compliance (Q3 2019-20)	Direction of travel and previous compliance
1	Has a Risk Summary been completed?	99%	⇔ 100%
2	Has the Clustering Assessment and Allocation been completed?	96%	⇧ 92%
3	Has HEF been completed (LD only)?	100%	⇔ 100%
4	Has the Pre-Discharge Planning Form been completed?	28%	⇧ 23%
5	Have the inpatient care plans been closed within 7 days of discharge?	45%	⇧ 26%
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?	88%	⇩ 93%
8	Has the 48 hour follow up been completed if the Community Team are not doing it?	73%	⇩ 92%

Quality Priority | Effective?

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.

Gloucestershire Health and Care NHS Foundation Trust

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

Outcome

During Q3

- In Gloucestershire 3 young people transitioned from CYPS to adult mental health services, all had a joint CPA meeting.
- In Herefordshire 1 young person transitioned from CYPS to adult mental health services, all had a joint CPA meeting.

We are currently meeting the target

Gloucestershire Services	Qtr. 1	Qtr.2	Qtr. 3	Qtr. 4
Joint CPA Review	100%	100%	100%	Available end March 2020

HerefordshireServices	Qtr. 1	Qtr.2	Qtr. 3	Qtr. 4
Joint CPA Review	100%	100%	100%	Available end March 2020

Quality Priority | User Experience

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Target 2. The local mental health survey (User Experience Quality Indicator) has an overall goal of improving patient and Carer experience with 4 associated targets:

2.1 Were you involved as much as you wanted to be in agreeing the care you will receive? > 84%
2.2 Have you been given information about who to contact outside of office hours if you have a crisis? > 71%
2.3 Have you had help and advice about taking part in activities that are important to you? > 64%
2.4 Have you had help and advice to find support for physical health needs if you have needed it? > 73%

Outcome :

Results show the combined totals for both Gloucestershire and Herefordshire mental health services

Analysis

Response rates have significantly reduced quarter on quarter for each county, which in turn impacts negatively upon levels of compliance.

Text messaging as a means of communicating and collecting survey responses ended in January 2019 when the contract with Healthcare Communications ended, although feedback/responses continued to be received for several subsequent months.

Significantly lower responses rates mean that singular + or – responses to questions bias the overall outcome dramatically.

Responses have dropped each consecutive quarter as follows:

- Herefordshire range **124** responses Q1 to **0 (Zero)** in Q3

- Gloucestershire range **97** responses Q2 to **10** in Q3

PALS visits to the Stonebow Unit in Hereford reduced from 3-2 in Q3 (a consequence of merger activity and relocation of the Service Experience Team to Edward Jenner Court.

As a balancing measure, the results of the 2019 CQC community mental health survey provides significant assurance of the Trust's delivery of high quality adult community mental health services.

We are currently meeting this target.

Actions Planned

- There is now a dedicated Survey Team in place to coordinate and promote patient and carer feedback .
- SNAP survey software will be the platform for managing the process going forward (GCS used SNAP very successfully) and core questions applicable in both mental health and physical health services have been agreed for use from April 2020.). This software solution enables us to design our surveys and distribute these in a number of ways including paper, online, mobile (tablets, mobile phones and kiosks). An action plan is in place.

Quality Survey Question	Qtr. 1	Qtr.2	Qtr. 3	Qtr. 4	Cumulative Outcome
Were you involved as much as you wanted to be in agreeing the care you will receive? **> 84%**	90%	79%	88%	Available end March 2020	86%
Have you been given information about who to contact outside of office hours if you have a crisis? **> 71%**	86%	74%	90%	Available end March 2020	83%
Have you had help and advice about taking part in activities that are important to you? **> 64%**	81%	74%	71%	Available end March 2020	79%
Have you had help and advice to find support for physical health needs if you have needed it? **> 73%**	82%	89%	71%	Available end March 2020	83%

Quality Priority | Safe?

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.

Gloucestershire Health and Care NHS Foundation Trust

We aim to minimise the risk of suicide amongst those with mental disorders through systematic implementation of sound risk management principles.

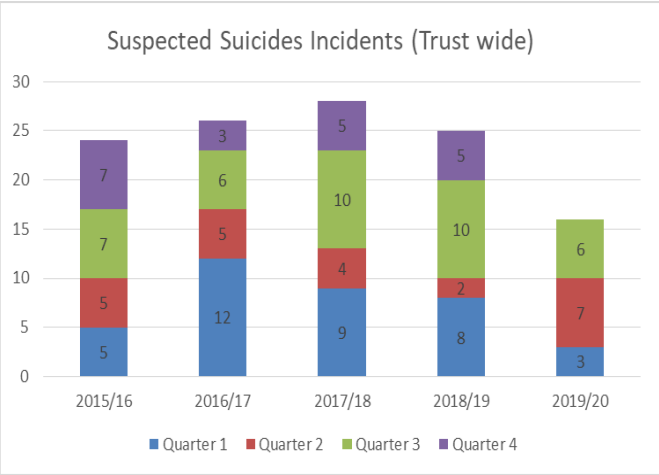
What we also know is that we are seeing more and more service users on our caseload year on year, so we measured this important target differently this year by reporting as a rate per 1000 service users on the Trust caseload.

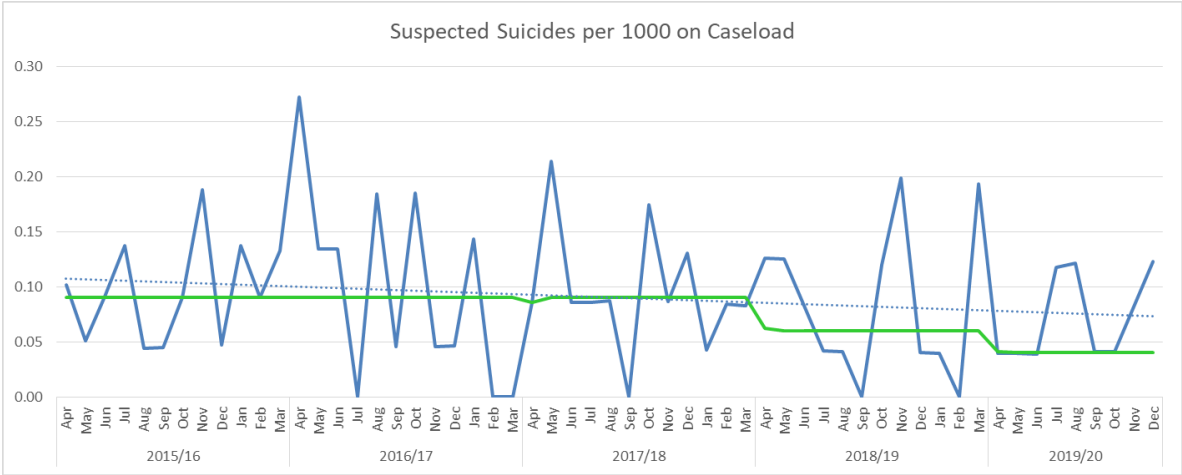
Outcome

The number of reported suspected suicides increased during 2016/17 to **26** suspected suicides and in 2017/18 further increased to **28**. We were pleased to report that by the end of 2018/19 the number had reduced and that we reported **25** suspected suicides. At the end of Quarter 3 2019/20, **16** suspected suicides have been reported , the lowest number for 5 years.

In terms of the rate per 1000 patients on the caseload, during 2015/16, 2016/17 and 2017/18 the median value was **0.09.** By the end of 2018/19 the median value reduced to **0.06** and at the end of Quarter 3 2019/20 this has reduced further to **0.04**.

We are currently meeting this target.





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

Gloucestershire Health and Care NHS Foundation Trust

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 detained service users who are AWOL come to serious harm or death, so we are measuring the level of harm that people come to when absent.

Outcome

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. In 2017/18 we reported **170** occurrences of AWOL (142 in Gloucestershire and 28 in Herefordshire) . **190** occurrences were reported during 2018/19 (144 in Gloucestershire and 46 in Herefordshire), none of these led to serious harm or death.

At the end of Q3 2019/20, **160** occurrences have been report with none of these events leading to serious harm or death

We are currently meeting this target.

	Absconded from a ward	Did not return from leave	Absconded from an escort	Total
Gloucestershire	71	46	13	**130**
Herefordshire	27	1	2	**30**
Total	**98**	**47**	**15**	**160**

Target 3.3 To increase the use of supine restraint as an alternative to prone restraint (on all adult wards & PICU)

Gloucestershire Health and Care NHS Foundation Trust

The use of prone restraint (face down) is sometimes necessary to manage and contain escalating violent behaviour, however it is also a response that has potential to cause serious harm to an individual. As a Trust we want to minimise the use of this wherever possible through therapeutic engagement and occupation in the inpatient environment; alongside effective de-escalation techniques and alternatives to prone restraint.

Outcome

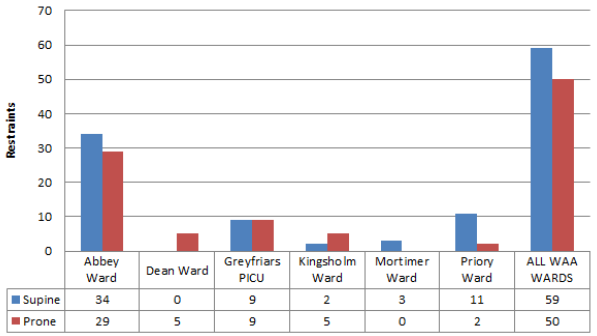
The Trust has a sub group focused on reducing physical restraint, in line with national guidance, reporting into our Quality Assurance Group. From reviewing our restraint data in detail over the past 3 years, we have seen a reduction in prone restraint and a positive increase in the use of supine restraint as an appropriate and safer alternative to prone restraint. This is due to active promotion of techniques used and additional training in the use of alternate injection sites.

Review of Q3 data shows that when restrictive techniques were required to safely manage a rapid escalating situation, **88.9%** of these resulted in the use of supine restraint, compared to **11.1%** requiring prone.

The pie chart below shows the spread of all physical interventions used on our adult wards and the PICU during Quarter 3 and it is reassuring to note that, wherever possible, the least restrictive practices e.g. seated or precautionary holds are used. Supine or prone restraint are only used when a person's safety becomes compromised.

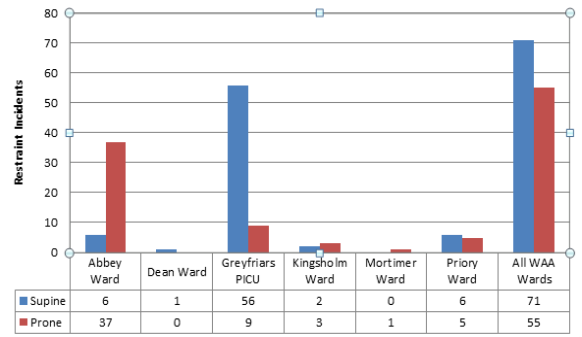
We are currently meeting this target.

Prone vs Supine restraints by inpatient ward (Inpatient Working Age Adults) - 2019/20 Q1



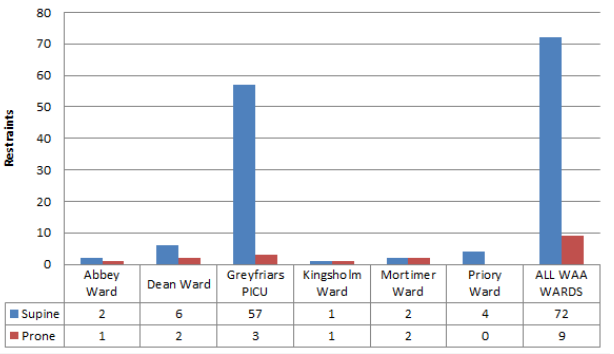
	Abbey Ward	Dean Ward	Greyfriars PICU	Kingsholm Ward	Mortimer Ward	Priory Ward	ALL WAA WARDS
Supine	34	0	9	2	3	11	59
Prone	29	5	9	5	0	2	50

Q2 2019/20 - Prone vs Supine restraints by inpatient ward (Inpatient Working Age Adults)



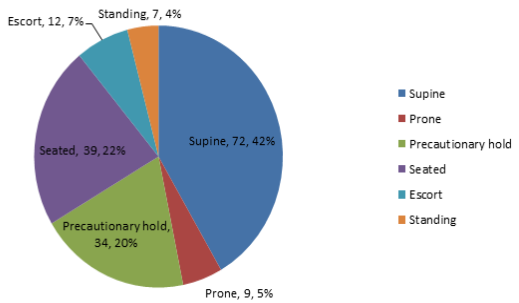
	Abbey Ward	Dean Ward	Greyfriars PICU	Kingsholm Ward	Mortimer Ward	Priory Ward	All WAA Wards
Supine	6	1	56	2	0	6	71
Prone	37	0	9	3	1	5	55

Q3 2019/20 - Prone vs Supine restraints by inpatient ward (Inpatient Working Age Adults)



	Abbey Ward	Dean Ward	Greyfriars PICU	Kingsholm Ward	Mortimer Ward	Priory Ward	ALL WAA WARDS
Supine	2	6	57	1	2	4	72
Prone	1	2	3	1	2	0	9

Q3 2019/20 Physical Intervention incidents by 'type of position used' (most restrictive) (Working Age Adults)



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Target 3.4 To ensure that 100% of service users within Berkeley House have a bespoke restrictive intervention care plan tailored to their individual needs.

The aim is for all patients to have a bespoke Positive Behaviour Management (PBM) assessment and care plan, written in conjunction with the Behaviour Support & Training Team, the PBM trainer within the staffing establishment at Berkeley House and the wider Multidisciplinary team. These plans must include sensory interventions formulated by an occupational therapist. The PBM assessment (Individual Patient Physical Intervention Technique Checklist) clearly identifies techniques to be implemented for each individual as and when proportional to the risk to self and others.

Outcome

Berkeley House currently has 7 patients all of whom have specific care plans for Positive Behaviour Management (PBM) interventions; these care plans are on RiO and a copy of an accessible care plan is available for the patient.

They also have Positive Behavioural Support (PBS) plans which contain detailed information regarding primary, secondary and tertiary strategies for each person. Within these plans are functional assessments of behaviours that individuals may display. These include what a good day looks like and individualised strategies to manage behaviours when a patient begins to show signs of distress.

Primary prevention strategies aim to enhance the service users' quality of life and meet their unique needs thereby reducing the likelihood of behavioural disturbances.

Secondary prevention strategies focus on the recognition of early warning signs of impending behavioural disturbance and how to respond in order to encourage the patient to be calm.

Tertiary strategies guide the responses required to manage behavioural disturbance and acknowledge that the use of proportionate restrictive interventions may be required to minimise harm

We are currently meeting this target.

Target 3.5 To further develop a quality improvement led approach to robustly embed lessons learned following serious incidents.

The Trust Serious Incident Review Process was reviewed during Quarter 4 2018/19 by Price Waterhouse Coopers (PWC) internal audit team. PWC assessed the effectiveness of the change in the Trust's Serious Incidents Requiring Investigation (reporting mechanisms, examined the processes in place for implementing relevant SIRI action plans and how lessons learned identified are shared across the Trust. The audit provided positive assurance regarding the quality of investigations and identified that there was a robust and effective mechanism to share lessons learned across the Trust, however there was scope to enhance the implementation in practice, embed the learning and the assurance mechanisms to determine effectiveness.

Actions Ongoing & Planned.

- Work is ongoing via the Nursing, Therapies & Quality Team regarding improving embedding lessons learned from serious incidents and this will be monitored and evaluated by the Quality Committee.
- Web based platforms for the dissemination of the learning from SIRIs are being explored, which would include confirmation that the recipient had both read the detail and taken any relevant action.
- An independent review of the Duty of Candour process was commissioned by the Director of Nursing, Therapies & Quality and undertaken during Q3. Recommendations have been made and implemented to improve this important process.
- The newly merged Clinical Governance & Compliance Team held a series of team workshops throughout November and December 2019 to review the legacy Incident Management (including SIRIs), Duty of Candour and Complaints processes from both GCS & 2G and begin harmonizing these in readiness to establish robust policy and practice to implement from April 2020. A further workshop will be held in January to consolidate the work on incident management and learning assurance processes.

We anticipate meeting this target by April 2020.

with you, for you

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AGENDA ITEM: 15/0120

Report to:	Trust Board – 29 January 2020
Authors:	Zoe Lewis, Patient Safety Administrator
Presented by:	Amjad Uppal, Medical Director
SUBJECT:	**LEARNING FROM DEATH 2019/20 Q2**

Can this report be discussed at a public Board meeting?	Yes

This Report is provided for:

Decision	Endorsement	**ASSURANCE**	**TO NOTE**

PURPOSE OF REPORT

To update the Board on the work completed in the period July to September 2019 inclusive

EXECUTIVE SUMMARY

The data presented represents those available for the period July to September 2019 (2019/20 Q2).

162 mental health patient deaths were reported during 2019/20 Q2.

127 death incidents were screened and then closed without further review due to being open to solely ACI-Monitoring caseloads or excluded due to a primary diagnosis of dementia and over 70 years of age.

27 patient death incidents were subjected to the mortality review process and 6 were subjected to serious incident investigations.

From 1 October 2019, both physical health patient deaths and mental health patient deaths will be reported on a quarterly basis, following the merger of CGS and 2G.

RECOMMENDATIONS

The Board is asked to note the contents of this Mortality Review Report which covers Quarter 2 of 2019/20.

CORPORATE CONSIDERATIONS	
Quality implications	Required by National Guidance to support system learning
Resource implications:	Significant time commitment from clinical and administrative staff
Equalities implications:	N/A
Risk implications:	N/A

WHICH TRUST VALUES DOES THIS PAPER PROGRESS (P) OR CHALLENGE (C)?			
Working together	P	Always improving	P
Respectful and kind	P	Making a difference	P

Reviewed by:		
Amjad Uppal, Medical Director	Date	19/01/20

Where in the Trust has this been discussed before?		
	Date	

What consultation has there been?		
	Date	

Explanation of acronyms used:
MoReC – Mortality Review Committee LD MRG - Learning Disabilities Mortality Review Group SJR - Structured Judgement Review CRR - Care Record Review EOL - End of Life SI – Serious Incident CI – Clinical Incident MHA – Mental Health Act

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 Since Quarter 3 2017/18, the Trust Board has received 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 care record review (now SJR Part 2+)
- 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 July to September 2019.

2. PROCESS

2.1 All 2gether NHS Foundation Trust staff are required to notify, using the Datix system, the deaths of all Trust patients. This comprises anyone open to a Trust caseload at the time of their death and who dies within 30 days of receiving care from 2gether. Following discussion at Mortality Review Committee (MoReC) in and at countywide Mortality Steering Groups in both Gloucestershire and Herefordshire, it was agreed to exclude from active review those open for ACI Monitoring only and those with a primary diagnosis of dementia who are over 70 years old. MoReC had become very aware that older people with dementia die whilst this had resulted in very little learning from this cohort of patients. There will be a continued focus on those 70 years and under.

2.2 Mandatory mortality reviews are required for:

- All patients where family, carers, or staff have raised concerns about the care provided.
- All patients with a diagnosis of psychosis or eating disorders during their last episode of care, who were under the care of services at the time of their death, or who had been discharged within the 30 days prior to their death.

- All patients who were an inpatient in a mental health unit at the time of death or who had been discharged from inpatient care within the last month.
- All patients who were under a Crisis Resolution & Home Treatment Team (or equivalent) at the time of death (noting that these deaths will likely be categorised as Serious Incidents).

2.3 The format of a Mortality Review was modified following the publication of the Royal College of Psychiatrists Structured Judgement Review in January 2019. With regard to process detail, "Table Top Reviews" are now referred to as SJR Part 1, and "Care Record Reviews" are SJR Part 2+ (including parts 2-7). The RCPsych SJR is attached for reference. The parts of the review consider:

- Part 1 The allocation and initial review or assessment of the patient (this is usually completed within Datix only) resulting in a Mazars categorisation
- Part 2 The ongoing care of the patient, including both physical health and mental health
- Part 3 Care during admission
- Part 4 Care at the end of life
- Part 5 Discharge planning
- Part 6 An option for organisations to rate particular aspects of care the reviewers feel is necessary for that individual
- Part 7 Overall care

2.4 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) (Table 2.1).

2.5 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.

Table 2.1 Mazars' Categories

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.

2.6 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.

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

2.8 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.

2.9 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 2gether"
- Category 3: “possibly due to problems in care within an external organisation”

2.10 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.

2.11 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 During 1 July 2019 – 30 September 2019 162 patients of ^{2}gether NHS Foundation Trust died (correct as of 13 January 2020). This comprised the following number of deaths which occurred in each month of that reporting period:

- 50 in July
- 62 in August
- 50 in September.

3.2 The terminology used to describe the stages of Mortality Review changed in December 2018 following publication of the Royal College of Psychiatrists’ Structured Judgement Review (SJR) documentation. The Mortality Review Committee (MoReC) adopted this methodology in January 2019 following discussion and agreement by the Mortality Review Committee (MoReC). The LD Mortality Review Group (LD MRG) have decided to continue with the

Care Record Review (CRR) of LD patient deaths in order to facilitate continuity with the LeDeR process.

3.3 Following discussion at MoReC in and at countywide Mortality Steering Groups in both Gloucestershire and Herefordshire, it was agreed to exclude from active review those patients open for ACI Monitoring only and those with a primary diagnosis of dementia who are over 70 years old. MoReC had become very aware that older people with dementia die as a natural consequence of the illness process resulting in limited learning from this cohort of patients. There will be a continued focus on those 70 years and under.

3.4 At the time of writing this paper, a total of 15 RCPsych Structured Judgment Reviews Section 2 (SJRs) at MoReC and Care Record Reviews at LD MRG had been completed.

3.5 The number of deaths in each month for which a Structured Judgement Review (either Section 1 and 2, or just Section 1), Care Record Review, Clinical Incident Review or a Serious Incident investigation was carried out was:

- 10 in July
- 10 in August
- 8 in September

3.7 The above figures do not include current open SJRs, CRRs, CI Investigations and SI Investigations from 2019/20 Q2.

3.8 At the time of writing this paper, 0 deaths representing 0.0% of the 162 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 (Table 3.1). In relation to each month, this consisted of:

- 0 representing 0% for July
- 0 representing 0.0% for August
- 0 representing 0% for September

3.9 In the case of 2 deaths, the mortality review process could not proceed due to GP practices failing to supply death information.

3.10 At time of writing, 5 deaths, which represented 3% of the 162 patient deaths during the reporting period were still open and undergoing mortality review (Table 3.2). 4 patient death incidents were awaiting death information, which includes waiting for toxicology results, and 1 was awaiting CRR at LD MRG. There were 0 open Serious Incident Investigations and 0 open Clinical Incident Investigations.

Table 3.1.Completed Mortality Reviews 2019/20 Q2

Mortality Review Closure Category		Month			Quarterly Totals
		July	August	September	
Closed - Mortality Review Criteria Unmet		37	48	42	127
Closed - Unable to Categorise		1	1	0	2
Closed Following SJR Section 1	Category 1: Not Due to Problems in Care	6	4	5	15
	Category 2: Possibly Due to Problems in Care within 2gether	0	0	0	0
	Category 3: Possibly Due to Problems in Care Within an External Organisation	0	0	0	0
Closed Following SJR Section 2 (MoReC) or Care Record Review (LD MRG)	Category 1: Not Due to Problems in Care	2	3	2	7
	Category 2: Possibly Due to Problems in Care within 2gether	0	0	0	0
	Category 3: Possibly Due to Problems in Care Within an External Organisation	0	0	0	0
Closed following Clinical Incident Review	Category 1: Not Due to Problems in Care	0	0	0	0
	Category 2: Possibly Due to Problems in Care within 2gether	0	0	0	0
	Category 3: Possibly Due to Problems in Care Within an External Organisation	0	0	0	0
Closed following Serious Incident Review	Category 1: Not Due to Problems in Care	1	3	1	5
	Category 2: Possibly Due to Problems in Care within 2gether	0	0	0	0
	Category 3: Possibly Due to Problems in Care Within an External Organisation	1	0	0	1
Monthly Totals		48	59	50	157

Table 3.2 Open Mortality Reviews 2019/20 Q2

Mortality Review Status	Month			Quarterly Totals
	July	August	September	
Awaiting Death Information (incl. tox results) for SJR Section 1	2	2	0	4
Awaiting SJR Section 2 (MoReC) or Care Record Review (LDMRG)	0	1	0	1
Open Clinical Incident Investigation	0	0	0	0
Open Serious Incident Investigation	0	0	0	0
Monthly Totals	2	3	0	5

4. LEARNING

4.1 Learning from Structured Judgement Reviews at MoReC during 2019/20 Q2

4.1.1 During 2019/20 Q2, following Structured Judgment Reviews of patient deaths, together with patient deaths brought for discussion only, MoReC has made the following Recommendations:

- Following the review of the expected death of an elderly inpatient at Stonebow Unit, the Committee noted that during the tos and fros to Hereford County Hospital, it was not clear in the notes that the patient continued to have capacity, which should have indicated a MCA assessment. Although the patient's family was included and were in agreement not to move the patient to a nursing home with best interests in mind, the Committee noted there was no evidence that a MCA2 was completed or that DoLS was considered. The Committee decided to reflect back to HfD Locality, via the locality's Deputy Medical Director, that frail and elderly inpatients need to have regular assessments of their capacity and where serious medical decisions are taken, they need to be accompanied by a MCA2.

- Following the review of the death of an elderly patient who had recently been discharged from CLH, the Committee noted that whilst an inpatient in CLH, the patient had been assessed as lacking capacity and was then discharged without a diagnosis of dementia. The Committee noted that no investigation took place to ascertain whether the patient was low due to depression. The Committee recommended that clinicians be more vigilant and think more holistically by considering all possibilities. This recommendation was taken to the OPS Consultants Meeting and also to the MHARS Team Manager. The Deputy Medical Director for Operations has agreed to facilitate Mini ACE training for psychologists going forward.

- Following the review of two expected deaths of inpatients suffering with dementia at CLH where usual doses of EOL medications struggled to control symptoms, the Committee noted that Palliative Care Consultant had recommended increasing doses above and beyond that of the norm. The Committee noted that patients dying of dementia seem often to require higher doses of EOL medications to control their symptoms and concluded that some research in this area would be worthwhile.

Mulberry Ward Manager has agreed to discuss with Palliative Care Nurses the possibility of research regarding doses of EOL medications for patients suffering with dementia, including an audit of what is currently being prescribed.

4.2 Learning from Care Record Reviews at LD MRG during 2019/20 Q2

4.2.1 Learning from deaths reviewed by the Learning Disability Mortality Review Group is currently developing.

4.3 Learning from Serious Incident Investigations completed during 2019/20 Q2

4.3.1 During 2019/20 Q2, 4 Serious Incident Investigations concerning patient deaths were completed. The Lessons Learned generated from the 4SI Investigations are as follows:

SERIOUS INCIDENT INVESTIGATION

LESSONS LEARNED SUMMARY SI-01-20

Incident Category:

Patient Death

What happened?

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

What did the Investigation find?

- **The patient had been assessed as MEDIUM risk of suicide. This was in the context of experiencing high levels of anxiety with a background of a serious mental health diagnosis, rather than any indication of a specific plan or intention to end their life.**
- **The patient and spouse had been appropriately supported by community mental health services; they had declined informal admission to hospital on several occasions, partly due to distance from the inpatient unit. The patient was not detainable under the Mental Health Act.**

What can we learn from this incident?

- **The review had identified exemplary care from mental health services and other clinicians involved. This included consistent communication between the inpatients, community services and physical health services.**
- **The inpatient Physiotherapists and Occupational Therapist ensured that appropriate rehabilitation following a hip operation was in place.**
- **The teams worked closely to the Triangle of Care Model when working with and supporting the patient's spouse, who was fully involved with all decisions regarding the patient's care, treatment and level of risk. The spouse's own care needs were recognised and supported.**
- **When the couple went on holiday the Crisis Team offered details of local mental health services as well as providing daily telephone support.**
- **The spouse raised the importance of providing support and advice in regards to relevant benefits available to patients and their family when a hospital admission takes place, especially when the ability to continue receive an income is compromised.**
- **Medical staff to be reminded to use written information more if there is any concern that the patient might not remember the treatment plan at an appointment, and to ensure any changes in medication are clear.**

SERIOUS INCIDENT INVESTIGATION

LESSONS LEARNED SUMMARY SI-02-20

Incident Category:

Patient Death

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

- **An inpatient utilised a period of leave and did not return as planned, the patient was found hanged at his home address.**

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

- **The patient had a long history of depression and anxiety and voiced fluctuating suicidal ideas and had made several attempts to end his life over a number of years.**
- **The patient received responsive care in the community with appointments being brought forward when risks increased.**
- **On admission, Consent to Share and next of kin details were gathered, but the next of kin details were not updated on RiO, which resulted in incorrect information being left on the system, which made contacting family difficult following an emergency.**
- **There was inconsistency in the documentation of risk. The risk level documented within the risk assessment was different to the recording within the Progress Notes.**

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

- **When informal patients utilise a period of leave, staff must agree with the patient and document what the expected return to the ward time is, and in the event of a patient being late, at what time the patient or their family will be contacted and an escalation process started.**
- **When next of kin, family and friends details are collected, staff should ensure that the information is updated on RiO.**

SERIOUS INCIDENT INVESTIGATION

LESSONS LEARNED SUMMARY SI-05-20

Incident Category:

Patient harm: Patient death

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

- **the patient was found deceased at her home after a suspected suicide**

What did the Investigation find?

- **The patient had a diagnosis of Emotional Unstable Personality Disorder. They had been supported over the last 5 years following the patient loosing custody of their son.**
- **The patient had been assessed as LOW risk of suicide. They had fleeting thoughts of ending their life, but had not acted on these for over the 16 years.**
- **The patient was not always concordant with prescribed medication and did not always take this as prescribed, and frequently did not attend outpatient appointments.**
- **In the 6 months prior to their death the patient reported to have experienced distressing memories of childhood abuse, had separated from their partner and had not attended appointments offered by the mental health services.**

What can we learn from this incident?

- **When incidents of alleged Domestic Violence are disclosed, clinicians must carefully document these within the patient record, together with their rationale for intervention or non-intervention, including the advice given to the patient**
- **When a patient has disengaged from a service and discharge is indicated, both the patient and their General Practitioner must be sent a letter with a summary of the care offered to date, the actual date of discharge, and any potential areas of risk to self or others and any handover of pertinent information to other professionals still involved. This must include a clear statement about the action to take, and who to contact, in the event of relapse or change with a potential negative impact on the person's mental well-being.**
- **When Teams are aware that a patient is potentially missing and the police are already aware, the MDT must clearly document a 'follow up' date for contacting the police for an update, and identify which member of the team will undertake this action.**
- **Staff to routinely revisit consent to share decisions and explore in detail which members of family this pertains to and in what circumstances.**

SERIOUS INCIDENT INVESTIGATION

LESSONS LEARNED SUMMARY SI-06-20

Incident Category:

Patient Death

What happened?

- **The patient was on holiday with their family in Canada when they found the patient hanged at the family's holiday home.**

What did the Investigation find?

- **The patient was diagnosed with a psychotic disorder, and experienced persistent symptoms of paranoid delusions and ideas of reference. The patient found it difficult to acknowledge that these experiences were the result of their illness and was not always concordant with prescribed antipsychotic medication.**
- **The patient used cannabis on a regular basis and at times to a high level. The patient's level of alcohol consumption appeared to have increased in the months prior to their death.**
- **The patient was provided with a comprehensive, responsive and compassionate service in line with expected operational policies and clinical guidelines.**
- **The staff involved in the patient's care demonstrated both care and consideration in the treatment they offered and were sensitive to the patient's experience of illness. This is also true of the family work which involved working with both the patient and their mother.**

What can we learn from this incident?

- **The investigation highlighted an improvement to be made to risk management planning with regard to the documentation of risk factors associated with the patient's disclosure about access to firearms. This is not considered contributory, particularly when balanced against the patient's international lifestyle and that access to guns in America is considered a fundamental right.**
- **It must be clearly documented in the RiO Risk assessment and management plan, where there is the risk of use of a firearm (especially when the patent has potential access to a firearm and is experiencing paranoid ideation).**

4.3.2 The Lessons Learned are routinely taken to Locality Governance Committee meetings for onward cascade. The SI Action-Planning Sub-Committee oversees the gathering of Assurance for each Action generated.

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

4.4 Learning from Clinical Incident Investigations Completed During 2019/20 Q2

4.4.1 There was no learning from Clinical Incident Reviews during 2019/20 Q2.

5. CONCLUSION

5.1 This, the Q2 report for 2019/20 of mortality review data under the Learning from Deaths policy and focusses on the progress made during Q2.

5.2 The now substantive Patient Safety Team Administrator continues to make a positive impact upon the mortality review process resulting in a more timely review of patient deaths, as demonstrated by the data contained in Tables 3.1 and 3.2, together with the output from MoReC (Section 4.1). Patient Safety Team Administrator's aim is to improve on this still further, whilst being mindful of the impact of Trust merger upon the mortality review process and her workload in other areas.

5.3 Mortality Review Committees have convened regularly since November 2018. However, whilst learning from these reviews is limited, the active review of patient deaths does provide assurance that End of Life Care and the care provided to our patients is of an excellent quality which seldom results in unexpected deaths, natural or otherwise.

5.4 As a Trust we are committed to the National Quality Boards (2017) Learning from Deaths guidance. The Trust ensures that it seeks to actively learn and implement changes in practice identified from reviews of death. The Trust is an active supporter of the Learning Disabilities Premature Mortality Review programme (LeDeR) in Gloucestershire and Herefordshire.

5.5 Learning from Deaths continues to provide vital guidance. As a Trust we are fully committed to recognising the need to improve services following learning from events both nationally and locally such as Gosport, Mid Staffordshire and the Learning Disabilities Premature Mortality Review (LeDeR), alongside our own local serious incidents.

6. MORTALITY REVIEW POST- MERGER

6.1 The Board is asked to note that from 1 October 2019, the learning from mortality review of the deaths of both mental health patients and physical health patients will be reported on a quarterly basis.

6.2 The Board is asked to note that from 1 October 2019, the former Gloucestershire Care Service's Mortality Review Group is known as the Physical Health Mortality Review Group (PH MRG) and the former 2gether Mortality Review Committee is known as the Mental Health Mortality Review Group (MH MRG). The name of the former 2G LD Mortality Review Group (LD MRG) remains unchanged.

6.3 Inpatient deaths of physical health patients are currently reported on MIDAS, however, from 1 April 2020, all patient deaths will be reported on the new joint Datix system, which will facilitate internal reporting, as well as reporting to NLRS and NHSI. Development of the relevant mortality review forms within the new Datix system is currently progressing.

with you, for you

Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 16/0120

Report to: Trust Board – 29 January 2020

Author: Dr Nader Abassi, Guardian of Safe Working

Presented by: Dr Amjad Uppal, Medical Director

SUBJECT: **GUARDIAN OF SAFE WORKING QUARTERLY REPORT**

Can this report be discussed at a public Board meeting?	Yes

This report is provided for:

Decision Endorsement **ASSURANCE** **INFORMATION**

EXECUTIVE SUMMARY

- The exception reporting process is part of the new Juniors Doctors Contract to enable them to raise and resolve issues with their working hours and training.
- The Guardian's quarterly report which summarises all exception reports, work schedule reviews and rota gaps, to provide assurance on compliance with safe working hours by both the employer and doctors in approved training programs, and will be considered by CQC, GMC, and NHS employers as key data during reviews.
- The purpose of the report is to give assurance to the Trust Board that the doctors in training are safely rostered and their working hours are complaint with the TCS.

RECOMMENDATIONS

The Board is asked to **note**:

1. The report from the Guardian of Safe Working Hours.
2. The trainees and supervisors response time to reports remains a challenge although there is ongoing work in progress.

Corporate Considerations	
Quality implications	Any quality implications are clearly referenced within the report
Resource implications:	Any resource implications are clearly referenced within the report
Equalities implications:	Any implications are clearly referenced within the report
Risk implications:	Any risk implications are clearly referenced within the report

WHICH TRUST VALUES DOES THIS PAPER PROGRESS (P) OR CHALLENGE (C)?			
Working together	**P**	Always improving	**P**
Respectful and kind	**P**	Making a difference	**P**

Report authorised by:	**Date:**
Dr Amjad Uppal, Medical Director	20th January 2020

Where has this issue been discussed before?	**Date:**
Trust Board Quality Committee	9th January 2020

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

GUARDIAN OF SAFE WORKING QUARTERLY REPORT

1.0 CONTEXT

1.1 The safety of patients is of paramount importance for the NHS and staff fatigue is a hazard both to patients and the staff. The 2016 national contract for junior doctors encourages stronger safeguards to prevent doctors working excessive hours. It was agreed during negotiations with the BMA that a 'Guardian of Safe Working Hours' will be appointed in all NHS Trusts employing trainees (junior doctors) to ensure safe working practice.

1.2 The role of 'Guardian of Safe Working Hours' is independent of the Trust management structure, with the primary aim to represent and resolve issues related to working hours for the junior doctors employed by it. The Guardian will ensure that issues of compliance with safe working hours are addressed, as they arise, with the doctor and/or employer, as appropriate; and will provide assurance to the Trust Quality Committee and Board or equivalent body that doctors' working hours are safe.

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

1.4 The Trust has invested in relevant software to help monitor the 'Exception Reports' in line with national guidance and the system is relatively well established in the Trust now.

1.5 The Guardian's quarterly report, as required by the junior doctor's contract, is intended to provide the Trust's Board Committee with an evidence based report on the working hours and practices of junior doctors within the Trust, confirming safe working practices and highlighting any areas of concern.

2.0 THE GUARDIAN OF SAFE WORKING HOURS REPORT

2.1 Exception Reporting

The Trust uses 'Allocate' as the reporting software system, which appears to function reasonably well for this purpose. Since beginning of May 2019 till end of July 2019, 12 exception reports (11 from Gloucestershire and 1 Hereford) have been generated and a break down has been provided in the full report.

2.1.1 All of 12 reports in this period have been related to hours. We had 8 resolutions addressed by educational supervisor and 4 of exception reports have to be addressed by Guardian of Safe Working Hours. This is due to educational supervisor being on the extended sick leave, although they already met and agreed on the outcome but didn't enter the outcome.

- 1/12 No further action

- 9/12 time in lieu agreed
- 2/12 overtime payments agreed
- There was no need for work schedule reviews in this period.

2.1.2 We have recently been provided with the option of closing historical reports down and the Guardian is waiting to discuss this option in the Medical Education Board and Junior Doctors Forum to close them on agreement of all parties involved.

2.2 Locum Booking and Vacancies

2.2.1 During this period five on call shifts in Gloucester were covered by agency doctors and none in Hereford.

2.2.2 In this time period we had no long term vacancy or sickness on Hereford site but six of our trainees on Gloucester site not able to complete on calls as normal.

2.3 Fines

1.1.1 At this stage no fines have as yet been applied.

3.0 Challenges

3.1 Completion of Exception Reports / Knowledge of the System: Although there has been improvement in the number of reports but response times remains a challenge. We had only one of our twelve reports in this quarter closed in a timely manner and the rest were addressed by delay. The Guardian has arranged meetings with trainees of all grades to discuss the issues and explore the challenges and ways to improve. We already had a meeting with our core trainees and addressed some of the issues and also arranged another meeting with our advance trainees. The Guardian also has arranged to present in weekly academic programme to update educational supervisors of the procedure and also explore their difficulties and challenges. The Guardian will continue to support junior doctors and supervisors in resolving these issues as soon as possible.

3.2 Software System: The Trust uses a nationally procured system for medical staff rotas called ‘Allocate Software System’; this system is now used for Exception reporting. All our junior doctors and educational supervisors are registered with the system. There are some issues with the system, which are nationwide and not limited to our Trust, and have been highlighted to the software company.

3.3 Junior doctor rota: Since changing rota in Gloucestershire to working ‘waking’ nights there has been a significant decline in number of exception reports. There has been significant improvement in number of reports raised by trainees working in Hereford following increase time allocated to on-call call out hours.

3.4 Workload: The new contract does have workload implications for the Guardian, administrator, DME, Educational and Clinical supervisors when a trainee submits an exception report.

3.5 Administrative support for the Guardian role: The Guardian is assisted by administration from medical staffing and they have been very supportive in introducing the new system and answering queries from users.

3.6 Junior Doctors Forum: Our Junior Doctors Forum predates the introduction of the new contract and has been further strengthened by the Guardian and the DME meeting quarterly. The attendance by junior doctors has been variable despite a proactive approach by the current junior doctors' rep to engage colleagues.

4.0 EXCEPTION REPORTS AND FINES

4.1 There have been 12 exception reports during this period with 4 being addressed by the Guardian due to educational supervisor sick leave.

4.2 There has been no breach of contract to initiate any fines against the Trust yet.

5.0 CONCLUSION

5.1 All of our junior doctors now are on the new contract and committed to use the exception reporting system to ensure safe working practice. Information gleaned from the exception reports enables the DME to keep informed of the challenges and threats to the provision of quality Trainee placements at the Trust.

5.2 The Exception Reporting process allows Trainees to give the Guardian notice of working unsafe hours. It is important that these issues are resolved in a timely manner.

5.3 The Guardian of Safe Working Quarterly Report provides assurance that Trust is positively engaged with its junior doctors via a number of routes and meetings. There was a surge of exception reports at the start of the implementation of the new contract but this has improved significantly with better understanding of the system through regular presentations at Induction and educating trainees and their supervisors.

5.4 There has been significant reduction in the number of exception reports raised by trainees on both sites. This is the result of collaborative work by The Guardian of Safe Working, DME and medical staffing on rotas.

5.5 There are some ongoing issues regarding engagement of both trainees and educational supervisors which are being addressed through regular training updates.

6.0 RECOMMENDATIONS

6.1 The Board is asked to note the assurance provided in the report.

6.2 Ongoing issues are being addressed through regular training updates and initial training at trainees' Induction which is mandatory.

AGENDA ITEM 17/0120

REPORT TO:	Trust Board – 29 January 2020
AUTHOR:	Lauren Edwards, Deputy Director of Therapies and Quality
PRESENTED BY:	John Trevains, Director of Quality
SUBJECT:	**CQC SURVEY OF PEOPLE WHO USE COMMUNITY MENTAL HEALTH SERVICES - 2019 RESULTS AND ACTION PLAN**

Can this subject be discussed at a public Board meeting?	Yes

This report is provided for:

Decision Endorsement **ASSURANCE** **INFORMATION**

PURPOSE OF REPORT

- To summarise the results of the 2019 CQC national community mental health survey. These results provide assurance of the quality of adult community mental health services previously delivered by ²gether NHS Foundation Trust, now delivered by Gloucestershire Health and Care NHS Foundation Trust.
- To provide assurance that the results of this national survey have been used to identify areas of focus for practice development activity over the next 12 months.

RECOMMENDATIONS

The Board is asked to:

- Note the contents of this report
- Receive assurance of our delivery of high quality adult community mental health services
- Receive assurance that this feedback has been used to support areas for practice development

EXECUTIVE SUMMARY

Enabling people to have positive experiences of NHS services which meet their needs and expectations is a key national strategic goal and is an underpinning core value of Gloucestershire Health and Care NHS Foundation Trust and its legacy organisations.

In 2018, Quality Health was commissioned by ²gether NHS Foundation Trust to undertake the 2019 national Community Mental Health Survey, which is a requirement of the Care Quality Commission.

This paper outlines the Care Quality Commission's published results of the data analysis of the survey sample of people who used [2]gether's services. The CQC makes comparison with all 56 English NHS mental health care providers' results of the same survey. Results are published on the CQC website.

Only 2 Trusts were classed as 'better than expected' in 2019 and our Trust was one of them. We are the only Trust to have received this rating for the third consecutive year.

The Trust's results are '*better*' than the expected range for 11 of the 29 questions (38%) and '*about the same*' as other Trusts for the remaining 18 questions (62%) These results **represent a further improvement** when compared with our results from last years' service user feedback in the same survey (Better = 36%, about the same = 64%). The Trust is categorised as performing 'better' than the majority of other mental health Trusts in 7 of the 11 domains (64%) (last year: 5 out of 11, 45%)

The scores for 'feedback' are disappointing, although are '*about the same*' as other Trusts (the highest score in England was only 4.4). This will be a significant area of focus for development, with the work being led by the Patient and Carer Experience Department.

An action plan has been co-developed with senior operational and clinical leaders (see appendix 1). An infographic has been produced to support effective dissemination of findings to colleagues and local stakeholders.

Assurance
These survey results offer **significant assurance** that the Trust's strategic focus and dedicated activity to deliver best service experience is having a positive effect over time.

The action plan offers **significant assurance** that we are using the results of this feedback to guide further practice development activity.

WHICH TRUST VALUES DOES THIS PAPER PROGRESS (P) OR CHALLENGE (C)?			
Working together	**P**	Always improving	**P**
Respectful and kind	**P**	Making a difference	**P**

Report authorised by:	**Date:**
John Trevains, Director of Quality	20/01/20

Where has this issue been discussed before?
Quality Assurance Group - October 2019 Trust Board (earlier version without infographic or action plan) – December 2019

What wider engagement has there been?	
Liaison with relevant colleagues across the organisation in order to co-produce the action plan (appendix 1)	

Community Mental Health Services

RESULTS FOR HEREFORDSHIRE AND GLOUCESTERSHIRE

1.0 Background

1.1 The Care Quality Commission (CQC) requires that all providers of NHS mental health services in England undertake an annual survey of patient feedback. For the 2019 survey, 2gether NHS Foundation Trust was the named provider of these services, prior to the creation of Gloucestershire Health and Care NHS Foundation Trust. As has been the case for several years, the Trust commissioned Quality Health to undertake this work.

1.2 The 2019 survey of people who use community mental health services involved 56 providers in England, including combined mental health and social care trusts, Foundation Trusts and community healthcare social enterprises that provide NHS mental health services.

1.3 The data collection was undertaken between February and June 2019 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 2018.

1.4 Full details of this survey questions and results can be found on the following website:
https://nhssurveys.org/wp-content/surveys/05-community-mental-health/05-benchmarks-reports/2019/2gether%20NHS%20Foundation%20Trust.pdf

2.0 Scores for 2gether NHS Foundation Trust in 2019

2.1 The CQC results for the 2019 survey of people who use community mental health services were published on the 26th November 2019[1]. The Trust's overall results are summarised in Table 1 below.

2.2 Only 2 Trusts were classed as 'better than expected' in 2019 and our Trust was one of them. We are the only Trust to have received this rating for the third consecutive year.

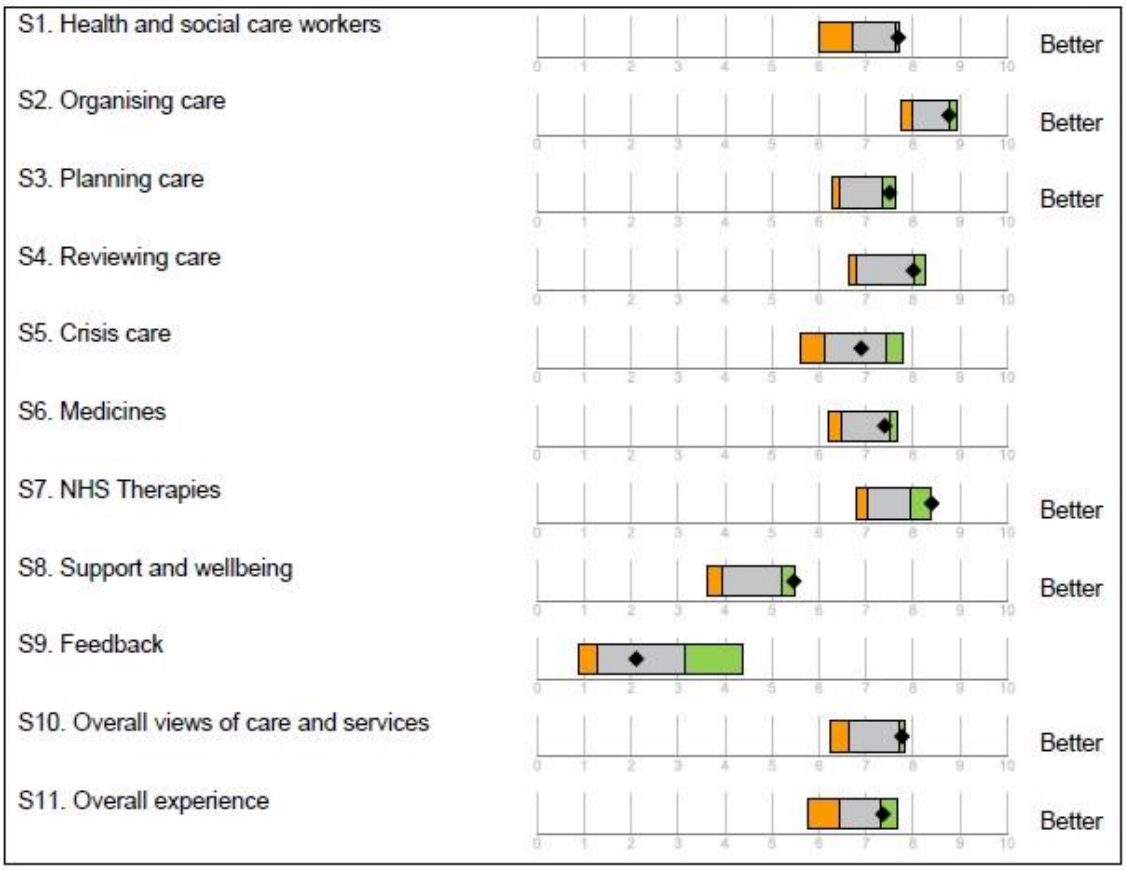
2.3 The Trust obtained the **highest Trust scores in England** on 6 of the 28 (n=21%) evaluative questions and on 4 of the 11 domains.

Table 1

[1] https://www.cqc.org.uk/provider/RTQ/survey/6

2019 Community Mental Health Patient Experience Survey
2gether NHS Foundation Trust

Section scores



Key to Table 1

Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

2.4 Our results are 'better' than most Trusts for 11 of the 29 questions (38%) and 'about the same' as other Trusts for the remaining 18 questions (62%) These results represent a further improvement when compared with our results from last years' performance in the same survey (Better = 36%, about the same = 64%).

2.5 An infographic of our results has been developed to share the results in a more accessible format with colleagues and local stakeholders.

3.0 Top areas for priority further development include:

3.1 Adult community mental health services provided by Gloucestershire Health and Care NHS Trust (GHC) scored well this year overall, being classed as 'better than expected' for the third consecutive year. However, there continue

to be areas where further development and continued effort would enhance the experience of people in contact with our services. For example, the results in the feedback domain suggest that further work is required in this area.

3.2 The 2019 survey scores and information from a range of other service experience information (reported to Board quarterly) suggest that actions being taken to enhance service experience over recent years are having a positive impact and that learning from feedback is being embedded into practice.

3.3 The following areas for further practice development have been identified:

- Giving people information about getting support from people with experience of the same mental health needs as them
- Discussing the possible side-effects of medication with people
- Asking people for their views on the quality of their care

4.0 Next steps

4.1 These results represent a further improvement when compared to our results from last years' service user feedback in the same survey. The results are a testament to the expert and dedicated effort that colleagues are making to understand need, involve and respond well to people who use our services and their carers.

4.2 There is a need to sustain the effort made to develop practice in the areas identified in previous years.

4.3 Where other organisations have scored well in particular areas we will collaborate and seek ideas to further develop local practice, particularly in relation to seeking feedback.

4.4 An action plan (appendix 1) has been co-developed with senior operational and clinical leaders and will be monitored via the Locality Updates regularly brought to the Quality Assurance Group.

4.5 The 2019 results will be 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 senior leaders for sharing with teams and for generating ideas for continued practice development. An infographic has been developed to share the results in a more accessible format.

2019 CQC Survey of people who use community mental health services

Gloucestershire and Herefordshire (previously delivered by 2gether NHS Foundation Trust)

NHS Gloucestershire Health and Care NHS Foundation Trust

827 people were sent the survey

273 people returned the survey

18 years plus

27% National response rate

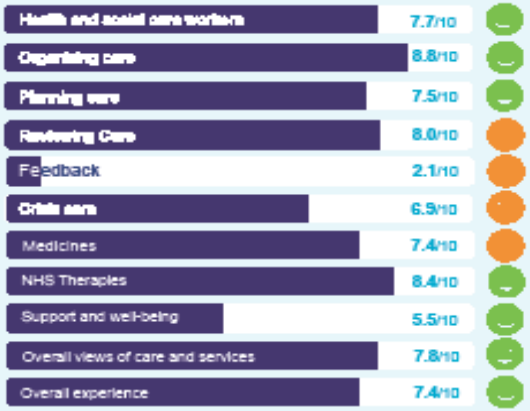
33% Our response rate

29 questions → **11** domains → **Our results:** In the top 20% of Trusts in 7 out of the 11 domains. 'About the same' as other Trusts in 4 domains.

Results of 11 domains

Each domain compared to other trusts

Better | About the same | Worse



Rated nationally as amongst the highest performing trusts for:

- Health and social care workers
- Organising and planning people's care
- Involving people in agreeing what care and therapies they will receive
- Giving help or advice with finding support for physical health needs, financial advice, work and activity.
- People's overall views of care and services
- People's overall experience

Areas for further focus:

- Giving people information about getting support from people with experience of the same mental health needs as them
- Discussing the possible side effects of medication
- Asking people for their views on the quality of their care

2019 CQC Survey of people who use community mental health services

Gloucestershire and Herefordshire (previously delivered by 2gether NHS Foundation Trust)

NHS
Gloucestershire Health and Care
NHS Foundation Trust

Results for 29 questions

Each domain includes a number of questions. These are each compared to other trusts using this key:

Better | About the same | Worse

Health and social care workers	7.7/10
Enough time to discuss needs	7.7/10
Understand how mental health affects life	7.6/10
Aware of treatment history	7.7/10
Organising Care	**8.8/10**
Kept informed of who organises care	8.0/10
Able to contact Care Co-ordinator	9.7/10
Care organised well	8.6/10
Planning care	**7.5/10**
Agreeing the care received	6.7/10
Involvement in care planning	7.8/10
Personal circumstances considered	7.9/10
Reviewing care	8.0/10
Discussed how care is working	7.9/10
Decisions made together	8.1/10
Feedback	**2.1/10**
Asked for your views on care	2.1/10
Crisis care	**6.9/10**
Know who to contact out of hours	6.9/10
Get the care needed out of hours	6.9/10
Medicines	**7.4/10**
Involved in decisions about medicines	7.4/10
Discussed medicines purpose	8.0/10
Discussed possible side effects	5.6/10
Medicines reviewed	8.6/10
NHS Therapies	**8.4/10**
Therapies explained	9.1/10
Involved in deciding on therapies	7.7/10
Support and well-being	**5.2/10**
Help finding physical health needs support	5.2/10
Help finding financial advice/benefits support	5.6/10
Help finding or keeping work	5.4/10
Support to take part in a group activity	5.7/10
Involving family or friends	7.1/10
Information about support from others with similar experiences	3.8/10
Overall view and experience of services	**7.8/10**
Enough contact with services	6.7/10
Treated with respect and dignity	8.8/10
Overall experience	**7.4/10**
Overall good experience of services	7.4/10

Appendix 1: 2019 CQC National Community Mental Health Survey Action Plan

Area for development	Action	Timescale	Lead

Giving people information about getting support from people with experience of the same mental health needs as them	**Signposting**
	• Teams to access Social Inclusion Development Workers as information resources in order to provide more clients with information about local peer support opportunities e.g. The Cavern, Independence Trust peer mentoring scheme
	• Networking locality events (with 3rd sector organisations for colleagues, people in contact with mental health services, and their carers
	• Monitoring via Social Inclusion Annual Report.
	
	Recovery Colleges
	• Teams to promote peer-led Severn and Wye Recovery College courses to people with mental health needs and their families.
	• Develop more co-produced and co-delivered services within Gloucestershire, including new initiatives with the Alexandra Wellbeing House (developing a hub model for self-management) and the *Live Better to Feel Better* programme (promoting/enabling recovery from long term conditions, recognising the link between physical and mental health).
	• Monitoring via Recovery College Annual Report
	
	Peer Support
	• Trust to explore opportunities and models for peer support workers in clinical settings within the Trust, in line with the NHS Long Term Plan
	• Continue to develop links with seldom heard groups in order to encourage informal peer support networks
	• Ongoing supportive initiatives, including:
	  • *Collaborative working with the Independence Trust and Nelson Trust*
	  • *Recovery College Peer Support Worker mentoring Peer Tutors and Experts by Experience using the GROW model.*
	  • *Recovery and Discovery College co-producing and co-delivering all*
		February 2020 onwards
		
		Ongoing
		
		June 2020
		
		Ongoing
		
		Ongoing
			Clinical teams with support from Social Inclusion Team
			
			Clinical teams with support from Consultant OT for Recovery and Social Inclusion Team
			
			Recovery College Team, Consultant OT for Recovery, Social Inclusion Team
			
			Consultant OT for Recovery, Social Inclusion Team, Experts by Experience
			
			Consultant OT for Recovery, Social Inclusion Team, Experts by Experience

Area for development	Action	Timescale	Lead
	courses. Acknowledging and actively promoting the crucial role lived experience has to play in a person's journey to recovery. • *Recruitment to peer support opportunities in the Perinatal Team and Criminal Justice Liaison Team.* • *Ongoing consideration of the specific support, training and supervision needs of Peer Support Workers, championing a positive culture across Gloucestershire.*		
Discussing possible side-effects of medication with people	**Providing timely information** • Ongoing subscription to *Choice and Medication website,* allowing practitioners to share/print medication information leaflets for patients. This will be actively promoted and supported through the Drug and Therapeutics Committee. https://www.choiceandmedication.org/2gether • Raising awareness of the website and encouraging discussions re: possible side effects through regular communications, for example Indi-to-go and Medicines Optimisation Newsletter. Chair of Drug and Therapeutic Committee and Medical Director will raise awareness with medical colleagues	January 2020 onwards January 2020 onwards	Head of Medicines Optimisation/Clinical teams Head of Medicines Optimisation, Communications Team, Chair of Drug and Therapeutics Committee
Asking people for their views on quality of care	**Friends and Family Test** • Rollout of the new Friends and Family Test (FFT) to ensure regular feedback about care. • Copies of the FFT to be made available across all services. • People asked for feedback on discharge via SMS. • Launch of a carers FFT to seek feedback on the experience of carers who are in contact with our services • Communications campaign to raise awareness of our feedback mechanisms • FFT, Carers FFT, and Carers survey all available on Trust website **Leaflets and comment cards** • New leaflets and comment cards to be made available throughout all Trust services.	April 2020 onwards February 2020 onwards	Patient Survey Manager, Patient & Carer Experience Team, Communications Team, Lead OT for Carers Patient & Carer Experience Team, Communications Team

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 18/0120

Report to:	Trust Board – 29 January 2020
Author:	Chris Woon, Associate Director of Business Intelligence (BI)
Presented by:	Sandra Betney, Director of Finance
SUBJECT:	**Combined Performance Dashboard (Dec 2020/ Month 9)**

Can this subject be discussed at a public Board meeting? Yes

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

PURPOSE OF REPORT

This *combined* performance dashboard report provides a high level view of key performance indicators (KPIs) across the organisation. The layout, focus and formatting of this document continues to develop in line with our BI development plan. Particular attention is being placed on improving assurance narrative through business partnering and the operational engagement cycle.

This month's performance dashboard report brings together activity from our two legacy organisations into a single automated presentation. To offer reader clarity, the visualisation is separated into the following reporting sections;

- MH – National Requirements (NHS Improvement & DoH)
- MH - Local Contract Gloucestershire (including Social Care)
- MH – Local Contract Herefordshire
- Community - National Requirements (Gloucestershire)
- Community - Local Requirements (Gloucestershire)

Performance covers the period to the end of December (month 9 of the 2019/20 contract period). Where performance is not compliant, operational service leads are addressing issues and work is ongoing in accordance with our agreed service delivery improvement plans to address the underlying issues impacting performance.

RECOMMENDATIONS

The Board are asked to:

- Note the aligned Performance Dashboard Report for December 2019.
- 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.

EXECUTIVE SUMMARY

Your specific attention is drawn to the following 22 key community performance thresholds that were not met for December 2019:

Community - Nationally Reported Measures

- 31: Bed days lost due to delayed discharge as percentage of total bed days
- 31c: Percentage of children in Reception Year with height and weight recorded
- 72: Percentage of patients waiting less than 6 weeks from referral for a diagnostic test
- 80: SUS+ (Secondary Uses Service) Data Quality Validity (available in arrears)
- 82: Proportion of eligible children who receive vision screens at or around school entry
- 85: Percentage of children who received a 6-8 weeks review
- 86: Percentage of children who received a 9-12 month review by the time they turned 12 months.
- 87: Percentage of children who received a 12 month review by the time they turned 15 months.
- 88: Percentage of children who received a 2-2.5 year review by 2.5 years.
- 91: Percentage of infants being totally or partially breastfed at 6-8 weeks (breastfeeding prevalence)

Community - Locally Reported Measures

- 29: % of direct admissions to community hospitals
- 41: Podiatry - % treated within 8 Weeks
- 42: MSKAPS - % treated within 8 Weeks
- 43: MSK Physiotherapy - % treated within 8 Weeks
- 44: ICT Physiotherapy - % treated within 8 Weeks
- 45: ICT Occupational Therapy Services - % treated within 8 Weeks
- 53 Paediatric Physiotherapy - % treated within 8 Weeks
- 67: Wheelchair Service: Adults: New referrals assessed within 8 weeks
- 68: Wheelchair Service: Adults: Priority referrals seen within 5 working days
- 71: Wheelchair Service: Under 18s: Equipment delivered within 18 weeks of referral
- 93: Chlamydia Screening of Gloucestershire residents aged 15-24 via the Chlamydia Screening Service (minimum positivity rate)
- 94: Number of Positive Screens - GCS and Joint responsibility

Your attention is drawn to the following 9 MH key performance thresholds that were not met for December 2019:

MH – National Requirements (NHS Improvement & DoH)

- 2.21: No children under 18 admitted to adult in-patient wards

MH - Local Contract Gloucestershire (including Social Care)

- 3.15: CYPS Referral to assessment within 4 weeks
- 3.20: Care plan audit to show dependent children and YP <18 living with adults
- 3.21: Transition of CYPS to Recovery Service – Joint discharge/CPA review meeting within 4 weeks
- 3.25: Percentage of CYP entering treatment in CYPs have pre and post outcomes recorded
- 3.37: Adolescent Eating Disorders: Urgent referral to NICE treatment within 1 week
- 3.39: Eating Disorders: Wait time for Adult Assessments will be 4 weeks
- 3.40: Eating Disorders: Wait time for Adult psychological interventions will be 16 weeks

MH – Local Contract Herefordshire

- 5.13: CYP Access: percentage of CYP in treatment

For Month 9, December 2019 workforce KPIs are as follows:

- Attendance was 95.11%, against an overall target of 96% (4% sickness).
- Statutory and mandatory training was 90.74%, just above the compliance target.
- Appraisal stood at 82.94%, 7% below a target of 90%. Medical staff appraisal was above this at 92.13%.
- Turnover stood at 13.19%, a modest reduction on the previous month's figure of 13.94%.

WIDER BUSINESS INTELLIGENCE UPDATE

Workforce Development

The Resources Committee receive detailed reports each meeting on the Trust's workforce Key Performance Indicators. These reports detail compliance over the last 12 month period for:

- statutory and mandatory training
- attendance / sickness absence and
- appraisal
- turnover

Detailed operational oversight of workforce KPI performance is through individual directorate Operational Governance Forums, the overarching Operational Governance Forum, development and change input through the Operational Development Forum. Escalation is via the Business Management Intelligence Group, Executives and Resources Committee as required.

Currently there are two legacy systems in place for the recording of appraisals and training – Learn^{2}gether and OLM/ ESR. Work is underway to combine the legacy systems into a single system. This is being project managed and is planned to be completed by May 2020.

On 26 October 2019 the two legacy databases from the Electronic Staff Record System (ESR) went through a 'technical' merge which means legacy information is now contained within one data base. Work has commenced on a wider ESR business consolidation project to build new work structures within the system so that seamless harmonised workforce reporting for the new Trust can take place without the current manual interventions. This work will also lead to commonality across all database systems to deliver a truly integrated 'BI stack'.

Business Intelligence Infrastructure and Reporting Development
To manage the significant development workload as we near April 2020, key tasks continue to be prioritised to ensure the continuity of business critical reports are maintained and business as usual functions protected.

The following tasks have been completed since the last Board update;

- Business as usual maintain
- Exception commentary now incorporated into historic data points with time stamps
- New pan-system database hierarchy proposal
- KPI Development Framework proposal to inform purposeful decision making for a range of stakeholders (portfolio review, service improvement plan programme, exception visibility and escalation lenses)

The following tasks continue to be 'in the development pipeline';

- Improved analytical and responsive narrative to support indicators in exception
- Reporting cycle delivery
- Dashboard visualisation capability further developed to include; threshold figures in place of variances, SPC and trend analysis visualisations for all services, benchmarking indicators and data quality flags (Q4 2019/20).
- The development of business critical operational performance reports (April 2020)
- Maintenance of JUYI community health data feed (April 2020)
- Commissioner led local contractual key performance indicator review (Feb 2020)
- Server capacity, infrastructure evaluation and development (Q3 2019/20).
- New Tableau front page navigation for all BI consumers (including legacy BI tools) (Jan 2020)
- Existing data source adjustments (to support data quality monitoring and historic activity) in new environment (Q4 2020).
- Data source replication (prioritisation for ESR, Integra and Datix) (Q4 2020, dependant on GL and ESR progress)
- Key financial reporting to support the new General Ledger (GL) for April 2020.
- Final legacy GCS reports migrated to Tableau (Q2 2020)
- BAU routine workforce BI reporting (Q1 2020 dependant on interdependencies of GL)
- Complete data sources replication for complimentary systems (Q3 2020)

- Supplementary system sources brought into BI reporting (Datix, Service Experience, Q4 2020)
- *Integrated* Business Intelligence Performance Dashboard (Q4 2021) for Board/ Resources Committee (incorporating full BI stack).
- Birtie decommissioning (Q4 2021)

PLEASE NOTE THAT THE DELIVERY OF THIS BI DEVELOPMENT TIMETABLE IS DEPENDANT ON THERE NOT BEING AN INCREASE IN DEMAND ON CURRENT CORPORATE/ OPERATIONAL BAU & ADHOC REPORTING.

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 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.
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 VALUES DOES THIS PAPER PROGRESS (P) OR CHALLENGE (C)?			
Working together	**P**	Always improving	**P**
Respectful and kind	**P**	Making a difference	**P**

Report authorised by:	**Date:**
Chris Woon, Associate Director of Business Intelligence	20/01/2020

Where has this issue been discussed before?
Business Intelligence Management Group (BIMG)
What wider engagement has there been?
From February 2020, corporate performance dashboards will be discussed through Operational Governance Forums (OGFs) and Performance & Finance (P&F) Meetings with Operational Service Leads.

Appendices:	*Tableau Combined Performance Dashboard* *HR Combined KPIs*

Performance Dashboard Report

Aligned for the period to the end December 2019 (month 9)

The Resources Committee is asked to:

Note the aligned Performance Dashboard Report for December 2019.
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.

Performance Dashboard: *Mental Health - National Requirements (NHS Improvements & DOH)*

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Mental Health - National Requirements Gloucestershire

		December	YTD	
2.21	No children under 18 admitted to adult in-patient wards	97.8% (-2.2%)	99.0% (-1.0%)	

Mental Health - National Requirements Herefordshire

		December	YTD	
2.21	No children under 18 admitted to adult in-patient wards	100.0% (0.0%)	99.0% (-1.0%)	

Performance Thresholds not being achieved in Month

2.21: No children under 18 admitted to adult in-patient wards (Gloucestershire)
A child known to CYPs Learning Disabilities was admitted to Maxwell Suite (136) following a social care placement breakdown. Social Care were unable to identify a placement to meet the Learning Disability needs and as it was not clinically appropriate for the young person to remain in the Maxwell suite they were admitted to Berkeley House. At the time of reporting, the young person continues to stay in Berkeley House.

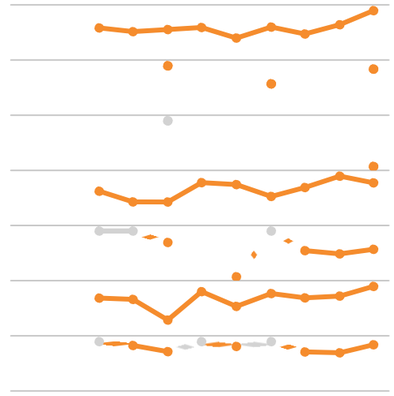
Performance Dashboard: *Mental Health - Local Contract (Including Social Care) Gloucestershire*

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Mental Health - Local Contract Gloucestershire

		December	YTD
3.15	95% accepted referrals receiving initial appointment within 4 weeks (excludes YOS, substance misuse, inpatient and crisis/home treatment and complex engagement) (CYPS)	47.1% -47.9%	30.2% -64.8%
3.20	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 impac..	63.3% -11.7%	57.6% -17.4%
3.21	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 a..	0.0% -100.0%	50.0% -50.0%
3.25	% of CYP entering partnership (treatment) in CYPS have pre and post treatment outcomes and measures recorded	40.0% -60.0%	32.7% -67.3%
3.37	Adolescent Eating Disorders - Urgent referral to NICE treatment start within 1 week	60.0% -35.0%	60.0% -35.0%
3.39	Eating Disorders - Wait time for adult assessments will be 4 weeks	47.3% -47.7%	35.9% -59.1%
3.40	Eating Disorders - Wait time for adult psychological interventions will be 16 weeks	93.7% -1.3%	89.3% -5.7%



Mental Health - Social Care Gloucestershire

None

Performance Thresholds not being achieved in Month

3.15: CYPS Referral to assessment within 4 weeks
This does not align to national reporting guidelines therefore it has been proposed that this indicator is suspended like the two referral to treatment KPIs. Discussions with Commissioners continue.

3.20: Care plan audit to show dependent children and YP <18 living with adults
Compliance has seen a 20% increase since the last audit carried out at the end of quarter 2. Both Eating Disorders and Recovery performance has risen since the previous quarter. This is one of four targeted areas for improvement which the Trust is taking forward. Trust Service Directors continue to be given trajectories which will be monitored through the Delivery Committee. Audit results will be shared with Service Directors to help inform this improvement work.

3.21: Transition of CYPS to Recovery Service – Joint discharge/CPA review meeting within 4 weeks
There is one non-compliant record reported for December. The Recovery service has been asked to investigate.

3.25: Percentage of CYP entering treatment in CYPs have pre and post outcomes recorded
Although the service has an action plan in place to improve recording performance has fallen slightly in December. The service has been asked for comments.

3.37: Adolescent Eating Disorders: Urgent referral to NICE treatment within 1 week
There were 2 non-compliant cases in December. One client was unable to start treatment until day 10 due to an increase in urgent assessments at that time alongside the team's capacity. The other client was offered an appointment within 7 days but declined. Treatment started at the next appointment which was 14 days after referral.

3.39: Eating Disorders: Wait time for Adult Assessments will be 4 weeks
There were 20 non-compliant cases in December. In 17 cases the clients were seen at the first available appointment. These were between 5 and 6 weeks after referral. For the remaining 3 clients all were offered the 1st available appointments but due to DNAs and cancellations are reported as waiting longer than the current average 5 to 6 weeks wait.

3.40: Eating Disorders: Wait time for Adult psychological interventions will be 16 weeks
There was 1 non-compliant case reported in December. The appropriate treatment for this patient is IPT (Interpersonal psychotherapy) for which there is a waiting list. The client started their treatment at the first available appointment which was 21 weeks after assessment.

3.37, 3.39 & 3.40 Additional Commentary:
An increase in adult ED referrals continues but the service has recognised that more can be done to improve process, waiting list management tools are being better utilised and the service trajectory model has being updated to support the established recovery plan.

Performance Dashboard: *Mental Health - Local Contract Herefordshire*

KPI Breakdown

Mental Health - Local Contract Herefordshire

		December	YTD	
5.13	CYP Access: Number and percentage of CYP entering treatment (30% of prevalence)	68.2% -31.8%	78.9% -21.1%	

Performance Thresholds not being achieved in Month

5.13: CYP Access: percentage of CYP in treatment
The performance threshold for 2019/20 remains at 30% of prevalence which equates to 973 young people accessing treatment during 2019/20. We are 177 below the anticipated number required to achieve this at the end of December.

Much of core CAMHS work is indirect via consultation and advice, and the service are working to capture this activity within our clinical system more accurately as it is felt this will further improve performance. Commissioners are closely engaged in this pursuit.

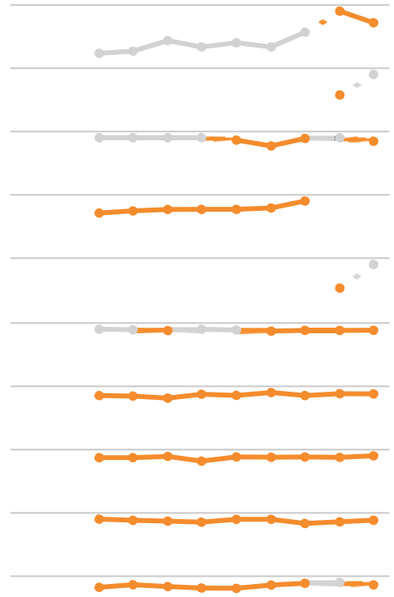
Performance Dashboard: *Physical Health - National Requirements Gloucestershire*

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Physical Health - National Requirements Gloucestershire

		December	YTD
31	Bed days lost due to delayed discharge as percentage of total beddays	4.4% 0.9%	2.9% -0.6%
31c	Percentage of children in Reception Year with height and weight recorded	114.8% 14.8%	87.7% -12.3%
72	Percentage of patients waiting less than 6 weeks from referral for a diagnostic test	94.0% -5.0%	96.6% -2.4%
80	SUS+ (Secondary Uses Service) Data Quality Validity (available in arrears)		81.6% -14.6%
82	% of eligible children who receive vision screens at or around school entry.	101.3% 1.3%	74.4% -25.6%
85	% of children who received a 6-8 weeks review	94.6% -0.4%	94.9% -0.1%
86	% of children who received a 9-12 month review by the time they turned 12 months	86.2% -8.8%	84.6% -10.4%
87	% of children who received a 12 month review by the time they turned 15 months	92.4% -2.6%	89.8% -5.2%
88	% of children who received a 2-2.5 year review by 2.5 years	84.4% -10.6%	83.6% -11.4%
91	% of infants being totally or partially breastfed at 6-8wks(breastfeeding prevalence)	56.0% -2.0%	55.3% -2.7%



31: Bed days lost due to delayed discharge as percentage of total bed days
December 2019 was the third consecutive month that the 3.5% target was not achieved (4.4%).

Community Hospitals that recorded bed days lost due to delayed transfer of care in excess of 3.5% in December were Dilke (14.7%), Stroud (7.4%), and Lydney (4.5%). North Cotswolds and Tewkesbury hospitals recorded zero bed days lost due to delayed transfer of care in December (second consecutive month recording zero delay days. NHS delays accounted for 131 and Social care 124 of the 255 delay days. Data quality and validation are high priority with more challenge from the Demand and Capacity team on the weekly Wednesday conference calls leading to more accurate reporting of DTOC. DTOC are monitored and escalated as appropriate both internally and externally with other partner organisations (e.g. adult social care). It is still felt that we are currently under-reporting and the higher levels in Stroud and the Forest are associated to a dedicated Discharge Coordinator and robust MDT review process. All stays over 30 days are reviewed.

31c: Percentage of children in Reception Year with height and weight recorded
The target of 30% of children in reception year to have height and weight measured by the end of December 2019 was not achieved. At the time the data extract was processed (7th January 2020) performance was 26.4%. Subsequent refresh of data has improved the November position previously reported as there were delays with loading data into the Thomson tool. The service have acknowledged that the threshold set for the year to date in 2019 (30%) was much higher than the same period in 2018 (18%) and with hindsight may have been too ambitious (although this has been achieved for children in Year 6). The rationale for this was to try and finish the programme earlier to allow more time for data cleansing before submission to NHS Digital. However, this does mean completing half of the programme within the first 3 months (November to January).

It should also be noted that 2 Health and Wellbeing Assistants will be leaving posts in January and February. There will be a gap between leavers and new starters being trained and competent. Consequently the threshold may be missed in the coming months.

72: Percentage of patients waiting less than 6 weeks from referral for a diagnostic test
The target has not been achieved in December (94% compared to greater than 99.0%). 3 patients waited longer than 6 weeks. During December GHFT took over the booking of Echo appointments (from 9th December). GHFT are booking patients into their available slots, using their staff and clinic times, thereby expanding patient choice to 7 days a week. GHFT staff are booking the patients into their system, and will then update the details on SystmOne. Despite this change the target was not achieved in December and early indications are that there is a risk to achievement of this in January.

80: SUS+ (Secondary Uses Service) Data Quality Validity (available in arrears)
Performance has improved following resubmission of data. Latest report from NHS Digital shows performance of 89.6% compared to target of 96.3%. There are a number of data quality issues within the Emergency Care Data Set data (missing investigation and treatment codes) and Admitted Patient Care Data Set (missing clinical coding diagnoses) which will be reviewed to improve future performance.

82: Proportion of eligible children who receive vision screens at or around school entry
The target of 30% of children to receive vision screens was not achieved in December. This programme is delivered to children in reception year in conjunction with the measurement of height and weight (metric 31c). Subsequent refresh of data has improved the November position previously reported as there were delays with loading data into the Thomson tool. The service have acknowledged that the threshold set for the year to date in 2019 (30%) was much higher than the same period in 2018 (18%) and with hindsight may have been too ambitious (although this has been achieved for children in Year 6). The rationale for this was to try and finish the programme earlier to allow more time for data cleansing before submission to NHS Digital. However, this does mean completing half of the programme within the first 3 months (November to January).

It should also be noted that 2 Health and Wellbeing Assistants will be leaving posts in January and February. There will be a gap between leavers and new starters being trained and competent. Consequently the threshold may be missed in the coming months.

85: Percentage of children who received a 6-8 weeks review
The target (95%) was missed in December 2019. Reasons for not meeting the target include parents declining the development review, movements in, and parental choice. If parents choose an appointment out of timeframe at a time and location that is convenient for them, this is accepted.

Public Health Nursing admin are now booking 6-8 week reviews to ensure that the visits are booked within timeframe and using text reminders as increase in no access visits (especially in Cheltenham, Stroud and Forest of Dean) as significant increase of no access visits and parental choice.

86: Percentage of children who received a 9-12 month review by the time they turned 12 months.
The target (95%) was missed in December 2019. Reasons for not meeting the target include parents declining the development review, movements in, and parental choice. If parents choose an appointment out of timeframe at a time and location that is convenient for them, this is accepted.

Significant improvement in the number of recording errors on SystmOne with Further support to be provided on a locality basis.

87: Percentage of children who received a 12 month review by the time they turned 15 months.
The target (95%) was missed in December 2019. Reasons for not meeting the target include parents declining the review, DNA appointments and then rebooked out of timeframe, children that have moved out of county, parental choice, and some DNA of a second appointment when no further appointments are offered.

88: Percentage of children who received a 2-2.5 year review by 2.5 years.
The target (99%) was missed in December 2019. Reasons for not meeting the target include parents declining the review, children moved into the county which would have been seen and had their review at the earliest opportunity, DNA appointments and then rebooked out of timeframe, movement out, parental choice to have review out of timeframe.

91: Percentage of infants being totally or partially breastfed at 6-8 weeks (breastfeeding prevalence)
The target (58%) was missed in November 2019.
Reasons for not meeting the target include parents declining the review, children moved into the county which would have been seen and had their review at the earliest opportunity, DNA appointments and then rebooked out of timeframe, movement out, parental choice to have review out of timeframe.

Additional Commentary 85, 86, 87, 88 and 91:
Capacity is an ongoing issue and the service is recruiting up to the Health Visitor trajectory, this is to recruit to 2.75 WTE Band 6 health visitors. Interviews took place in December. The service also has an action plan in place to improve reporting covering all key metrics. Public Health Nursing admin are now booking visits and reviews to ensure that the visits are booked within timeframe. New birth visits this focusses or recording and effectiveness of admin booking to ensure that the visits are booked within timeframe. The service are also promoting the service on social media and on the GHC Health Visiting website page to share the importance and value of the development reviews.

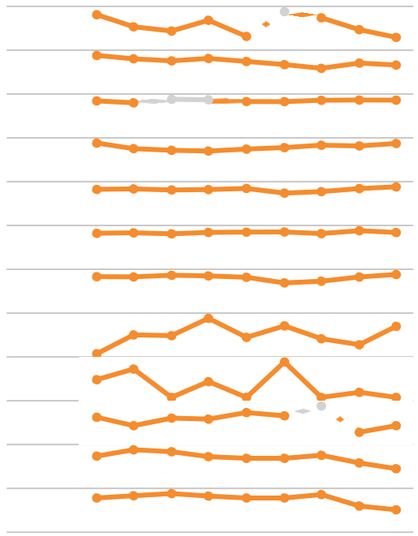
Performance Dashboard: *Physical Health - Local Requirements Gloucestershire*

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Physical Health Community - Local Requirements Gloucestershire

		December		YTD	
29	% of direct admissions to community hospitals	7.1%	-11.9%	13.5%	-3.5%
41	Podiatry - % treated within 8 Weeks	67.1%	-27.9%	74.4%	-20.6%
42	MSKAPS - % treated within 8 Weeks	94.1%	-0.9%	92.8%	-2.2%
43	MSK Physiotherapy - % treated within 8 Weeks	79.4%	-15.6%	72.0%	-23.0%
44	ICT Physiotherapy - % treated within 8 Weeks	86.4%	-8.6%	80.3%	-14.7%
45	ICT Occupational Therapy Services - % treated within 8 Weeks	84.3%	-10.7%	84.0%	-11.0%
53	Paediatric Physiotherapy - % treated within 8 Weeks	92.1%	-2.9%	84.3%	-10.7%
67	Wheelchair Service: Adults: New referrals assessed within 8 weeks	37.0%	-53.0%	28.8%	-61.2%
68	Wheelchair Service: Adults: Priority referrals seen within 5 working days	0.0%	-95.0%	13.4%	-81.6%
71	Wheelchair Service: Under 18s: Equipment delivered within 18 weeks of referral	50.0%	-42.0%	66.1%	-25.9%
93	Chlamydia Screening of Gloucestershire residents aged 15-24 (minimum positivity rate)	40.7%	-59.3%	62.9%	-37.1%
94	Chlamydia Screening - Number of Positive Screens	44.3%	-55.7%	65.1%	-34.9%



Performance Thresholds not being achieved in Month

29: % of direct admissions to community hospitals
Direct admission rate continues to decrease. December performance (7.1%) remains below the threshold (19%) based on 2018/19. This has an impact on average length of stay as direct admissions generally have a lower average length of stay than transfers from acute hospital. All Community Hospitals with the exception of Lydney (23.5%) were below the threshold in December. The Vale hospital recorded no direct admissions.

41: Podiatry - % treated within 8 Weeks
Target continues to be missed with performance of 67.1% in December. 227 out of 690 patients were seen outside of 8 weeks with 3 of these patients seen outside of 18 weeks. The current action plan, which is ongoing work has a focus on three main areas:

1. SystmOne process review and redesign to improve data quality and performance reporting.
2. Review and redesign care pathway by speciality level to improve efficiency including;
   a. triage process
   b. flexible rota's to meet specialist and locality need
   c. a focus on rebooking cancellation slots
   d. innovation in delivery models e.g. telephone assessments and MDT clinics
3. Redesign of workforce model based on demand and capacity modelling.

42: MSKAPS - % treated within 8 Weeks
December 2019 is the fifth consecutive month that the 95% target has been missed. Performance was 94.1%. 23 out of 393 patients were seen outside of the 8 week target with all patients seen within 18 weeks. Recruitment to vacancy has been successful so once induction programme completed service performance will further improve.

43: MSK Physiotherapy - % treated within 8 Weeks
Performance remains below target at 79.5% in December 2019, increased from 74.6% in November. 300 out of 1,463 patients were seen outside of the 8 week target, of which 5 were seen outside of 18 weeks.
Ongoing discussions continue regarding the mismatch of demand versus capacity, noting this is a similar issue across both Community MSK therapy providers.

44: ICT Physiotherapy - % treated within 8 Weeks
In December 86.5% of patients were seen within 8 weeks compared to target of 95%. 40 patients out of 296 were seen outside of 8 weeks, of which 15 were seen outside of 18 weeks (9 Cotswolds locality, 4 Gloucester locality, 2 Stroud locality). In the first 9 months of 2019/20, the ICT Physiotherapy service saw 63.4% of patients within 4 weeks of referral and 95% of patients within 17-18 weeks. When the activity in the referral centre is included, December performance increases to 90.1%.

There is an ongoing issue with vacancy recruitment, with overall pressure across all localities. Locum cover now available in some places, new allocations now distributed by management. Locums catch up with patients waiting

which in turn affects the longest waiters and Referral to Treatment.

45: ICT Occupational Therapy Services - % treated within 8 Weeks
In December 84.3% of patients were seen within 8 weeks. 54 patients out of 345 were seen outside of 8 weeks, of which 8 were seen outside of 18 weeks (5 Gloucester locality, 3 Cotswolds locality). In the first 9 months of 2019/20, the OT service saw 66.0% of patients within 4 weeks of referral. 95% of patients seen year to date were seen within 17-18 weeks. When the activity in the referral centre is included, December performance increases to 91.2%.

Vacancies, particularly in Gloucester locality and in more junior roles (i.e. Band 5) have also impacted on target achievement. The service has secured clinicians via temporary contract and are actively seeking locums, recognising there is a further 2 years in the re-structuring of the service model to align to the revised commissioning intentions and resources available. Recruitment difficulties continue due to the OT review.

53: Paediatric Physiotherapy - % treated within 8 Weeks
The target continues to be missed and has not been achieved since October 2018, but continued to improve in December 2019 to 92.1%, highest performance since March 2018. 18 patients out of 229 were seen outside of the 8 week target.

Internal recovery action plan in place, monitored by service lead and clinician actions reviewed in supervision. Additional capacity following recruitment has started to show some impact. The service is working with Business Intelligence team during January 2020 to finalise Demand and Capacity model.

67: Wheelchair Service: Adults: New referrals assessed within 8 weeks
Target continues to be missed. 10 out of 27 referrals were assessed within the 8 week timeframe.

Formal report, following the declaration of a second SIRI has been shared with Execs and CCG with detailed analysis of concerns and a further developed action plan. This has been developed alongside some 'quick wins' and an improved management structure and increased performance visibility.

68: Wheelchair Service: Adults: Priority referrals seen within 5 working days
Target continues to be missed. 9 priority referrals were received in December, none were seen within 5 working days.
Formal report, following the declaration of a second SIRI has been shared with Execs and CCG with detailed analysis of concerns and a further developed action plan. This has been developed alongside some 'quick wins' and an improved management structure and increased performance visibility.

71: Wheelchair Service: Under 18s: Equipment delivered within 18 weeks of referral
Target continues to be missed. 1 out of 2 patient's equipment was delivered within 18 weeks of referral.
Formal report, following the declaration of a second SIRI has been shared with Execs and CCG with detailed analysis of concerns and a further developed action plan. This has been developed alongside some 'quick wins' and an improved management structure and increased performance visibility.

93: Chlamydia Screening of Gloucestershire residents aged 15-24 via the Chlamydia Screening Service (minimum positivity rate)
The minimum positivity rate for Chlamydia Screening of Gloucestershire residents aged 15-24 continues to decline during 2019/20 compared to 2018/19. There has been a stepped change down to the level reported in early 2017/18.
The service is investigating the reasons for this reduction.

94: Number of Positive Screens - GCS and Joint responsibility
Number of positive screens have continued to decline during 2019/20 compared to 2018/19.
This influences the (reducing) positivity rate (metric 93).
The service is investigating the reasons for this reduction.

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NHS Foundation Trust

Workforce KPIs

Month 9 (as at 31/12/2019)

All Staff Turnover - 12 month rolling rate %	13.19%
Attendance Rate - 2 month rolling %	95.11%
Sickness Absence Rate - 12 month rolling %	4.89%
AfC Staff Appraisal Rate (12 Month Rolling or YTD as report to Board)	82.94%
Medical Staff Appraisal Rate (12 Month Rolling or YTD as report to Board)	92.13%
Mandatory Training Completed (12 Month Rolling or YTD as report to Board)	
Number of up to date competencies:	5620
out of x Number of staff:	6193
	90.74%

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Agenda Item: 19/0120

Report to: Trust Board – 29 January 2020

Author: Stephen Andrews, Deputy Director of Finance

Presented by: Sandra Betney, Director of Finance

SUBJECT: **Finance Report for period ending 31st December 2019 Month 9**

Can this report be discussed at a public Board meeting?	Yes

This report is provided for:

Decision Endorsement **ASSURANCE** **INFORMATION**

PURPOSE OF REPORT

To update the Board on the current month 9 finance position.

RECOMMENDATIONS

To note the finance position for the period ending 31st December 2019.

EXECUTIVE SUMMARY

- The month 9 position is a surplus of £1.630m which is slightly better than the planned surplus.
- The month 9 forecast outturn of £2.327m is £137k better than the Trust's control total. PSF accounts for £2.042m of this.
- The Trust has an Oversight Framework segment of 1 as at December 2019.
- The agency cost forecast is £6.231m which is £1.981m above the agency ceiling
- The cash balance at month 9 is £39.0m which is £3.8m above the plan.
- Capital expenditure is £2.109m at month 9, with the forecast at £6.275m.
- The Cost Improvement Plan (CIP) target for the merged Trust is £5.402m. The CIP amount removed so far is £1.545m.

CORPORATE CONSIDERATIONS	
Quality implications:	Any implications are referenced in the report.
Resource implications:	Any implications are referenced in the report.
Equalities implications:	Any implications are referenced in the report.
Risk implications:	Any implications are referenced in the report.

WHICH TRUST VALUES DOES THIS PAPER PROGRESS (P) OR CHALLENGE ©?			
Working together	P	Always improving	P
Respectful and kind	P	Making a difference	P

Report authorised by:	**Date:**
Sandra Betney, Director of Finance	16 January 2020

Where has this issue been discussed before?	**Date:**

Appendices:	Appendix 1 – Finance report

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Finance Report
Month 9

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

Gloucestershire Health & Care Overview

Gloucestershire Health and Care
NHS Foundation Trust

- This first half of this report outlines the financial position for Gloucestershire Health and Care NHS Foundation Trust (GHC). For reference the financial position for GHC in the first half of the report is the combination of months 1-12 for [2]gether NHSFT and 7-12 for Gloucestershire Care Services (GCS). The second half of the report outlines the final position for Gloucestershire Care Services, months 1-6.
- The year to date surplus for GHC is slightly better than plan at £1.630m. The full year forecast is a surplus £137k better than the control total of £2.156m which is a similar position as last month, but there remains some risks to this. PSF accounts for £2.042m of the control total surplus.
- The revised agency ceiling for GHC is £4.250m. The year to date actual is £4.393m which is over the ceiling by £1.485m. The full year forecast spend is £6.231m, which is £1.981m, or 47%, above the agency ceiling, and leads to a 3 in the Single Operating Framework for the agency metric. This is a reduction of £115k on last month's forecast and puts the Trust £144k below the agency ceiling threshold of 50% above target where the Trust would score 4 on the agency metric.
- The Cost Improvement Plan (CIP) target for the merged Trust is £5.402m. The CIP amount removed so far is £1.545m, an increase of £0.268m on last month. The forecast is £3.402m.
- Capital spend for GHC is £2.109m. The plan for the merged Trust is £6.275m, a reduction of £570k on last month due to delays in the Montpellier ensuite scheme and slippage in a number of other schemes.
- Cash balance at the end of month 9 for GHC is £3.8m above the plan at £39.0m. All of the increase in cash relates to underspends on capital against plan.

Gloucestershire Health & Care Overview part 2

Gloucestershire Health and Care
NHS Foundation Trust

- A mid-year review of the financial position of the Trust has been undertaken during December based on the financial position at month 8. This is slightly later than in previous years due to the work undertaken on the merger process. Income and expenditure forecasts for the remainder of 2019/20 have been updated in light of performance to date and known changes from the assumptions that budgets were based upon. Cost pressures, developments, reserves, financial opportunities and delivery of savings have all been reassessed to give an up-to-date, clear assessment of the likely financial outturn position for 2019/20.
- A review of the cost Improvement programme identified a number of schemes that will not deliver the planned level of recurring savings. A workshop was held with senior managers to identify a number of alternatives proposals which are now being developed.
- The Trust is reviewing Herefordshire savings before the services transfer on the 1st April. To date the Trust has identified a number of savings and is assessing if there is a shortfall against the target that would need to be added onto next years savings programme.
- Work is underway to review the balance sheets of the two organisations before the end of financial year. This will focus on ensuring the approach to recording provisions, stock, capital assets, debtors and creditors are consistent and enable adjustments to be reflected in the end of year accounts.

Gloucestershire Health & Care Overview part 3

Gloucestershire Health and Care
NHS Foundation Trust

- The Trust has also reviewed the capital programme scheme by scheme to ensure the forecast is delivered.
- The capital and cash forecasts assume that the sale of 18 Denmark Road will take place in 2019/20. The sale is almost complete and is expected to go through in February.
- The conclusions of the review are that the assumptions underpinning the Trust's finance reported position at month 8 are robust and the Trust remains on track to deliver its financial control total.
- The financial position in December supports the findings of the mid year review and no new material issues have come to light.

GHC Income and Expenditure

Gloucestershire Health and Care
NHS Foundation Trust

The year to date performance at Month 9 is better than plan at £1.630m surplus.

The Trust anticipates it will meet its full year planned surplus of £2.156m.
A number of operational directorates are in deficit YTD, including Social Care, Entry Level (IAPT & Primary Mental Health nurses) and the Medical Directorate. A small number of Corporate directorates are in deficit YTD and forecast. This is predominantly due to the asset lives cost pressure, agreed non-recurrent costs funded by Trust underspends, and still to be identified savings.

	Aggregated 2g & GCS		2g months 1-9 and GCS mths 7-9			2g months 1-12 and GCS mth 7-12		
Statement of comprehensive income £000	2017/18	2018/19	2019/20			2019/20		
	Full Year Actual	Full Year Actual	Plan	Actual	Variance	Plan	Full Year Forecast	Variance
Operating income from patient care activities	220,232	228,678	117,413	120,131	2,718	175,304	180,121	4,817
Other operating income exc PSF	8,415	9,390	4,421	5,710	1,289	6,149	8,166	2,017
Provider sustainability fund (PSF) income	5,557	6,444	1,128	1,128	0	2,042	2,042	0
Employee expenses	(163,685)	(169,910)	(91,723)	(91,226)	497	(136,592)	(137,839)	(1,247)
Operating expenses excluding employee expenses	(74,613)	(63,303)	(27,713)	(32,098)	(4,385)	(41,805)	(47,405)	(5,600)
PDC dividends payable/refundable	(3,973)	(3,345)	(2,019)	(2,198)	(179)	(3,034)	(3,026)	8
Other gains / losses	9	120	39	149	110	57	199	142
Surplus/(deficit) before impairments & transfers	**(8,067)**	**8,074**	**1,546**	**1,596**	**50**	**2,121**	**2,258**	**137**
Add back impairments	15,731	(283)	0	0	0	0	0	0
Remove capital donations/grants I&E impact	105	(212)	43	34	(9)	69	69	0
Surplus/(deficit) inc PSF	**(2,405)**	**7,579**	**1,589**	**1,630**	**41**	**2,190**	**2,327**	**137**
Surplus/(deficit) exc PSF	**(7,962)**	**1,135**	**461**	**502**	**41**	**148**	**285**	**137**

GHC Balance Sheet

Gloucestershire Health and Care
NHS Foundation Trust

STATEMENT OF FINANCIAL POSITION (all figures £000)		Aggregated 2g & GCS	2g months 1-9 and GCS mths 7-9			2g months 1-12 and GCS mth 7-12		
		2018/19	2019/20 Year to Date			2019/20		
		Full Year Actual	Plan	Actual	Variance	Plan	Forecast	Variance
Non-current assets	Intangible assets	2,819	2,454	2,460	6	2,269	2,283	14
	Property, plant and equipment: other	114,893	115,965	113,523	(2,442)	117,855	114,838	(3,017)
	Total non-current assets	**117,712**	**118,419**	**115,983**	**(2,436)**	**120,124**	**117,121**	**(3,003)**
Current assets	Inventories	288	288	245	(43)	288	245	(43)
	NHS receivables	9,051	8,769	11,575	2,806	8,511	8,456	(55)
	Non-NHS receivables	8,066	7,606	6,646	(960)	6,224	5,723	(501)
	Cash and cash equivalents:	32,474	35,219	39,031	3,812	33,682	27,317	(6,365)
	Property held for sale	500	500	500	0	500	500	0
	Total current assets	**50,379**	**52,382**	**57,997**	**5,615**	**49,205**	**42,241**	**(6,964)**
Current liabilities	Trade and other payables: capital	(1,780)	(1,155)	(476)	679	(1,655)	(1,784)	(129)
	Trade and other payables: non-capital	(11,184)	(11,702)	(12,181)	(479)	(11,190)	(1,996)	9,194
	Borrowings	(76)	(76)	(200)	(124)	(2)	(2)	0
	Provisions	(371)	(371)	(651)	(280)	(371)	(604)	(233)
	Other liabilities: deferred income including contract liabilities	(10,259)	(10,724)	(13,525)	(2,801)	(9,044)	(9,044)	0
	Total current liabilities	**(23,670)**	**(24,028)**	**(27,033)**	**(3,005)**	**(22,262)**	**(13,430)**	**8,832**
Non-current liabilities	Borrowings	(1,821)	(1,662)	(1,516)	146	(1,638)	(1,638)	0
	Provisions	(616)	(706)	(996)	(290)	(451)	(451)	0
	Total net assets employed	**141,984**	**144,405**	**144,435**	**30**	**144,978**	**143,843**	**(1,135)**
Taxpayers Equity	Public dividend capital	126,956	126,956	126,956	0	126,956	125,181	(1,775)
	Revaluation reserve	7,098	7,098	7,098	0	7,098	7,098	0
	Other reserves	(1,241)	(1,241)	(1,241)	0	(1,241)	(1,241)	0
	Income and expenditure reserve	9,171	11,592	11,622	30	12,165	12,805	640
	Total taxpayers' and others' equity	**141,984**	**144,405**	**144,435**	**30**	**144,978**	**143,843**	**(1,135)**

Capital – Multi-Year Plan

Gloucestershire Health and Care
NHS Foundation Trust

	2gether mths 1-12 and GCS mths 7-12								
	GHC Plan		YEAR TO DATE	FORECAST OUTTURN	Plan	Plan	Plan	Plan	Plan
£000s	2019/20		2019/20	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
Land and Buildings									
Buildings	2,071		354	1,008	3,759	4,000	2,500	2,500	1,000
Forest of Dean	750		53	696	5,000	3,600			
Backlog Maintenance	1,874		804	1,853	1,393	1,300	1,050	1,050	250
Urgent Care	1		0	0	475	0	0	0	0
Information Technology									
IT Device and software upgrade	299		120	266	600	600	600	600	600
IT Infrastructure	1,575		696	1,672	1,828	409	1,400	300	300
Medical Equipment	**512**		82	780	280	1,030	1,030	1,030	3,330
Total	**7,082**		**2,109**	**6,275**	**13,335**	**10,939**	**6,580**	**5,480**	**5,480**

Year to Date capital spend is £2,109k, an increase of £246k on month 8.

Cash Flow Summary

Gloucestershire Health and Care
NHS Foundation Trust

Statement of Cash Flow £000	ACTUAL YTD 19/20		FORECAST 19/20	
Cash and cash equivalents at start of period		**33,553**		**33,553**
Cash flows from operating activities				
Operating surplus/(deficit)	3,645		3,831	
Add back: Depreciation on donated assets	34		34	
Adjusted Operating surplus/(deficit) per I&E	**3,679**		**3,865**	
Add back: Depreciation on owned assets	3,104		4,555	
Add back: Impairment	0		0	
(Increase)/Decrease in inventories	0		0	
(Increase)/Decrease in trade & other receivables	(863)		3,111	
Increase/(Decrease) in provisions	(100)		0	
Increase/(Decrease) in trade and other payables	2,506		(8,140)	
Increase/(Decrease) in other liabilities	86		(1,074)	
Net cash generated from / (used in) operations		**8,412**		**2,317**
Cash flows from investing activities				
Interest received	126		199	
Purchase of property, plant and equipment	(1,979)		(6,098)	
Sale of Property	0		529	
Net cash generated used in investing activities		**(1,853)**		**(5,370)**
Cash flows from financing activities				
PDC Dividend Received				
PDC Dividend (Paid)	(1,000)		(3,026)	
Finance Lease Rental Payments	(80)		(157)	
		(1,080)		**(3,183)**
Cash and cash equivalents at end of period		**39,032**		**27,317**

Risks

Gloucestershire Health and Care
NHS Foundation Trust

Risks to delivery of the 2019/20 position are as set out below:

Gloucestershire Health & Care Risks	19/20 Risk at month 09	Made up of: Rec		Likelihood
Delivery of Cost Improvements incl. Challenge Scheme CIPs	100	2,200		Almost Certain
Unidentified Planned CIP for Differential Schemes:	100	50		Possible
Agency costs increase above the forecast	0			Unlikely
VAT changes impacting recovery on Systm1 19/20 (FY £80k in position)	0	80		Almost Certain
QIPP risk share and milestones	500			Possible
CQUIN	0			Unlikely
Asset lives depreciation impact - 2g	0	450		Possible
Asset lives Dep'n & PDC impact - GCS acceptance (FY £540k in position)		540		Certain
Transfer of Herefordshire services		1,000		Likely
A failure to control costs due to some risks materialising leads to the Trust to miss its FTC and lose PSF	777			Unlikely
	1,477	**4,320**		

Health Economy Risks	Probability	Risk £000)	Opportunity (£000)
Delivery of GHFT control total	Likely	3,000	
Delivery of CCG control total	Likely	3,000	
System Control Total PSF Risk	Unlikely	99	
		6,099	

Single Operating Framework Ratings

Current FT Financial Risk Rating - Single Oversight Framework
Use Of Resource

Finance and use of resources rating Metric	Audited PY 31/03/2019 Year ending	Plan 31/03/2020 Year ending	Actual 31/10/2019 YTD	Forecast 31/03/2020 Year ending
Capital service cover rating	1	1	1	1
Liquidity rating	1	1	1	1
I&E margin rating	1	1	1	1
I&E margin: distance from financial plan	1	1	1	1
Agency rating	3	1	3	3
Risk ratings after overrides	1	1	1	1

Gloucestershire Health and Care
NHS Foundation Trust

Gloucestershire Care Services

Finance Report

April – September 2019

Overview

- No amendments to the reported position of GCS have occurred this month.
- The Final Accounts for GCS, months 1-6, are currently being audited by External Audit.
- No significant issues have been identified to date by the audit.
- The Trust ended the period with a surplus of £0.903m, in line with the plan.
- The agency ceiling was £1.116m and the GCS spend for months 1-6 was £1.116m.
- Cost Improvement Plan (CIP) target for GCS months 1-6 was £2.268m and the amount of savings delivered was £2.848m.
- Capital spend was £1,055k against a six month plan of £1.737m.
- Cash balance at the end of month 6 was £0.4m above plan at £18.9m. All of the increase in cash related to underspends on capital against plan.

Gloucestershire Care Services Income & Expenditure

Gloucestershire Health and Care NHS Foundation Trust

Statement of comprehensive income £000	2018/19	2019/20 Month 1 - 6		
	Full Year Actual	Plan	Actual	Variance
Operating income from patient care activities	112,668	56,834	57,131	297
Other operating income exc PSF	2,099	759	895	136
Provider sustainability fund (PSF) income	3,962	569	569	0
Employee expenses	(80,782)	(42,331)	(42,141)	190
Operating expenses excluding employee expenses	(31,719)	(13,926)	(14,689)	(763)
PDC dividends payable/refundable	(1,739)	(1,032)	(905)	127
Other gains / losses	(56)		(5)	(5)
Surplus/(deficit) before impairments & transfers	**4,433**	**873**	**855**	**(18)**
Add back impairments	885			
Remove capital donations/grants I&E impact	(249)	30	48	18
Surplus/(deficit) inc PSF	**5,069**	**903**	**903**	**0**

Surplus/(deficit) exc PSF	**1,107**	**334**	**334**	**0**

Control total including PSF	**3,078**	**903**	**903**	**0**

GCS Balance Sheet

Gloucestershire Health and Care
NHS Foundation Trust

STATEMENT OF FINANCIAL POSITION (all figures £000)		2018/19	2019/20 Year to Date		
		Full Year Actual	Plan	Actual	Variance
Non-current assets	Intangible assets	829	658	667	9
	Property, plant and equipment: other	63,315	63,475	62,794	(681)
	Total non-current assets	**64,144**	**64,133**	**63,461**	**(672)**
Current assets	Inventories	288	288	245	(43)
	NHS receivables	5,800	5,355	5,263	(92)
	Non-NHS receivables	2,978	2,978	3,667	689
	Cash and cash equivalents:	17,837	18,435	18,916	481
	Total current assets	**26,903**	**27,056**	**28,091**	**1,035**
Current liabilities	Trade and other payables: capital	(1,454)	(829)	(116)	713
	Trade and other payables: non-capital	(9,518)	(9,518)	(9,325)	193
	Borrowings	(76)	(76)	(200)	(124)
	Provisions	(371)	(371)	(751)	(380)
	Other liabilities: deferred income including contract liabilities	(389)	(389)	(1,291)	(902)
	Total current liabilities	**(11,808)**	**(11,183)**	**(11,683)**	**(500)**
Non-current liabilities	Borrowings	(1,593)	(1,487)	(1,368)	119
	Total net assets employed	**77,646**	**78,519**	**78,501**	**(18)**
Taxpayers Equity	Public dividend capital	80,276	80,276	80,276	0
	Revaluation reserve	4,679	4,679	4,679	0
	Other reserves	(2,398)	(2,398)	(2,398)	0
	Income and expenditure reserve	(4,911)	(4,038)	(4,056)	(18)
	Total taxpayers' and others' equity	**77,646**	**78,519**	**78,501**	**(18)**

Capital and Cost Improvement Programmes

Gloucestershire Health and Care
NHS Foundation Trust

Gloucestershire Care Services NHST CAPITAL PROGRAMME	Months 1-6		
	Plan £000's	Actual £000's	Variance £000's
Buildings	1,136	859	277
Backlog Maintenance	50		50
Urgent Care	25		25
Network Replacement	0	11	(11)
Laptops	100		100
Medical Equipment	426	132	294
Forest of Dean	0	53	(53)
TOTAL	**1,737**	**1,055**	**682**

Gloucestershire Care Services NHST COST IMPROVEMENT PROGRAMME	Months 1-6		
	Plan £000's	Actual £000's	Variance £000's
Trust 1.25% Scheme	1,372	1,372	0
Differential - Hospitals	84	178	94
Differential - ICTs	199	93	(106)
Differential - Countywide	318	446	128
Differential - CYPS	256	256	0
Differential - Urgent Care	2	4	2
Differential - Human Resources	32	32	0
Differential - Executive	1	1	0
Differential - Finance Directorate	4	4	0
Challenge Schemes - TBC	0	462	462
TOTAL	**2,268**	**2,848**	**580**

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NHS

Gloucestershire Health and Care

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

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AGENDA ITEM: 20/0120

Report to: Trust Board – January 2020

Author: Simon Crews, Interim Trust Secretary

Presented by: Lavinia Rowsell, Head of Corporate Governance and Trust Secretary

SUBJECT: **TERMS OF REFERENCE – APPOINTMENTS AND TERMS OF SERVICE COMMITTEE**

Can this subject be discussed at a public Board meeting?	Yes

This report is provided for:

Decision **ENDORSEMENT** Assurance Information

PURPOSE OF REPORT

To seek Trust Board approval to the revised Terms of Reference for the Appointments and Terms of Service Committee.

RECOMMENDATIONS

The Board is recommended to adopt the Terms of Reference in order to ensure they accurately reflect the identity of the new organisation and in order for the Trust to be compliant with current national governance requirements, the Trust's Standing Financial Instructions and Constitution.

Corporate Considerations	
Quality implications	Reflects governance requirements
Resource implications:	Nil
Equalities implications:	Nil
Risk implications:	Failure to establish the Committee with agreed Terms of Reference would place the Trust in breach of the NHS Code of Governance and is a requirement set out in the Trust's Standing Financial Instructions and Constitution.

WHICH TRUST VALUES DOES THIS PAPER PROGRESS (P) OR CHALLENGE (C)?			
Working together	**P**	Always improving	**P**
Respectful and kind	**P**	Making a difference	**P**

Report authorised by:	Date:
Executive Team	10 December 2020

Where has this issue been discussed before?
Executive Team
What wider engagement has there been?
Executive Team

TERMS OF REFERENCE

THE APPOINTMENTS AND TERMS OF SERVICE COMMITTEE (FOR THE CHIEF EXECUTIVE, EXECUTIVE DIRECTORS AND VERY SENIOR MANAGERS) (VSMs)*

1.0 CONSTITUTION

The Trust Board (the Board) hereby resolves to establish a Committee of the Board to be known as the Appointments and Terms of Service Committee. The Committee has only those powers delegated by these Terms of Reference.

2.0 MEMBERSHIP

2.1 The Committee will comprise:

- The Trust Board Chair
- Three Non-Executive Directors (To include the Vice Chair)
- Chief Executive

2.2 The Trust Chair will chair the Committee. When the Trust Chair is unavailable the Vice Chair will chair the Appointments and Terms of Service Committee or in this persons absence the Committee will elect a Non-Executive Director from those present.

2.3 The Chief Executive will not be present when the Committee is dealing with matters concerning them.

3.0 QUORUM

3.1 No business shall be transacted at a meeting of the Committee unless at least two Non-Executive Directors are present

4.0 IN ATTENDANCE

4.1 If requested, the Director of HR and Organisational Development and Director of Finance and Performance should be available to attend in an advisory capacity only. Any attendees will not be present when matters discussed affect them personally.

5.0 FREQUENCY OF MEETINGS

5.1 The Committee will convene as often as is necessary, but normally 6 meetings will be scheduled each year.

6.0 AUTHORITY

6.1 The Committee will advise the Board on the appointment, dismissal, remuneration and terms of service of the Chief Executive and Executive Directors of the Board.

6.2 The Committee has delegated authority to manage and oversee the appointment and appraisal processes for the Chief Executive and Executive Directors on behalf of the Board.

6.3 Agree the remuneration and terms of service of staff employed on VSM contracts including all aspects of salary and any performance related pay or bonus, severance payments and the provision of other benefits (for example, cars, allowances or payable expenses).

6.4 Seek opinion from NHSI where required with reference to 'Guidance on Pay for Very Senior Managers in NHS trusts and foundation trusts'. (March 2018)

7.0 PURPOSE

Nominations role

7.1 The Committee shall, in respect of nominations:

7.1.1 Regularly review the structure, size and composition (including the skills, knowledge, experience and diversity) of the Executive Directors and make recommendations to the Board with regard to any changes.

7.1.2 Give full consideration to and make plans for succession planning for the Chief Executive and Executive Directors taking into account the challenges and opportunities facing the Trust and the skills and expertise needed on the Board in the future.

7.1.3 Be responsible for identifying and nominating for appointment, candidates to fill Executive Director posts within its remit as and when they arise.

7.1.4 Be responsible for identifying and nominating a candidate, for approval by the Council of Governors, to fill the position of Chief Executive.

7.1.5 Ensure that Executive Directors meet the requirements of the 'Fit and Proper Persons Test'.

7.1.6 Before an appointment is made, evaluate the balance of skills, knowledge, diversity and experience of the Executive Directors and in the light of this evaluation, prepare a description of the role and capabilities required for a particular appointment. In identifying suitable candidates, the Committee shall use:

- open advertising or the services of external advisers to facilitate the search;
- consider candidates from a wide range of backgrounds; and
- consider candidates on merit against objective criteria.

7.1.7 Consider any matter relating to the continuation in office of any Executive Director at any time, including the suspension or termination of service of an individual as an employee of the Trust.

7.1.8 To consider the engagement or involvement of any suitably qualified third party or advisers to assist with any aspects of its responsibilities.

8.0 Remuneration Role

8.1 The Committee shall in respect of remuneration:

8.1.1 Establish and keep under review a remuneration policy for Executive Directors.

8.1.2 Consult the Chief Executive about proposals relating to the remuneration of Executive Directors

8.1.3 In accordance with all relevant laws, regulations and the Trust's policies, determine the terms and conditions of office of the Executive Directors. To include all aspects of salary and any performance related pay or bonus and the provision of other benefits (for example, cars, allowances or payable expenses) ensuring they are fairly rewarded for their individual contribution to the NHS Foundation Trust – having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such staff.

8.1.5 Use national guidance and market benchmarking analysis in the annual determination of remuneration of the Executive Directors.

8.1.6 Approve the arrangements for the termination of employment of any Executive Director and other contractual terms, having regard to any national guidance.

8.1.7 Approve all redundancies which attract a monetary value over and above contractual entitlement.

8.1.8 Ensure that any proposed compromise agreement is justified and that it is drafted in such a way as not to prevent proper public scrutiny by NHSI, the Department of Health or external auditors.

8.1.9 Oversee the performance review arrangements for the Executive Directors ensuring that each Executive Director receives an annual appraisal.

8.1.10 Agree the service contracts for Very Senior Managers, including, remuneration, other benefits and allowances, pensions arrangements, performance related pay, and termination payments taking note of current advice and requirements nationally.

9.0 CONFIDENTIALITY

9.1 A member of the Committee must not disclose any matter brought before the Committee until the Committee has either reported to the Board or otherwise concluded the matter.

9.2 A member of the Committee must not disclose any matter, whether concluded or not, that the Board or the Committee had determined is confidential or would otherwise breach a reasonable expectation of confidentiality.

10.0 REPORTING AND RECORDING

10.1 The Trust Secretary will minute the proceedings and resolutions of the meetings including recording the names of those present and in attendance.

10.2 The Chair of the Committee will submit a short report of each meeting to the next Board meeting for information or decision, as appropriate.

10.3 The Trust Secretary shall ascertain at the beginning of each meeting the existence of any conflicts of interests and record them accordingly.

10.4 Minutes of Committee meetings shall be agreed by the Chair prior to being circulated promptly to all members of the Committee unless a conflict of interest exists.

11.0 OTHER MATTERS

11.1 The Trust Secretary will provide administrative support to the Committee, including:

- Agreement of agenda
- The collation of papers
- Ensuring the minutes are taken and a record of matters arising kept and issues carried forward
- Ensuring that Committee reports are made available to the Board

12.0 MONITORING ARRANGEMENTS

12.1 The Board will review the Committee's Terms of Reference at least once every two years.

12.2 Annually the Committee will review its own performance and recommend any changes it believes are necessary to the Trust Board for approval.

*VSMs is defined by NHS Employers as 'other senior managers with Board level responsibility (March 2018)

Version Control

Version 1	28/10/19	Draft for consideration by Executive Team 12th November
Version 2	06/12/19	Re draft amended to reflect SFIs section 8.1.7
Version 2	28/01/20	Submission to Trust Board for approval

AGENDA ITEM: 21/0120

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Resources Committee

COMMITTEE CHAIR: Graham Russell, Non-Exec Director

DATE OF COMMITTEE MEETING: 19 December 2019

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

FINANCE REPORT – MONTH 8

The Committee received the month 8 finance report. It was noted that there was a surplus of £1.272m, which was in line with the Trust's planned surplus. The Committee was assured that the forecast outturn for the Trust was £2.156m which was in line with the control total. For month 8, the cash balance was £39m, which was £4.5m above plan.

The risk ratings regarding QIPP and CQUIN targets were expected to reduce within the following month. The Committee was informed that the PSF would be received; however, the bonus for achieving the control total at the end of the financial year was not expected.

BUDGET 20/21 PROCESS

The Committee was informed that a business planning workshop had taken place in which the process was outlined along with consideration given to the national landscape and local issues relating to the amount of funding that would be available. The Committee noted that the submissions for the 20/21 Budget process were due to be submitted to NHSE/I by 10th January.

ANNUAL OPERATING PLAN & SYSTEM OPERATING PLAN 20/21 PROCESS/ GUIDANCE

The Committee was informed that the national guidance concerning the Annual Operating Plan had not yet been received by the Trust and that it was expected in January. The Committee was told that the plan would require System sign-off, which would tie in with the revised Long term plan submission deadline of 10th January 2020.

E-ROSTERING BUSINESS CASE

As part of a discussion on sustainable staffing the E-Rostering Business Case was approved by the Committee. The Committee ratified the proposal to move to using Allocate and noted that that this would aid safer staffing and that it should have a positive financial implication in regards to efficiencies in the long term.

OTHER ITEMS

The Committee also:

- Noted that action plans were in place relating to performance issues in podiatry and paediatric physiotherapy and improvements had already been achieved.
- Agreed the Digital Framework subject to an inclusion and alignment of the national paper on personalised care under the heading 'empower people.'
- Noted that internal auditors, Price Waterhouse Cooper (PWC) would be undertaking a review of Committee working at the beginning of 2020.

ACTIONS REQUIRED BY THE BOARD

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

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Quality Committee

COMMITTEE CHAIR: Maria Bond, Non- Executive Director

DATE OF COMMITTEE MEETING: 5 December 2019 and 9 January 2020

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

Quality Committee is meeting on a monthly basis for the first 6 months of the newly merged organisation to provide Board oversight of quality as the two organisations are brought together. The Board should note that until reporting systems are aligned as one organisation the Quality Committee will continue to review papers in line with the reporting timelines of the originating organisation.

COMMITTEE HELD ON 5th DECEMBER 2019 SUMMARY:

REVIEW OF QUALITY COMMITTEE RISKS

The Committee received an update of the risks scoring 12 and above relating to quality for both legacy organisations. Workforce risks remain the main and highest scoring risk. Assurance was given on how risks are managed and an update was provided regarding work to refine the new combined Risk Register and the establishment of the new Trust Risk Management Sub Group.

CLINICAL PRESENTATION – LEARNING FROM LEARNING DISABILITY DEATHS (LEDER)

The Committee received a presentation from the Gloucestershire Clinical Commissioning Group (CCG), "Learning from Learning Disability Deaths", providing details from the recent Gloucestershire Annual Report. The national annual report of 2018, showed that there were 4,302 deaths notified in England, 1,081 of these deaths were reviewed with 50% of these deaths deemed having received care which was good or better than standard. Gloucestershire is an area where LEDER reviews are better established and the local report shows that circa 80% of deaths reviewed within Gloucestershire had received better standards of care than the national average. The need for more reviewers was noted and the committee was updated on NHSE funding expected for 2020/21 to support the programme locally.

SERIOUS INCIDENT – PATIENT SAFETY MONTHLY UPDATE

The Committee received the monthly update on serious incidents (SIRI). There have been 3 SIRIs reported in November 2019, 2 of these were Mental Health SIRIs and 1 was a Physical Health SIRI. There have been 24 SIRI's this year to date. The Committee discussed how learning was being identified and subsequently embedded in practice. The Committee also challenged if there were any emerging themes.

SAFE STAFFING

Safe staffing information has been published for mental health services for the months of October & November in line with national requirements. Physical health service staffing data was also received for these time periods, but at a lesser level of detail as per historical arrangements. The Committee again noted that whilst safe staffing levels were maintained,

there is significant reliance on bank and agency workers, which is recorded on the Trust Risk Register. The Committee noted the lack of nationally required data available in regard to the community staffing levels and asked that the CCG and Executive Team consider how this might be locally addressed in the 2020/21 contracting round.

SAFEGUARDING QUARTERLY REPORT

The committee received the Trust quarterly safeguarding report. Trust safeguarding dashboards were presented with good assurance provided on reporting and training. Ongoing work is required to provide assurance for data quality in RIO record keeping and Mental Capacity Act related development work was noted. The committee was updated on staffing arrangements as part of merging legacy Trust teams, Herefordshire transfer arrangements and the appointment of the head of safeguarding post.

INFECTION CONTROL UPDATE REPORT

The Committee received an update report on new trust infection control arrangements. This included an update on team arrangements and reporting of infection control issues. A recent rise in C.Difficile cases was discussed and assurance given regarding the circumstances and safeguards in place. The Committee was assured to hear that all infection control policies for the new organisation have been merged. The new Trust Infection Control Committee is now established. Work is in progress in establishing a new combined work plan noting the needs of the new organisation.

MEDICINES OPTIMISATION UPDATE REPORT

The Committee received an update regarding medicines management arrangements for the new Trust. A robust medicines optimisation governance structure has been established post-merger. The Controlled Drug Accountable Officer role is established and embedded in the work plan of the Head of Medicines Optimisation. The Committee received updates on anti-microbial stewardship developments, medication safety and new development work regarding the allocation of national funding to support electronic prescribing in mental health services.

QUALITY ASSURANCE GROUP UPDATE

A verbal update was provided on the establishment of the combined Quality Assurance Group and how this will steward quality governance development and assurance for the Committee. Work has been conducted to ensure balanced membership from both organisations. Reports were received at the November Quality Assurance Group included a CQUIN update report, the review of the legacy quality accounts, update on flu vaccinations and an update from the Clinical Policy Review Group.

MEDICAL EDUCATION REPORT

The Committee received the annual medical education report. The report updated the committee on medical education work within the Trust and the development of the 3 counties medical school. The committee noted the challenges in medical education arrangements and relationship with staffing and capacity challenges. The Committee received assurance that the Medical Director is taking these issues seriously and work is ongoing to improving capacity and support for medical education.

COMMITTEE HELD ON 9th JANUARY 2020 SUMMARY:

REVIEW OF QUALITY COMMITTEE RISKS

The Committee received a verbal update on the work of the recently formed Risk Management Group and how work is ongoing to review and refresh individual risks. The Committee was advised that all risks continue to have appropriate controls in place and owners are well informed of their responsibilities.

UPDATE ON MENTAL HEALTH HOMICIDE INVESTIGATION

The Committee received notification of the completion of the Trust internal Serious Incident investigation into the tragic mental health homicide that occurred in May 2019. The report has been submitted to NHS England and the CCG for next stage review. NHSE will update the Trust in due course on any further action and independent reviews required. The Committee received assurance that learning to prevent reoccurrence was identified and work is in progress. The Committee will receive an update at the April 2020 meeting. The CCG confirmed verbally in the meeting that they were satisfied with the reports content and actions identified.

DEEP DIVE REPORT CATHETERS

The Committee received a Deep Dive report and presentation into the quality of care in regard to catheters in the community. The purpose of the deep dive approach is to provide additional focus on key Trust quality and patient safety matters. Good quality catheter care and reduction of associated infections is a quality requirement for the Trust. Non – Executive Directors challenged assurance that the Trust is working to ensure appropriateness of catheter usage, and questioned contributing factors increasing the usage of catheters. Assurance was provided on Trust approaches and the need to further challenge the appropriateness of catheters in the community. Ongoing work in collaboration with the CCG and Gloucestershire Hospitals Trust was described.

DEEP DIVE REPORT – FALLS PREVENTION (COMMUNITY HOSPITALS)

The Committee received a Deep Dive report regarding falls prevention work at our community hospitals. This report provided a range of information regarding quality improvement initiatives, progress and assurance related to the associated CQUIN for falls reduction.

SERIOUS INCIDENT REPORT

The Committee received the monthly patient safety serious incident update report. The Committee discussed the 7 incidents that were reported for December 2019, noting higher incidence compared to previous years December data. The Committee requested that a further update is received at the next meeting on related learning development work in progress.

SAFE STAFFING

The Committee received the regular Safe Staffing report for in-patient services. Workforce risks were noted alongside Trust actions in progress to address this. No staffing escalations to Director level were reported and assurance was provided on staffing levels being maintained. The Committee highlighted again that there is no data available for community nursing and this remains an area of weakness in regard to assurance.

QUALITY COMMITTEE DEVELOPMENT SESSION

The Quality Committee agreed at the December meeting that a development session would be held in January to review how the Committee was operating, to review the work plan going forward and the frequency of meetings. The Director of Nursing, Therapies and Quality provided a presentation on the work achieved to date (3 months) confirming that all areas of the

Quality Governance Framework and actions required in the Quality Governance Board Memoranda have been delivered; or there are plans in progress to deliver. A discussion took place on critiquing the annual work plan to achieve a balance of escalations of issues, enabling robust discussions of Trust quality assurance matters and how this links to Trust ambitions for transformation. The Committee highlighted the importance of the work of the sub-committees in providing assurance and raising areas of concern to the Quality Committee. The Committee agreed that these development sessions were useful for reflecting on the effectiveness of the Committee and reviewing the work plan. Quarterly Committee development sessions of an hour to be scheduled within the agenda.

ACTIONS REQUIRED BY THE BOARD

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

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Nomination and Remuneration Committee

COMMITTEE CHAIR: Ingrid Barker

DATE OF COMMITTEE MEETING: 9th January 2020

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

APPOINTMENT OF A 7TH NED WITH GP EXPERIENCE

The Trust's Constitution provides for there to be a full complement of 7 Non-Executive Directors (NED) on the Trust Board. Agreement had previously been reached to fill this vacancy with a NED with GP experience.

Following a recruitment exercise in December, the Committee noted the appointment of Dr Stephen Alvis as an Associate Non-Executive Director still leaving the Trust with a vacancy for a 7th substantive 7th NED.

The Committee agreed that arrangements to recruit to this position should commence immediately and that having reviewed the existing skills, and experience of current Non-Executive Directors, that there should be an emphasis placed on appointing someone with business and commercial knowledge and experience. The remuneration for this post should be in line with the Trust's previously agreed remuneration framework for NEDs. Further, and following advice from the Director of Human Resources and Organisational Development, that recruitment should be supported by specialists engaged from the NHS Framework, a practice that had delivered the greatest success previously.

The Committee would inform the Council of Governors of their decision at the Councils meeting on 21st January 2020 of the following decision.

ACTIONS REQUIRED BY THE BOARD

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

GLOUCESTERSHIRE HEALTH AND CARE NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS MEETING

Thursday, 14 November 2019

Abbeydale Community Centre, Glevum Way, Gloucester

PRESENT:

Ingrid Barker (Chair)	Katie Clark	Mervyn Dawe
Vic Godding	Miles Goodwin	Said Hansdot
June Hennell	Jenny Hincks	Bren McInerney (part)
Stephen McDonnell	Nic Matthews	Anneka Newman
Mike Scott	Jo Smith	Simon Smith (Interim Lead Governor)
David Summers	Stephen Wright	

IN ATTENDANCE:

Maria Bond, Non-Executive Director
Simon Crews, Interim Trust Secretary
Marcia Gallagher, Non-Executive Director
Marianne Julebin, Trust Secretariat
Kate Nelmes, Head of Communication
Angela Potter, Director of Strategy
Paul Roberts, Chief Executive
Lavinia Rowsell, Future Head of Corporate Governance
Graham Russell, Non-Executive Director (Vice Chair)
Neil Savage, Director of HR and Organisational Development
John Trevains, Director of Nursing, Therapies and Quality (part)
Bernie Wood, Deputy Director of IT & Systems

1.0 WELCOMES AND APOLOGIES

1.1 Apologies were received from Jan Marriott, Amjad Uppal, John Campbell, Sandra Betney, Sumita Hutchison, Helen Goodey, Cherry Newton, Lawrence Fielder, Jane Melton, Colin Merker, Carole Allaway-Martin, Kate Atkinson.

1.2 The Chair opened the first meeting of the Council of Governors of the new Trust by greeting all and welcoming newcomers. Paul Roberts advised he would cover for Colin Merker. Bernie Wood was representing Sandra Betney.

2.0 DECLARATION OF INTERESTS

2.1 Nic Matthews reported he is the new staff-side Deputy. David Summers confirmed he sits on the Herefordshire Health & Wellbeing committee.

3.0 COUNCIL OF GOVERNOR MINUTES

3.1 The minutes of the Council meeting held on 18 June 2019 were agreed as a correct record.

4.0 MATTERS ARISING AND ACTION POINTS

4.1 The Council reviewed the actions arising from the previous meeting and no comments or updates were received. Simon Smith (SS) requested that Council's agreement for the merger reached in the private meeting be publicly recorded. Ingrid Barker (IB) confirmed that the private minutes would be reviewed by Council in its private meeting later today following Council approval. Mervyn Dawe (MD) requested that individual governor comments be included for the record. The Chair recommended a further conversation in the private meeting to decide which comments should be included or redacted for public release. IB thanked Governors for their feedback from the June meeting. It was separately noted that papers had arrived in good time for this meeting.

ACTION: Conversation on redaction for private-to-public minutes (IB)

5.0 FORMAL BUSINESS

5.1 **Constitution**
Simon Crews (SC) confirmed that NHS Improvement had formally approved the amended Constitution requiring only one change: the word AND in the Trust's name in place of the ampersand symbol.

6.0 Terms of Reference for the Nomination and Remuneration Committee
SC asked Governors to approve the revised Terms of Reference for the Nomination and Remuneration Committee which had a minor change to reflect the title of the new organisation. APPROVED.

7.0 Standing Orders
Governors were asked to note the cosmetic changes to the Standing Orders – and approve the changes which reflect the title of the new organisation. APPROVED.

8.0 Appointment of Governor Observers
IB invited Governor Observers to the Trust's newly-configured Board Committees. There are vacancies on the Audit & Assurance Committee, the Quality Committee, with two vacancies on the Mental Health Legislation Scrutiny Committee and the Resources Committee. SS confirmed there had been a pre-meeting discussion about the role of Governors including their role as Observers. It was felt that there should be a formal Governor scrutiny framework. SS noted that the Observer role was a key action for Governors and recommended that broader spans of people are involved. It was agreed that current Observers will be in post for now and that SS and SC will issue new invitations and develop a formal Governor scrutiny framework. IB reiterated that public Board meetings are open to observation and Governors are hereby invited to attend. Please see dates on the back of the Agenda.

ACTION: SS and SC will send Governors a document explaining the role of individual Board committees and asking for expressions of interest to act as Observers. This will form part of the Governor scrutiny framework which SS, IB and SC will develop.

9.0 ELECTION UPDATE

IB informed the meeting that the Trust changed its Constitution prior to the merger to enable additional Staff Governors to be created, with ring-fenced spaces for GCS staff. SC confirmed that voting for Staff Governors concludes on 25 November. For Admin & Management there were seven nominations, four from GCS, and three from 2G. At least one position must be filled by a former-GCS member of staff. Governor elections for Health & Social Care, Dental, Nursing and Medical categories received no nominations. SC and IB proposed that external company Civica should run a further election to fill the remaining vacancies. June Hennell (JH) noted in hindsight that, as Governors, we could have had conversations with staff encouraging them to register while on site visits. MD queried the cost of the external contractor. SC responded that external contractors are commonly used for reasons of independent facilitation but did not have a cost to hand. IB and others commented that word of mouth was key for recruitment. A more focussed and detailed communications strategy for future elections should be considered.

ACTION: SC to arrange a re-run of the election through Civica and collaborate on a refresh of the communication strategy for election of Governors.

10.0 CHAIR'S REPORT

IB presented her September Board report covering the merger, regional and national partner working and an excellent meeting with the CQC Chief Inspector of Hospitals who was hugely impressed with the good practice at Wootton Lawn. IB also met with Chair of Worcestershire Health & Care for ongoing conversations which included the roles of Herefordshire Governors. IB has been party to the ICS process for appointing a new Chair for Gloucestershire (to be announced shortly). IB is stepping down from the Health & Wellbeing Board which Angela Potter will attend and report on in future. There is now good inter-connectedness between the Health & Wellbeing Board, the ICS and Local Enterprise Partnership for health and economic development work in the county. There was also an excellent tea party for volunteers and experts by experience.

10.1 **NED ROLES**

IB highlighted her paper showing NED portfolios and pointed out that some roles are statutory requirements. Governors' questions were invited. Mike Scott (MS) asked where we were with GP NEDs. NS responded this had been challenging but we now have two very experienced GP candidates and were finalising interviews on 2nd December. Appointing the right candidate would be critical. IB advised that the Review and Refresh meeting was happening later today and in future everyone will be given the opportunity to participate.

11.0 CHIEF EXECUTIVE'S REPORT

We are in a General Election phase and public organisations are not to initiate or comment on politically-contentious issues. Paul Roberts (PR) reported that it is an incredibly busy time in our newly-merged organisation that we have reached a milestone

and are wholly focussed on the future. We have many leaders and managers identifying opportunities and working well across the merged Trust. PR pointed out that NHS

Performance results had been announced today and that national targets have been missed, reflecting pressure in the system. PR praised the Governors for their site visits which staff value and very much appreciate.

11.1 PR welcomed Lavinia Rowsell, future Head of Governance and thanked her for her attendance today. PR also thanked SC for stepping in to help as Interim Trust Secretary. PR reported that Jane Melton is currently seconded to the ICS and Glos University leading on Therapies. Finally, in addition to business-as-usual, the Board's focus is on the three Ts: Transaction, Transition and Transformation. Objectives have been set across five areas: consolidation; instigating a strategy process; the Herefordshire transition; leadership, values and models for quality improvement; and urgently establishing our position within the Gloucestershire Integrated Care System, Integrated Locality Partnerships and Primary Care networks. We cannot achieve our objectives without working in partnership with others.

11.2 **DIRECTOR OF STRATEGY**

PR invited Angela Potter (AP) to talk to the strategy process mapping our future direction. AP reported that there is co-production with staff, service users, stakeholders and the Council of Governors to identify priorities for each of the localities being represented. By March we will test our findings and distil our thinking. We will undertake a stakeholder audit with partners such as the CCG and Regulators to understand what the system thinks of us and testing out our plans with them. PR thanked AP and requested Governors to look out for the diary dates for this.

11.3 **'Fit for the Future'**

PR commented that under 'Fit for the Future' we are mapping out plans for the Forest of Dean Hospital and the future arrangements for urgent care in community settings and these will be shared in due course, after the news moratorium is lifted. SS asked whether comment had been received about the chosen site for the hospital. PR, AP and Neil Savage (NS) confirmed that there had been positive comment and the idea had been well-received. IB said that the local council and MPs had been strongly supportive. IB advised that the hospital would be in the centre of Cinderford, Steam Mills Road on the site of a skateboarding park, which will be relocated. BI had heard a Radio Glos report highlighting transport issues with the site. MD asked if the hospital will be on a bus route and can we persuade transport providers to ensure that it is? AP said we cannot commission bus routes but we are in discussion with the CCG to see how these can be provided. In our other new hospital sites, bus routes had been created. PR commented that we are negotiating with Council regarding Lydney and a possible new primary care facility. PR assured Council that work on the long term plan published in January this year and many of these issues which cannot be reported on during the General Election news moratorium will be shared again in January 2020.

11.4 **Health and Wellbeing and forthcoming events**

PR reported that 1600 colleagues had completed the latest Health and Wellbeing survey with some really clear messages: 80% of respondents said they had issues with disrupted sleep patterns. As a Trust we will address the health and wellbeing of our

colleagues and issues regarding how we manage and communicate change. Bren McInerney (BI) mentioned that the Glos Chief Constable had raised the Health & Wellbeing levels of his force and there may be some cross-learning available. PR agreed that his team have done a fantastic job and in fact one of his deputies is coming to our next senior leadership meeting. Finally, PR advised of forthcoming events: University of Birmingham, Better Care 2Gether on the 27th and on the 4th December there are two events on personalised care (one in the morning, one in the afternoon.)

ACTION: Details of the events to be sent to Governors who wish to attend

Questions were invited and JH asked for clarification on the Governors' role in expressing personal opinions during the General Election period. PR confirmed that as long as you are not speaking on behalf of the NHS or the Trust, you may express your personal opinion.

12.0 GLOUCESTERSHIRE HEALTH AND CARE PRESENTATIONS

12.1 Presentation: Homeless Mental Healthcare - the people and the service

IB welcomed Andy Telford and said she had visited the mental health team and the homeless health care team based at the George Whitefield Centre who are commissioned separately. Andy presented a very interesting and saddening picture of rough sleeping in Gloucestershire. Andy said our particular local issues are: mean age of death on the streets of Gloucester is 45 for men and 43 for women, 24% rough sleepers in Glos are female and vulnerable to abuse. There are high levels of complex trauma and distress but only four with diagnosable mental health illness. There were 726 deaths across the UK in 2018 and this has risen 50% since records began in 2013. Our team find rough sleepers in the early hours and we have two 24-hour Rapid Assessment centres. Governors thanked Andy for his excellent presentation and his fantastic work and asked many questions. In response, Andy informed Governors that they use P3 and START to find flats and homes. Street homeless people are top of the list for emergency accommodation. Andy confirmed there is a Government plan to "eliminate" street homelessness by 2025 and new legislation is helpful in achieving this. The local team have made great progress in Glos and we've done it differently with quick throughput of people into normalised accommodation. Fortunately, for young Glos residents who leave the care system, we find they are not falling into street homelessness. The Governors expressed their gratitude and admiration to Andy.

12.3 Presentation: Quality and Clinical Governance in the new Trust, John Trevains

John Trevains (JT) stated that he was privileged to be leading and overseeing the quality governance system for the new Trust. Jo Smith (JS) has been very active and helpful in its development. JT provided an outline of the approach taken for the transition work and gave an update on mitigation of risk and the support provided to Herefordshire colleagues. We consulted with the NEDs, NHSI, External Auditors, internal and external stakeholders and other NHS organisations for best practice working and received great

feedback for what we have in place. JT spoke to the slides highlighting the new model which blended the high standards and good performance of both Trusts. JT shared a document on the new Quality Governance System with new groups marked in orange (please see Appendix 1). In addition to the new quality assurance groups, other changes include: locality operational governance reporting, the new "improving care" group for a refreshed focus on quality improvement, further enabling of Better Care Together, a requirement for co-production in all groups and we now have a resident Chief Pharmacist and a "Speak Up" representative for colleagues. Every single new group will have Expert by Experience involvement to achieve a truly co-produced system. We will roll this out to all teams who will receive training in quality improvement. We are having a sense check in six months' time to ensure all is working as planned, smoothly and efficiently.

In finishing, JT invited Governors to get in touch if they had any questions or wanted more information. Governors praised JT and his team for this solid performance and achievement. BI and JH asked why the patient experience group is not called patient and carers experience group? JT welcomed the challenge and said that while the group did include carers, it did not say so and the name will be changed. BI queried what policies are still not in place? JT responded that all our Day One essential policies were merged, in place and ready by Day One. All policies are on the Intranet and we now have a list of specific policies such as low secure forensic unit, still being completed and on an audit tracker until their deadline.

IB thanked Maria Bond, Jo Smith and Vic Godding for their work on the Quality Committee.

13.0 HEREFORDSHIRE SERVICES

13.1 PR represented Colin Merker for this report and gave particular thanks to Governors Miles Goodwin, David Martin and Cherry Newton who have been involved in the process. After a lot of discussion, the last board meeting of 2Gether decided to recommend to the CCG that they commission their mental health and LD services for Herefordshire from Worcestershire Health and Care NHS Trust. The Board were keen to get assurances for future resources and investment for Herefordshire and this has been received. We were also pleased to receive acknowledgement of the good work of the 2Gether Trust in the past. There is a meeting being set up with our Herefordshire Governors to talk about the continuing relationship. We have given assurances to our colleagues in Herefordshire that we will support them in a smooth transfer in April. IB invited questions from Herefordshire Governors. In response to a question, IB confirmed that any Herefordshire Governor could stand as a Greater England Governor after 1st April 2020.

14.0 ANY OTHER BUSINESS

David Summers asked whether the Trust works with schools and academies to promote mental health and wellbeing programmes. IB responded that there is a body of work being undertaken called "Trailblazer" and more information could be provided outside the meeting.

Appendix 1: Quality Governance System handout

COUNCIL OF GOVERNORS

MAIN MEETING ACTION POINTS

Item	Action	Lead	Progress
14 November 2019 Main meeting			
4.1	Conversation on redaction of comments for private-to-public minutes of September meeting	Ingrid Barker	Completed
8.0	All Governors to be sent a document explaining the role of individual Board committees and asking for expressions of interest to act as Observers.	Simon Smith and Simon Crews	Completed
8.0	Formalise a Governor scrutiny framework to monitor competence and contribution.	Simon Smith, Ingrid Barker and Simon Crews	
9.0	SC to re-run the election process through Civica and instigate a refresh of the communications strategy for elections.	Simon Crews	

AGENDA ITEM: 25/0120

Report to: Trust Board – 29 January 2020

Author: Simon Crews **-** Interim Trust Secretary

Presented by: Lavinia Rowsell - Head of Corporate Governance/Trust Secretary

SUBJECT: **USE OF TRUST SEAL**

Can this subject be discussed at a public Board meeting?	Yes

This report is provided for:
Decision Endorsement **ASSURANCE** **INFORMATION**

PURPOSE OF REPORT
To provide information to the Trust Board on the use of the Trust Seal, as required by the Trust's Standing Orders, reference section 7.3.

RECOMMENDATIONS
The Board is asked to note the use of the Trust Seal during the period 1Oct 2019 to 31 Dec 2019.

EXECUTIVE SUMMARY

The Trust's Standing Orders require that use of the Trust's Seal be reported to the Trust Board at regular intervals. Extract below:

7.3 The Chief Executive shall keep a register in which he/she, or another manager of the Trust 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 the quarter ending 31st Dec 2019 the Seal has been used on the occasions detailed on the attached schedule.

Corporate Considerations	
Quality implications:	Nil
Resource implications:	Nil
Equalities implications:	Nil
Risk implications:	There is a requirement to report the use of the seal to the Trust Board and failure to do so would be a breach of the Constitution.

WHICH TRUST VALUES DOES THIS PAPER PROGRESS (P) OR CHALLENGE (C)?			
Working together	**P**	Always improving	**P**
Respectful and kind	**P**	Making a difference	**P**

Report authorised by: Paul Roberts, Chief Executive Officer	**Date:** 14 January 2020

Where has this issue been discussed before?	**Date:**
N/A	
What wider engagement has there been?	**Date:**
N/A	

Appendices:	Appendix A: Register of Seals – 01 October 2019 to 31 December 2019

Register of Seals (01 October 2019 – 31 December 2019)

AGENDA ITEM: 25/0120

Date of Sealing	Document Description	No. of Copies	Document Signatory (1)	Document Signatory (2)
01.10.19	TR1. Churchdown Clinic: Transfer from NHS Property Services Ltd to Gloucestershire Health and Care NHS Foundation Trust	2	Sandra Betney	Paul Roberts
01.10.19	Cheltenham Dental and Podiatry Clinic: Transfer to Gloucestershire Health and Care NHS Foundation Trust.	0	Sandra Betney	N/A
01.10.19	Deed of covenant: George Moore Clinic, Hope House, North Cotswold, Tewkesbury Hospital, Vale Hospital	2	Sandra Betney	Paul Roberts
01.10.19	TR1. Private Suites, Winchcombe Medical Centre. Transfer from Gloucestershire Care Services to Gloucestershire Health and Care NHS Foundation Trust.	2	Sandra Betney	Neil Savage
01.10.19	TR1. Southgate Moorings. Transfer from Gloucestershire Care Services to Gloucestershire Health and Care NHS Foundation Trust.	2	Sandra Betney	Neil Savage
01.10.19	TR1. Independent Living Centre Transfer from Gloucestershire Care Services to Gloucestershire Health and Care NHS Foundation Trust.	2	Sandra Betney	Amjad Uppal
01.10.19	TR1. Edward Jenner Court. Transfer from Gloucestershire Care Services to Gloucestershire Health and Care NHS Foundation Trust.	2	Sandra Betney	Neil Savage
01.10.19	TR5. Portfolio transfer of 15 freehold titles to Gloucestershire Health and Care NHS Foundation Trust.	2	Sandra Betney	Neil Savage
01.10.19	TR5. Portfolio transfer of 2 freehold titles to Gloucestershire Health and Care NHS Foundation Trust.	2	Sandra Betney	Neil Savage
01.10.19	TR1. St Pauls Medical Centre: Transfer from NHS Property Services Ltd to Gloucestershire Health and Care NHS Foundation Trust	2	Sandra Betney	Paul Roberts
22.10.19	Deed of covenant North Cotswold Hospital, Land adjoining Fosse way Farm	2	Sandra Betney	Paul Roberts

Date of Sealing	Document Description	No. of Copies	Document Signatory (1)	Document Signatory (2)
23.12.19	Transfer of property: Property 18 Denmark Road, Gloucester, GL13H2. Transferee-Reference SL 1007 Ltd – 69 Tweedy Road, Northside House, Bromley, BR1 3WA. Co Reg11870122	1	Sandra Betney	John Trevains
23.12.19	Sale of property – 18, Denmark Road. Gloucester GL1 3HR. Buyer-Ref SL1007 Ltd, 69 Tweedy Road, Northside House, Bromley, BR1 3WA Co Reg. 11870122.	1	Sandra Betney	N/A

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

TRUST BOARD
Public papers
Wednesday 25 March 2020, 10:00 – 13:00 hrs
The Boardroom, Edward Jenner Court, Gloucestershire Health and Care NHS Foundation Trust and by Teleconference

Due to the current coronavirus situation, this meeting will be held in PRIVATE

AGENDA

Agenda Item	Title	Purpose		Presenter
Opening Business				
01/0320	Apologies for absence and quorum	Note	Verbal	Chair
02/0320	Declarations of interest	Note	Verbal	Chair
03/0320	Unconfirmed Minutes of the meeting held on 29 January 2020	Approve	Paper	Chair
04/0320	Matters arising and Action Log	Note	Paper	Chair
05/0320	Questions from the Public	Note	Verbal	Secretary
Strategic Issues				
06/0320	Report from the Chair	Note	Paper	Chair
07/0320	Report from the Chief Executive Officer and Executive Team	Note	Paper	CEO
08/0320	System wide update	Note	Paper	CEO / DoSP
09/0320	Trust's Strategic Framework	Approve	Paper	DoSP
10/0320	Board Assurance Framework	Notew	Paper	Secretary
11/0320	2020/2021 Budgets and Planning a) Business plan 2020/2021 b) Budgets 2020/2021	Approve	Paper	DoF
12/0320	Herefordshire Report – Transfer of Services	Approve	Paper	MD of HS
13/0320	Our merger: • PME closure report • Corporate Governance Certificate	 Approve Approve	 Paper Paper	 DoF Secretary
14/0320	Staff Survey Report	Note	Paper	DoHROD
15/0320	Gender Pay Gap Report	Approve	Paper	DoHROD
Performance and Patient Experience				
16/0320	Quality Report Q3 including Patient Experience Report Q3	Note	Paper	DoNTQ
17/0320	Guardian of Safe Working Hours Quarterly Report – Aug to Oct 2019	Note	Paper	MD
18/0320	Learning from Deaths - Q3	Note	Paper	MD

Agenda Item	Title	Purpose		Presenter
19/0320	Safe Staffing	Note	Paper	DoNTQ
20/0320	NED Audit of Complaints	Note	Paper	Secretary
21/0320	Performance Report	Note	Paper	DoF
22/0320	Finance Report	Note	Paper	DoF
Governance				
23/0320	Revised Constitution	Approve	Paper	Secretary
24/0320	Terms of Reference • Charitable Funds Committee • Mental Health Legislation Committee	Approve	Paper	Secretary
Items for Information				
25/0320	Quality Committee Summary (6 February and 5 March 2020)	Note	Paper	Committee Chair
26/0320	Audit and Assurance Committee Summary (13 February 2020)	Note	Paper	Committee Chair
27/0320	Resources Committee Summary (27 February 2020)	Note	Paper	Committee Chair
28/0320	Charitable Funds Committee Summary	Note	Paper	Committee Chair
29/0320	Mental Health Legislation Committee Summary (27 February 2020)	Note	Paper	Committee Chair
30/0320	Appointments and Terms of Service (25 March 2020)	Note	Verbal	Committee Chair
31/0320	Minutes of the Council of Governors (21 January 2020)	Note	Paper	Secretary
Closing Business				
32/0320	Any other business	Note	Verbal	Chair
33/0320	Date of next meeting Wednesday, 03 June 2020 The Pavilion, Cheltenham	Note	Verbal	All

Abbreviations

CEO	Chief Executive Officer
DoF	Director of Finance
DoHROD	Director of Human Resources and Organisational Development
DoNTQ	Director of Nursing, Therapies and Quality
DoSP	Director of Strategy and Partnerships
MD of HS	Managing Director of Hereford Services
MD	Medical Director
Secretary	Trust Secretary

UNCONFIRMED MINUTES
Trust Board
MEETING IN PUBLIC
Held on Wednesday, 29 January 2020
at Forest Green Rovers Football Club, The New Lawn Stadium, Nailsworth, GL6 0FG

PRESENT:
Ingrid Barker, Trust Chair
Paul Roberts, Chief Executive
Sandra Betney, Director of Finance
Maria Bond, Non-Executive Director
Sumita Hutchison, Non-Executive Director
Neil Savage, Director of HR & Organisational Development
John Trevains, Director of Nursing, Therapies and Quality
Dr Amjad Uppal, Medical Director
Helen Goodey, Director of Locality Development and Primary Care
Sue Mead, Associate Non-Executive Director
Graham Russell, Non-Executive Director
Duncan Sutherland, Non-Executive Director
Colin Merker, Managing Director for Herefordshire
Dr Stephen Alvis, Associate Non-Executive Director

APOLOGIES:
Jane Melton, Director of Therapies
Jan Marriott, Non-Executive Director
Angela Potter, Director of Strategy and Partnerships
John Campbell, Chief Operating Officer
Marcia Gallagher, Non-Executive Director

IN ATTENDANCE:
Kate Nelmes, Head of Communications
Lavinia Rowsell, Head of Corporate Governance/Trust Secretary
Hazel Braund, Programme Director for Better Care Together
Sian Thomas, Deputy Chief Operating Officer
Louise Moss, Deputy Head of Corporate Governance
Hazel Braund, Programme Director
Claire Kenny, Board, Committee & Membership Officer
Peter Keevil, Katza Baczko, Ruth Davey, Miranda Eeles, Trish Dickinson, Emma Keating-Clark (Compassionate Stroud)
Karen Bennett, Anne Roberts, David Summers (Staff Governors)
Bren McInerney (Governor)
Sue Tomilinson, Independent Trust
Roz McDonald, Staff Observer

1.0 CHAIR'S WELCOME

1.1 The Chair welcomed everyone to the meeting and noted apologies. An introduction was received from Dane Vince, General Manager at Forest Green Rovers Football Club.

1.2 The Chair welcomed Dr Stephen Alvis to his first meeting of the Board in his capacity as Associate Non-Executive Director (NED) and Lavinia Rowsell as the new Head of Corporate Governance.

1.3 The meeting was declared quorate.

2.0 DECLARATIONS OF INTEREST

2.1 There were no declarations of interest received.

3.0 COMPASSIONATE STROUD

3.1 The Chair welcomed Compassionate Stroud to the meeting.

3.2 Compassionate Stroud shared a presentation with the Board on their work and the background to their establishment. Compassionate Stroud is a grassroots project, involving a partnership between the NHS, local councils, Independence Trust, the Stroud Library Service, various charities and individuals. The project was established in 2018 based on a successful Social Prescribing Project set up in Somerset.

3.3 The project aims to bring people together within the local community and support people in navigating the complexity of the health and social care system, working in collaboration with other organisations. The group highlighted their focus on social isolation and the impact this can have on an individual's health and wellbeing. The underlying message to their work was 'treating ourselves and others with compassion'.

3.4 Peter Keevil highlighted the main work-streams of the group and played a short video clip of an individual who had used their service demonstrating the positive impact the service could have.

3.5 Following the presentation, a discussion took place on how the Trust and Compassionate Stroud could work together to further their joint ambitions for place based care. Compassionate Stroud asked the Trust to consider nominating an individual to join their core group. It was agreed that the presentation would be circulated to all Board Members after the meeting and individual Board Members would liaise directly on any support they could offer. The Director of Strategies and Partnerships would act as the key point of contact.

3.6 On behalf of the Board, the Chair thanked Compassionate Stroud for their informative presentation and their work to further a person-centered approach to care which mirrored the ambitions of the Trust.

ACTION: Presentation to be circulated to all Board Members.

4.0 MINUTES OF THE MEETING HELD ON 28TH NOVEMBER 2019

4.1 The minutes of the Public Trust Board meeting held on 28th November 2019 were accepted as a true and accurate record.

5.0 MATTERS ARISING AND ACTION LIST

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

6.0 QUESTIONS FROM THE PUBLIC

6.1 The Board received a response to a question from a member of the public on how the evaluation report on the Workforce Race Equality Standard (WRES) supported and enhanced the work of the Trust in implementing the WRES. An initial response had been provided at the November 2020 meeting of the Board, following which further clarification was sought. The member of the public who had submitted the question was present at the meeting and confirmed their satisfaction with the response received.

6.2 The Board **noted** the response.

7.0 REPORT FROM THE CHAIR

7.1 The Board received the report from the Chair summarising her activities and those of the NEDs since the last meeting of the Board.

7.2 The Chair highlighted the work being undertaken by the Governors as part of a 'Review and Refresh' which would look at the Council's ways of working and the development of the Trust Membership in light of the merger.

7.3 The Chair expressed her thanks to Kate Atkinson, Steven Wright and Mike Scott who had recently stepped down as public Governors and acknowledged the valuable contribution they had made. The Chair welcomed Karen Bennett and Anne Roberts, who had recently been elected as staff Governors. It was noted that Lead Governor, Simon Smith, had agreed to extend his term for a further six months.

7.4 The Chair informed the Board that the Governors had approved the proposal for the recruitment of a seventh NED as set out in the Trust's constitution. Having reviewed the skills and experience of the existing NEDs, it was agreed that the

focus would be on appointing an individual with a business and commercial background.

7.5 An update was provided on meetings attended at a regional and national level and work with the communities and people served by the Trust.

7.6 Updated NED portfolios and visits and activities undertaken by NEDs since the last meeting of the Board were noted.

7.7 The Board **noted** the report and the assurance provided.

8.0 REPORT FROM THE CHIEF EXECUTIVE OFFICER AND EXECUTIVE TEAM

8.1 The Chief Executive Officer (CEO) introduced to his report. It was noted that activities had focused on working towards the five short term priorities as agreed at the last Board meeting.

8.2 The CEO reported that a two day Board strategy session had been held earlier that month to develop the strategic framework for the Trust. The Board had hosted a visit from the Regional Director and two senior members of the NHS Improvement/NHS England regional team, where a helpful discussion had taken place regarding shared priorities and challenges.

8.3 The arrangements for the Deputy CEO were relayed to the Board. Until the end of March 2020 both Sandra Betney, Director of Finance (DoF), and Colin Merker, Managing Director for Herefordshire (MDH), would remain as deputies. From April, Sandra Betney, would be the single Deputy CEO, following the retirement of Colin Merker at the end of March 2020.

8.4 The CEO congratulated John Campbell, Chief Operating Officer (COO), on being selected to participate in the Aspiring Chief Executive programme, run by the Leadership Academy.

8.5 The report referenced the reduction in the opening hours of x-ray departments on the community sites, following staffing issues at Gloucestershire Hospitals NHS Foundation Trust (GHFT), an issue which had been raised at the November 2019 meeting of the Board. The report offered assurance that GHFT were actively recruiting bank and/or agency staff where possible to help resolve the issue. There had been a significant improvement during 2019, which continued into 2020.

8.6 It was noted that the Trust had recently been visited by Chef Prue Leith as part of a national review of NHS hospital food. Graham Russell commented on the Trust's work in relation to nutrition and hydration and asked how the Trust would be promoting healthy eating. The CEO confirmed that sustainability would be a key part of the Trust's future priorities.

8.7 The Board **noted** the report and the assurance provided.

9.0 DEVELOPING OUR STRATEGY

9.1 Hazel Braund, Programme Director for Better Care Together, presented the report to the Board on behalf of The Director of Strategy and Partnerships. It was noted that the Board had previously agreed to move forward with a process to engage colleagues, service users, carers, partners and stakeholders in the co-production of the Trust's priorities for the next five years. The Board noted the timeline for the development of the strategy and achievements to date in seeking stakeholder input.

9.2 The Board was invited to attend the Better Care Together conference on 19 February 2020, at which partners, service users, carers and stakeholders would be able to share and discuss emerging priorities.

9.3 It was noted that the draft strategic framework would be presented to the Board in March. Following this, a further engagement process would run until the end of June 2020 to test the priorities and develop the strategy in further detail.

9.4 The Chair stressed the importance of the co-production of the strategic framework and that the Board must be satisfied that this ambition had been met.

9.5 The Board **noted** and supported the ongoing activities and timetable to develop the Trusts five year strategic framework.

10.0 SYSTEM WIDE UPDATE

FIT FOR THE FUTURE

10.1 The CEO presented an overview of the next steps associated with the pre-consultation business case for Fit for the Future across Gloucestershire. It was noted that a number of key priorities had been delayed due to the General Election but progress was now being made.

10.2 The Board was made aware of the key components included within Fit for the Future. These were; general surgery, image guided interventional surgery, emergency and acute medicine and urgent care within the community.

10.3 The CEO reported that focused discussions had taken place in the Forest of Dean regarding the development of a new hospital, which it was hoped would be built within the next few years. A meeting with the Forest of Dean District Council had taken place to discuss this matter. Key issues raised included bed numbers and the urgent care model.

10.4 Sue Mead highlighted that in order to achieve the ambition for improvements in community urgent care, the reliability, responsiveness and access to diagnostic

services were key to relieving pressure on acute services. The CEO responded that the issues with reliability and access were largely workforce driven and the introduction of a national strategy for imaging and national approach to pathology would help.

10.5 It was noted that the Board would be asked to approve the pre-consultation business case prior to submission to NHS England/Improvement. A process to achieve this was currently being agreed with system partners.

10.6 The Board **noted** the timetable and requirements for the approval of the pre-consultation business case for the Fit for the Future programme.

ONE GLOUCESTERSHIRE ICS LEAD REPORT

10.7 The Board received the One Gloucestershire ICS Lead report which provided an update on progress of key programmes and projects across the ICS.

10.8 The CEO reported that the Trust continued to play a central role within the ICS and members of the senior team were making a significant contribution to the programme. The Director of Finance had been coordinating the system finance leaders to develop a system finance plan.

10.9 It was noted that the work-streams within the programme, including 'enabling active communities' and 'one place, one system', linked with the work presented by Compassionate Stroud earlier on the agenda. The importance of highlighting local activities at ICS Board level was noted.

10.10 The Board **noted** the ICS Lead report.

11.0 SUSTAINABLE WORKFORCE

11.1 Neil Savage, the Director of HR & Organisational Development (DoHR&OD) updated the Board on the Trust's approach to sustainable workforce and the strategy and actions being taken to mitigate the challenges and risks in this area. The paper had been developed in partnership between operational and human resources colleagues and highlighted three key component parts of the strategy related to temporary staffing, recruitment and retention.

11.2 In relation to the issue of retention, Graham Russell asked what was known about the demographic of the Trust's workforce and whether modelling had been undertaken to understand the future impact on the workforce e.g. the increased number of staff reaching retirement age. Neil Savage (DoHR&OD) responded that targeted initiatives were being considered to improve retention e.g. a nurse led 'Itchy Feet Clinic' which had been set up in order to understand why staff may be considering leaving. The issue of retention and developing the talent pipeline in the Trust was raised and Neil Savage (DoHR&OD) agreed to discuss this with Roz McDonald outside the meeting. **Action: Neil Savage**

11.3 Sumita Hutchinson highlighted the importance of understanding the potential impact of the use of temporary staffing/agency staff on the quality and continuity of patient care and the impact of high usage of temporary staff on permanent colleagues. The CEO reported that the results of the recent National Staff Survey report would be presented to the next meeting of the Board and may provide some insight into this area.

11.4 It was reported that current forecasts indicated an end of year position of £6.231m for temporary staffing spend against an NHSI/E ceiling of £4.25m. This was highlighted as a challenge and recognised that although many NHS providers were facing a similar situation, the Trust needed to take action to address this. It was noted that the actions relating to temporary staffing would be coordinated, in part, through a re-focused Agency and Bank Management Group led by John Campbell, COO.

11.5 The Board considered the proposals in relation to the recruitment of staff. Neil Savage (DoHR&OD) reported that an Integrated Care System group had been established to look at this.

11.6 The Board **considered** the report and **supported** the proposed strategy. Progress would be regularly reviewed by the Resources Committee.

12.0 FUTURE DELIVERY OF MENTAL HEALTH AND LEARNING DISABILITY SERVICES IN HEREFORDSHIRE

12.1 Colin Merker, Managing Director for Herefordshire Mental Health updated the Board on the future delivery of mental health and learning disability services in Herefordshire. The report set out the work associated with the transfer of services in Herefordshire to Worcestershire Health and Care NHS Trust (WHCT) by 1 April 2020. A transition programme was in place being led by WHCT as the incoming provider.

12.2 The outcomes of WHCT CQC inspection were noted by the Board. The overall inspection outcome maintained the “Good” rating achieved by the Trust in 2018. WHCT’s CAMHS service was rated as ‘outstanding.’, however, WHCT’s Adult Community Mental Health Services was rated as ‘inadequate’. Trust colleagues were assured that there was a robust action plan in place to deal with the issues related principally to staffing challenges.

12.3 In relation to Governors, it was reported that Herefordshire Governors continued to receive invitations to attend the Herefordshire Senior Leadership Forum and attended meetings with the Managing Director for Herefordshire Mental Health and Learning Disability Services and Duncan Sutherland as lead NED for the locality. The future arrangements for Governors and the wider trust membership from Herefordshire were being discussed. It was noted that there were 491 members that would need recanvasing as to whether they would like

to stay a member of GHC or become part of a new engagement/reference group to be created by WHCT.

12.4 On behalf of the Board, the Chair thanked Colin Merker and Duncan Sutherland for their work.

12.5 The Board **noted** the current position.

13.0 OUR MERGER – PME UPDATE

13.1 Sandra Betney, DoF updated the Board on the work of the Programme Management Executive (PME) in delivering its strategic intent responsibilities. The PME is the executive group which has led the delivery of the merger and the integration of the two trusts.

13.2 It was reported that the programme delivery was largely met and the PME was assured it would have fully served its purpose by 1 April 2020. As such, a final review would be undertaken and a proposal put to the March 2020 meeting of the Board that the PME be stood down as an executive working group from 1 April 2020. Any outstanding risks held by PME would be transferred to business as usual. In addition, the Board was informed that there would be the requirement to submit a revised Corporate Governance Certificate to NHS Improvement, a draft of which would be presented to the March 2020 meeting for approval.

13.3 Maria Bond asked about the timeliness of the PME closure and whether further capacity was required to support the next phase of transition. Sandra Betney, DoF assured the Board that the PME had not yet been stood down and this would be considered further. Consideration was also being given to retaining the expertise of the Transition Director past the closure of the PME.

13.4 The NEDs sought clarification on how the benefits of the merger would be monitored and measured following the closure of the PMO. The CEO confirmed that as previously discussed by the Board, a conservative approach to measuring the benefits of the merger had been agreed with NHS Improvement and that benefits realisation would be picked up as part of the development of the Trust's new strategic framework being led by the Director of Strategy and Partnerships.

ACTION: Benefits realisation and ongoing capacity to support the transition to be considered.

13.5 Sumita Hutchison requested further information on understanding the impact of the merger on colleagues. Sandra Betney, DoF, clarified that this was being monitored through regular staff surveys, however acknowledged that there had been an increase in staff turnover of which the merger may have been one

factor. As a result there was a renewed focus on leadership development throughout the organisation.

13.6 The Board **noted** the report.

14.0 SUMMARY QUALITY REPORT

14.1 John Trevains, Director of Nursing, Therapies and Quality (DoNTQ) presented the summary Quality report to the Board. The report provided an overview of the Trust's quality activities inclusive of April to December 2019. It was acknowledged that there was duplication between this report and the performance report. John Trevains (DoNTQ) informed the Board that work continued on producing an integrated performance report which would be submitted to a future meeting.

14.2 In relation to physical health services, it was highlighted that the Safety Thermometer Harm free score had increased in December to 92.5% compared to 91.9% in November. The target was 95%, and it remained below the mean at 93.75%. However it was recognised that the Trust was doing well in comparison to local indicators and benchmarking. Acquired pressure ulcer quality metrics continued to progress on a positive trajectory. Sue Mead requested ongoing monitoring of this area. John Trevains confirmed that deep dive work on pressure ulcers was being carried out by the Quality Committee and this work would continue.

14.3 In relation to mental health and learning disability services quality indicators, it was noted that a detailed report would be provided to the March 2020 meeting of Board as part of the quality report update. The DoNTQ assured the Board that positive progress was being made in the delivery and achievement of the indicators.

14.4 The DoNTQ thanked Trust staff for the high delivery of flu vaccinations, achieving the 90% staff mark of compliance. Maria Bond requested clarification on how the data detailing the vaccination rates in children was collected and whether children that were not in mainstream education and/or in care were included in the measure.

ACTION: The Director of Nursing, Therapies and Quality to review this and discuss with Maria Bond outside of the meeting.

14.5 Sue Mead requested that the Board have greater sight of how vulnerable children within the community and those with safeguarding needs are being served by the Trust and asked whether this information could be made more visible within future Board reports.

ACTION: The Director of Nursing, Therapies and Quality to consider.

14.6 Dr Stephen Alvis asked what consideration had been given to recruiting more physiotherapists. The DoNTQ responded that there were challenges with recruitment of physiotherapists and work was being taken forward with the University of Gloucestershire who were developing a physiotherapy course. This would hopefully improve the future recruitment pipeline.

14.7 The Board **noted** the December 2019 Quality Summary Report.

15.0 LEARNING FROM DEATHS Q2

15.1 The Medical Director presented the Learning from Deaths Quarter 2 report to the Board, noting that the data presented represented the period July to September 2019, which was before the merger of the 2Gether and GCS Trusts.

15.2 The Medical Director reported that 27 patient death incidents were subjected to the mortality review process and six were subjected to serious incident investigations. 162 mental health patient deaths were reported during 2019/20 Q2.

15.3 In the legacy Trust GCS, deaths were reported using the MIDAS system, whereas 2Gether Trust had used the *Datix* system. This had been reviewed and it had been agreed that GHC would use the *Datix* system, allowing the Trust to make comparisons with other Trusts and allowing easier reporting to NHSI. From 1 October 2019, both physical health patient deaths and mental health patient deaths would be reported on a quarterly basis.

15.4 In response to a question submitted by Jan Marriot via email asking how GCS reporting would be moved forward, the Medical Director provided assurance that all reporting of deaths would move to the *Datix* system and all unexpected deaths would be reviewed. The previous standard held by GCS would be maintained and improved upon. The Clinical Director for community hospitals would also be involved with this process.

15.5 The Board **noted** the report.

16.0 GUARDIAN OF SAFE WORKING REPORT Q2

16.1 The Medical Director introduced the Guardian of Safe Working report for Q2. The role of 'Guardian of Safe Working Hours' is independent of the Trust's management structure with the primary aim of representing and resolving issues relating to working hours for junior doctors.

16.2 It was reported that during the period under review 12 exception reports (11 from Gloucestershire and one from Herefordshire) had been received. All 12 reports related to hours and had been resolved.

16.3 The Board **noted** the report from the Guardian of Safe Working Hours.

17.0 CQC COMMUNITY MENTAL HEALTH PATIENT SURVEY RESULTS

17.1 John Trevains (DoNTQ) introduced the CQC survey results for people who used Community Mental Health Services during 2019 and the associated action plan. It was reported that only two Trusts were classed as 'better than expected' in 2019 and that the GHC Trust was one of them. The Board was assured further that the legacy 2Gether Trust was the only Trust to have received this rating for the third consecutive year.

17.2 The Board noted that an action plan had been produced to address the areas in which the Trust had not improved upon with the aim to learn further for next year. Sumita Hutchison commented that the development work could lie within the Trust's People Participation agenda which was currently under consideration.

17.3 The Board **noted** the report and received assurance on the delivery of high quality adult community mental health services.

18.0 PERFORMANCE REPORT

18.1 Sandra Betney (DoF) presented the performance report to the Board. The report brought together activity from both legacy organisations into a combined report to provide a high level view of key performance indicators across the organisation. The format of the report would continue to develop, with the inclusion of benchmarking data in the Q4 report. The Director of Finance continued that work was underway to review all indicators not meeting the required performance threshold.

18.2 In response to a question from the Chair, the Board was assured that there was a service action plan in place to address the wheelchair issues regarding wait times being delivered by operational colleagues with progress being overseen by the Resources Committee.

18.3 The Board **noted** the report.

19.0 FINANCE REPORT – MONTH 9

19.1 The Director of Finance presented the Finance report for month 9 to the Board, noting that the report still covered GCS and 2Gether Trusts separately and updated the Board on the financial position. The month 9 forecast outturn of £2.327m was £137k better than the Trust's control total, with PSF accounting for £2.042m of this. Capital expenditure was £2.109m at month 9, with the forecast at £6.275m. The Cost Improvement Plan (CIP) target for the merged Trust was £5.402m. The CIP amount removed so far was £1.545m.

19.2 The revised agency ceiling for the Trust was reported as £4.250m. The year to date actual was £4.393m, which was over the ceiling by £1.485m. The full year

forecast spend was £6.231m, which was £1.981m, or 47%, above the agency ceiling, leading to a 3 in the Single Operating Framework for the agency metric. This was a reduction of £115k on the previous month's forecast, putting the Trust £144k below the agency ceiling threshold of 50% above target where the Trust would score 4 on the agency metric.

19.3 Duncan Sutherland asked what the position was in relation to capital expenditure. The Director of Finance responded that this was £0.5m away from the expected position at this point in the year and NHSI had been notified. This was due in part to a delay in the refurbishment of Montpellier. In addition, a number of capital projects had started later than expected. This position was being monitored by the Executive Team and would be reviewed by the Resources Committee.

19.4 Further to the discussion under item 11 on the agenda relating to Sustainable Workforce, the Chair asked what the consequence of receiving an Agency Risk Rating from NHSI/E of 3 would be given the current forecast on the year end position on temporary staffing spend. The Director of Finance responded that there would be no direct financial consequence and any action taken by NHSI/E would depend of where the Trust is in relation to the segment.

19.5 In regards to CIP, the Director of Finance reported that an initial workshop had been held to discuss the delivery of CIP targets for 20/21 and work in this area would continue.

19.6 The Board **noted** the finance position for the period ending 31st December.

20.0 TERMS OF REFERENCE: APPOINTMENTS AND TERMS OF SERVICE COMMITTEE

20.1 The Board received and **approved** the terms of reference for the Appointments and Terms of Service Committee.

21.0 RESOURCES COMMITTEE SUMMARY – 19 DECEMBER 2019

21.1 The summary report was received by the Board. The Committee Chair, Graham Russell, reported that the budget setting process had been a key issue under consideration. In relation to the finance report for month 8, it was noted that the forecast outturn for the Trust was in line with the control total. Maria Bond queried why it was not expected that the Trust would receive a bonus for achieving the control total this year. It was confirmed that this was the feedback received from NHSI on the operation of the system.

21.2 The Board **noted** the summary.

22.0 QUALITY COMMITTEE SUMMARY – 5 DECEMBER 2019 AND 9 JANUARY 2020

22.1 The Board received the summary report from the meetings of the Quality Committee held on 5 December 2019 and 9 January 2020. The Committee Chair, Maria Bond, reported that the Committee had recently reviewed its work-plan and would be moving to bi-monthly meetings from April 2020. Deep-dives on particular aspects of the service had been scheduled for each meeting.

22.2 The Board **noted** the summary.

23.0 NOMINATION AND REMUNERATION COMMITTEE SUMMARY – 9 JANUARY 2020

23.1 The Board **noted** the summary of the Nomination and Remuneration Committee held on 9 November 2019.

24.0 MINUTES OF COUNCIL OF GOVERNORS MEETING HELD ON 14 NOVEMBER 2019

24.1 The Board **noted** the minutes of the Council of Governors meeting held on 14 November 2019.

25.0 USE OF TRUST SEAL

25.1 The Board **noted** the use of the Trust Seal during the period 1 October 2019 to 31 December 2019.

26.0 ANY OTHER BUSINESS

26.1 There was no other business raised.

27.0 QUESTIONS FROM THE PUBLIC

27.1 No questions from the public were received.

28.0 DATE OF NEXT MEETING

28.1 Wednesday 25th March 2020, at The Anglo Asian Centre, GL1 4HR.

Signed: …….. **Dated: ……**

Ingrid Barker (Chair)
Gloucestershire Health and Care NHS Foundation Trust

with you, for you

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NHS Foundation Trust

AGENDA ITEM: 04/0320

PUBLIC SESSION TRUST BOARD: Matters Arising Action Log – 25 March 2020

Key to RAG rating:

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

Minute reference (Item No. & Date)	Item	Action Description	Assigned to	Target Completion Date	Progress Update	Status
28 Nov 2019	12.9	Further details to be provided in the timescale for the Children's Services Strategy.	Chief Operating Officer	25 March 2020	Update to be provided at meeting	
25 Jan 2020	3.6	Compassionate Stroud presentation to be shared with the Board	Secretary	31 Jan 2020	Completed. Graham Russell to join core group	
25 Jan 2020	11.2	Discussion with staff observer on retention and development of the talent pipeline	DoHROD	25 March 2020	Meeting diarised	
25 Jan 2020	13	Benefits realisation and capacity for transition to be addressed in strategic framework and PME close down considerations	CEO/DoF	25 March 2020	On agenda	
25 Jan 2020	14.4	Quality report: further information of cohort for flu vaccinations to be provided.	DoNTQ	25 March 2020	Completed. Info provided to Maria Bond and Quality Committee	

with you, for you

Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 05/0320

Questions from the Public

Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 06/0320

REPORT TO: Trust Board – 25 March 2020

PRESENTED BY: Ingrid Barker, Chair

AUTHOR: Ingrid Barker Chair

SUBJECT: **REPORT FROM THE CHAIR**

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

The purpose of this report is to
To update the Board and members of the public on my activities and those of the Non-Executive Directors to demonstrate the processes we have in place to inform our scrutiny and challenge of the Executive and support effective Board working.

Recommendations and decisions required

The Board is asked to:

- **Note** the report and the assurance provided.

Corporate considerations

EXECUTIVE SUMMARY

This continues to be a time of significant activity for everyone within the Trust at all levels, particularly now that the impact of Covid19 is being clearly felt. I would like to pay tribute to all our colleagues, including executive directors, who are working exceptionally hard to create and deliver on plans to manage this major national incident. Whether the team undertaking the swab testing, the Coronavirus Incident Response Team, front line clinicians, managers, corporate services, cleaners or porters, everyone is pulling together and as a Board we have reason to be proud of them all.

Due to the Coronavirus outbreak, steps have been taken to minimise transmission risk and reduce pressure on colleagues during this period. The revised arrangements for Board, Committees, Council of Governors will be considered separately on the agenda.

Today's meeting is the final Board meeting for Colin Merker, Deputy Chief Executive and Managing Director for Herefordshire. Colin has made an enormous contribution to our Trust, to our predecessor Trust, 2gether, and to the NHS over more than 30 years. Colin will be retiring at the end of the month having successfully secured the smooth transfer of our Herefordshire services to our sister Trust in Worcestershire. I know the Board will join me in offering Colin our deep gratitude for what has been a very significant contribution.

Quality Implications	None identified
Resource Implications	None identified
Equality Implications	None identified

Report authorised by: Ingrid Barker	**Title:** Chair

CHAIR'S REPORT

1.0 Introduction and Purpose

This report seeks to provide an update to the Board on the Chair and Non-Executive Directors activities in the following areas:

- Board developments
- Working with our system partners
- Working with our colleagues
- National and regional meetings attended and any significant issues highlighted

2.0 Board

2.1 Non-Executive Director Update

We are currently seeking to appoint a 7th Non-Executive Director with a business or commercial background. The role has been advertised and recruitment agency Gatenby Sanderson is currently conducting the search. Interviews are scheduled for 30th April 2020.

In this report I would just like to recognise the time and energy Duncan Sutherland has committed over the last year to supporting the transition work within Herefordshire to take forward the plans which will enable the greater joining up of physical and mental health as we are taking forward in Gloucestershire. Duncan's position as the Herefordshire locality Non-Executive Director has provided a helpful Non-Executive point of contact for Herefordshire service users, staff, commissioners and our partner NHS Trusts. Duncan's willingness to support this broad level of engagement has ensured we could give this work the focus and concentration it needed at the same time as we were progressing the merger. I am very grateful for his support.

Associate Non-Executive Director, Sue Mead, has now stood aside from the role, having offered important expertise and continuity during the first months of the merger. I would like to thank her for her contribution.

On 4th February, the Non-Executive Directors and I undertook a team development day facilitated by the Kings Fund. We will build on this through our bi-monthly NED meetings which are scheduled for the remainder of the year.

2.2 Board Development

We continue to devote significant time to considering our Board ways of working, and considering how we ensure that transformation remains central to how we work, whilst the necessary focus is maintained on ensuring clinical safety and staff wellbeing.

The Board is committed to engaging in the Reciprocal Mentoring scheme in which we are being supported by the Leadership Academy as the 'trailblazer'. This is an

important way of mutually learning with colleagues from different backgrounds and experiences from across the Trust. I and others on the Board have now started to meet with our 'mentor buddies' and we look forward to enriching our awareness and understanding.

A Board Development Seminar was held on 26th February where we considered public value and value-based approaches which provided an opportunity to discuss value and value-based approaches. I was heartened by the opportunity this session gave to enable us to consider how we can support our community with a whole range of partners to improve outcomes and lives!

3.0 National and Regional Meetings

I attended the NHS Providers Board on 4th March. We discussed a number of important policy and national operational issues, including the likely legislative programme relating to the NHS, implementation of the Long Term Plan, Coronavirus response and the forthcoming People Plan.

The national NHS Providers Chair/ Chief Executive network scheduled for 17th March was cancelled in view of Coronavirus issues.

4.0 Working with our Partners

I have continued my regular meetings with key stakeholders and partners. Highlights are as follows:

I was represented by Vice-Chair, Graham Russell, at the Gloucestershire Integrated Care System (ICS) Board on 20th February. Matters discussed included current challenges in the health sector and future planning.

Due to the Coronavirus situation, Gloucestershire Health Overview and Scrutiny Committee (HOSC) scheduled for 17th March 2020 was postponed.

Following a competitive interview process, I have been appointed as a Governor for the University of Gloucestershire with effect from 1st March. I am delighted to have this opportunity to further strengthen our links with an important partner, particularly as together we seek to address our workforce challenges.

I continue to hold informal one to one meetings with colleague Chairs, most recently with Peter Lachecki from GHT and Chris Burdon from Worcestershire. I have also met with Bob Lloyd Smith as he leaves his role as the Chair of Healthwatch in Gloucestershire. I would like to record my thanks to him for his contribution.

Following the very sad passing of our County Council Cabinet colleague, Cllr Roger Wilson, I represented the Trust at a moving thanksgiving service in Winchcombe church. Cllr Carole Allaway Martin has taken up Roger's portfolio and Cllr Brian Robinson has taken up what were Carole's responsibilities. These include being Chair of HOSC and sitting on our own Council of Governors as the County Council nominee. I met individually with Brian to discuss how we can best work together.

4.1 Working with the Communities and People We Serve

At our 6th Better Care Together event on 19th February I was represented by Vice-Chair, Graham Russell, who feedback positively on the quality of external speakers who further encouraged us to think differently about what we do to meet the needs of our community.

On 10th March we had a helpful meeting with the Leagues of Friends where we were able to update them on the ongoing work within the hospitals and they were able to provide informed comment from service users. We are fortunate to have such a committed group of volunteers supporting our work, and I am pleased at the higher profile now provided to them on our website.

I visited Inclusion Gloucestershire on 5th February. It's CEO, Vinci Livingstone Thompson gave me a helpful update on developments on the organisation and we are thankful to her for the support she is giving the Trust, especially through our Better Care Together events.

The CEO of Gloucestershire LEP (David Owen) met with myself and our CEO on 27th February to discuss how we might better work together on economic development matters in the County. It was a helpful meeting which has opened some new possibilities for future joint working. I was also able to accompany David on a visit to Wotton Lawn and the allotment project to seek advice on future funding possibilities.

Dame Janet Trotter is leading an important piece of work commissioned by the Police and Crime Commissioner called 'Child Friendly Gloucestershire'. I met with Janet on 27th February along with Eddie O'Neil (Deputy Director of Strategy & Partnerships) to discuss how our Trust might be able to contribute to this.

4.2 Engaging with our Trust Colleagues

As a result of recent elections we have some new staff governors. They are Sarah Nicholson and Katherine Stratton. The Head of Corporate Governance and I provided an induction session for three new governors on 12th March. This is new approach to reflect the merged organisation.

The Council of Governors met on 19th March with Vice-Chair Graham Russell kindly taking the chair in my absence. There was an update from the Trust CEO and next steps in the Review and Refresh of Governors were agreed. This was the last meeting for a number of Governors and we thanked them for their contribution, particularly those from Herefordshire who had a key role as those services have transitioned to the Worcestershire Trust.

I continue to have a range of 1:1 sessions with Executive and Non-Executive colleagues as part of my regular activities and have also met with a number of colleagues during visits to sites.

5.0 NED activity

5.1 Activities undertaken by the Trust's Non-Executive Directors are detailed below:

Graham Russell

- NEDs meeting
- NEDs development session with King's Fund
- Visit with Governors to Health Visitor Team, Quedgeley
- Audit and Assurance Committee
- ICS Board
- Board Seminar (x2)
- Resources Committee
- Charitable Funds Committee
- Meeting with Head of Corporate Governance
- Better Care Together – Development Trust Priorities
- Visit to Criminal Justice Team
- Meeting with Trust Chair
- Council of Governors meeting

Jan Marriott

- Quality Committee (x 2)
- Audit & Assurance Committee
- Board Seminar
- Resources Committee
- Gloucestershire Nursing and Midwifery Professional Council Planning Meeting
- Better Care Together – Developing Trust Priorities
- Meeting with CCG lead for Cheltenham
- Quarterly Audit of Complaints meeting
- Mental Health Legislation Committee
- Meeting with Cllr Said Hansdot
- Visit to Friendship Café, City Farm and GARAS
- Mental Health Act Managers Forum
- Council of Governors meeting

Maria Bond

- NEDs meeting
- NEDs Development Session with King's Fund
- Quality Committee (x 2)
- Audit and Assurance Committee
- Better Care Together – Developing Trust Priorities
- Board Seminar (x 2)
- Senior Leadership Network meeting
- NHS Providers Effective Chairing of Meetings, Birmingham
- Mental Health Act Managers Forum
- Telephone meetings with Director of Nursing

- Council of Governors meeting

Marcia Gallagher

- NEDs meeting
- NED development session with King's Fund
- Visit to Cheltenham Crisis Team, Lexham Lodge, Cheltenham
- Audit and Assurance Committee
- Meeting with Head of Corporate Governance
- Meeting with Head of Counterfraud
- Meeting with CEO/Medical Director and Director of Nursing
- Board Seminar (x 2)
- Charitable Funds Committee
- MHA Hearing
- Telephone call with Elizabeth O'Mahony
- Council of Governors meeting

Sumita Hutchison

- NEDs meeting
- NEDs development session with King's Fund
- BAME Engagement event
- Board Seminar
- Resources Committee
- Bishop of Gloucester Brunch
- Quality Committee
- Charitable Funds Committee
- Meeting with Cllr Said Hansdot
- Visit to Friendship Café, City Farm and GARAS
- Meeting with Director of HR
- Visit to Southgate Moorings Dental Clinic
- Council of Governors meeting

Duncan Sutherland

- Board Meeting
- Internal Audit review calls
- Hereford Health and Wellbeing Board
- Herefordshire ICAB
- Meeting re property strategy
- Site visits to Gloucester properties
- Council of Governors meeting

Steve Alvis

- Meeting with Trust Chair
- NEDs meeting
- NEDs Development session with King's Fund
- Council of Governors meeting

6.0 Conclusion and Recommendations

The Board is asked to **NOTE** the report and the assurance.

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 07/0320

REPORT TO: Trust Board – 25 March 2020

AUTHOR: Chief Executive Officer and Executive Team

PRESENTED BY: Paul Roberts, Chief Executive Officer

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

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

The purpose of this report is to:

To update the Board and members of the public on my activities and those of the Executive Team.

Recommendations and decisions required

The Board is asked to **note** the report.

EXECUTIVE SUMMARY

Every year the NHS continues to demonstrate the key elements that drew me to the NHS as a career – making a real difference to the lives of individuals, regular new challenges, a stimulating and regularly changing environment and the opportunity to work with skilled, professional and dedicated staff who are committed to supporting our community. Responding to the challenge of Covid-19 has again demonstrated this clearly – I have seen the adaptability and responsiveness to a quickly changing environment and a willingness to put the needs of our community at the heart of this work. I update on this, and the more routine, but also important, work that continues:

- CEO Engagement
- Partnership Activities
- National and Regional meetings attended
- Herefordshire Update
- Executive Update
- Operational Update

Risks associated with meeting the Trust's values
As identified in the report.

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

Where has this issue been discussed before?
Meetings of the Executive.

Appendices:	Report attached.

Report authorised by:	**Title:**
Paul Roberts	Chief Executive Officer and Executive Team

CHIEF EXECUTIVE OFFICER AND EXECUTIVE TEAM REPORT

1.0 CHIEF EXECUTIVE ENGAGEMENT

I remain committed to spending a significant proportion of my time vising front-line services and meeting frontline colleagues in a variety of settings and continue to be impressed and heartened by the professionalism and commitment of colleagues across the organisations and in the pride that they take in the delivery of, in many cases, outstanding services. You will have seen from headlines in the papers the ongoing pressures which the NHS is responding to, notably Covid-19. Our Trust continues to play an important role in the Gloucestershire system with colleagues working committedly to meet the needs of our community.

I have continued to attend a range of meetings including:

1.1 **Council of Governors meetings -** these are reported on in the Chair's report and elsewhere in this agenda.

1.2 **Corporate Induction** – I have welcomed new colleagues at three sessions on 3rd February, 17th February and 3rd March, where I gave the Executive overview. I plan to attend, representing the Board, as many of these sessions as possible in the future as I am keen to demonstrate from day one that as an Executive team we are approachable and open to ideas. New starters have fed back positively on this approach.

1.3 A **Board Development Seminar** was held on 26th February which provided an opportunity to discuss value and value based approaches. These sessions continue to be really helpful in developing Trust leadership and achieving our core value of always improving. The session helped us look further at working in partnership across the range of services that support a community; health, social care, education, housing etc., recognising the part that each play.

We also had a follow up Board Seminar regarding the Trust's Strategy on 3rd March.

1.4 **Senior Leadership Network –** two meetings have been held on 30th January and 25th February. These sessions continue to be really helpful opportunities to discuss Trust and county wide issues across the wider Trust leadership. The session on 25th February provided an update to the Senior Leadership on the important issues of flooding and Coronavirus currently facing the community and also more workforce focused updates, including the Staff Survey results, launch of the 'Your Voice' survey and Staff Awards.

1.5 **The Leagues of Friends Chair's meeting** was held on the 10th March. These meeting are reported on in the Chair's report.

1.6 The Trust's excellent series of **Better Care Together** events has continued, with our sixth event held on 19th February 2020, focused on "Developing Our Trust Priorities". These events are a core part of our commitment to co-production and

provide a forum for service users, Trust employees', Partners' and Stakeholders' to all share their experiences and expertise with a wider audience.

1.7 I attended the **JNCF** meeting held on 11th March. As usual this was an effective meeting with attendees prepared to raise concerns and issues – again a demonstration of the open organisation we are determined to foster.

1.8 I attended a regular meeting of the **Medical Staffing Committee** on 7th February 2020.

1.9 I hosted **Team Talk** sessions at Edward Jenner Court on 10th February and at Charlton Lane Hospital on 9th March, which are open for all Trust employees to attend. Other members of the Executive Team covered additional dates and venues across the county, at which the Executive team provided Trust updates and invited discussions on any topics the different teams wished to share. The Team Talks programme helps to ensure effective communication across the Trust and provides an opportunity to recognise the hard work and commitment of colleagues.

I have also had several follow up one to one meetings with staff members who have attended Team Talks to further specific discussions.

1.10 I have had a **number of meetings with clinical colleagues** in preparation for attending interviews to progress their careers to more senior roles in the Trust. We always look to develop and invest in our staff as it is key to employee satisfaction, engagement and retaining talent within the organisation.

1.11 I am involved in the **Reciprocal Mentoring Scheme** and in February was paired with a reciprocal mentoring 'buddy'. The scheme is based on the concept of reverse mentoring, with the addition of the relationship between the mentor and mentee being reciprocal in nature, enabling allies and equal partnerships designed to create systemic transformational change.

1.12 On 6th February, Bren McInerney invited me to attend a session during the **BME and local NHS event.** It was a great opportunity to discuss engagement and connectivity with the BME communities. We hope there will be filming opportunities to recognise this work, subject to other pressures.

2.0 PARTNERSHIP WORKING

I continue to have regular meetings with the CEO of Gloucestershire Hospitals NHS Foundation Trust (GHFT) and the Accountable Officer for Gloucestershire Clinical Commissioning Group (GCCG). I also continue to attend regular meetings of the ICS Board and ICS Executive which are focused on taking forward our joint One Gloucestershire ambitions. On 25th February we had a Joint Executive Meeting attended by the Executive teams from Gloucestershire Health and Care and Gloucestershire Hospital Trusts, to strengthen our close working relationships and collaboration. Resilience during this period of particular pressures on the NHS has been an issue of continuing focus, with regular

meetings with senior colleagues across the health system to ensure joined up working.

A number of our team had a meeting with Ron Shields on 24th February to discuss the strategic focus on Mental Health in the South West.

2.1 Fit for the future

I attended the Fit for the Future Solutions Appraisal Workshop as an observer on 5th February. The pre-consultation business case is progressing as per the previously agreed timeline.

2.2 ICS

As part of my work with the Gloucestershire ICS, I continue to lead on three major strategic works streams including chairing meetings of the Diagnostics Programme Board and the Community Based Urgent Care Programme Board (part of the Fit for the Future programme). I attended a meeting on 21st February, with a further one scheduled for 20th March. These meetings are a useful opportunity to discuss progress, joint working and avoid silo thinking.

3.0 HEREFORDSHIRE INTEGRATED WORKING DEVELOPMENTS

This month sees the conclusion of the ongoing work to support the greater integration of mental and physical health work in Herefordshire as Gloucestershire Health and Care NHS Foundation Trust steps back from provision of mental health services within Herefordshire. As previous reports have made clear this has been the culmination of detailed consideration, planning and discussion with interested parties, including staff and service users and there is a detailed paper elsewhere within the agenda which sets out the formal processes to ensure this revised pathway.

Within this report I want to pay tribute to the leadership which has enabled this transition to be so smoothly put in place. From Gloucestershire Health and Care this is particularly Colin Merker, Managing Director Herefordshire, and Duncan Sutherland, Non-Executive Director, who have worked tirelessly with their opposite numbers within Worcestershire Health and Care NHS Trust and the related Clinical Commissioning Groups. I would also like to thank the staff who will be transitioning to Worcestershire Health and Care NHS Trust for their ongoing commitment to meeting the needs of the Herefordshire Community, which has been at the heart of this work. I attended the Hereford Senior Leadership Network on 10th February to ensure that staff had the opportunity to be briefed directly and raise any concerns.

4.0 NATIONAL AND REGIONAL MEETINGS ATTENDED

I attended the West of England Academic Health Science Network (AHSN) Board meeting on 6th March which provided helpful information on the opportunities and ways we could do things differently.

This was followed by the CRN West of England Partnership Group meeting in the afternoon.

I had a meeting with Kay Haughton from AHSN to discuss current issues.

I attended the CEO Development Network Event, hosted by the NHS Leadership Academy, in Leeds on 11th and 12th February. During these sessions we explored ways of thinking differently, in particular during periods of heightened complexity, change and uncertainty, and collaborative working, looking at NHS leadership from the perspective of other services.

5.0 EU EXIT

The Trust continues to follow national guidance on this issue and respond to guidance from the Department of Health and Social Care/ NHS England/Improvement and other government departments as the changes are taken forward.

6.0 EXECUTIVE UPDATE

At the moment and until the end of March 2020, Colin Merker and Sandra Betney remain as my two deputies as they have been since I started in 2018, running the two previous Trusts. In April, Sandra will continue as the single Deputy Chief Executive following on from Colin's second attempt to retire!

I would like to formally put on record my thanks to Colin Merker, Managing Director Herefordshire, who is stepping down from his role with the Board on 31st March and wish him a healthy and happy retirement. Colin played a pivotal role at 2gether NHS Trust for eleven years and the NHS as a whole for over forty years and has continued to play a key role in the merged Trust with the coming together of Gloucestershire Care Services NHS Trust and 2gether NHS Foundation Trust.

Colin is an engineer by background and has applied this discipline to the NHS from the perspective of "How does it work? How could it best work?" – for services users? for staff? for the Trust? for the wider healthcare system. This ability to review the way we work through multiple lenses is at the heart of what makes Colin, and what makes him such an effective leader and director. He has made a tremendous contribution to the Gloucestershire and Herefordshire healthcare systems, and the care of individuals. I, and his fellow Executives, will miss his informed and strategically focused challenge and his supportive and compassionate consideration of issues.

I would also like to record my personal thanks for his welcome to me when I took on my role at 2gether NHS Foundation Trust. Having him at my side, and at my ear, proved invaluable as I built up my knowledge of the Trust and its services – information which Colin had at his fingertips and was happy to share. He has been an invaluable colleague and friend.

7.0 OPERATIONAL UPDATE

7.1 Covid-19 Virus Update

As Board members are aware, the NHS as a whole has in place comprehensive Emergency Preparedness Preparation and Resilience processes which are

refreshed, as a minimum on an annual basis. These plans are in place across the country, and Gloucestershire is part of this process with Gloucestershire Health and Care NHS Foundation Trust an element within the Gloucestershire Plan. This plan is reviewed by the Board's Quality Committee with sign off by the Board.

These processes are used on an ongoing basis through the year, for example to ensure preparedness and joint working across Gloucestershire for winter planning. These processes underlie the arrangements which are being used to respond to the Covid-19 virus.

Gloucestershire Health and Care NHS Foundation Trust is working closely with health and social care colleagues in the county to respond to the national guidance from NHS England and Public Health England and ensure the necessary support is in place for our community, including our staff.

Sian Thomas, Deputy Chief Operating Officer is the Accountable Emergency Officer for Covid-19 for the Trust with Michael Richardson**, Deputy Director of Nursing and Director Infection Prevention and Control** (DIPC) the Deputy Senior Accountable Officer and clinical lead in this area. There is a direct line of communication through to the Executive and the Board.

We have put in place an oversight group which is charged with responding to national requests for information and guidance, regular communications to staff – both to meet their own needs but also to enable them to engage most effectively in communication with service users and their families and carers and ensuring required supplies are held. We have also reviewed our business continuity arrangements to ensure they are up to date and fit for the current circumstances.

As further actions are identified as required the Trust is ready to respond with timeliness and is continuing to review its plans and approaches to best meet the needs of the community in these changing circumstances. To date this has included provision of drive in facilities at Edward Jenner Court for testing, as well as provision of testing processes to individuals through our community staff.

As always I have been impressed by the professionalism and dedication of our staff, both clinical and support, as they work flexibly to respond to these concerns, and support our preparations.

7.2 NHS Staff Survey

The NHS staff survey results have been recently published and are covered in a separate paper.

8.0 Conclusion and Recommendations

The Board is asked to **NOTE** the report and the assurance provided.

with you, for you

Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 08/0320

REPORT TO: Trust Board – 25 March 2020

PRESENTED BY: Angela Potter, Director of Strategy & Partnerships

AUTHOR: Angela Potter, Director of Strategy & Partnerships
Emily Beardshall – Deputy ICS Programme Director

SUBJECT: **INTEGRATED CARE SYSTEM UPDATE**

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

The purpose of this report is to
This paper provides an update on the activities that are taking place across the Gloucestershire Integrated Care System (ICS).

Recommendations and decisions required

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

Executive Summary

One Gloucestershire Integrated Care System (ICS) Lead Report
The attached report provides an update to Board members on the progress to date of key programmes and projects across Gloucestershire's ICS. The report is written from a system perspective, reflecting the integrated approach of the "One Gloucestershire" partnership.

Board Members will, in particular, note the significant contributions that Gloucestershire Health and Care NHS Foundation Trust is making in delivering key elements of the plan, including:

- Clinical involvement in all four of the Clinical Programme Approach focus areas: Respiratory, Diabetes, Circulatory and Frailty & Dementia
- Active role in the development and implementation of the Place Based model, including ensuring that our integrated services are configured to support the development of the Primary Care Networks and providing senior leadership in the Integrated Locality Partnerships across the county
- Director and other senior expert involvement in all of the enabling strategies

Board Members will note the link to the "Bitesize" summaries, which give a very brief summary of key services that have been developed by the "One Gloucestershire"

partners, many of which will be familiar as areas of delivery by the Trust.

Risks associated with meeting the Trust's values
None identified

Corporate considerations	
Quality Implications	The integrated care system change programmes has impact to all key stakeholders across the Gloucestershire Health and Care system.
Resource Implications	
Equality Implications	

Where has this issue been discussed before?
The Board has received the monthly system update at previous meetings.

Appendices:	One Gloucestershire Integrated Care System (ICS) Lead Report

Report authorised by: Angela Potter	**Title:** Director of Strategy & Partnerships

One Gloucestershire Partner Boards

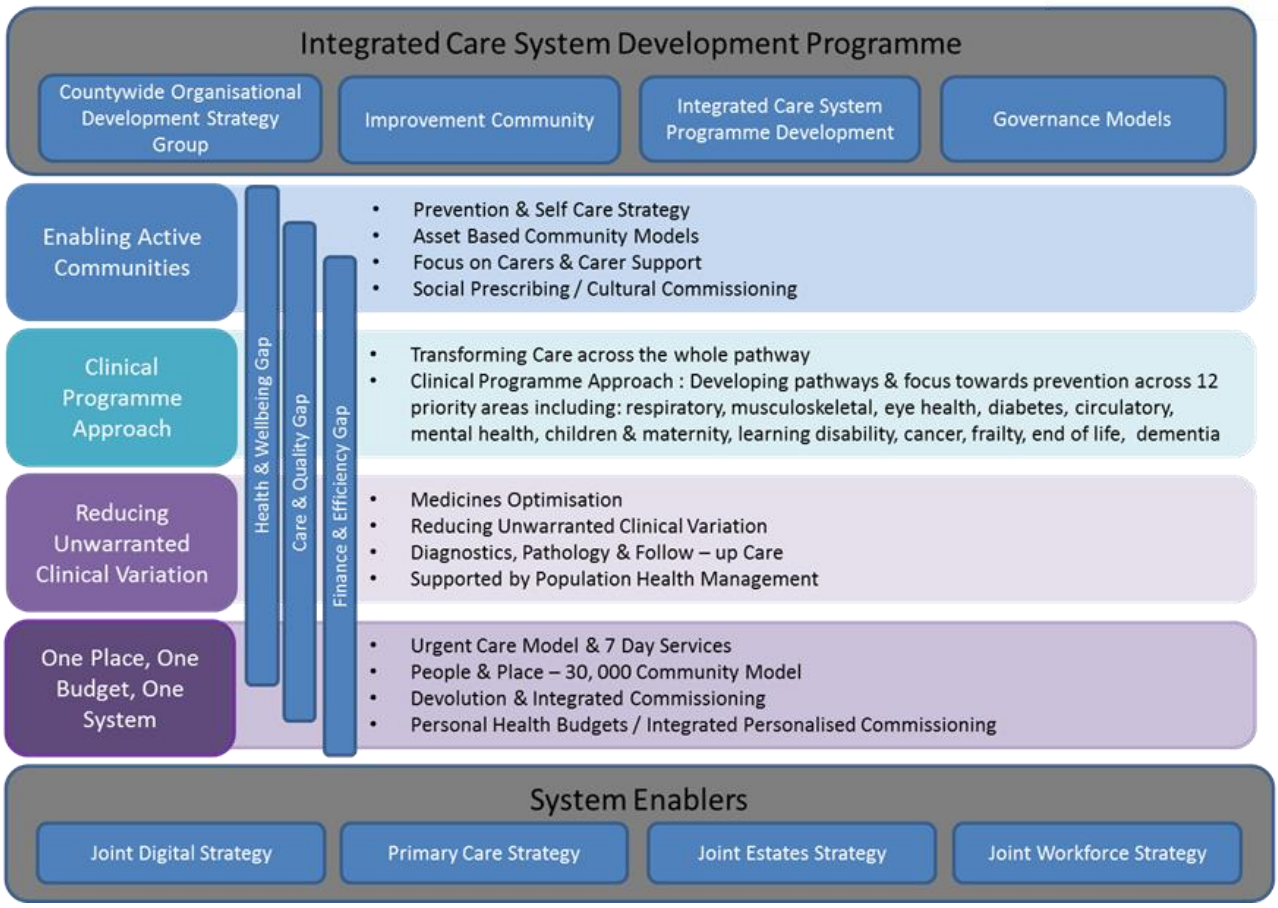
March 2020

One Gloucestershire ICS Lead Report

1. Introduction

The following report provides an update to Board of One Gloucestershire partners on the progress of key programme and projects across Gloucestershire's Integrated Care System (ICS) to date.

Gloucestershire's Sustainability & Transformation Plan commenced year three of four in April 2019. Priorities continue to be delivered across the main transformation programmes and we have reviewed the plans as part of our ongoing work on the One Gloucestershire Long Term Plan. In this report we provide an update on 2019/20 plans and the progress made against the priority delivery programmes and supporting enabling programmes included within the ICS. One of the roles of the ICS is to improve the quality of Health and Care by working in a more joined up way as a system.



Gloucestershire's ICS Plan on a page

2. Enabling Active Communities

The Enabling Active Communities programme looks to build a new sense of personal responsibility and improved independence for health, supporting community capacity and working with the voluntary and community sector.

The development of the Gloucestershire Prevention and Shared Care Plan, led by Public Health England, aims to improve health and wellbeing. It recognises that a more efficient approach to preventing ill health is very important. This will improve the health of the population and make an important contribution to the maintenance of sustainability in our ICS.

Key priorities for 2019/20 are aligned to the refreshed Health & Wellbeing Strategy and are split across the 4 main work streams: **supporting pathways, supporting people, supporting places and communities** and **supporting our workforce**. The sections below give an update on our progress and achievements within each work stream.

Supporting Pathways

- A total of 18 families are being supported through the Matson cohort of the **Tier 2 Child Weight Management Service**. There are a further 14 families being supported through the Cinderford cohort. **Tier 3 (specialist) Child Weight Management-** it is expected in the first instance that clinics will be set up to run from Bristol, with a view to exploring outreach clinics in Gloucester once the service is better established.
- The Gloucester cohort of the **Blue Light Change Resistant project** currently has 10 people on the programme. One client has been removed from the cohort as she has been able to be discharged successfully.

Supporting People

- The **Self-Management – Live Better, Feel Better** have trialed a new model of delivery using the Hadwen/Kingsway Primary Care Network (PCN). This has proven to work well. Connections have been made with all PCN link workers to spread this method of delivery further.
- Integrated community teams continue to receive **Patient Activation Measures (PAM)** training to enable the successful implementation of PAM into day-to-day practice.

Supporting Places & Communities

We Can Move Programme:

- By the end of January 1,362 people had received falls materials.
- Social movement – The new **We Can Move** website has been launched, it can be viewed here – www.wecanmove.net
- There are a total of 164 schools currently undertaking the **Daily Mile**.

- **Beat the Street** (BTS) – The 6 month follow up survey from the summer 2019 BTS has been completed. A total of 265 people provided feedback. 88% of sustain survey respondents felt they had continued the changes they had made during taking part in BTS.

Strengthening Local Communities

The **Strengthening Local Communities** film has been completed. The film highlights the work that has been going on in each of the districts and the impacts the projects have been creating. The film will soon be made publically available.

Supporting Workforce

The Gloucestershire Workplace Wellbeing Accreditation is now fully in delivery with a total of 21 businesses across Gloucestershire signed up. These are a mixture of previous Workplace Charter clients and new businesses that have come on board through the engagement work undertaken while the accreditation was being developed.

Focus on Homeshare Gloucestershire

Gloucestershire ageUK

homeshare Gloucestershire

Housemates Re-invented

Bringing together older people who have spare rooms, with people who need affordable accommodation and who are happy to chat and lend a hand

The Householder benefits from some low-level support and company at home

The Sharer is offered not just a place to live, but a real home

Together Householders and Sharers share home life, time, skills and experience


Matching Process
Age UK Gloucestershire's Homeshare Project carefully matches people, oversees the arrangements and provides professional ongoing support.
Application/ Referral
Interview
Home visit & Inspection
Agreement
Introductions
Profiles
References & DBS
Trial Period
Contact Schedule
Move in date!
For more information contact
Age UK Gloucestershire
01452 422660
07760 419260
homeshare@ageukgloucestershire.org.uk
homeshare
Gloucestershire

3. Clinical Programme Approach

The Clinical Programme Approach has been adopted across our local health care system to make sure services work together to redesign the way care is delivered in Gloucestershire. By reorganising the way care is delivered and services that deliver this care we can make sure that people get the right care, in the right place, at the right time. During 2019/20 we have identified 4 clinical programmes which will be moved forward more quickly. These are **Respiratory, Diabetes, Circulatory and Frailty & Dementia**.

Achievements and Progress

Respiratory

- Funding has been approved to support the education and training approach across primary care, community and hospital care.
- There has been a positive shift in integrated working enabled by a computer system called **Systemone**.
- There was an agreement to change the process for the **Home Oxygen Assessment Service** to enable an integrated approach to supported discharge to be embedded across the respiratory specialist team
- Respiratory pathway work has expanded from COPD and now currently includes Breathless, Bronchiectasis, Tuberculosis, Sleep Apnoea and Asthma.

Diabetes

The National Diabetes Prevention Programme (NDPP) provider ICS Health and Wellbeing is working well with approximately 1250 referrals. The CCG is working closely with Primary Care Networks to increase referrals onto NDPP and share good practice examples. The CCG is close to meeting its increased referral target set by NHS England.

- The CCG is an early implementer site for the Healthy Living for People with **Type 2 Diabetes.**
- The date for the CCG to take part as one of the national pilot sites for Low Calorie Diet and remission of **Type 2 diabetes** has been put back to June 2020.

The CCG was successful in being awarded **£40,500** for using volunteering approaches to appoint somebody with a lived experience of diabetes to interact with others within a community setting to improve health & wellbeing outcomes. There is an initial focus on Gloucester City and

Cinderford areas in collaboration with the City and District Councils respectively.

Circulatory

Final cohorts for **Nature on Prescription** programme for people who have had a cardiac event commenced at the end January 2020. A new leaflet was designed and circulated to further promote the programme along with a short video.

The Hypertension Pathway has been updated with the latest **National Institute for Health and Care Excellence** (NICE) guidance. A study day for Practice Nurses and Pharmacists was held during February with further education being designed.

- Four cohorts have completed the **Reach HF programme** and three cohorts are currently underway. 51 participants have been enrolled, which is in line with the requirements of the pilot.
- A project team has been established for **Reducing CVD Risk** with the intention to develop a communications plan for healthcare professionals and patients.
- Arrhythmia has demonstrated a significant improvement in **Quality and Outcome Framework** (QOF) indicators, which are now exceeding the national targets.

Frailty & Dementia

- Stroud and Berkeley Vale ILP have chosen to work on **'recognising the deteriorating patient living with frailty**' and **'carers'** as their areas of work, and support will be given to scope those two areas and plan for development.
- **Dementia Diagnosis Rate** (DDR) at 68% remains above NHSE target. The 6 month Stroud & Berkeley ILP Vale Integrated Dementia project evaluation suggests positive experiences by patients and staff.
- **People living with severe frailty** and **Identifying & prioritising the deteriorating patient living with frailty** now have a workstream co-ordinator identified. A review of the projects within these workstreams is being undertaken.

Focus on Pulmonary Rehabilitation

Pulmonary Rehabilitation is a course that offers respiratory patients group sessions that include activity and education about their respiratory disease and improves the patient's confidence and ability to self-manage. Pulmonary Rehabilitation (PR) is delivered in sites throughout the county by physiotherapists, occupational therapists and nurses. It is highly recommended after hospital discharge and has overwhelming evidence that it has positive impacts for patients and the health community.

tThe Service Improvement Team has been working with the PR team and relevant stakeholders

and has gathered patient feedback to improve the access and uptake of the service. The PR service has therefore undergone some positive changes and is now pleased to be able to offer a suite of PR programmes to patients including;

- **Group Exercise and Education** rolling programme sessions are to be extended so that they are ran across the county - additional groups have already started in Cheltenham and Stroud (Hospital) . Booked for Forest (Belle Vue Centre, Cinderford) – starting May 2020, North Cotswold's starting April and August, South Cotswold's starting June and October.
- A 3 month trial is underway to offer additional IT support to a current **on-line tool** (myCOPD)

Also due to start by May 2020 are the following additional offers;

- A one year pilot to offer a '**Home Exercise and Education offer'** via a Manual with clinician assessment and follow up telephone support (learning from this will inform future commissioning) - staff have been trained and patients are currently being assessed for eligibility.
- An '**Education only'** group session called **PREPARE** which consists of 2 hour sessions running for 3 weeks during evenings.

4. Reducing Clinical Variation

The Reducing Clinical Variation programme looks to elevate key issues of clinical variation to ICS level. This will include having conversations with the public around some of the harder priority decisions we will need to make. This includes building on a different approach with primary care, promoting 'Choosing Wisely', thinking about how medicines can be used in a better way to reduce cost and waste, undertaking a review of diagnostic services and working to improve Outpatient services.

Key priorities for 2019/20 are

- We will continue to use the successful **Prescribing Improvement Plan** (PIP) to ensure that we carry on saving money and improve benefits for as much of the year as possible. Actions include working with GP practices via the prescribing support team to identify and record beneficial changes to prescribing activity.
- Continue to work with Hospital colleagues to consider areas including medication choice and how medicines are supplied so that benefits are shared across the ICS.

- Continue to include **Medicines Optimisation** topics within the annual Primary Care offer to support primary care colleagues to maximise savings available from prescribing in a better way
- Continue the successful provision of the **Clinical Pharmacist Team** working within many GP practices by recruiting to fill current vacancies.
- Implement a two year programme **Medicines Optimisation in Care Homes Scheme**, specifically in residential homes.
- Develop & improve mechanisms to allow GPs to access specialist opinion/advice and guidance.
- Develop appropriate alternatives to Hospital outpatient services where there are opportunities to manage patients in a less specialist and lower cost setting.
- Support changes to how **Outpatient Care** in delivered across the ICS Improve how money is spent to commission services through changing and developing relevant policy.
- Referrals to Hospitals will be triaged and managed using improved procedures. A review of diagnostic services across the ICS will be undertaken to support programmes of change.

Achievements and Progress

- Uptake of **Cinapsis** for dermatology has been very positive with a total of 768 requests having been made to date. Dermatology Advice and Guidance continues to be available for GPs.
- The **referral assessment service** (RAS) for gastroenterology has avoided 15% of attendances in Outpatients by returning patients to their GP
- A **public and patient involvement strategy** has been devised for the Diagnostics Programme and will be trialled within plain film services. A questionnaire has been written in conjunction with engagement colleagues.
- **Prescribing Support work** within GP practices continues to promote and encourage the 2019-2020 Prescribing Improvement Plan and Primary Care Offer, which is focused on quality improvements and savings.
- **Clinical Pharmacists** are supporting practices with their clinical workload which helps to maximise the use of practice clinician time.
- There is ongoing communication with the public relating to medicines policies including the prescribing of over the counter medicines.

5a. One Place, One Budget, One System

New Models of Care & Place Based Model

The One Place, One Budget, One System programme takes a place based approach to resources and ensures we deliver best value. Our community care redesign will ensure responsive community based care is delivered through a transformative ICS approach to health and social care.

The intention is to enable people in Gloucestershire to;

- Be more self-supporting and less dependent on health and social care services,
- Live in healthy communities,
- Benefit from strong networks of community support
- Be able to access high quality care when needed.

New locality or Place led 'Models of Care' trials started in 2016/17. The trials were to 'test and learn' from this process including benefits, challenges and working across organisational boundaries. This led to the formation of 16 locality clusters/ PCNs across the county.

Key priorities for 2019/20 are

- Senior leaders from health and social care, locally elected government and non-professional representatives are working together to inform and support integration at Primary Care Network (PCN) level. This will help with unlocking issues and sharing responsibility for finding local solutions to deliver ICS priorities and tackling issues which arise for their population which can only be resolved by working together. .
- Clinically-led integration, involving staff and local people in decisions, to support more people in the community and out of hospital.
- **Integrated Locality Partnerships** (ILP) plan to deliver an approach which concentrates on their population which includes keeping people healthy (prevention) and public health. The agreed priorities will help to improve health and wellbeing for their population.
- Develop how teams made up of different health and social care staff will work together at a PCN level.

Achievements and Progress

- Plans have been progressing for an **Age Friendly Tetbury**.
- Forest of Dean District Council, primary care and the Department of Work and Pensions (DWP) are working collectively to support people with **long term conditions** back to work. This pilot commenced on 1st February
- There have been 165 referrals to the **Complex Care at Home Service** to date with a current case load of 76 patients with the majority of referrals from GPs. The **Frailty and Carers and Dementia pilot** have seen highly positive qualitative feedback to date across all partners involved in the pilot

South Cotswolds Frailty Service

- There were over 150 attendees at the **Paramedic/Out Of Hours** (OOH) Community Frailty Day
- There is improved working with **Cirencester Hospital** following delays due to ward closures.
- New process for identifying to GP's patients known to frailty service going is progressing well although not yet rolled out across the whole team.

5b. Fit For The Future

Fit For The Future

Our vision for Urgent Care will deliver the right care for patients, when they need it. In order to make this vision a reality and provide safe and sustainable services into the future, we need to consider how to make best use of our resources, facilities and beds in hospitals and in the community.

We want to improve arrangements for patients to access timely and senior clinical decision making about their treatment and ensure specialist support is accessed as soon as possible. We propose potentially changing the way some care and support is organised in Gloucestershire to meet changing demands, make best use of our staff, their skills and the money we have.

Regular updates on the Fit for the Future Programme have been shared with HOSC, describing how the programme aims to deliver an integrated urgent care system and hospital centres of excellence to ensure we realise the vision for urgent care.

Our key deliverables for 2019/20 include

- Continue to develop and refine the "Fit for the Future" strategy focussing upon development of same day urgent care services, Centres of Excellence and Integrated Urgent Care (Clinical Advice and Assessment Service).
- To further develop and deliver plans identified within the Emergency Department attendance (A&E) admission avoidance programme and length of stay management.
- To further develop and deliver plans which look at the journey patients take from the time they are admitted until discharge which will reduce bed occupancy of long stay patients by 25%:
- To further develop and deliver plans identified within the Community Admission Prevention programme.
- To further develop and deliver plans identified within the Find and Prevent programme.

Achievements and Progress

- Solutions Appraisal Workshop has taken place along with a pre-event online questionnaire. On the day scorecards following discussions allowed a preferred shortlist

of solutions to be proposed

- Citizens Jury Jurors report has been received and circulated to key stakeholders and made public on the Citizens Jury website.
- A consultation timeline is being developed, including a proposal to accelerate a planned consultation on Emergency General Surgery (EGS) due to increasing service delivery risks in that service.
- The need for a facilitating move to make space for EGS identified an opportunity to bring forward a proposed relocation of Neurology services from phase 2 of the FFTF programme. To hear people's views on this a further phase of engagement focussed on Neurology has recently been completed.
- The next step is for the NHS to write a 'Pre Consultation Business Case' which sets out more details of our preferred options, and seeks assurance from our regulators, approval from NHS Boards and support from the Health Overview and Scrutiny Commmittee
- Once each of these steps are complete, then proposals would be put forward for public consultation later in the year.

6. Enabling Programmes

Our vision for future Health and Social Care in Gloucestershire is supported by our enabling programmes. These are working to ensure that the ICS has the right capacity and capability to deliver on the clinical priorities which have been identified.

Achievements and Progress

Joint IT Strategy: Local Digital Roadmap

- The Final version of the **Digital Strategy** has been amended following prioritisation of the digital roadmap for 2020/21.
- Cyber threat notifications moved from Amber to Green. There is an agreed ICS Anti-Virus approach both short term and long-term.
- **Cinapsis Advice and Guidance** has been rolled out to all practices with a utilisation of 62%.This is an increased utilisation up to 30 cases per day.
- **Joining Up Your Information** (JUYI) utilisation demonstrates an average of 280 views a day with over 2,300 users (+300), and 84,000 (+15,000) views.
- **NHS App** now supports all practice systems and initial communications have gone out to practices to prepare for increased patient usage.
- **Digital Champions** met and agreed to work together on developing a common basic digital literacy training option for staff.

Joint Workforce Strategy

A successful celebration event for Cohort 3 (Urgent Care) and Cohort 4 (Dementia & Frailty) of the Gloucestershire System Leadership Programme was held on 19th February 2020. Cohorts 5 (CVD & Diabetes) and 6 (Respiratory & End of Life Care) are progressing well. A one day condensed executive cohort is being organised to be held in 2020 as well as two additional cohorts that will start in April 2020 following an application process.

Workforce planning resource has been secured until the end March 2020.

Three Gloucestershire Health and Care (GHC) workshops have now been completed with 3 more being organised. These will conclude the main workshop programme and organisations will then collate their workforce plans which will inform an ICS 5 year plan.

Joint Estates Strategy

Cinderford has celebrated the completion of structural work on its brand new £5 million health centre with the final beam being put in place. The facility on Valley Road will replace the town's existing health centre which currently houses both Dockham Road surgery and Forest Health Care. Completion and opening is scheduled for the summer.
Construction is scheduled to begin week commencing 6th April 2020 for the Cheltenham 'Edward Wilson Centre' GP development which will support up to 25,000 patients.

Primary Care Strategy

Our first ICS digital primary care priority is to have a main offer for all practices. It will test further digital improvements to establish the benefits for patients and GP practices. At the same time it will keep an eye to the future developments with 111 Online and the NHS App roll out.
The 2019-2024 Primary Care Strategy must demonstrate how the ICS will:

- enable services to remain flexible and sustainable,
- improve integration and partnership working,
- detail priorities and how these will be achieved,

- describe how Primary Care Networks will be the focus as the key enabler to the strategy.

Achievements and Progress

- Having been recommended for approval via the Primary Care Commissioning Committee, the Primary Care Strategy Refresh was signed off by CCG Governing Body in January 2020
- In February the BMA published an update to the GP Contract, NHS England has updated the contract.
- The Additional Roles Reimbursement scheme is now 100% funded (within the funding allocation per role).

Developing the Primary Care Workforce

The Primary Care Workforce Website has been developed - https://glosprimarycare.co.uk/ . with the official launch took place at the Health Professionals In Primary Care conference on the 30th January 2020.

Engagement with ICS colleagues involved with the five professional groups in the Additional Roles Reimbursement scheme is continuing. A Gloucestershire ICS stakeholder workshop for Physiotherapy took place on the 15 January 2020 with local and national speakers.

Health Equalities Fellowships: The Fellowship model has been adapted for GPs to encourage wider applications with having an option to choose different post-grad learning options, with the project focus remaining around Health Equalities.

A 3 day International GP Recruitment event is scheduled Gloucestershire on the 23rd to 25th March 2020. This will include visits to a local GP practice and the Hospitals Trust showcasing the local system and infrastructure to welcome and attract International GPs.

7. Integrated Care System

As a Wave 2 Integrated Care System we are working towards increased integration to improve health and wellbeing, we believe that by all working better together, in a more joined up way, and using the strengths of individuals, carers and local communities, we will transform the quality of care and support we provide to local people.

The System Development work stream captures the work to develop the overarching ICS programme. The responsibilities of this programme are as follows:

- Provide Programme direction to the Gloucestershire ICS
- Manage a Communications and Engagement approach on behalf of the ICS, including ensuring the Health and Social Care Act duties regarding significant services changes are met in relationship to the ICS
- Ensure the ICS has a robust resources plan in place that all ICS partners are signed up to and that is aligned to organisational level plans.
- To ensure that the ICS has clear governance and performance management in place to ensure the system can manage and oversee delivery.

Achievements and Progress

- A successful visit from the South West Regional Director of NHSE/I Elizabeth O'Mahoney along with the Director of Strategy & Transformation and Chief Nurse was undertaken within the system on 16th January. Colleagues were accompanied with the ICS Lead and the ICS Independent Chair.
- One Gloucestershire Bitesize Priority Summaries can be found here: https://www.onegloucestershire.net/bitesize-priority-summaries/
- The launch of the public facing response to the NHS Long Term Plan is due for publication around mid-May.

8. Recommendations

This report is provided for information and Board Members are invited to note the contents.

Mary Hutton
ICS Lead, One Gloucestershire ICS

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM 09/0320

REPORT TO:	Trust Board – 25 March 2020
PRESENTED BY:	Angela Potter, Director of Strategy & Partnerships
AUTHOR:	Angela Potter, Director of Strategy & Partnerships
SUBJECT:	**TRUST'S STRATEGIC FRAMEWORK**

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

The purpose of this report is to
This paper presents the draft Five Year Strategic Framework for the Board to consider and a proposed approach to enable a further period of engagement on this document.

It also outlines the next steps to develop the full five year strategy and associated enabling strategies.

Recommendations and decisions required

The Board is asked to:

- **Endorse** the draft Strategic Framework which contains the Trust's Mission, Vision and Strategic Aims and Priorities
- **Support** a further period of engagement to enable comment and refinement of the draft Strategic Framework
- Receive the final Trust Five Year Strategy at a future meeting.

Executive Summary

The development of the Trust's Five Year Strategy commenced in December 2019 with a 3 month period of engagement to seek views and inputs from a wide range of stakeholders. This has resulted in over 1,000 responses. The engagement process was supplemented by 3 development sessions held by the Trust Board and a workshop with the Council of Governors. The outputs from all of these approaches have shaped the draft Mission, Vision and a set of Strategic Aims and Priorities.

Trust Board members had a development session on the 3rd March 2020 to refine the proposed Mission, Vision and Strategic Aims and Priorities for the Trust. These recognise that the Trust offers a wide range of services in a variety of settings, but that the messages we want to communicate need to be inherently simple and relate to all who use our services, our staff and our stakeholders. The proposed Mission and Vision statements are:

Our Mission *Our Purpose*	**Enabling people to live the best life they can: *with you, for you***
Our Vision *Where we want to be in the future*	**Working together to deliver outstanding care**

We identified four Strategic Aims that we will need to focus our efforts on to achieve our vision. These are:

- High Quality Care
- Better Health
- Great Place to Work
- Sustainable

Stage Two of the engagement process will comprise of a number of key activities:

- Test out the priorities identified in the draft strategic framework to ensure the strategy resonates with staff, patients and stakeholders
- Commence the development of the enabling strategies
- Move forward with the development of the next level of detail for a clear implementation plan and ambitious but achievable milestones for delivery.

Risks associated with meeting the Trust's values

None

Corporate considerations	
Quality Implications	Consideration of quality implications and service user outcomes is at the heart of the strategy development.
Resource Implications	Resources have been identified to support the engagement process from within the existing teams and from existing budgets. The identification and allocation of any resources investments for the delivery of the strategy will be made through the annual planning process.
Equality Implications	The Social Inclusion Team is leading engagement with seldom heard and hard to reach groups in our communities. The Strategy will take into account health inequalities across a number of strands

Where has this issue been discussed before?
Trust Board Meeting – January 2020 Board Development Sessions – December 2019; 15th & 16th January 2020 and 3rd March 2020 Council of Governors workshop – 21st January 2020.

Appendices:	Report Appendix 1 – Engagement approaches Appendix 2 – Key Themes from Engagement Appendix 3 – Draft Five Year Strategic Framework

Report authorised by:	**Title:**
Angela Potter	Director of Strategy & Partnerships

Gloucestershire Health & Care NHS Foundation Trust
FIVE YEAR STRATEGIC FRAMEWORK

1.0 Introduction

Following the formal establishment of Gloucestershire Health and Care NHS Foundation Trust, the Board agreed that the Trust should launch a period of engagement and co-production to develop a strategy that would help shape its Mission and Vision and guide its priorities during the next five years. This paper presents the draft Five Year Strategic Framework for the Board to consider and a proposed approach to enable a further period of engagement on this document. It will also outline the next steps to be taken to develop the full five year strategy and associated enabling strategies.

2.0 Process of Engagement

A wide range of engagement activities have taken place between December 2019 and February 2020. Over 1,000 responses have been received through a wide variety of mediums including on-line surveys; face to face discussion groups; management meetings; drop in sessions and conferences. Figure 1 shows the breakdown of the different methods of engagement used during Phase 1 and the total number of people who participated through each route.

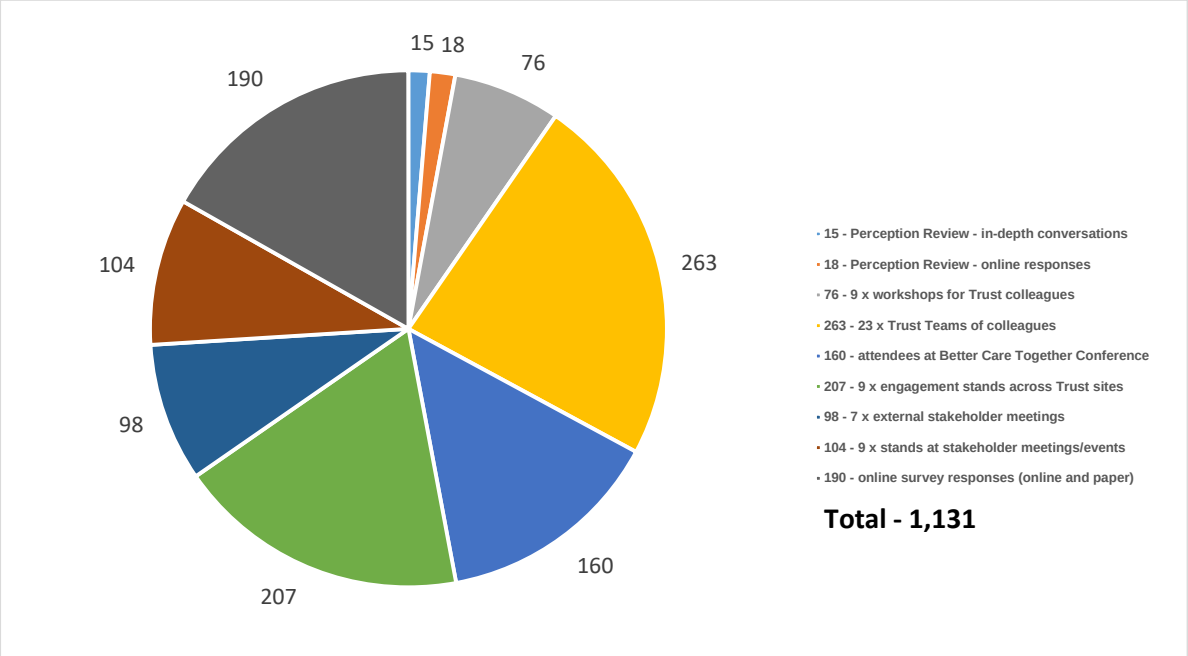


Figure 1 - Breakdown of participants for each method of engagement

Social media, internal e-mails, inclusion in newsletters and targeted communication methods were used to raise the profile of the work so it is anticipated that some people are likely to have contributed through more than one route. For example, some of the colleagues who attended the Better Care Together Conference on 19th February may also have participated in the on-

line survey, internal workshops or internal meetings. A brief summary of the approaches used is included at **APPENDIX 1**.

A key part of initial engagement to inform our strategy has been the stakeholder perception audit which has now been completed by Keigh Communications and the final report is being prepared and will be made available to Board Members on request. It is clear from initial feedback, that whilst our partners believe we offer excellent services, this is not always reflected in the way in which we communicate or engage and this must be addressed within our strategic vision and plans moving forward.

2.1 What People Told Us

We received a wealth of information through the engagement process and we would like to thank everyone who took the time to participate in a conversation with us. As part of the process we engaged with the Senior Leadership Network at its meetings in December, January and February and we held a specific workshop with the Council of Governors on 21st January. One of the areas we explored with colleagues was *what words they would like people to use when describing our Trust?* Figure 2 shows the words most frequently used by colleagues when responding to this.

Figure 2 – Words colleagues would like people to use when describing the Trust

The Trust Board has participated in three development sessions in December 2019 January and March 2020 which have stimulated some extremely rich discussion and debate around the wider political and socio-economic landscape; the local health economy context, and the specific workforce and business issues that the Trust faces.

Since then, there has been a significant amount of work across the organisation to develop a strategic service vision, acknowledging the drivers

and challenges identified in the 2 day development session in January and the potential impact and response at a clinical service level.

APPENDIX 2 provides an overview of the key themes that we have heard through the engagement events.

3.0 The Five Year Strategic Framework

Trust Board members had a development session on the 3rd March 2020 to refine the proposed Mission, Vision and Strategic Aims and Priorities for the Trust. These recognise that the Trust offers a wide range of services in a variety of settings, but that the messages we want to communicate need to be inherently simple and relate to all who use our services, our staff and our stakeholders. The proposed Mission and Vision statements are:

Our Mission *Our Purpose*	**Enabling people to live the best life they can: *with you, for you***
Our Vision *Where we want to be in the future*	**Working together to deliver outstanding care**

We identified four Strategic Aims where we will need to focus our efforts to achieve our Vision. These are:

High Quality Care	Better Health	Great Place to Work	Sustainable

We will deliver this Vision by focusing on the experience of all people, particularly those who work for us. Evidence strongly suggests that creating a great place to work and valuing and respecting the people who work for us will directly lead to enhanced quality of care and outcomes for the people who use our services. We will also maximise the opportunities that technology, research and education offer to us and these are all key features in our strategic vision moving forward.

APPENDIX 3 provides the draft Strategic Framework.

A second phase of engagement is proposed for the future. At the appropriate time, we will aim to continue the engagement approach that we have taken to date to test out the draft strategic framework and the proposed aims and priorities with colleagues, partners and others who have been actively engaged in Phase 1.

This will allow us to ensure that our strategy resonates with people and that the language we are using is clear. We will also use this opportunity to increase further the knowledge and understanding of the role and the purpose of the Trust amongst members of the public and other stakeholders who may be less aware of GHC.

Final amendments to the strategic framework will then be signed off by the Board.

4.0 Next Phase of Work

Over the coming months, and whilst the Phase 2 engagement is taking place, a number of additional key activities will also be taken forward. These include:

- Refinement of the measures of success, including the baseline position and ambition for achievement over the next five years
- Development of the Enabling Strategies - At the Board Development session in March we confirmed that the following enabling strategies were essential requirements to support the delivery of the Trust's ambition and future direction:

    - Quality Strategy
    - Best People Strategy
    - Clinical/Service Strategy
    - Investment and Resources Framework
    - Digital Transformation Strategy
    - Infrastructure & Estates
    - Research & Innovation

These are in the process of being aligned to Executive leads and a detailed timeline is being confirmed.

5.0 Recommendations

The Trust Board is asked to;

- Endorse the draft Strategic Framework which contains the Trust's Mission, Vision and Strategic Aims and Priorities
- Support a further period of engagement to enable comment on and refinement of the draft Strategic Framework
- Receive the final Trust Five Year Strategy at a future meeting.

Angela Potter
Director of Strategy & Partnerships

APPENDIX 1

The Engagement approaches taken were as follows:

- **Survey - 190 responses** – the survey was co-produced by expert colleagues from within the Trust, using learning and feedback from the survey used to support the development of the Trust Values. Both on-line and paper copies were available. The majority of the responses were completed on-line and were from colleagues, although some were from service users and stakeholders.

- **Trust team discussions x 23 – 263 participants** – the engagement process was launched at the Senior Leadership Network (SLN) meeting on 17th December encouraging members to take this into their teams using a standard presentation and questionnaire. Feedback suggested some teams struggled to fit in an in-depth discussion due to other work pressures so from January, teams were offered the option of a more limited discussion, focusing on priorities and perceived challenges to delivery and this led to further engagement.

- **Workshops for colleagues x 9 – 76 participants** – workshops were held at 9 sites across the County open to all members of staff. These had varying numbers of people participating but received very positive feedback with some participants going on to run workshops with their teams.

- **Engagement stands at Trust sites x 9 – 207 participants** – stands supported by members of the Social Inclusion or Engagement teams were placed in the reception areas of key sites across the Trust (eg Community Hospitals, Pullman Place, Wotton Lawn), targeted at staff, but also open to members of the public and service users to comment if they wished.

- **Stands at stakeholder meetings and events x 9 – 104 participants** – the Social Inclusion and Engagement teams provided stands at a series of existing meetings and events with a wide range of partners and groups.

- **External stakeholder meetings x 7 – 98 participants** – in addition to the above, the Social Inclusion and Engagement teams collaborated to provide a series of meetings/focus groups for Experts by Experience and seldom heard groups.

- **Better Care Together Conference – 160 participants** – a conference focusing on developing the Trust's strategy where the emerging priorities were shared and tested with participants. The event included opportunities for round-table discussions, and participants provided a very significant volume of commentary. Feedback from this event has been very positive.

- **Perception Review – 15 in-depth interviews and 18 on-line survey responses** - an external organisation was identified via The Consultation Institute to undertake a
  "Perception Review" of the Trust. The aim of the review was to provide the Trust with an insight into how the organisation is perceived currently by key partners and other stakeholders, and where they believe the Trust should focus in the future.

APPENDIX 2

Feedback from Engagement

The following is a top level summary of the most frequently occurring responses extracted from the on-line survey

Q1. What do we do well as a Trust that we should continue doing?

- Caring for people – putting the patient first
- Team working – within and across teams
- Research and evidence based care
- Listening to people who use our service, including minority groups

Q2. Are there any significant challenges we need to overcome to continue doing this?

- Staffing levels – recruitment and retention
- Communication – internal and external
- Information Technology – making sure systems work and talk to each other
- Culture – pulling the two organisations together, creating a positive culture

Q3. What should our role be in improving the health and wellbeing of local communities?

- Focus on inequalities
- Working with community partners, including through the PCNs and ILPs
- Share expertise and research to support improvements for local people
- Supporting people to help themselves
- Health promotion
- Prevention and earlier intervention

Q4. In five years time, what words would you like people to use when describing our Trust?

Q5 What priorities should we focus on over the next five years?

Workforce

- Recruitment and Retention
- Staff wellbeing
- Training and development opportunities across all professions and areas
- Organisational and leadership culture
- Listen to and engage staff in service and organisational developments (co-production)

Integrated care

- Closer working between health and social care services
- Bringing physical and mental health services together
- Closer working with primary care
- Closer working with local community organisations.

Quality of care

- Getting the basics right – quality of care, safety and effectiveness

Personalised care

- Listening to what service users and carers tell us (co-production)
- Supporting people to manage their own care

Access

- Improving access to care across all services

Information Technology

- Reliable, integrated IT infrastructure
- Ability for professionals to access records for the whole person (health and social care)

Communication

- Improving internal and external communication at all levels

Prevention

- Focus on prevention and earlier intervention

Q6. What do you think can help us achieve these priorities?

- Listening to staff
- Listening to service users and partners
- Working with partners, including in localities
- Improved recruitment and retention
- Clear and robust governance arrangements

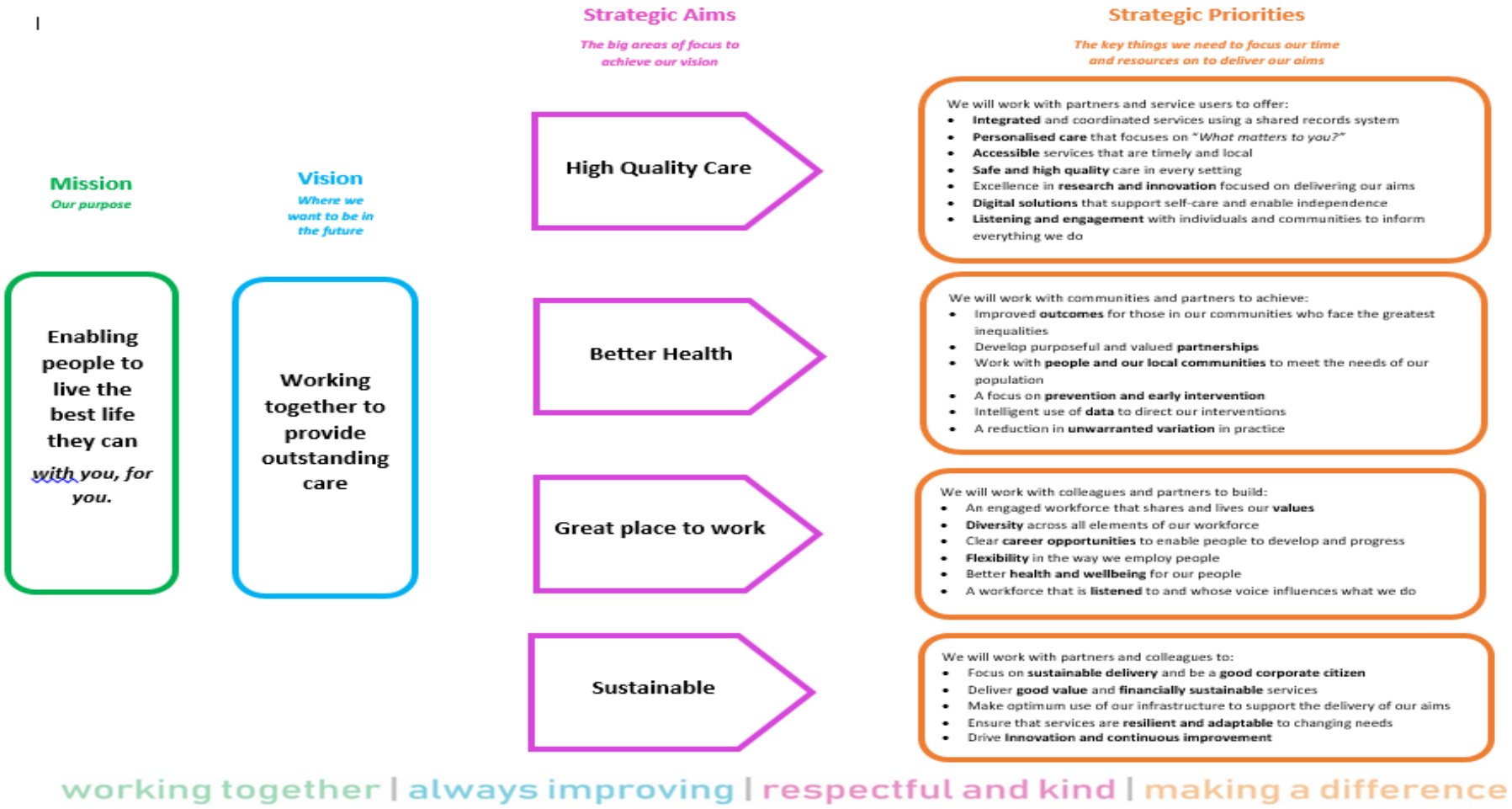
Q7. What could you do to help us achieve our priorities?

- participating and sharing views
- working as a team to deliver clear aims and objectives
- Sharing expertise
- Working with partners more effectively

Q8. Do you have any other comments on what the trust should be focussing on and what will help us get there?

- Wide range of responses picking up themes from previous questions
    - Workforce
    - Integrated working
    - IT
    - Listen to staff, service users, partner

Appendix 3 – Strategic Framework



with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 10/0320

REPORT TO:	Trust Board – 25 March 2020
PRESENTED BY:	Lavinia Rowsell, Head of Governance and Trust Secretary
AUTHOR:	Lavinia Rowsell, Head of Governance and Trust Secretary Alan Borne-Jones, Risk Manager
SUBJECT:	**BOARD ASSURANCE FRAMEWORK AND CORPORATE RISKS**

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

The purpose of this report is to
To provide assurance to the Board on the management of risk. Along with the corporate risk register the BAF supports the creation of a culture which allows the organisation to anticipate and respond to adverse events, unwelcome trends and significant business and clinical opportunities. It helps to clarify what risks are likely to compromise the trust's strategic and operational objectives and assists the executive team in identifying where to make the most efficient use of their resources in order to improve the quality and safety of care.

Recommendations and decisions required
The Board is asked to **note** the report

Executive summary
The Trust's Board Assurance Framework was considered and approved at the November 2019 meeting of the Board as an interim measure in advance of the finalisation of the GHC strategy.

The BAF has been updated in consultation with members of the Executive and reviewed by the Audit and Assurance Committee at its meeting in February 2020. The strategic risk relating to the Coronavirus will be discussed under the private session of the Board and once approved, will be added to the BAF.

As the GHC approach to risk management embeds, regular 1-2-1 risk meetings between members of the Executive and the Trust Secretary and Risk Manager will be scheduled in order to provide timely updates to the BAF/Corporate risk register and promote an approach to risk management that will underpin the delivery of the GHC strategy. It should be noted that the current BAF is an interim document and will undergo a full review once the Strategy has been finalised. The BAF and Risk Appetite will be considered as part of the Board seminar session scheduled for June 2020.

The following key changes to the BAF since Board consideration in November 2020 are highlighted as follows:

Amendments made: All risks have been reviewed and actions/additional controls added where appropriate. The risk rating of SR 11 (*The risk that we do not maintain robust internal controls (including financial) and governance systems.)* has been reduced on the recommendation of the Director of Finance following the implementation of additional controls. ***Strategic risks removed this quarter*:** Risk 13 will be removed from the register following the transfer of Herefordshire services.

Risks associated with meeting the Trust's values
As set out in the paper

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

Where has this issue been discussed before?
With individual risk owners and at the February Audit and Assurance Committee.

Appendices:	None

Report authorised by:	**Title:**

Board Assurance Framework

The design of the Board Assurance Framework (BAF) adopts the NHS standard format and identifies risks to the delivery of the new Trust's strategic objectives and also to capture the controls and assurance in relation to strategic risks. Strategic risks are defined as those risks that, if realised, could affect the way in which the Trust exists or operates.

Strategic risks will be identified by Directors, and will be aligned to the Trust's strategic objectives. The nominated lead for each strategic risk will be responsible for identifying controls and sources of assurance to ensure that these controls operate effectively. Sources of Assurance are classified into type – Management, Board and External reflecting the three lines of defense to enable the Board to understand how fully its assurance basis. Any gaps will be identified and action plans put in place to strengthen controls. Risks will be assigned to board or board committees for consideration at each meeting to provide appropriate visibility, monitoring and assurance.

The BAF will be fully reviewed by the Board three times a year, and the Audit and Assurance Committee three times a year and it will support the Chief Executive in completing the Annual Governance Statement at the end of each financial year.

Strategic Risks are those risks which could fundamentally affect the way in which the Trust operates, and that could have a detrimental effect on the Trust's achievement of its strategic objectives.

Corporate Risks which relate to the Strategic Risks (12 or more) are detailed with their scores. The Corporate Risks which are over 12 are reviewed by the Board Committee which covers the related area.

1.1 Risk Appetite - The Board met in May and July 2019 to agree its risk appetite - a key element of its risk management process.

1.2 The Risk Management Policy has been put in place – as detailed within the agreed Board Memorandum – Financial Reporting Procedures.

1.3 Strategic Objectives Development- Recognising that the refining of the Strategic Objectives for the Gloucestershire Health and Care NHS Foundation Trust, is a process still being taken forward, to enable an interim Board Assurance Framework to be put in place until the Board have their development and review session on it in June 2020, the Strategic Objectives from within the Strategic Intent have been reduced to their core elements to provide a starting point which can then be used as a building block further down the process.

1.1 Strategic Risks - Summary of strategic risks

Trust strategic objectives	Strategic risks							
	Ref	Risk	RAG	Exec Lead	Assurance Body	Inherent Risk Score	Current Risk Score	Target Risk Score
Strong System Leader and Partner	SR1	There is a risk that we fail to support and progress effective working within the health and care system and cannot fully achieve the benefits of integration targeted within the Strategic Intent for the merged Trust and meet the NHS Long Term plan.	**M**	CEO	Board	12 3x4	**8** **2x4**	4 1x4
Strong System Leader and Partner	SR2	There is a risk that services are not sustainable and do not continue to improve and develop to meet needs.	**M**	CEO	Board	12 3x4	**8** **2x4**	4 1x4
Outstanding Care	SR3	There is a risk that failure to: (i) meet consistent quality standards for care and support; (ii) address variability across quality standards; or (iii) reconcile conflicting quality standards or guidance, will result in poorer outcomes for patients/service user and carers and poorer patient safety and experience.	**M**	DoNTQ	Quality Committee	12 3x4	**8** **2x4** **On Target**	8 2x4
Outstanding Care	SR4	There is a risk that the Trust does not maintain robust focus on either/or mental and physical health.	**H**	CEO	Board	15 3x5	**10** **2x5**	5 1x5
Personalised Experience	SR5	There is a risk that we fail to keep service users and carers at the heart of what we do and do not deliver genuine co-production.	**M**	COO	Quality Committee	12 3x4	**8** **2x4**	4 1x4

Trust strategic objectives	Ref	Strategic risks Risk	RAG	Exec Lead	Assurance Body	Inherent Risk Score	Current Risk Score	Target Risk Score
Engaged, Empowered and Skilled Workforce	SR6	There is a risk that we are unable to recruit and retain the workforce we need to meet our ambitions to: • provide outstanding, joined up care • maintain colleague well-being • minimise use of agency and bank staff.	**H**	Dir HR & OD	Resources Committee	16 4x4	**16** **4x4**	8 2x4
Engaged, Empowered and Skilled Workforce	SR7	There is a risk that we fail to establish a culture which : • engages and empowers colleagues engendering a sense of collective ownership • supports discretionary innovation.	**H**	Dir HR & OD	Resources Committee	16 4x4	**12** **3x4**	4 1x4
Innovation and Research Driven	SR8	There is risk that we don't enable colleagues to support Innovation and Research through appropriate: funding, time and focus and strategic drivers.	**M**	DoNTQ & MD	Quality Committee	9 3x3	**9** **3x3**	6 2x3
Innovation and Research Driven	SR9	There is a risk that we do not have in place structures and processes which enable colleagues to look beyond the organisation to identify leading edge practice to inform practice.	**M**	DoNTQ & MD	Quality Committee	9 3x3	**9** **3x3**	6 2x3
Best Value	SR10	There is a risk that the One Gloucestershire transformation plans become frustrated and impact on our individual Trust aims and objectives and the whole system plans.	**H**	CEO	Board	16 4x4	**16** **4x4**	8 2x4
Best Value	SR11	There is a risk we **do not** maintain robust internal controls (Including financial) and governance systems; resulting in potential financial and organisational instability.	⇧	Dir Finance	Resources Committee Audit & Assurance Committee	12 3x4	**8** **2x4**	4 1x4

Trust strategic objectives	Strategic risks								
	Ref	Risk	RAG	Exec Lead	Assurance Body	Inherent Risk Score	Current Risk Score	Target Risk Score
Best Value	SR12	There is a risk we do not achieve our individual organisations financial sustainability and contribute to whole system sustainability.	**M**	Dir Finance	Resources Committee	12 3x4	**8** **2x4**	6 2x3
Best Value	SR13	There is a risk that the transfer of Herefordshire Services to Worcestershire Health and Care NHS Trust impacts on our capacity to progress our strategic objectives before April 2020	**L**	MD Herefordshire	Board	12 3x4	**8** **2x4**	4 1x4

Strategic Objective		Strong System Leader and Partner
Risk Ref :	**Latest Rating and Direction of Travel**	**Risk Description**
SR1		There is a risk that we fail to support and progress effective working within the health and care system and cannot fully achieve the benefits of integration targeted within the Strategic Intent for the merged Trust and meet the NHS Long Term plan.

Type	Quality	**Executive Lead**	Director of Nursing	Med Director

Risk Rating	**Likelihood**	**Impact**	**Total**	**Assurance Committee**	Quality Committee
Inherent (without controls being applied) Risk Score	3	4	12	**Date Identified**	Nov 2019
Previous Meeting Risk Score	2	4	8	**Date of Review**	February 2020
Current Risk Score	**2**	**4**	**8**	**Date Next Review**	April 2020
Tolerable (Target) Score	1	4	4	**Date to Achieve Target**	March 2021

Key 2020 Deliverables	**Update**
Overall 5 Year Trust Strategy developed	Ongoing – to be taken forward within Board Development Sessions

Key Controls To Manage Risk	**Assurance on Controls**	**Type of Assurance**	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
CEO & Chair members of the Integrated Care System – engaged in all processes, regular meeting structure in place. Attendance levels and partner engagement strong.	Reports to Board on ICS work, priorities & action plans. Two way communication processes in place.	Board	ICS Governance requires further development	ICS Memorandum of Understanding, including delegation & ways of working	June 2020	ICS Chair	New ICS Chair in post from 1/1/2020. Strong engagement/attendance at ICS meetings by Chair/Exec. ICS MoU currently under review with input from the Director of S&P
Director of Locality and Primary Care Post – Joint post with Clinical Commissioning Group which has embedded ongoing	Reports to Board (attendance at Board by Director of Locality and Primary Care to ensure issues reviewed through	Board	Deputy MD Community Health Services & Clinical Director Hospital Services not yet	Appointments to be put in place	June 2020	Medical Director	Deputy MD ad CD Board development session on 'Place' scheduled for June

partnership working with Primary Care, which is supporting effective cross system working.	this lens on ongoing basis.		appointed.				2020
Key Controls To Manage Risk	**Assurance on Controls**	**Type of Assurance**	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
Executive membership & leadership of key ICS Groups, Local Medical Committee, Primary Care Networks. Attendance levels and partner engagement strong.	Feedback from Groups to Executive	Management	Executive capacity during transition implementation phase can mean lack of time to engage.	Up-skilling next layer of management team	June 2020	CEO	Development planning ongoing COO Gloucester City ILP and Cheltenham ILP (from 1/4/20)
Effective Engagement in the Primary Care Networks (PCN). Meetings with Clinical Directors.	Reports to Board & Executive	Board	Capacity to personalise support and take forward actions from PCN.	Development of roles below directors to enhance capacity. Development processes planned	Sept 2020	CEO	Development planning ongoing. CEO meetings and regional presentations to Clinical Directors.
Long Term Plan integrated into strategic planning work	Strategic Intent & approved Merger documentation	External – NHSE/I	Any long term proposals for NHS following December election to be considered.	Executive to consider any short and long term implications	March 2020	CEO	Discussions ongoing Board strategy day with Regional Office Snr Team – discussed national/local priorities ICS Long Term Plan submitted. Alignment process to Trust objectives and plans underway
Director of Strategy and Partnerships post Partnership work is Board level focus and supports capacity	Board Strategic Discussions	Management & Board	Operational Delivery processes and funding basis not fully transparent to all partners due	Joined up Executive working with Executive agreeing	Ongoing	Chief Operating Officer & Director of Strategy &	Ongoing Executive discussions. Operating plan development for 2020-21 ongoing.

			to variations in funding practice	practice collectively to reflect operational plan		Partnership	
Links to Risk Register							

Strategic Objective		Strong System Leader and Partner
Risk Ref :	**Latest Rating and Direction of Travel**	**Risk Description**
SR2		There is a risk that services are not sustainable and do not continue to improve and develop to meet needs.

Type	Quality	**Executive Lead**	Director of Nursing	Med Director

Risk Rating	**Likelihood**	**Impact**	**Total**	**Assurance Committee**	Quality Committee
Inherent (without controls being applied) Risk Score	3	4	12	**Date Identified**	Nov 2019
Previous Meeting Risk Score	2	4	8	**Date of Review**	February 2020
Current Risk Score	**2**	**4**	**8**	**Date Next Review**	April 2020
Tolerable (Target) Score	1	4	4	**Date to Achieve Target**	March 2021

Key 2020 Deliverables	**Update**
ICS Strategy Implemented taking forward One Gloucestershire proposals	Ongoing – to be taken forward within Board Development Sessions

Key Controls To Manage Risk	**Assurance on Controls**	**Type of Assurance**	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
ICS Board ensures focus is on sustainability across the Gloucestershire health sector. GHC Chair and CEO fully engaged in ICS Board and ICS Development to ensure forward looking agenda.	Reports to Board. Non-Executive Director Sessions. Executive meetings with counterparts	Board and management.	Experts by Experience embedded in 2g ways for working and needs to be reviewed, customised and, then embedded across GHC.	Co-production methodology implementation.	July 2020	DoSP	Ongoing BetterCare together work on place. Fit for the Future workshops/engagement
Fit for the Future Engagement – publication and engagement programme developed collectively with staff from across the Healthcare system delivering.	Board involvement in Fit for the Future Engagement	Board	Council of Governors to reflect the wider Trust need to be appointed and developed.	Appointment process to be carried forward,	July 2020	DoSP	Governor 'review and refresh' to report in April Full involvement in the Fit for the Future engagement process and ongoing Solutions Appraisal work

Key Controls To Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
Co-production central to Trust's operation and this is being built into ways of working and ways of reviewing practice.	Development work of Director of Strategy and Partnerships and Chief Operating Officer	Management	Clear approach to co-production and people participation not in place	People Participation Committee to be established	April 2020	DoSP	Discussions commenced including a People Participation Committee .
Gloucestershire Health Finance Directors meet regularly to ensure up to date understanding of the financial position across the local Health economy	Reports to Executive and Board Management Accounts	Management and Board				DoF	ICS Financial updates given as part of Board Reports and review of ICS Long Term Plan at January 2020 Board
Executive involvement in development of key pathways within ICS.	Reports to Board	Management & Board				DoSP	DoSP attending New Models of Care Board to ensure alignment with key work programmes
Links to Risk Register							

Strategic Objective		Outstanding Care
Risk Ref :	**Latest Rating and Direction of Travel**	**Risk Description**
SR3		There is a risk that failure to: (i) meet consistent quality standards for care and support; (ii) address variability across quality standards; or (iii) reconcile conflicting quality standards or guidance, will result in poorer outcomes for patients/service user and carers and poorer patient safety and experience.

Type	Quality	**Executive Lead**	Director of Nursing	Med Director

Risk Rating	**Likelihood**	**Impact**	**Total**	**Assurance Committee**	Quality Committee
Inherent (without controls being applied) Risk Score	3	4	12	**Date Identified**	Nov 2019
Previous Meeting Risk Score	2	4	8	**Date of Review**	February 2020
Current Risk Score	**2**	**4**	**8**	**Date Next Review**	April 2020
Tolerable (Target) Score	2	4	8	**Date to Achieve Target**	Ongoing

Key 2020 Deliverables	**Relevant Key Performance Indicators**
Quality Strategy in place with Performance Measures	

Key Controls To Manage Risk	**Assurance on Controls**	**Type of Assurance**	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
Patient Safety Controls: Clinical Risk Management Processes, Risk Management Strategy & Policy, Patient Safety Team processes. (for example – medication management – including Annual Report, Never Event and Serious Incidents Requiring Investigation & Never Event monitoring & learning, Mortality Review processes).	Reports to Quality Committee and sub Committees	Management & Board	Quality Committee frequency of meeting and combined quality report not yet in place.	During transition phase Quality Committee will meet on a monthly basis and separate Quality Reports will continue for at least 6 months to ensure breadth of focus.	Ongoing	DoNTQ	Five meetings held to date. Reporting process to Board now defined. All sub-groups and work-plan in place. Committee review in April in advance of reduction to bi-monthly meetings. Board consideration of Quality Reports at each meeting.

Key Controls To Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
Patient experience controls (including compliments, complaints and learnings identified, communicated, embedded and confirmed through audit and review).	Reports to Quality Committee Reports to Executive	Management and Board	Experts by Experience not embedded within community services	Experts by Experience actions to be embedded	July 2020	DoNTQ	Ongoing programme of Bettercare Together events. Expert by Experience on Quality Committee. Looking to extend to physical care.
Co-production actions – Bettercare together engagement events & related clinical and operational review to reflect feedback.	Reports to Quality Committee Reports to Executive	Management and Board	Co-production to be further developed across the combined Trust.	Co-production further developed and embedded across Trust	July 2020	Chief Operating Officer	Colleague development programme ongoing.
Workforce Controls – safe staffing processes and ways of working – defined and reported on within Quality reporting processes.	Reports to Resources Committee and Quality Committee. Reports to Executive	Management and Board	Staff turnover and staff sickness which may lead to increased use of agency staff who have less knowledge of Trust processes and procedures	Staff recruitment and Retention actions.	Ongoing	Dir HR & OD. DoNTQ	Use of practices such as Safety huddles to update staff within working day. Use of GHC Bank and Master Vendor Contract to ensure greater consistency of staffing. Agency Group with recruitment, high usage, and BI workstreams.
Freedom to Speak Up and Whistleblowing processes fully embedded across Trust.	Reports to Board (covering processes, volumes, types of issues, resolution practices, benchmarking & good practice guidance and internal audit report.	Board		Internal Audit and action plan	March 2020	DoNTQ	New policy being developed. Incorporated Guardian in senior team. Board development session in April.

Links to Risk Register

253 – Reduced consultant psychiatrist capacity in Wotton Lawn and Crisis Services – **Risk Confirmed Closed December 2019**
562 – There is a risk that acquired pressure ulcer incidence and prevalence remains at unacceptable high levels within the Trust in community services. - **Current Risk Score - 12**
609 – There is a risk we do not attract and retain key clinical staff we will be unable to meet service demands which may have an impact on patient care - **Current Risk Score – 12**
558 – ICNet Upgrade reporting process - - Current Risk Score - 12
116 – If Agency Management control is not effective then this may impact on quality and safety of services as well as the Trust's overall financial controls. – **Current Risk Score - 16**
173 /258– That we fail to recruit the medical and nursing staff which may impact on patient safety and service delivery - **Current Risk Score – 16**
6 - S Serious Incidents Requiring Investigation – **Current Risk Score - 16**

Strategic Objective		Outstanding Care
Risk Ref :	**Latest Rating and Direction of Travel**	**Risk Description**
SR4		There is a risk that the Trust does not maintain robust focus on either/or mental and physical health.

Type	Quality	**Executive Lead**	Director of Nursing	Med Director

Risk Rating	**Likelihood**	**Impact**	**Total**	**Assurance Committee**	Quality Committee
Inherent (without controls being applied) Risk Score	3	5	15	**Date Identified**	Nov 2019
Previous Meeting Risk Score	2	5	10	**Date of Review**	February 2020
Current Risk Score	**2**	**5**	**10**	**Date Next Review**	April 2020
Tolerable (Target) Score	1	5	5	**Date to Achieve Target**	Nov 2020

Key 2020 Deliverables	**Relevant Key Performance Indicators**
Quality Strategy in place with Performance Measures	

Key Controls To Manage Risk	**Assurance on Controls**	**Type of Assurance**	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
Patient Safety Controls: Clinical Risk Management Processes, Risk Management Strategy & Policy, Patient Safety Team processes. (for example – medication management – including Annual Report, Never Event and Serious Incidents Requiring Investigation & Never Event monitoring & learning, Mortality Review processes).	Reports to Quality Committee and sub Committees Reports to Executive	Management & Board	Quality Committee frequency of meeting and combined quality report not yet in place.	During transition phase Quality Committee will meet on a monthly basis and separate Quality Reports will continue for at least the first 6 months to ensure focus continues across the breadth of the new Trust's services.	Ongoing	Director of Nursing, Therapies & Quality	Five meetings held to date. Reporting process to Board now defined. Five meetings held to date. Reporting process to Board now defined. All sub-groups and work-plan in place. Committee review in April in advance of reduction to bi-monthly meetings. Board consideration of Quality Reports at each meeting.

Key Controls To Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
Management Structure developed through merger process ensures focus on mental and physical health, whilst not acting as a barrier to integration.	Management Structure	Management	Medical Strategy	To develop Medical Strategy	Nov 2020	Medical Director	Draft strategy to be reported to March Board
Co-production and engagement activities with carers, service users and staff reflect the need to ensure integration is not achieved at the expense of necessary specialism and that all relevant groupings are appropriately engaged.	Co-production and engagement methodology	Management	Quality Strategy	To develop Quality Strategy	Nov 2020	DoNQT	Draft strategy to March Board. Experts by Experience on Quality Comm. Looking to extend to sub-comms,
Board composition reflects the need to ensure the history and legacy of each precursor Trust is maintained and that the Board has the skills to challenge to enforce appropriate focus on both areas of activity.	Board appointment process and Development processes. Associate Non-Executive Director in place for transition period	Board NHSE/I	Service User feedback process does not currently review against commitment to physical & mental health for early indications.	To be incorporated in review process as the systems are integrated.	Dec 2020	DoNQT	Service User feedback regularly reported to Quality Committee and considered by Executive – ongoing. Board development sessions/seminars in place
Medical Committee and Staff Forum provide feedback mechanism from colleagues across the Trust, with different specialisms and foci, to ensure focus is maintained.	Reports to Executive. Staff Engagement	Management	Membership for Trust may not currently reflect spectrum of service users.	Focus on Membership with aim balance of service users across the Trust's provision	Sept 2020	CEO	Governance mechanism in place - Senior Leadership Network, Team Talk and creation of bi-monthly Senior Leadership Team business meetings. Governor Review and Refresh

Reporting frameworks from 2021 demonstrate equity of physical and mental health assurance.	Governors, Resources Committee	Management Board	Central guidance issued w.c. 31/01		May 2020		
Links to Risk Register							
112 /260 – IAPT Service Performance Gloucestershire & Herefordshire [until 31/3/2020]– Current Risk Score – 12 31 – Data Quality - Current Risk Score – 12 121 – RiO Record Compliance - Current Risk Score – 12 247 – National Shortage CAMHS trained practitioners - Current Risk Score – 12 999 - Wheelchair Service- Current Risk Score – 12							

Strategic Objective		Personalised Experience
Risk Ref :	**Latest Rating and Direction of Travel**	**Risk Description**
SR5	⟷	There is a risk that we fail to keep service users and carers at the heart of what we do and do not deliver genuine co-production.

Type	Strategic	**Executive Lead**	Chief Operating Officer	Med Director

Risk Rating	**Likelihood**	**Impact**	**Total**	**Assurance Committee**	Quality Committee
Inherent (without controls being applied) Risk Score	3	4	12	**Date Identified**	November 2019
Previous Meeting Risk Score	2	4	8	**Date of Review**	February 2020
Current Risk Score	**2**	**4**	**8**	**Date Next Review**	April 2020
Tolerable (Target) Score	1	4	4	**Date to Achieve Target**	November 2020

Key 2020 Deliverables	**Relevant Key Performance Indicators**
Co-production Methodology embedded across Trust.	

Key Controls To Manage Risk	**Assurance on Controls**	**Type of Assurance**	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
Patient Safety Controls: Clinical Risk Management Processes, Risk Management Strategy & Policy, Patient Safety Team processes. (for example – medication management – including Annual Report, Never Event and Serious Incidents Requiring Investigation & Never Event monitoring & learning, Mortality Review processes).	Reports to Quality Committee and sub Committees	Management & Board	Quality Committee frequency of meeting and combined quality report not yet in place.	Quality Committee to meet monthly. Separate Quality Reports to continue for first 6 mths to ensure focus across breadth of Trust's services.	Ongoing	DoNQT	Five meetings held to date. Reporting process to Board now defined.
Co-production and engagement activities with carers, service users and	Co-production and engagement methodology	Management	Quality Strategy	To develop Quality Strategy	Nov 2020	DoSP	Strategy development infrastructure being put in place.

staff reflect the need to ensure integration is not achieved at the expense of necessary specialism and that all relevant groupings are appropriately engaged.							2 key management posts advertised, Clinical Director/deputy medical director
Patient experience controls (including compliments, complaints and learnings identified).	Reports to Quality Committee	Management	Experts by Experience not embedded within community services	Experts by Experience actions to be embedded	July 2020	DoNQT	Bettercare Together engagement programme ongoing. Patient experience report to the Quality Committee. DoSP focus on co-production and extension of Experts by Experience for physical health
Links to Risk Register							
559 - Mental Capacity Act and Deprivation of Liberty Training Programme - - **Current Risk Score - 12**							

Strategic Objective		Engaged, Empowered and Skilled Workforce
Risk Ref :	**Latest Rating and Direction of Travel**	**Risk Description**
SR6		There is a risk that we are unable to recruit and retain the workforce we need to meet our ambitions to: • provide outstanding, joined up care • maintain colleague well-being • minimise use of agency and bank staff

Type	Workforce			**Executive Lead**	Director of HR
Risk Rating	**Likelihood**	**Impact**	**Total**	**Assurance Committee**	Resources Committee
Inherent (without controls being applied) Risk Score	4	4	16	**Date Identified**	Inherited risk from 2g and GCS
Previous Meeting Risk Score	4	4	16	**Date of Review**	February 2020
Current Risk Score	**4**	**4**	**16**	**Date Next Review**	April 2020
Tolerable (Target) Score	2	4	8	**Date to Achieve Target**	Sept 2020 – Trust led activities, **BUT** it is recognised that the national context is a significant driver in ensuring impact.

Key 2020 Deliverables	**Relevant Key Performance Indicators**
Workforce Plan in place	

Key Controls To Manage Risk	**Assurance on Controls**	**Type of Assurance**	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
Workforce planning processes. (integrated within business planning process to ensure impact considered across the range of staffing types and levels)	Reports to Resources Committee and Executive and ICS LWAB. Workforce planning and narrative submissions.	Board	National approach to NHS pension limits impacts on recruitment & retention	Key staff being trained in workforce planning via HEE. Lobbying at national level with NHS Providers and NHS Employers	Ongoing	Dir. HR & OD	Workforce planning presentation included in annual planning workshop. New national People Plan is expected in Spring 2020.
Implementation of the Interim People Plan	Reports to Resources Committee	Board	Lack of integrated workforce planning data	Promotion of system approach to workforce planning, including shared	March 2021	Dir. HR & OD	Workforce systems projects to integrate ESRs, NHS Job systems and the two ledgers. Transition workforce reporting

				career pathways			workstream. ICS working of development robust system interim People Plan ongoing.
Key Controls To Manage Risk	**Assurance on Controls**	**Type of Assurance**	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
Skills Mix Reviews	Reports to Chief Operating Officer & Executive	Management			Ongoing	Dir. HR & OD	Skills mixes carried out in Phase 3 Transition programme. Reviews requested with all turnover
Monitoring of Agency Use & Vacancies	Reports to Executive, Agency and Bank Management & Resources Committee	Management & Board		Refocused Agency and Bank Management Group with 3 additional workstream task and finish groups	Ongoing	COO and Dir. HR & OD	Sustainable Workforce strategy paper received and agreed at January 2020 Board meeting. New Agency and Bank Management group and workstreams proceeding with their action plans. End to end process QI review of recruitment has commenced with PMO support.
Safe Staffing Reports	Reports to Quality Committee and Executive	Board	Trust doesn't commission all training.	Completion of Staff workforce planning training and programme of workforce planning workshops with support from HEE.	July 2020	DNQ&T	

Recruitment & Retention Plans and actions	Reports to Resources Committee	Board	Limited Resources for promoting Trust jobs and enabling innovative approaches to recruitment & retention	Recruitment Action Plan and New recruitment strategy & action plan – ensuring best use of funds available	December 2019 March 2020	Dir. HR & OD	Additional Recruitment and Retention lead post commenced 3rd February 2020
Career pathway developments	Reports to Executive	Management	Legacy succession planning and talent management processes from former GCS and 2G		March 2020	Dir. HR & OD	Succession planning and talent management approach discussion by Exec in spring 2020. ICS NA, ACP and HEE workforce transformation programmes in place
Partnership arrangements with academic organisations.	Reports to Resources Committee	Board			Ongoing	Dir. HR & OD	Monthly Gloucs Strategic Workforce Development Partnership Board with ICS colleagues. Sustainable Workforce strategy paper to Jan 2020 Board. Working with Uni of Worcestershire on proposed Medical School.
Vacancy Monitoring	Reports to Resources Committee	Board			April 2020	COO and Dir. HR & OD	Director level sign off. New vacancy BI plan being developed reporting to Agency and Bank Management Group

Agency and Bank Management	Reports to Executive	Management	Workstreams have 6/9 mth lead in time for many actions				Jan Board paper covering approach and expected timelines to temporary staffing received agreed
Flexible working, retire and return options	Reports to Executive and JNCF	Management	Related business intelligence harmonisation	Review 2019 Staff Survey opportunities for flexible working patterns scores and feedback and develop response.	March 2020	Dir. HR & OD	BI under review. New flexible working policy agreed and implemented October 2019. Flexible retire and return options being rolled out.
Co-production of opportunities, working patterns etc with staff	Staff Friends and Family Test and staff survey	External		Review 2019 Staff Survey "Staff Engagement" and "Ability to contribute to improvements" scores and feedback, develop response	March 2020	Dir. HR & OD	Focus groups and new Vital Sign monthly survey being rolled out from end February 2020. E-rostering project will provide further co-production opportunities through 2020/21
Links to Risk Register							
Risk 48 – That we fail to secure, retain & develop the workforce and evolve the organisation culture necessary to deliver our strategic objectives. - Current Risk Score 12 Risk 609 – Retention of key clinical staff - Current Risk Score – 12 Risk 173/989/962/258 – That we fail to recruit to the medical and nursing workforce which may impact on patient safety and service delivery - Current Risk Score - 16 Risk 116 - If Agency Management Control is not effective then this may impact both on quality and safety of services as well as the Trust's overall financial control. – Current Risk Score – 16							

Strategic Objective		Engaged, Empowered and Skilled Workforce
Risk Ref :	**Latest Rating and Direction of Travel**	**Risk Description**
SR7		There is a risk that we fail to establish a culture which : • engages and empowers colleagues engendering a sense of collective ownership • supports discretionary innovation

Type	Strategic			**Executive Lead**	Director of HR & OD
Risk Rating	**Likelihood**	**Impact**	**Total**	**Assurance Committee**	Quality Committee
Inherent (without controls being applied) Risk Score	4	4	16	**Date Identified**	Nov 2019
Previous Meeting Risk Score	3	4	12	**Date of Review**	February 2020
Current Risk Score	**3**	**4**	**12**	**Date Next Review**	April 2020
Tolerable (Target) Score	1	4	4	**Date to Achieve Target**	September 2020

Key 2020 Deliverables	**Relevant Key Performance Indicators**
Implementation of the Interim People Plan	

Key Controls To Manage Risk	**Assurance on Controls**	**Type of Assurance**	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
Values developed through co-production	Reports to Board	Board	Strategic Objectives to be fully developed	Strategic Objectives to be developed using co-production principles	June 2020	CEO	Board Development session timetabled. Cascading process to be developed.
Interim People Plan	Reports to Resources Committee	Board	Full implementation of Plan	Communication & implementation through future "Best People" Strategy. Respond to new national People Plan once releases	Sept 2020	Director of HR & OD	Development and agreement of "Best People" strategy and actions. Regular updates to Resources Committee in place.

Bettercare together engagement processes	Reports to Board	Board	Implementation outcomes of Bettercare together	Outcomes to be built into strategies	Sept 2020	Director of Strategy & Partnerships	Ongoing Bettercare Together Programme in place.
Heads of Professional Knowledge Network in place	Reports to Director of Nursing	Management					
Research Knowledge Partnership in place	Reports to Executive	Management					
Freedom to Speak Up Guardian & supporting processes	Reports to Board (covering processes, volumes, types of issues, resolution practices, benchmarking & good practice guidance.)	Board				Director of Nursing, Quality and Therapies.	
Colleague Communication & Engagement activities	Reports to Executive	Management			March 2020	Director of HR & OD	Regular review of colleague communications. "You said, we did" comms with colleagues, new monthly survey and quarterly Staff FFT surveys. Paul's Open Door. Staff Hub on intranet. New Executive visit process being scoped.
Staff Surveys	Reports to Resources Committee and Board	Board		2019 Staff Survey outcomes from former GCS and 2G due February 2020 – to be used to develop plan.	June 2020	Director of HR & OD	New Vital Signs monthly surveys from end February 2020
Links to Risk Register							

Strategic Objective		Innovation and Research Driven
Risk Ref :	**Latest Rating and Direction of Travel**	**Risk Description**
SR8	⟺	There is risk that we do not enable colleagues to support Innovation and Research through appropriate: funding, time and focus and strategic drivers

Type	Quality	**Executive Lead**	Director of Nursing	Med Director

Risk Rating	**Likelihood**	**Impact**	**Total**	**Assurance Committee**	Quality Committee
Inherent (without controls being applied) Risk Score	3	3	9	**Date Identified**	Nov 2019
Previous Meeting Risk Score	3	3	9	**Date of Review**	February 2019
Current Risk Score	**3**	**3**	**9**	**Date Next Review**	April 2020
Tolerable (Target) Score	2	3	6	**Date to Achieve Target**	Feb 2021

Key 2020 Deliverables	**Relevant Key Performance Indicators**
Research Strategy in place with Performance Measures	

Key Controls To Manage Risk	**Assurance on Controls**	**Type of Assurance**	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
Research Actions & Activities	Reports to Quality Committee	Board	Research Strategy in development	Put in place Research Strat.	March 2021	Medical Director	Reviewing current strategy to align with organisations research vision.
Annual Research Conference	Reports to Executive	Management	Trust 5 year Strategic Plan	To be developed	March 2021	CEO	
Learnings from Incidents, Complaints and compliments	Reports to Quality Committee	Board	Clinical Strategy	Develop clinical safety strategy	March 2021	MD	Assurance reports provided to the quality committee and Board (mortality review and SI reports)
Good Practice Identification & Follow Up process	CQC working group	Management	Quality Strategy	To be developed	March 2021	Director of Quality	
Training & Development Activities	Reports to Executive	Management	Training and development strategy	To be developed	March 2021	Medical Director and DQNT	

Quality Improvement Unit activities	Reports to Executive	Management		To be developed			
Bettercare together activities	Reports to Board	Management		To be developed			
Links to Risk Register							

Strategic Objective		Innovation & Research Driven
Risk Ref :	**Latest Rating and Direction of Travel**	**Risk Description**
SR9		There is a risk that we do not have in place structures and processes which enable colleagues to look beyond the organisation to identify leading edge practice to inform practice.

Type	Quality	**Executive Lead**	Director of Nursing	Med Director

Risk Rating	**Likelihood**	**Impact**	**Total**	**Assurance Committee**	Quality Committee
Inherent (without controls being applied) Risk Score	3	3	9	**Date Identified**	Nov 2019
Previous Meeting Risk Score	3	3	9	**Date of Review**	February 2020
Current Risk Score	**3**	**3**	**9**	**Date Next Review**	April 2020
Tolerable (Target) Score	2	3	6	**Date to Achieve Target**	Jan 2021

Key 2020 Deliverables	**Relevant Key Performance Indicators**
Research Strategy in place with Performance Measures	

Key Controls To Manage Risk	**Assurance on Controls**	**Type of Assurance**	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
Research Actions & Activities	Reports to Quality Committee	Board	Research Strategy in development	Put in place Research Strategy	March 2021	Medical Director	
Annual Research Conference	Reports to Executive	Management	Trust 5 year Strategic Plan	To be developed	June 2020	CEO	
Learnings from Incidents, Complaints and compliments	Reports to Quality Committee	Board	Medical Strategy	To be developed	March 2021	MD	
Good Practice Identification & Follow Up process	CQC working group	Management	Quality Strategy	To be developed	March 2021	DoNTQ	
Training & Development Activities	Reports to Executive and Board Committees	Management and Board					
Quality Improvement Unit activities	Reports to Executive	Management					

Links to Risk Register

Strategic Objective		Best Value
Risk Ref :	**Latest Rating and Direction of Travel**	**Risk Description**
SR10		There is a risk that the One Gloucestershire transformation plans become frustrated and impact on our individual Trust aims and objectives and the whole system plans.

Type	Strategic			**Executive Lead**	CEO
Risk Rating	**Likelihood**	**Impact**	**Total**	**Assurance Committee**	Board
Inherent (without controls being applied) Risk Score	3	4	12	**Date Identified**	Nov 2019
Previous Meeting Risk Score	3	4	12	**Date of Review**	December 2019
Current Risk Score	**3**	**4**	**12**	**Date Next Review**	Feb 2020
Tolerable (Target) Score	2	4	8	**Date to Achieve Target**	September 2020

Key 2020 Deliverables	**Update**
One Gloucestershire Engagement complete and clear road map in place.	

Key Controls To Manage Risk	**Assurance on Controls**	**Type of Assurance**	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
Engagement Plan in place	Report to Board	Board	Original timeline revised, impact of updated timeline required.	Impact of updated timeline to be considered against other key strategic activities, eg Hospitals in Forest of Dean	June 2020	Dir Strat & Partnerships	Board updated on the Fit for the Future timeline and outputs of engagement process at Jan 2020 meeting. FoD Full Business Case development underway to align with revised timeline.
External Specialist Advice to ICS to support engagement process	ICS Board Board	External & Board			June 2020		
Ongoing ICS Updates to ICS Board & Board	Reports to Board to support scrutiny, challenge & openness in working	External & Board			June 2020	Dir Strat & Partnerships	System update standing item on Board agenda.

Links to Risk Register

Strategic Objective		Best Value
Risk Ref :	**Latest Rating and Direction of Travel**	**Risk Description**
SR11		There is a risk we do not maintain robust internal controls (Including financial) and governance systems; resulting in potential financial and organisational instability.

Type	Strategic			**Executive Lead**	CEO
Risk Rating	**Likelihood**	**Impact**	**Total**	**Assurance Committee**	Board
Inherent (without controls being applied) Risk Score	3	4	12	**Date Identified**	Nov 2019
Previous Meeting Risk Score	3	4	12	**Date of Review**	Feburary 2019
Current Risk Score	**2**	**4**	**8**	**Date Next Review**	Feb 2020
Tolerable (Target) Score	2	4	8	**Date to Achieve Target**	September 2020

Key 2020 Deliverables	**Update**
Budget and CIP targets to be achieved	

Key Controls To Manage Risk	**Assurance on Controls**	**Type of Assurance**	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
Clinical and corporate governance arrangements enable controls to be effectively managed.	The Board Committee structure provides assurance on all corresponding controls to the Trust Board. Management Groups report exceptions to Committees	Board	Combined Quality Reporting development is ongoing	Integrated Quality Report to be developed	July 2020	Director of Nursing, Therapies and Quality	Development ongoing

Key Controls To Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
Committee / reporting structures enable controls to be monitored and reviewed.	Grant Thornton Reporting Accountant Opinion	External	External Audit Annual Feedback Internal Audit Opinion	Year End Report Internal Audit Report on Corporate Governance	May 2020 March 2020	Director of Finance Head of Corporate Governance	GCS External Audit clean opinion
Internal and external audit and plans provides additional scrutiny	Combined Internal Audit Plan Agreed Reports by Internal & External Audit to Audit Committee	External	Audit Recommendations Follow Up to be reviewed as combined organisation	Routine agenda item on Audit and Assurance Committee	Sept 2020	Head of Corporate Governance	Audit Recommendations Report considered every Audit and assurance Committee meeting.
The Trust's Standing Orders, Standing Financial Instructions, Scheme of Reservation and Scheme of Delegation in place	Based on best practice	Management and Board	.Assurance on compliance	Internal Compliance Review to be undertaken	March 2020		
Robust governance framework to ensure continual monitoring and reporting with clear escalation	Reports to Board and Executive	Management and Board	Full range of Strategies not yet in place	Strategies to be developed & put in place	Sept 2020	Director of Strategies & Partnerships (with Board)	

Links to Risk Register
116 – Agency Usage Control - **Current Risk Score - 16** 177 / 943 – Cost Improvement Plan Delivery – **Current Score – 12 [2g] / 15 [GCS]** 992 / 998 – GP IT Security / Direct Internet Access - **Current Risk Score - 16** 1002 - Operational Resilience - Multiple System Changes in next 6 months - **Current Risk Score 16**

Strategic Objective		Best Value
Risk Ref :	**Latest Rating and Direction of Travel**	**Risk Description**
SR12		There is a risk we do not achieve our individual organisation's financial sustainability and contribute to whole system sustainability

Type	Financial			**Executive Lead**	Dir Finance
Risk Rating	**Likelihood**	**Impact**	**Total**	**Assurance Committee**	Board
Inherent (without controls being applied) Risk Score	3	4	12	**Date Identified**	Nov 2019
Previous Meeting Risk Score	2	4	8	**Date of Review**	February 2020
Current Risk Score	**2**	**4**	**8**	**Date Next Review**	March 2020
Tolerable (Target) Score	2	3	6	**Date to Achieve Target**	June 2020

Key 2020 Deliverables	**Update**
Budget and CIP targets to be achieved	

Key Controls To Manage Risk	**Assurance on Controls**	**Type of Assurance**	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
Financial Management	Board Reports and mid-Year Review	Board	Board oversight of budgets Identification of 20/21 CIPS	Budget approval efficiency Targets delivered Differential targets Planned Challenge Schemes Planned	Match 2020 March 2020 April 2020 June 2020	Director of FInance	Budget Setting in progress CIP workshops completed CIP targets 20/21 issued

Financial reporting	Board Reports & Resources Committee Reports	Board	Finance systems in integration	Finance system integration processes to be completed	April 2020	Director of Finance	Integration process on plan.
Agency Management Group	Reports to Resources Committee Sustainable staffing paper to Board	Board	Comprehensive plan to reduce agency reliance Recruitment to Medical vacancies	Trajectory for improvement	June 2020 June 2020	Chief Operating Officer Medical Director	Key workstreams identified and in planning
Key Controls To Manage Risk	**Assurance on Controls**	**Type of Assurance**	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
ICS Financial Plan Monitoring	Board Report	Board					
Links to Risk Register							
177/943 – Cost Improvement Plan Delivery - **Current Risk Score – 12/15** 973 **–** Medical Devices Replacement process **-** - **Current Risk Score – 12** 116 – Agency Usage Control - **Current Risk Score - 16**							

Strategic Objective		Best Value
Risk Ref :	Latest Rating and Direction of Travel	Risk Description
SR13		There is a risk that the transfer of Herefordshire Services to Worcestershire Health and Care NHS Trust impacts on our capacity to progress our strategic objectives before April 2020.

Type	Strategic	Executive Lead	CEO	Managing Dir Herefordshire

Risk Rating	Likelihood	Impact	Total	Assurance Committee	Board
Inherent (without controls being applied) Risk Score	3	4	12	Date Identified	Nov 2019
Previous Meeting Risk Score	2	4	8	Date of Review	December 2019
Current Risk Score	**2**	**4**	**8**	Date Next Review	Feb 2020
Tolerable (Target) Score	1	4	4	Date to Achieve Target	April 2020

Key 2020 Deliverables	Update
Herefordshire Service Transfer of services completed	

Key Controls To Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
Managing Director Herefordshire Mental Health and Learning Disabilities	Reports to Board	Board	Potential financial impact on Trust	Potential impact being fully reviewed	March 2020	DoF	Discussions with Commissioners and staff ongoing.
NED with dedicated lead for Herefordshire	Reports to Board	Board	Insufficient NED oversight		October 2019	Chair/CM	NED appointment and active in role
Partnership working with Herefordshire and Worcestershire Health System	Reports to Board	Board	No formal mechanism for engagement	Establish effective engagement processes	End March 2020	MDH	Transition plan in place with WHCFT.

Links to Risk Register

Definitions

The overall risk ratings below are calculated as the product of the Probability and the Severity

LEVEL	INJURY / HARM	SERVICE DELIVERY	FINANCIAL / LITIGATION	REPUTATION / PUBLICITY
5 CATASTROPHIC	Fatality, Multiple fatalities or large number injured or affected.	Complete breakdown of critical service/ 'Significant under-performance' against key targets.	Losses; claims/damages; criminal prosecution, over-spending; resourcing shortfall: >£1M.	National adverse publicity/reputation irreparably damaged.
4 Major (HIGH)	Fatality/multiple serious injuries/major permanent loss of function/increased length of stay or level of care >15 days.	Intermittent failures of a critical service/'under-performance against key targets'.	£501K - £1M	Adverse national publicity
3 Moderate (MEDIUM)	Semi-permanent harm (1 month-1 year). Increased length of stay / level of care 8-15 days, >1 month's absence from work.	Failure of support services/under-performance against other key targets'.	£51K - £500K	>3 days local media publicity
2 Minor (LOW)	Short-term injury (<1 month). Increased length of stay or level of care <7 days, 3 days-1 month absence for staff.	Service Disruption	£11K - £50K	<3 days local media publicity
1 (Insignificant)	No harm. Injury resulting in <3 days' absence from work for staff.	No service disruption	<£10K	

LIKELIHOOD SCORE		
Level		
5	Almost certain	Will occur frequently given existing controls
4	Likely	Will probably occur given existing controls
3	Possible	Could occur given existing controls
2	Unlikely	Not expected to occur given existing controls
1	Rare	Not expected to occur, except for in exceptional circumstances, given existing controls

RISK RATING MATRIX

Likelihood	IMPACT				
	1	**2**	**3**	**4**	**5**
5	**5** (LOW)	**10** (MEDIUM)	**15** (HIGH)	**20** (CATASTROPHIC)	**25** (CATASTROPHIC)
4	**4** (LOW)	**8** (MEDIUM)	**12** (MEDIUM)	**16** (HIGH)	**20** (CATASTROPHIC)
3	**3** (LOW)	**6** (MEDIUM)	**9** (MEDIUM)	**12** (MEDIUM)	**15** (HIGH)
2	**2** (LOW)	**4** (LOW)	**6** (MEDIUM)	**8** (MEDIUM)	**10** (MEDIUM)
1	**1** (LOW)	**2** (LOW)	**3** (LOW)	**4** (LOW)	**5** (LOW)

Impact Score x Likelihood Score = Risk Rating:

Key Terms:

Type of Assurance – Three t

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 11/0320

REPORT TO: Trust Board – 25th March 2020

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

AUTHOR: Lisa Proctor, Associate Director of Contract and Planning

SUBJECT: **ANNUAL BUSINESS PLAN**

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

The purpose of this report is to

This report sets out the Trust Annual Business Planning process for 20/21 and the proposed Business Planning Objectives for operational and corporate teams. There are a total of 118 objectives which are detailed in Appendix A of this report.

Recommendations and decisions required

The Board is asked to:

- **Approve** the business planning objectives
- **Note** the proposed refresh of objectives during Quarter 2.

Executive summary

The Business Plan has been developed in context with the Trust's main priorities and the key deliverables of the One Gloucestershire Operational Plan for 2020/21. The business plan is developed annually in conjunction with the National Operational Planning Guidance and incorporates Workforce Planning, Budget Setting and Contract Management processes.

This report sets out the business planning process and performance monitoring methodology for 20/21. The Board will receive a 6 month progress report at the end of Quarter 2 and an annual report at the end of the year.

The Annual Business Plan informs the wider forward planning submission to NHSE/I for 20/21. The forward planning requirements include the Trust Operational Plan response aligned to the System Operational Plan and information regarding the membership and elections of governors. The full Annual Business Plan submission is required by the 29th April 2020. At the time of writing this report, national guidance is expected to

confirm that this deadline will be suspended.

Risks associated with meeting the Trust's values
Impact of the Covid-19: The business planning process has been constrained due to the urgent preparations in response to Covid-19. This has meant some of the planning information has not been fully addressed within the business plans and the impact on resources is unknown. There will be a refresh of the business planning objectives during Quarter 2 which will include an assessment of the impact of Covid-19 on the priorities for the business plan and the resources required for delivery. **Impact of System Prioritisation on Investments**: At the time of writing there are key investment opportunities awaiting the outcome of the system prioritisation and subsequent contract negotiation. These will be refreshed once agreed.

Corporate considerations	
Quality Implications	As set out in the report
Resource Implications	As set out in the report
Equality Implications	As set out in the report

Where has this issue been discussed before?
The Business Planning process has been presented to the Resource Committee on the 27th February 2020 and is being rescheduled for discussion with the Council of Governors in March 2020.

Appendices:	*Appendix 1 – Table of Business Planning Objectives*

Report authorised by: **Sandra Betney**	**Title:** **Director of Finance**

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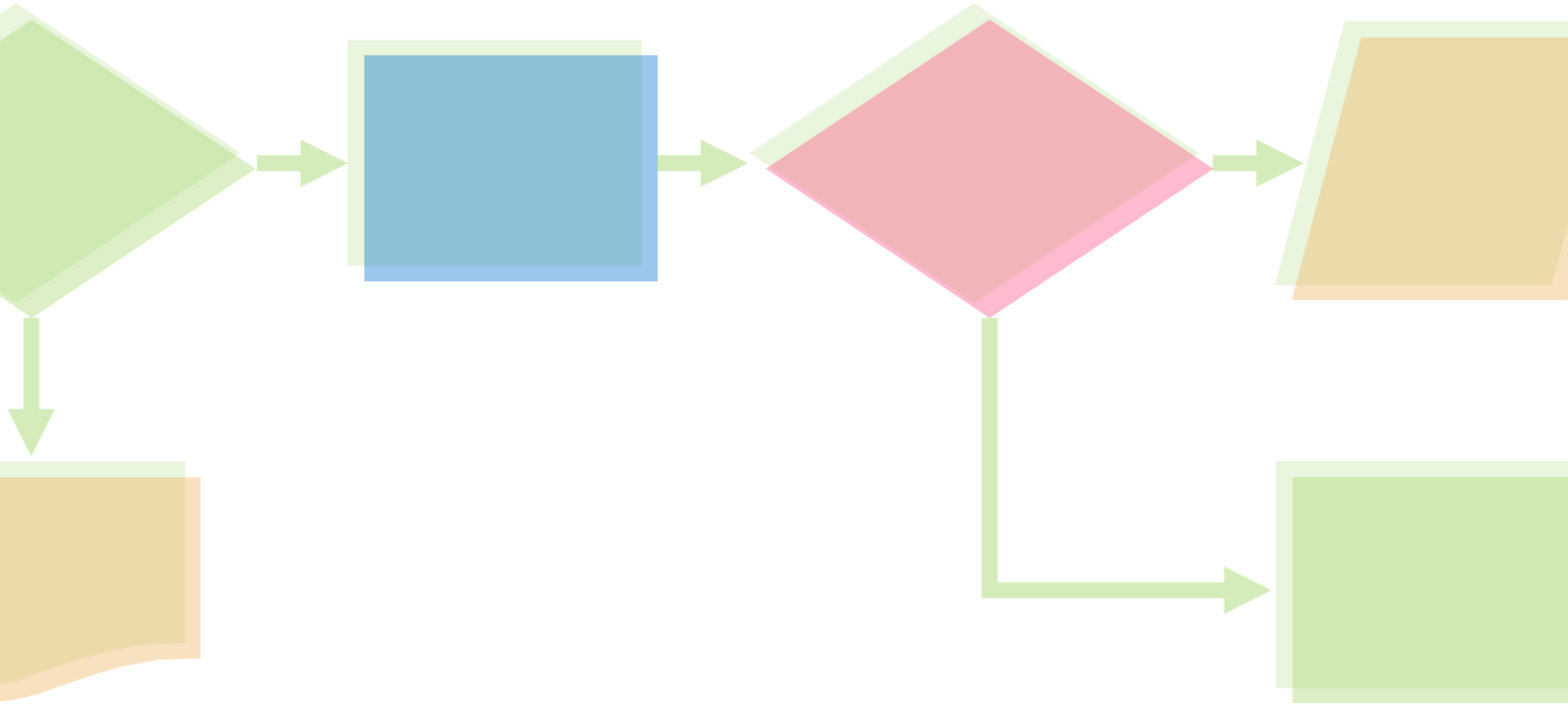
Annual Business Plan 2020-21



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

Contents

1. Introduction

The Business Plan report sets out the annual business planning process and the Business Planning Objectives for operational and corporate teams for 2020/21. The Business Plan has been developed in context with the Trust's main priorities and the key deliverables for the One Gloucestershire Operational Plan for 2020/21. This will inform the wider forward planning submission required by NHSE/I by the 29th April 2020.

2. Background and context

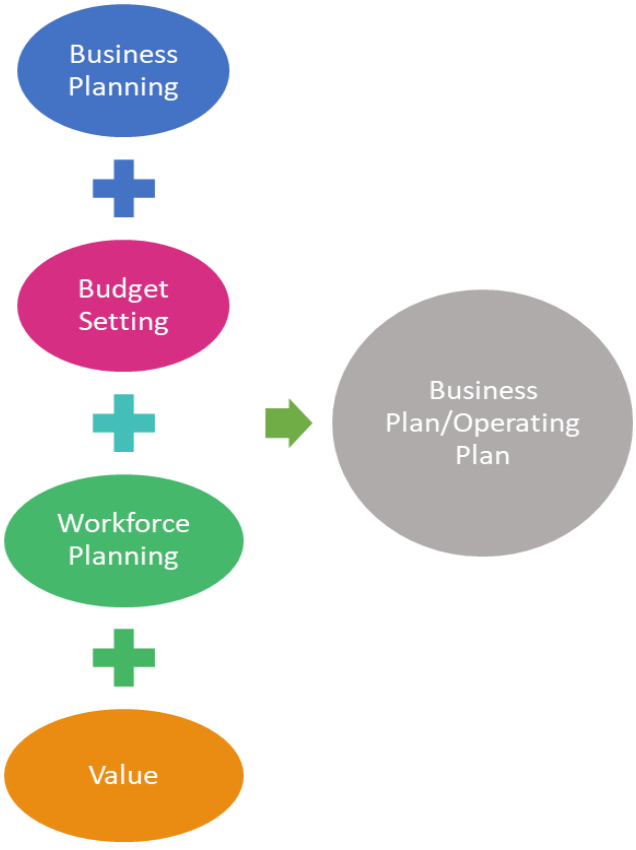
2.1 The annual business planning process ensures the Trust meets the forward planning requirements and achieves the following key objectives:

- To create a process that aligns individuals objectives with organisational goals
- To stimulate colleague engagement with the planning and delivery of our services
- To ensure that business planning is aligned with the annual planning cycle
- To encourage links between support services and operational objectives
- To create a mechanism to allow and encourage prioritisation in the context of scarce resources
- To ensure the views of the Council of Governors influence the plans for the Trust
- To provide the opportunity for Board to have oversight and approve the plan for the Trust
- To provide a mechanism to maintain consistency with system plans and externally submitted plans

2.2 The business plan is developed in conjunction with the Operational Plan and incorporates Workforce Planning, Budget Setting and Contract Management processes.

The Trust's internal planning timescales have been aligned and form a coordinated annual planning cycle that brings together the operational managers, HR and financial leads to ensure the capacity, capability and affordability is planned appropriately to deliver the objectives in the coming year.

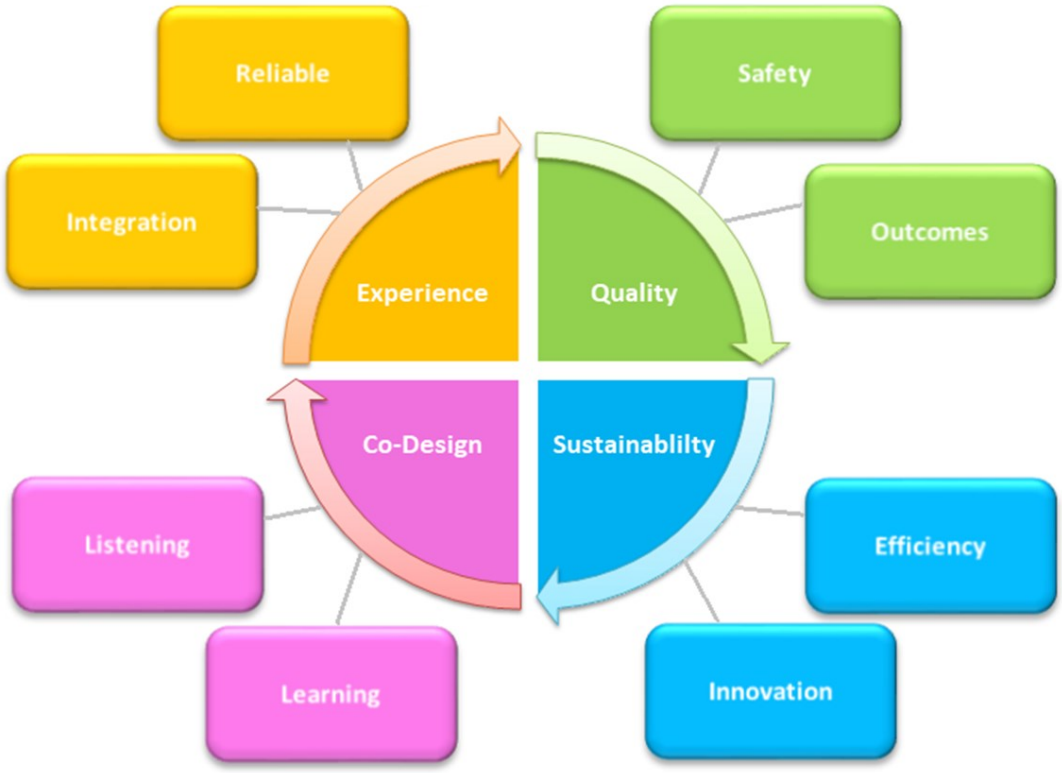
This wide engagement ensures the priorities for the organisation are owned and connected across operational and corporate boundaries.



2.3 The business planning objectives are also informed by national policy changes and are monitored as 'live' plans enabling adjustments to be made in-year when necessary. The business plan will also be refreshed to align with the Trust Strategy and key strategic themes when agreed.

3. Business Planning Themes

3.1 The current business planning process is underpinned by eight key themes as set out below:



3.2 The themes were chosen to reflect the different activities across the organisation. Each objective is linked to one of the key themes to show the balance of activity at directorate, team and organisational level. The business planning themes will be aligned with the Trust Strategy when agreed.

4. Metrics

4.1 The business plan performance will be measured using a balanced scorecard of metrics linked to each theme as follows:

Quality
Metric 1: Percentage of objectives delivered
Metric 2: Staff Survey – staff recommendation on organisation as a place to receive care

Experience
Metric 1: Percentage of objectives delivered
Metric 2: Experience – staff recommendation on organisation as a place to work

Sustainability
Metric 1: Percentage of objectives delivered
Metric 2: Proportion of next financial year CIP plans developed
Metric 3: Staff turnover ratio

Co-design
Metric 1: Percentage of objectives delivered
Metric 2: Quarterly evaluation of service user involvement in changes

4.2 The business plan performance will be monitored online by a quarterly self assessment of progress. Teams will discuss their progress with Executive Directors throughout the year to ensure the business plans are resourced appropriately and to remove any barriers to delivery where possible. The Board will receive a 6 month progress report at the end of Quarter 2 and an annual performance report at the end of the year.

5. Business Planning Requirements

5.1 The business planning objectives have been developed with directorates and teams for delivery during the 12 month period from April 2020 to March 2021.

5.2 All business planning objectives have been developing using the principles of SMART to ensure plans can be evaluated appropriately. Each objective has an outcome measure and quarterly milestones to track progress.

5.3 The objectives have clear links with wider internal work programmes including:

- Service improvements
- Quality goals
- Efficiencies
- Workforce plans
- Productivity (inc digital) goals

5.4 The business planning process for 20/21 was launched in December 2019. The timetable for completion is:

● December	Executive Directors set their key priorities
● January	External planning guidance applied
	Alignment with Budget Setting
● February	Plans finalised
● March	Executive review of plans
	Feedback from Council of Governors
	Board oversight

Senior Leaders have been engaged throughout the process and the national business planning guidance and key policy changes have been presented to the Resources Committee in February.

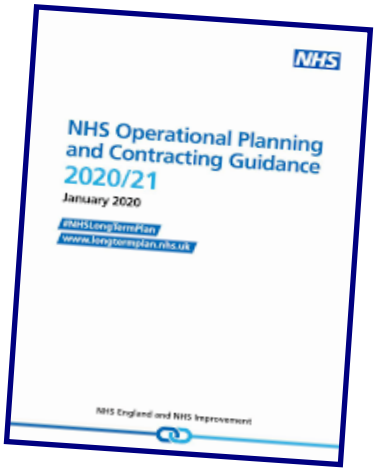
6. Business Planning Objectives

6.1 Key policy changes that will impact the business plans for 2020/21 are as follows:

- **The Long Term Plan:** The role of community and mental health service providers should support:
  - PCNs delivering transformation at place level
  - 2h crisis response and 48h response for reablement care
  - Digital mobile services for the community workforce
  - First Contact Practitioner new roles (FCP)
  - Acute frailty services for 70 hours per week.
  - Personal Health Budgets.
  - Mental Health Investments Standard (MHIS) inc. liaison, crisis and community bids and IAPT expansion
  - Developing alternatives to hospital for children and young people with a learning disability, autism or both

- **NHS Standard Contract:** The new community and mental health contractual requirements for 20/21 are to:
  - Align community services with primary care networks (PCNs)
  - Implement new national service specifications New infection control targets
  - All staff are vaccinated against flu.
  - New waiting times for mental health
  - Screening and advice for smoking and alcohol use on admission
  - New environmental requirements for a “green plan”,
  - New food standards and compliance with smoke free premises
  - Comply with EU exit guidance.
  - Offer patients a choice if they have waited more than 26 weeks.

- **New national metrics for 2020/21**: The new Operational Planning measures require community and mental health providers to:
  - Increase Perinatal Mental health – increased number of women accessing services
  - Increase Number of people accessing individual placement and support
  - Increase IAPT—increased access and decrease in-treatment pathway waits
  - Increase Availability of IAPT Long Term Condition pathways
  - Increase Coverage of 24/7 adult crisis resolution and home treatment teams operating in line with best practice
  - Increase Activity within community mental health services for adults and older adults with severe mental illnesses
  - Reduce length of stay for patients in hospital for 21 days and over
  - Eliminate out of area inpatient placements for acute care (Mental Health) by 2021
  - Reduce reliance on inpatient care for people with a learning disability and/or autism – under 18



6. Business Planning Objectives (contd)

6.2 The 2020/21 business plans are included in Appendix A. Key highlights from the business plans are as follows:

Development of a new Community Hospital for the Forest of Dean community:
The Full Business Case is planned for 2020/21 and will be developed as a key part of the wider investment proposed in the Forest of Dean to address primary and community infrastructure needs.

Place-based Primary Care and Community Partnerships:

- We will continue to embed multidisciplinary working across primary care and our community teams to plan and deliver care closer to people's home, utilising population health management systems to redesign services to meet local needs.
- A key priority for community teams in 20/21 is to improve peoples ability to live well in their own homes in support of the work with system partners in developing the Enhanced Independence Offer. This proposed new integrated Home First and Reablement service model seeks to improve system flow out of hospital and improve outcomes.
- As part of reducing clinical variation across the integrating community mental health teams, the Mental Health Recovery Model will also be reviewed to identify gaps in provision against national requirements and best practice.

Urgent Care:

- We will continue to deliver and evaluate the 'Test and Learn' schemes to transform urgent care services. Alongside the multidisciplinary teams, the Rapid Response service provides a crisis response within 2 hours of referral 7 days a week to support people in their own homes and avoid visits to A&E and hospital admissions. As part of this response, 2 hour appointment slots will be made available from November 2020, including through online booking via NHS 111, for ambulance services and other organisations.
- The Rapid Response team has been expanded to provide in-reach into care homes and improve support for people who are at risk of rapid deterioration, by embedding an MDT approach, improving advanced care planning, and improving the skills and knowledges of care home workforce. This will be aligned to the contractual requirements to work with primary care colleagues to deliver the new Enhanced Health in Care Homes service from September 2020.

Community Hospitals:

- We will review the multidisciplinary workforce model across the inpatient wards to ensure resources are sustainable and resilient. We will also support the service design for recovery and rehabilitation services to reduce variation and improve patient experience.
- Through improved mental health therapy support we will reduce the number of out of area patients for acute mental health and PICU in line with the System Operational Plan commitment for 2020/21.

Childrens and young peoples services:

- We will continue to review demand and capacity in the childrens complex care team and work with commissioners to co-design innovative ways of supporting families for the hours they need.
- In conjunction with PCNs we will provide early years support with schools to identify ACES and offer personalised integrated care and support. We will also work more closely with the special schools in Gloucestershire to provide support for the staff in caring for the specialist needs of the children. As part of the trailblazer workstream we will continue to ensure timely access to community mental health services across a range of schools.

6. Business Planning Objectives (contd)

- We will also support joint working with health, social care, education and VCSE to support the needs of 18-25 transitioning to adulthood.

Specialist Mental Health:

- We will continue to improve access to IAPT and we will work with system partners to develop a new approach for Gloucestershire city to provide a coordinated service for people with complex emotional needs.
- We will continue to model demand and capacity for services eg Perinatal, Eating Disorders, ASC and ADHD to improve waiting times and to explore alternative methods of providing therapy eg digital solutions where appropriate.

Therapy and Specialist Equipment:

- We will review the structure of MSK services in context with the rollout of the First Contact Physiotherapy roles in primary care.
- We will also review podiatry and adult SLT services in conjunction with GHFT MDT services to improve access to therapists and achieve referral to treatment requirements.

We will also work with partners to improve telecare, community equipment and wheelchair services where required and introduce effective PROM/PREM outcome reporting.

Dental and Sexual Health:

- We will continue to prepare in anticipation of the Community Dental Services tender. As part of our service improvement programme we will pilot IV Sedation where appropriate and investigate converting to digital radiography in line with best practice.
- We will continue to deliver the requirements of the recent successful tenders for SARC and HIV services and we will review the PAS service model to plan future needs in line with national guidelines.

6.3 In addition to our clinical and operational plans, our enabling systems are aligned to support the programmes of work. These plans include:

IT Strategy

- We will continue to rollout the Joining Up Your Information (JUYI) programme to include information from IAPTus.
- We will continue to improve the network capabilities in line with the requirement to replace the current N3 network and support mobile working including expanding the use of mobile devices.

Estates Strategy

- Plans for the creation of a community clinical and administrative hub through the re-provision of community hospital services in the Forest of Dean will remain a priority in 2020/21.
- Maximise the use of resources to improve estates and facilities management across the property portfolio

Workforce Strategy

- We will implement the Trusts new 'Best People Strategy' ensuring improved people management to maximise our workforce potential
- We will improve the health and well-being of staff including supporting work/home-life balance

Clinical Strategy

- Involving Experts by Experience in projects to improve clinical services will be a priority.
- We will raise the profile of nursing and therapy clinical practice to support the retention of staff.

6. Business Planning Objectives (contd)

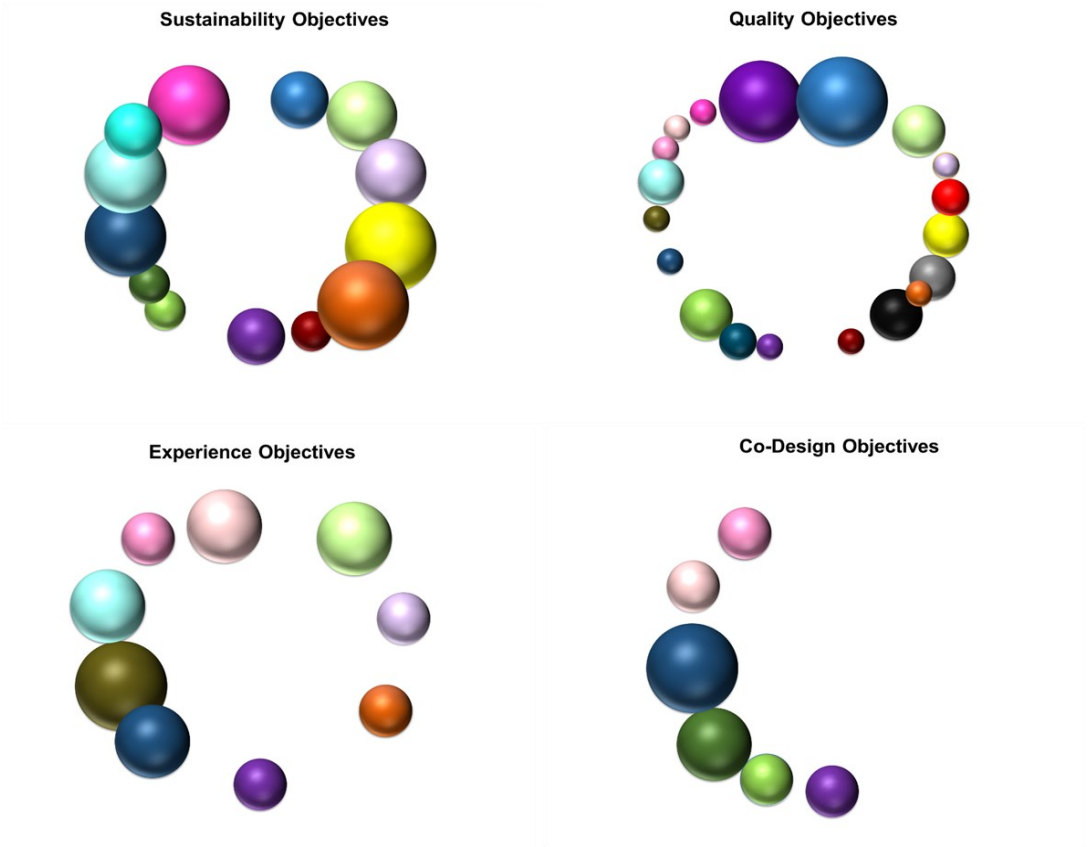
Finance

- We will continue to embed Business Partnering to improve the support for budget holders
- We will deploy an integrated performance dashboard that integrates all system data sources and make available existing operational reports in Tableau
- EVO (Engagement, Value, Outcome) methodology will be applied to agreed mental health services to understand patient level costing insight into clinical variation.

7. Business Planning Outcomes

7.1 One of the key aims for the business planning process is to demonstrate a preferred balance of objectives across the organisation.

7.2 The diagram below shows the balance of business planning objectives for 2020/21 by theme for each team across our operational and corporate directorates. The operational teams are coloured red/orange and the corporate teams are coloured blue/green. (The position of the bubble within each theme on the diagram has no significance.)



7.3 The diagram evidences a focus on quality and sustainability with 80% of objectives linked to these themes across the organisation. Some teams focus more on one theme than another. Corporate teams focus on experience and co-design the most.

7.4 There are 118 objectives in total with just over half belonging to corporate teams. There are 348 milestones identified.

7.5 The business planning objectives are included in Appendix 1. Please note: this does not include the full details of each objective, for ease of reading.

8. Risks

The key risks to delivering the Business Plan are identified as follows:

- **Impact of the Covid-19**: The business planning process has been constrained due to the urgent preparations in response to Covid-19. This has meant some of the planning information has not been fully addressed within the business plans and the impact on resources is unknown. There will be a refresh of the business planning objectives during Quarter 2 which will include an assessment of the impact of Covid-19 on the priorities for the business plan and the resources required for delivery throughout the year.

- **Impact of System Prioritisation on Investments**: At the time of writing there are key investment opportunities awaiting the outcome of the system prioritisation and subsequent contract negotiation. These will be refreshed once agreed and any unfunded objectives will be removed or an alternative delivery method will be explored.

9. Recommendations

The Board is asked to agree the business planning objectives and note the proposed refresh of objectives during Quarter 2.

Team or Service	Obj ID	OBJECTIVE DETAILS		
		Title of Objective	Smart Description Of Objective	Outcome Measures
Business Intelligence	**1**	Integrated business intelligence warehousing and data flows	To establish unified a BI warehousing infrastructure which integrates legacy approaches and meet business requirements by end 2020/21.	New warehousing infrastructure established and functioning to fully support Objective 2.
Business Intelligence	**2**	Integrated business intelligence performance dashboard and associated operational reporting	To deploy an integrated performance dashboard visualisation which integrates all system data sources by end of 2020/21. In addition to replicate and replace all existing operational reports in Tableau by end of Q2 in 2020/21.	Integrated performance dashboard deployed. Existing operational performance reports replicated and replaced. Decommissioning of existing BI tools.
Business Intelligence	**3**	Service specification reviews	To review all Applicable Quality Requirements (performance indicators) within existing service specifications by end Q3 2020/21, informing recommendations for variations.	Service specifications for mental health, learning disabilities and physical health in Gloucestershire reviewed and recommendations formulated.

Business Intelligence	**4**	Strategy, policy and process review	To develop a new BI strategy, review and update all existing policy and update processes by end of Q2 2020/21.	New BI framework written. Existing policy reviewed, updated policy documents written. Existing process document reviewed, updated processes written.
Estates, Facilities & Medical Equipment	**5**	EFD support to Business Development	Estates & Facilities team provide effective support to GHC Business Development initiatives	Estates & Facilities department able to evidence tangible value add (cost or risk reduction / enhanced quality / resilience) in joint working initiatives
Estates, Facilities & Medical Equipment	**6**	Property portfolio management	GHC property portfolio effectively managed in line with Estates Strategy and broader Trust strategies	Estates & facilities CIP targets for 2020/21 achieved and support to other departments targets evidenced. Property transactions progressed in line with Estates Strategy priorities Property income / tenants effectively managed in line with Estates strategic priorities

Estates, Facilities & Medical Equipment	**7**	Estates & facilities contract management	Processes and procedures to ensure Estates & facilities contracts are effectively managed are optimised	Contract Management processes and procedures evidence Estates & facilities contracts are effectively managed to deliver measurable cost saving, reduction in risk and/or increase in staff satisfaction through role enrichment
Estates, Facilities & Medical Equipment	**8**	Estates & Facilities development	Estates & Facilities team and reporting developed to address existing gaps in provision / capability / evidence	Performance reporting used to inform strategic departmental planning Performance reports available for all sites at least monthly Reporting demonstrates maintenance or improvement in performance standards across all key estates and facilities indicators
Community Hospitals	**9**	Out of area patients	To reduce the number of out of area patients for acute mental health inpatient areas and PICU so that it does not exceed the agreed level of 800 bed days at the end of March 2021,	No more than 800 bed days attributed to out of area placements for patients from acute mental health inpatient areas and PICU in 2020/21.

Community Hospitals	**10**	Workforce Development	To review the multi-disciplinary staffing model on inpatient wards (physical and mental health) to ensure they are able to meet the needs of our patients and are sustainable and resilient	Improved recruitment and retention (fewer vacancies/reduced turnover) Improved flexibility, responsiveness and resilience (reduced sickness absence rates) Reduced bank and agency spend (secondary to the two outcome measures above)
Community Hospitals	**11**	Ambulatory Care Review	To implement the actions identified in the Out-patient review by March 2021	Reduced or no gap between income and expenditure
Community Hospitals	**12**	Learning Disability Services	To participate in the development of a service design and workforce plan to deliver an Assessment and Treatment model for LD services	Service design and workforce plan for LD services in place by March 2021
Community Hospitals	**13**	Recovery/Rehabilitation services	To participate in the development of a service design and workforce plan to deliver a service for the local population in association with National Standards.	Service Design and workforce plan for Recovery/Rehabilitation services by April 2021.

HR Operations	**14**	Organisational Development 1	To co-develop, agree & commence implementation the Trust's new "Best People Strategy" ensuring that the Trust is in the best possible position for maximising it workforce potential and mitigating associated risks.	Improved people management practices, policies, procedures and outcome as measured via delivery of the implementation plan, improved workforce KPIs, Your Voice, Staff FFT and Staff Survey ratings.
HR Operations	**15**	Organisational Development 2	Respond to the requirements of the new National People Plan with local actions to deliver the national vision and improve the Trust's workforce and organisation development.	Unable to confirm until the Plan is published (March / April?)
HR Operations	**16**	Operational HR 1	To co-develop, agree & commence the delivery of a new GHC Recruitment & Retention Strategy & implementation plan to ensure the Trust has effective supply pipelines, strong relationships with HEIs, & that the Trust can maximise the attraction and retention of colleagues.	On target delivery of implementation plan, e.g. improved recruitment & retention BI data, reduced vacancy rates, shortened recruitment end to end lead times, refreshed web & social media presence, increased cover at local, regional & national recruitment fayres, reduced bank & agency spend, increased provision of local supply of key training programmes for prioritised professions,

HR Operations	**17**	Organisational Development 3	Delivery of a Health and Well-being Strategy and implementation plan. This includes the relocation of the Working Well team from GRH to Rikenel	To improve the health and well-being of staff as measured through quantitative metrics of staff self-referral physio uptake and outcomes, attendance percentages and qualitative metrics in the staff survey & health and well-being survey improvements
HR Operations	**18**	Operational HR 2	To ensure that there is improved Executive & Board scrutiny & oversight of disciplinaries, grievances & dignity at work case, that workforce policies incorporate “Just Culture” expectations & that management training, development & support enable the delivery of fairer colleague experience	To reduce the number of formal disciplinary, grievance & dignity cases, for the Staff Survey to evidence improvement in related Theme & individual question ratings, evidencing that the Trust has a culture of fairness, reflection, feedback & learning to deliver great care & employment.

HR Operations	**19**	Operational HR 3	Supporting flexibility & work/home-life balance for colleagues to deliver joined up physical, mental health & learning disabilities & support services	To ensure that the Trust has improved knowledge of and uptake of flexible working where feasible, leading to higher recruitment and retention rates and is rated by staff as an employer of choice which can be promoted to attract and retain staff.
HR Operations	**20**	Operational HR 4	To maintain Establishment Control in ESR throughout 2020/21	Establishment control totals accurately reflected in ESR Accurate workforce data pertaining to vacancies Establishment updated on a monthly basis
HR Operations	**21**	Operational HR 5	To complete the Business Consolidation Process in ESR during April 2020	Two payrolls successfully running from April onwards
HR Operations	**22**	Operational HR 6	To roll out Health Roster (Allocate) e-rostering system to teams currently using Kronos roster-pro by March 2021	All e-rostered teams successfully completing rosters through the new system
HR Operations	**23**	Operational HR 7	Maintain and establish EASY expenses system throughout the Trust	All staff have access and continue to have access to EASY expenses system

HR Operations	**24**	Operational HR 8	Roll out e-job planning	All relevant staff groups have access and are using e-job planning by the end of the year 2020/21
HR Operations	**25**	Operational HR 9	Implement TIS interface for Drs in training	Deanery TIS interface working efficiently
HR Operations	**26**	Operational HR 10	Working with BI team establish a set of Workforce management and KPI reports	Set of reports that are easily to access and understand
HR Operations	**27**	Operational HR 11	Continue the roll out of ESR supervisor self-service and link with pay progression training	Managers reporting ability, better data Quality, availability of absence data improved and improved team information for managers
HR Operations	**28**	Operational HR 12	To lead the workforce planning element of the new hospital within the Forest of Dean	A comprehensive workforce plan to ensure safe delivery of services
HR Operations	**29**	Operational HR 13	To create an admin champion network for Workforce Systems.	There is a body of staff who are able to provide place based advice and guidance for staff.
HR Operations	**30**	Operational HR 14	To continue to support and provide expertise to the Workforce Planning process across the Trust and wider ICS	Workforce plans developed and updated

HR Operations	**31**	Organisational Development 4	Ensure delivery of an easy-to-use Learning Management System which accurately reflects and records the Trust's Statutory/Mandatory training requirements.	All staff have an individual training record which they can access, which indicates their statutory/mandatory training requirements and which gives the Trust access to accurate training compliance figures.
HR Operations	**32**	Organisational Development 5	Design an effective, welcoming Corporate Induction programme of activity which meets Trust requirements and the needs of staff new to the Trust.	Corporate Induction runs twice weekly, with effective links to recruitment systems to ensure smooth on boarding and ensuring new staff do not unnecessarily repeat in-date training (passporting).
HR Operations	**33**	Organisational Development 6	Help ensure a competent, compassionate and safe workforce through continued provision of a range of high quality educational, learning and development activity.	Evaluation methodology confirmed that staff feel the Quality of the Trust's educational, learning and development activity is high, and that it helps support them to feel more competent and confident in carrying out their work roles.

HR Operations	**34**	Organisational Development 7	Develop and implement a strategy to supplement the Recruitment strategy for all aspects of widening access and apprenticeships across the Trust which support the Trust's service ambitions.	The Trust has an agreed and approved Apprenticeship and a Widening Access strategy, which informs decisions about apprenticeship development, including levy spend, and work experience opportunities all of which support the Trust's service ambitions.
HR Operations	**35**	Organisational Development 8	Provide a range of interventions including its new OD Leadership Development Programmes, designed to ensure an accessible and inclusive work culture in which all our staff are treated fairly, decently and free from discrimination.	The Trust's staff survey results show an improvement to the views of staff in terms of feeling they work in an accessible and inclusive work culture in which staff are treated fairly, decently and free from discrimination.
HR Operations	**36**	Organisational Development 9	The Trust will implement the requirements of the WDES and WRES schemes through its 2020/21 implementation plan	Data from sources such as the annual WRES & WDES reports, and the annual Staff Survey will show improvements over the previous year's data and rating.

HR Operations	**37**	Organisational Development 10	Introduce new staff engagement and pulse check methodologies to listen to staff views and respond to highlighted needs	Improved Staff Engagement Scores and response rates to monthly Your Voice surveys, annual Staff Surveys, and quarterly FFTs. Uptake examples of successful engagement on Staff Hub
Specialist Services Mental Health	**38**	Develop Long Term Conditions Service (LTC)	Develop clinical pathways and outcome measures to support co-delivery of LTC programmes across cardiac and pulmonary rehab courses. Work with Urgent Care to further develop co-delivery of other LTC groups, including diabetes and the LTC hub model.	Clear pathway for co-delivery of LTC groups, including scores to be collected pre and post intervention. Increase numbers of LTC patients in casesness being referred to IAPT service.
Specialist Services Mental Health	**39**	Review group courses	Review group courses across the county including administration processes for recording outcome measures. Identify efficiency improvements in the management of group courses which may lead to a reduction in staff requiring to deliver.	Staggered programme of group courses which reduces wait times for group interventions. Improved efficiency of model to support capacity and demand planning.
Specialist Services Mental Health	**40**	Capacity and Demand Planning	Developing workforce model needed to deliver access KPI's and increasing national trajectories. Modelling workforce based on trainee programmes and when trainees become clinically active.	Develop a model which is based on a clinically active workforce.

Specialist Services Mental Health	**41**	Digital solutions to providing therapy	Pilot use of video consultation to deliver therapy.	Provide a digital option to providing CBT therapy.
Specialist Services Mental Health	**42**	Early Intervention Team CCQI Compliance	Achieve Level 3 CCQI Compliance in Autumn 2020 Audit	Level 3 Compliance in CCQI Audit
Specialist Services Mental Health	**43**	ASC Waiting Times	Achieve 18 week wait times for ASC Assessment	18 week wait times for assessment
Specialist Services Mental Health	**44**	ADHD Waiting Times	Achieve 18 Week Wait Time KPI	Achieve 18 week wait Time KPI
Specialist Services Mental Health	**45**	Perinatal Team Development	Further development of Perinatal Team in line with LTP parameters.	7% of women in perinatal period accessing MH support, development of Maternity Outreach Clinic by end 2020/21.
Specialist Services Mental Health	**46**	Accommodation Transformation Project	Reconfiguration of Accommodation Team, Move contracts to GCC, Agree assessment format and move first cohort of patients to new accommodation	Improved accommodation for service users, meeting minimum core standard of 'own frint door' and en suite facilities for first cohort of service users . Accommodation offers countywide.

Therapies & Specialist Equipment	**47**	Align MSK services (including additional roles in primary care) Year 1	To agree, by the end of the financial year, a future structure for MSK services.	Evidence of engagement with Primary care ref deployment of Additional Roles. Future structure described. Implementation plan in place (for year 2)
Therapies & Specialist Equipment	**48**	Podiatry 8 week RTT Improvement Plan Year 2	Service to consistently achieve 8 week RTT within 1 year through staff led change	8 week RTT reporting Patient experience (FFT, complaints. Concerns)
Therapies & Specialist Equipment	**49**	Adult SLT Service Improvement plan Year 2	To maintain an active programme of continuous service improvement throughout the year	Achieve recruitment to hard to fill posts Improve and maintain 8 week RTT (KPI) Implement PROM Evaluate care home work stream (measure to be determined)
Therapies & Specialist Equipment	**50**	Telecare and Community Equipment Engage with service review	To actively engage with the planned service review until its conclusion.	CCG recognise as active partners in the review e.g. provision of information, attending and contributing to meetings and workshops as required.

Therapies & Specialist Equipment	**51**	Wheelchair Service Improvement plan Year 2	To improve service delivery by the end of the year.	Access to assessment (KPI) Delivery of equipment within 18 weeks (KPI) Reduction in concerns, complaints and serious incidents Introduction of a PROM/PREM
Dental & Sexual Health Services	**52**	Preparation for Tender Process	Continue with transformation. Ensure the service fits criteria for accreditation Expression of Interest	tbc
Dental & Sexual Health Services	**53**	Reduction of waiting times	E-referral made only route for referrals to ensure robust triage by senior dental officers in a timely manner. Dedicated booking office administration team to ensure full utilisation of clinical time	tbc
Dental & Sexual Health Services	**54**	I.V. Sedation	Start pilot study following approval from QAG/Board. Evaluation of clinical process and outcome data on a monthly basis with feedback to management team	tbc
Dental & Sexual Health Services	**55**	Recruitment	Review current structure and establishment to identify areas for re-evaluation/restructure and possible recruitment. Recruitment process for vacancies in B4 dental nurses/dental officers/decontamination assistants/reception/admin	tbc

Dental & Sexual Health Services	**56**	Digital Radiography	Identify need and advantages of converting to digital radiography in line with best practice.	tbc
Dental & Sexual Health Services	**57**	IT System	Review the current Lilie EPR system to ascertain whether the current IDOX system is sustainable	tbc
Dental & Sexual Health Services	**58**	HIV Care	Review HIV care pathway to ensure patients are seen at the right time by the right clinician to support patient's self-care	tbc
Dental & Sexual Health Services	**59**	Medical Staffing	Review current medical staffing provision of the PAS service and plan future needs of the service in line with national guidelines	tbc
Corporate Governance	**60**	Health and Safety Training for managers	Provide Supervising Safely accredited mandatory training to allow team managers to fulfil their obligations under H&S law.	20 Courses to be arranged to allow 300 team leaders to successfully complete post training assessment in this year with a further 150 for 21/22.
Corporate Governance	**61**	Health & Safety Training for Executives and NED's	Provide accredited mandatory training to allow Executive Directors and Non-Executive Directors to fulfil their obligations under H&S law.	H&S training compliance for all Board members.
Corporate Governance	**62**	Health & Safety Manual	Develop and distribute the H&S Manual throughout all GHC sites to assist managers in delivering their H&S obligations	Manuals distributed for each directorate/site across the whole trust by SRO's
Corporate Governance	**63**	Security Audit	Develop and deploy a Trust wide Security Audit tool	To have a robust Security Audit to provide reports detailing security risks across the Trust.

Corporate Governance	**64**	Violence and Aggression Risk Assessment standardisation	Confirmation and assurance that all units and departments within the new Trust have completed risk assessments	Trust fully assured and viable risk assessments available
Corporate Governance	**65**	Lone Working Risk Assessment standardisation	Confirmation and assurance that all units and departments within the new Trust have completed risk assessments	Trust fully assured and viable risk assessments available
Corporate Governance	**66**	CCTV Centralisation review, planning and costing	To review, identify and plan a Trust wide cloud based CCTV strategy	Each camera to have its own operational requirement sheet and data protection impact assessment. Cameras and system to be fit for purpose and necessary. The Trust to be fully compliant with current ICO codes of practice and data protection legislation.
Corporate Governance	**67**	Information Governance IMT IG 1	To represent Gloucestershire in the IG work stream for the Gloucestershire's Local Health Care Records Exemplar (LHCR), providing advice, guidance and expertise for IG Work streams. Report LHCR progress to the IG Group (IGG)	Liaise with the LHCR work stream lead Represent and attend LHCR meetings Report periodically to the IGG on LHCR activity

Corporate Governance	**68**	Information Governance IMT IG 2	To update and monitor the Data Security and Protection Toolkit (DSPT) progress for the Trust, reporting periodically to the IG Group (IGG) progress. To ensure GHC continues to achieve the appropriate Toolkit compliance level.	Periodic Cyber Security reports to IGG DSPT audit DSPT Interim submission reviewed by IGG DSPT Interim Submission made DSPT final submission reviewed by IGG DSPT submission published
Children & Young People's Service	**69**	CAMHS Service Transformation Plan	A whole service re-design to develop a service that offers children and young people timely access to the level of care they need in a way that suits them best. To deliver recommendations and action plan which will be an output from the Trailblazer (4WW) Work streams which will involve staff from all areas of the service: 1. to understand the needs of young people 2. determine the best referral process 3. develop the operating model 4. review the workforce 5. ensure that there is participation involvement and communication with stakeholders 6. develop improved personalised care 7. develop the use of digital and information technology to enhance care. Progress reviewed monthly by the '4WW' Project Group.	95% children and young people receive the first appointment within 4 weeks and 95% receive the second appointment in 8 weeks.

Children & Young People's Service	**70**	Immunisation Service - Web Based Application for Commissioner Reporting	To fulfil the contractual requirement to provide an integrated online consent system ,thereby facilitating the objective of populating, recording and reporting of information, notifications to GP's & CHIS and enabling the imms team to assess statistical information for the purpose of enhancing and maximising uptake of all programmes provided by the service.	The service will have the ability to run reliable reports from the web based application, in real time, to enable them to maximise uptake and for the current method of manual spreadsheets to be used only for business continuity rather than as the primary reporting tool.
Children & Young People's Service	**71**	Early years integration stepped model	Establish a pilot under 5's clinic in a PCN footprint based at Evergreen House in Cheltenham. Test an integrated pathway and new ways of working with integrated CYPS and other key stakeholders using QI approach. Going forward the model could be expanded to other PCN sites to develop an under 5's model that transforms services by integrating CAMHS services with current early years, HV and other services. Pilot cohort identified through current cases and referral routes then wider scoping across integrated services and early years and consider extending to primary provision.	Measure school readiness, Integrated joined up working across ILP services , identification of ACES with plan based on need , evidence of personalised care.

Children & Young People's Service	**72**	Promoting positive parenting through NBO & VIG	Maximise potential for parent-child relationship , secure attachment and development of resilience factors from birth . This support CYP and families to self- manage ACES .	Increase in UP family offer to provide packages to develop resilience factors to support infant and perinatal mental health. Reduce high impact referral to perinatal mental health service .

Children & Young People's Service	**73**	18-25yeas CAMHS	To support the emotional wellbeing and mental health needs of young adults aged 18 to 25 in Gloucestershire whom may otherwise fall between gaps in provision from children's and adult's mental health services. The initial proposal is to follow a model of joint working between Gloucestershire's statutory Mental Health services and Youth Information Advice and Counselling Services as recommended as an approach within Future in Mind 2015. In this instance the partnership would be between GHC CAMHS and Young Gloucestershire who already deliver a successful YIACS service in Gloucestershire with a strong emphasis on Participation.	• Commitment to improve the lives of Children and Young People up to the age of 25 • Build on previous learning and identifying gaps • An integrated approach across health, social care, education & the VCSE • Give particular consideration to those young people from identified vulnerable groups such as care leavers and those with an EHCP, who now have tailored services in education and social care that extend from childhood to age 25. • Promote engagement and provide an accessible service that reduces the higher DNA rate for this age group • Provide a new approach to young adult mental health services for people aged 18-25 will support

Nursing, Therapies & Quality	**74**	Increase the involvement of Experts by Experience in the Directorate's work streams	In 2020/21, the NTQ Directorate will increase the number of projects it leads which involve Experts by Experience (service users and carers) by 50%, compared to 2019/20.	50% increase in the number of activities led by the NTQ Directorate involving Experts by Experience.
Nursing, Therapies & Quality	**75**	Successful delivery of the merged Trust Governance structure	Each Governance committee will achieve a minimum of 85% in an audit of quality and effectiveness	Audit by the NTQ Directorate against the following areas: quoracy; adherence to Terms of Reference; effective reporting/escalation; Expert by Experience attendance
Nursing, Therapies & Quality	**76**	Delivery of a nursing and AHP strategic plan	During 2020/21, the NTQ Directorate will ensure engagement with the Nursing and AHP clinical workforce in order to co-produce and launch a Nursing and AHP strategic plan	Engagement with frontline teams using a range of methodologies (workshops, online survey, team feedback). Evidence of feedback shaping the content of the strategic plan. Communications to deliver effective launch of strategy.

Nursing, Therapies & Quality	**77**	Promotion of the profile of nursing practice	In order to increase engagement with the nursing workforce and improve retention rates, the NTQ Directorate will lead the design and delivery of a detailed action plan to increase the profile of nursing practice across the Trust and ICS. This will include the links to 'Year of the Nurse' activity.	Plan designed and delivered by Q2. 2% increase in nursing retention rates compared to 2019/20.
Nursing, Therapies & Quality	**78**	Delivery of electronic job planning for AHPs	By April 2021, 100% of the Allied Health Professions groups will have electronic job planning in place to support effective and efficient service delivery: to support manageable workloads, to protect time for supervision/CPD/quality improvement, and to support effective capacity mapping	Electronic job plans in place within Physiotherapy, Occupational Therapy, Speech and Language Therapy, Podiatry, and Dietetics
Nursing, Therapies & Quality	**79**	Delivery of the Quality Strategy	Delivery of all targets outlined within the 2020/21 Quality Strategy in order to continuously improve the quality of our services	Quality Strategy clearly linked the Trust priorities; targets across the breadth of services delivered by GHC; quarterly monitoring within the Quality Governance structures; effective engagement and co-production with Operational colleagues
Urgent Care	**80**	Urgent Care 1	To work with system partners to describe and implement the Community Urgent Care service in MIIU	Offer a streamline and efficient urgent care community provision across the county and reduce variance

Urgent Care	**81**	Urgent Care 2	To work with the Clinical Commissioning Group developing the intravenous therapy team model	Work with system partners to deliver on the action plan identified out of the development workshops Define the model of delivery. Define the model of service delivery
Urgent Care	**82**	Urgent Care 3	Year 2 To work with system partners in a test and learn approach to deliver the nationally mandated Clinical Advice & Assessment Service	Work with existing SPCA staff to build competencies, skills and operational abilities that can enable GCS to be able to deliver a strong CAAS model for the system
Urgent Care	**83**	Urgent Care 4	Improve the District nursing offer in collaboration with Day teams to improve efficiencies and ensure a stable and sustainable workforce	Review how demand is met by adjusting how the resource is used (shift times) so that recruitment is improved and patients are seen in the most appropriate time, reducing waits and inefficiencies; links with
Urgent Care	**84**	Urgent Care 5	Extend the hours of the First Point of Contact Centre to work 07.00 to 22.00 7 days a week in line with Long Term Plan	Review demand and capacity and NHS 111 requirements
Urgent Care	**85**	Urgent Care 6	Homeless Healthcare Team meets requirement of service specification	Homeless Healthcare Team meets requirement of service specification

Contracts & Planning	**86**	New FoD Hospital	Support on modelling for new FoD Hospital	Model complete as required
Contracts & Planning	**87**	MH Inpatient Recovery Unit	Modelling & Costing Re-Design of IP Mental Health Recovery Unit	Costed IP MH recovery unit and out of county cost reduction as a result
Contracts & Planning	**88**	Costing BI	To enhance Trust-wide insight from costing through the continuing development of patient-level cost data, and use of service line reporting (SLR).	3 services with data integrated into Tableau
Contracts & Planning	**89**	Aligning Physical & MH Costing	Aligning Physical & MH Costing	Fully aligned physical and mental health costing models
Contracts & Planning	**90**	EVO continuation	Engagement - Value - Outcome (EVO) workgroups organised for Mental Health Teams	2 Mental Health teams having EVO methodology applied to them to afford greater understanding of services
Contracts & Planning	**91**	NHSI CTP Roadmap Partnership	NHSI CTP Roadmap Partnership	Mental health and physical health pilot submissions for CTP compliant programme
Contracts & Planning	**92**	Income Contract Management	To improve the contract management process for income contracts with key commissioners and other organisations to deliver high quality contract support and response	All contracts and actions are up to date
contracts & planning	**93**	Outsourced Clinical System Contract Management	Ensure best possible outcomes from outsourced clinical service providers	Full contract compliance

contracts & planning	**94**	Procurement Services	To ensure procurement contract delivers high quality and responsive service	Trust outcomes met
Contracts & Planning	**95**	Business Development Pipeline	To proactively identify new opportunities for business development and align with the business planning cycle to ensure timely decision making and implementation	All income business development opportunities following correct business planning process
Programmes & Change Management	**96**	Establish Qulity Improvement (QI) Hub	To create and embed a Quality Improvement Programme including established resources, structure and reporting and QI training functions By March 2021.	Resources required identified and established recurrently. Systematic, Logging, monitoring and capture of QI iniatives.Service user representation embedded in the QI process is clear and measurable through levels of Ladder of engagement and participation (Arnstien-1969)
Programmes & Change Management	**97**	Better Care Together	Progression of the current BCT programme through estbalishing a clear and consistent programme management support function with defined work streams aligned to Strategic and Operational priorities	Programmes of work are established with work streams having clear outcome measures agreed by stakeholders that are monitored through robust project management structure.

Partnerships & Inclusion	**98**	Relaunch Partnership & Inclusion Team/Hub	By April 2021 relaunch the P&I team to ensure staff and partners understand the purpose of the team and what they can offer providing a central resource for engagement, co-production and the resources and expertise they have.	1. Established resource within the trust to deliver the objective. 2. Establish a clear baseline of colleagues and partners understanding of co-design, partnership and engagement within the trust. 3. Develop an improvement plan to increase the profile of the team, awareness among colleagues, partners, service users and carers.
Partnerships & Inclusion	**99**	People Participation	By April 2021 develop the people participation programme.	People who use our services are able to participate and involved in co-design of our services.
Partnerships & Inclusion	**100**	Engagement at ILPs	By April 2021 establish the strategy for the P & I team for place based working.	Clear and coherent strategy that identifies and informs how the P & I team engage with partners and people who use our services at a Place based level.

Information Management & Technology	**101**	Deliver RIO Electronic Prescribing Medication Administration (EPMA) Project Year 1 - In Patients	Implement an electronic system to facilitate and enhance the use of prescriptions to Mental Health In Patient Services measured by completion of implementation	Facilitate and enhance the communication of medicines and prescriptions, aiding choice, administration and supply of medicine and providing a robust audit trail for the prescribing use process improving patient safety
Information Management & Technology	**102**	Hereford transition to Worcestershire Health & Care (WHC) for Clinical Systems	Ensure a smooth transition of clinical systems from GHC to WHC by October 2020	Support no longer required from GHC for Hereford
Information Management & Technology	**103**	Upgrade to RIO v 20.1	Ensure a smooth and seamless upgrade to RIO clinical system thereby users being unaffected	System enhancements to improve patient care
Information Management & Technology	**104**	JUYI Development to include information from IAPTus	IAPTus data will be added to the JUYI system to do further enhance the information available in JUYI	Better patient care
Information Management & Technology	**105**	Review options for replacement of MS Office 2010 and implement Solution	Review options to replace MS Office 2010 by June 2020 and implement solution by October 20 for all GHC staff	Secure and robust IT systems for all GHC staff
Information Management & Technology	**106**	Embed the use of Teams and Kaizala In O365 across the trust to support business continuity and collaboration	Review options to roll out Teams and Kaizala by June 2020. Work on POC with chosen staff groups and then work on wider roll out across the trust	The provision of both collaboration and business continuity tools to support GHC in day to day operational business

Information Management & Technology	**107**	Migration of Former 2G apps	There are a number of former 2G applications that will be impacted by the merge with both a change of infrastructure setup to support the BI team changes and also the need to consolidate certain in house developed Apps into the same coding format. There is a particular risk around Apps that were developed by CITs that are no longer supported in the current format	The movement of former 2G Apps from the former 2G server infrastructure to the server infrastructure at EJC (movement of databases and application front ends) will be managed through. The review of former in-house coding applications will take place to ensure they are still required before a prioritisation plan is put in place to recreate these with the same coding language used to ensure commonality for both support purposes and to ensure code used is in-line with recent coding developments
Information Management & Technology	**108**	• Work with countywide to deliver HSN. Replacement firewall setup	There is a need to replace the current N3 network infrastructure and the Firewall setup that supports the county with a national requirement to replace N3 and move to HSCN and the firewall is EOL and causing operational issues with constant failures	This central network infrastructure that needs to be replaced will provide the county with: - Replacement for N3 with HSCN infrastructure - Replacement for Sophos UTM with Secure Boundary Firewall infrastructure - Replacement of EOL countywide firewalls

Information Management & Technology	**109**	Ensure Transition activities are completed to include wi-fi, Uniflow and 2G Domain	As part of the merger of 2G and GCS there has been a large IT transition program to rationalise both systems and infrastructure. A number of pieces of work have already completed in this area however the work is ongoing this year with a number of large infrastructure projects that are ongoing including: - 2G Domain decommissioning - WIFI roll out - Printing infrastructure merge	This work will ensure: - All work relating to the former 2G domain is completed and the domain decommissioned - All former 2G sites WIFI is replaced with Aruba WIFI - The printing infrastructure is merged and replacement devices are roll out across the former 2G estate
Information Management & Technology	**110**	Embed Clinical systems service desk in with IT	As part of the Transition the IT and Clinical service desk models have been reviewed and it has been confirmed the preferred approach would be to centralise the service desks to maximise support across the team improving the service for staff	This work will ensure the former 2G clinical systems service desk is integrated with the wider IT service desk (in GCS this had already been integrated)
Information Management & Technology	**111**	Network Improvements	There are a number of network issues that been impacting on GHC users and need to be resolved. As the network is a county resource this work needs to be completed in conjunction with CITS to enable the improvements to be made	This work will improve user experience for staff day to day working experiences by implementing a range of technical fixes and solutions to the network

Adult Community Services	**112**	Primary Care Networks and partnership working	To continue to work closely within the Primary Care Networks over the coming year on a realistic number of locally agreed developments and joint initiatives based on local need and Population Health Management	
Adult Community Services	**113**	ICT Referral Centre Developments	To Improve access to ICT services by developing a more patient facing Referral Centre supported by robust triaging and health coaching approaches.	
Adult Community Services	**114**	Develop and Implement EIO (Enhanced Independence Offer) model across Gloucestershire	Extending the impact of the ICTs on people's ability to live well in their homes by implementing of an improved community offer of re-ablement / rehabilitation.	Improved independence underlying the need for long term care. Reduce hospital admissions Reduce Hospital length of stay Reduce Readmissions
Adult Community Services	**115**	To ensure the work completed on clinical variation is embedded and rolled out to ensure high it is used in the design of high quality effectice and efficient serivces	Roll out the EVO model across the remaining Integrated Community Teams and begin work on developing the model in mental health with the Cheltenham MH Recovery Team	

Adult Community Services	**116**	A Review of the Gloucestershire Mental Health Recovery Model	To work closely with commissioners, staff and service users to redesign the Adult Community Mental Health Recovery Services to meet:- best practice national direction local requirements user views and feedback	Agreed new service specific contract re-negotation. Implementation plan with revised KPI agreed with CCG.
Adult Community Services	**117**	Community Dementia Services	To begin to realise the opportunity of ensuring people living with dementia benefit from the closer alignment of physical and mental health teams as part of the recent organisational merger	Improved outcomes in cases of joint working. Narrative quality case examples.
Adult Community Services	**118**	IPS	Implement a Individual Placement and Support model for secondary care. T	Evidence of fidelity to the national IPS model through annual audit. National return of employment gained on IPS Grow web site

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AGENDA ITEM 11b/0320

REPORT TO: Trust Board – 25th March 2020

PRESENTED BY: Sandra Betney, Director of Finance

AUTHOR: Stephen Andrews, Deputy Director of Finance

SUBJECT: **BUDGET SETTING PAPER 2020/21**

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

The purpose of this report is to
The Trust's Standing Financial Instructions state in section 2 'Business Planning, Budgets, Budgetary Control and Monitoring' that the Director of Finance will 'prepare and submit budgets for approval by the Board'.

This paper sets out the level of budgets proposed and how they have been prepared in order to meet this annual obligation under the Standing Financial Instructions.

Recommendations and decisions required

The Board is asked to:

- Note the budget-setting process and linkages within business planning and Cost Improvement Programme development processes
- Approve the revenue and capital budgets for 2020/21 and note the remainder of the five year capital plan
- Note the risks associated with the proposed budgets for 2020/21

Executive summary
The paper sets out the budget setting process for 2019/20. It highlights the links with the NHSI planning, contracting and business planning processes and sets out risks and opportunities within the financial targets that have been set for each service and directorate.

The budgets proposed in this paper form the financial basis of the System Operational Plan and Trust forward plan which will be submitted in due course to NHS Improvement, subject to approval by the Board.

The budgets proposed deliver the NHS Improvement trajectory set for the Trust of £621k and delivers an additional £600k surplus in order to support Gloucestershire Integrated Care System (ICS) meet its overall trajectory. These budgets will deliver a surplus of £1.221m.

In order to deliver these budgets recurring cost improvement schemes of £5.462m will be required. In addition £2.224m of non-recurring savings will need to be found to support non-recurring expenditure and non-recurring cost pressures.

A Capital budget of £9.945m is proposed for 2020/21. The Capital Management Group has met to discuss the priorities for next year. The main focus of the programme will be the development of the new Hospital in the Forest of Dean and the upgrade of the Low Secure Montpellier Unit to fit en-suite facilities into each room, and further significant investment in IT equipment to upgrade the spec. of the current equipment and roll it out across the newly merged organisation.

Risks associated with meeting the Trust's values
Risks have been identified within the paper under section 7.

Corporate considerations	
Quality Implications	Accurate and sufficient budgets are required to deliver high quality services.
Resource Implications	The Trust must get its financial budgets right to deliver services and successfully meet its statutory financial targets.
Equality Implications	

Where has this issue been discussed before?
Business Planning workshop December 2019, Executive team meetings, Capital Management Group.

Appendices:	

Report authorised by: Sandra Betney	**Title:** Director of Finance

FINANCE: BUDGET SETTING PAPER 2020/21

1.0 Introduction and Purpose

The purpose of this paper is to update the Trust Board on:

1) The progress made to date in setting budgets for 2020/21.
2) Risks arising from the budget setting process.
3) To give the Board sufficient information to approve budgets for 2020/21.

National planning guidance was issued to the NHS at the beginning of February 2020. As part of the national planning framework for 2020/21 the Trust has been given a Financial Trajectory Total of a £621k surplus.

2.0 Financial targets for 2020/21

The financial targets for 2020/21 were based on the following steps:
Recurrent 2019/20 month 8 budgets, adjusted for:

a. Pay and non-pay inflation (NHS funded and additional expected)
b. Cost pressures funded by the Trust
c. Relief of undelivered Cost Improvement Plans (CIP) from previous year
d. Demographic growth budgets to be apportioned to services.
e. Efficiency 1.0% CIP target
f. Differential CIP targets for Directorates
g. Challenge CIP schemes
h. Non-recurrent income and expenditure for services
i. CQUIN (Care Quality and Innovation) income expected
j. Known developments including Mental Health Investment Standards (MHIS)
k. Requirement of ICS and system partners

Final 2020/21 budget targets are set.

These calculations resulted in a budget position of a £621k surplus overall, matching the financial trajectory total plus an additional surplus of £600k which was a requirement for the Trust to deliver for the Gloucestershire ICS leading to a total surplus of £1.221m in 2020/21.

Financial targets were then allocated to services and budget holders proposed budgets for the New Year. Where there were difficulties in bringing the budgets within target, resolution meetings were held with the Director of Finance and the Service Leads to explore alternative options to reduce any gaps.

2.1 **Table 1: Financial targets**

Directorate	£000s
Adult Community Care	38,705
Hospitals	44,392
Specialist	27,019
Urgent Care	16,605
Childrens & Young Persons	18,668
Medical	12,977
Board	3,771
Finance	23,978
HR & OD	5,422
Nursing, Quality & Therapies	7,173
Strategies & Partnerships	902
Operations Management	6,798
Non Operational	12,959
TOTAL	219,370

3.0 Budget Setting Process

The budget setting process for 2020/21 followed a similar format and timeframe to the previous year for both the predecessor organisations. There had been some differences in approach but overall the method of setting budget targets for each directorate based on the planning assumptions, and then calculating the actual budgets from a bottom up approach and comparing the results was similar.

3.1 The budget setting process was as follows:

- Budget setting and business planning guidance was presented to Senior Operational staff at a workshop in December. This guidance was then disseminated by the operational finance teams to Directors, Service Directors and budget holders.
- Financial targets were calculated that gave an outline financial framework against which budget proposals could be measured.
- Business partners met with budget holders during December and January to prepare draft 2020/21 budgets.
- As part of preparing the 2020/21 budgets the Efficiency cost improvement of 1.0% was identified across all budgets.
- Cost pressures were submitted, considered and included within budgets.
- Budgets were finalised with budget holders.
- 2020/21 contracting discussions are continuing to take place with Gloucestershire CCG. The Trust has submitted proposed finance schedules which are now under review.

3.2 The assumptions used for budget setting are:

- Net tariff inflator of 1.4%. (inflation 2.5%, efficiency -1.1%)
- Average pay award of 3.1%.
- General non pay of 1.8%.

There were some differences in the respective approaches to budget setting which were altered during the process for 20/21. The two predecessor organisations had a different approach to setting budgets for people not in the pension scheme. To be consistent it was agreed that where staff are not in the pensions scheme then no budget is set for them. There is a risk however that this could change in year.

Another difference concerned vacancy abatement targets that reduced some budgets but not others. There were inconsistencies both between organisations and within them. All directorates now have a vacancy abatement budget at 2.5% except for Inpatient areas, IAPT, Medical staffing and Board, all of which have a 0% vacancy abatement budget.

Budget holders have been involved in the budget-setting process, both in agreeing their recurrent M8 baseline and working through the changes required to set their budgets for 2020/21 within financial targets. Budget setting was completed alongside business planning and there is a degree of integration between the business planning objectives and the budgets set. Workforce establishments have also been completed during this process.

The operational finance team worked with budget holders and service leads to align expenditure budgets to service needs, using a mixture of actual, forecast and in some cases activity data to agree realistic budget proposals for 2020/21.

A similar approach to dealing with costs pressures has been followed to that used in both predecessor organisations. A list of cost pressures was gathered from all services and submitted to the Deputy Director of Finance which totalled £4.412m. These were reviewed and discussed before a refined list of potential cost pressures was put forward to the Director of Finance. These were then reviewed and either approved, or rejected because they were deemed either avoidable or affordable within existing resources.

£1.078m of recurring cost pressures were approved and added to the proposed budget target across a number of directorates.

The medical staffing restructure was funded, with the funding (£0.324m) coming from the merger savings.

£0.576m of non-recurring cost pressures were approved including Out of Area Bed costs of £150k and peripatetic nursing teams of £267k.

3.3 **Table 2: Summary of Cost Pressures**

Cost Pressures	£000's
Funded	
Recurringly funded	1,078
Non Recurringly funded	576
Medical staffing structure	349
Not Funded	
Budgeted	1,356
Avoided	543
In risks	500
Total	**4,402**

Budget resolution meetings were held with Hospitals, Urgent Care, Estates, and Adult Community Care. These identified pressures in setting budgets within budget targets and met with the Director of Finance to agree ways forward to close the gap between the target and budget, where possible. Agreement was reached with all directorates which either had their target adjusted or were asked to find ways to mitigate the pressure. A small number of issues remain risks and these have been added to the risks listed in section 7 of this report.

No allowance has been made in budgets for the 6.3% increase to employer's pension contributions that was implemented in 2019/20. National guidance has recently stated that the impact of this should continue to be excluded from operational plans and financial projections as the additional costs will be paid by the Department of Health and Social Care in 2020/21 and not affect Trust finances.

As part of the merger the Trust expected to deliver a recurrent saving of £996k. After investing in the creation of an Organisational Development reserve of £0.1m and the funding of the Deputy Director of Strategy and Partnerships post of £0.116m the Trust has set a central budget of £0.780m. This will be held centrally until the financial year 2021/22 as per the Trust's merger business case.

In 2019/20 the merger programme was £0.341m under budget and the transition budget was £0.136m over budget. No budget has been set for any further transition or merger costs in 20/21.

The budget setting process this year has been more complicated due to the merger, having two finance ledgers and the condensed timescale. Safeguards and checks have been put in to ensure appropriate budgets have been set but there is a risk that adjustments may need to be made.

4.0 Income

Contract discussions are progressing with Gloucestershire CCG from which the Trust will get over 80% of its income in 20/21. A number of schemes funded non recurringly in 19/20 will be recurringly funded in 20/21, including £300k for MIIUs and £229k for rental charges.

As part of the contract negotiations with Gloucestershire CCG a level of investment is anticipated to be put into the contract to meet the Mental Health Investment Standard (MHIS). Built into budgets currently is £3.9m of income and a matching level of expenditure £3.9m. The agreed list of developments will be finalised as part of the contract negotiations but will not have an impact on the I&E surplus proposed in these budgets as the final expenditure budgets created will match the income that is received.

Proposed areas of investment currently include IAPT, Psychiatric Liaison, and some targeted investment in the Gloucester City locality.

As part of the discussions to agree the contract with Gloucestershire CCG it is anticipated that demographic growth funding will be received of £1.3m. During the budget setting process the Trust has committed £0.47m of this to Hospitals to support recurring specialling costs, and £0.1m for Mental Health Nurse Practitioners pilot thus far. The remaining balance (£0.709m) will be held in a central budget to support other demographic growth costs identified but not sufficiently quantified in budget setting e.g in integrated community teams and recovery teams.

There may need to be adjustments made to budgets once all contracts are finalised.

5.0 Cost Improvement Plans (CIPs)

The national savings requirement in the planning guidance for 2020/21 is 1.1% of NHS income. The Trust CIP is significantly higher than this, as illustrated in Table 5. CIPs have been set at a level required to deliver the control target if all expenditure budgets are spent and the budgeted level of income is earned.

The CIP requirement is made up not only of the national savings requirement but also from a number of other factors.

In 2019/20 the two predecessor Trusts had significant cost improvement programmes from which there was a combined shortfall of recurring savings of £2.2m which is then added to the cost improvement target. This was made up of a shortfall in the Challenge schemes from GCS of £1.280m and a shortfall in the overall delivery on the ^{2}gether programme of £0.920m. Overall this £2.2m shortfall represents a £0.3m increase on the original planning

figure due to the reduced level of recurring savings now indicated from the Modern Equivalent Asset valuation just undertaken for the Trust.

As part of the budget setting process the financial implications of the transfer of Herefordshire Mental Health services to Worcestershire Health & Care NHST have had to be built into the calculation of budgets for 20/21. The deficit from the transfer has been added to the cost improvement requirement and is £0.906m. This figure is a £0.175m reduction on the original planning figure identified in February.

A summary by original 2gether directorate is below.

	TOTAL SAVING REQUIRED	VALUE DELIVERED	FORECAST	TOTAL DELIVERABLE	SHORTFALL
Engagement & Integration	£77,709	£68,862	£0	£68,862	-£8,847
Quality & Performance	£233,537	£195,609	£33,468	£229,077	-£4,460
Operations / Service Delivery	£351,830	£281,905	£0	£281,905	-£69,924
Human Resources / OD	£353,895	£242,812	£47,901	£290,713	-£63,182
Finance & Commerce	£757,948	£173,265	£94,268	£267,533	-£490,414
Other Corporate Costs	£1,250,081	£473,000	£348,000	£821,000	-£429,081
Extra savings since identified			£158,941	£158,941	£158,941
TOTAL	**£3,025,000**	**£1,435,454**	**£682,578**	**£2,118,032**	**-£906,968**

There are several reasons for the under delivery.

- Around **£353k** of the shortfall occurred where the original assumption has since been tested and the basis of the original assumption when assessed when the saving was due to be delivered is not now valid.
- **£73k** of savings had been identified as Herefordshire corporate savings when they were also identified as savings realised as part of the merger process.
- There is a shortfall of **£81k** where although the reasoning behind the assumption was valid at the time, other factors have meant that the saving has not been wholly or in part delivered.
- The original plan assumed £873K of reserves when only £656K of reserves were set in the 19/20 budgets. In addition had allocated reserves been utilised an additional CIP would have been required to reinstate the reserves. This led to a shortfall of **£400K**

Recognising that this was a corporate saving, corporate services have been set the highest differential CIP savings, 1.5%, in addition to the efficiency savings at 1% and the 3% corporate merger savings delivered in 19/20.

CIP is expected to be recurrent, and result in reduction in budget, rather than just cost avoidance. In order to deliver the CIP requirement identified above the CIP is aligned to four main schemes:

a) Efficiency 1.0%, £2.148m. This is intended to target efficiency in every budget at individual budget holder level, is expected to be delivered full year and removed at budget setting.

b) Differential, £1.54m. This is spread over all areas between 0% and 1.5%, and is allocated based on previous delivery, and the ability and scope to deliver additional following the merger.

c) Challenge, £1.776m. It is expected that a small number of transformational schemes will be developed across the Trust. They will not be evenly distributed, and it is expected that significant phasing issues will be covered by NR underspends and over planning. They will require QEIAs to be completed. A number of areas have been identified where Challenge schemes could be sought and these include consolidation of Estate building usage, and reviews of Library services, Transport and Admin.

d) Non-recurring, £2.224m. £600k of non-recurring slippage in developments are anticipated in order to support delivery of the Countywide Integrated Care System (ICS). £812k of non-recurring savings are also planned to support the ICS. Other non-recurring savings are required to cover non recurring costs identified such as excess mileage payment, pay protection and non-recurring costs pressures such as out of area beds and the peripatetic nursing teams.

The overall savings programme of £7.686m equates to 3.5% of total Trust income in 20/21. This compares to 1.9% in 2gether last year and 4.5% in GCS.

5.1 **Table 3: Calculation of CIP requirement**

Gloucestershire Health & Care NHSFT Savings Requirement 20/21		£000's
Contract Efficiency CIP (1.1%)		2,232
Non delivery of CIP 2019/20		2,207
Herefordshire savings not delivered		906
Remove contingency budget and unallocated budgets	-	961
Cost Pressures funded		1,078
Recurring TOTAL		**5,462**
Non recurring - system contribution		813
Non recurring - costs and pressures		811
Non recurring - devt slippage		600
Non Recurring TOTAL		**2,224**
REQUIREMENT RECURRING & NON RECURRING TOTAL		7,686

The table below shows the current progress towards delivery of the different CIP schemes anticipated delivery of CIP by quarter through the year. It shows that the 1% Efficiency schemes and some of the Differential schemes have already been fully identified during budget setting. This equates to 42% of the total savings being already identified before the start of the financial year, or 58% of all recurring schemes being already identified. It also shows the Trust currently has 30% not identified which highlights a significant financial risk for 20/21.

5.2 **Table 4: CIP schemes and delivery to date**

CIP SUMMARY Scheme	Target £000's	Delivered in budget setting £000's	Planned, not delivered £000's	Identified, not planned £000's	Not identified £000's	Total £000's
Efficiency	2,148	2,148				**2,148**
Differential	1,540	1,007	120	413		**1,540**
Challenge	1,774			321	1,453	**1,774**
Non recurring	2,104		1,412	0	812	**2,224**
Total	**7,566**	**3,155**	**1,532**	**734**	**2,265**	**7,686**

CIP delivery is reported monthly as part of the Finance and Performance Reviews within Operations, at the Resources Committee and at CIP Management Group, where escalations are employed to expedite delivery.

6.0 Summary Position

The summary Income and Expenditure position for the Trust from the proposed budgets is as follows:

6.1 **Table 5: Trust Summary Income and Expenditure plan 20/21**

	£000's
Income	-220,486
Expenditure	209,619
Depreciation	5,732
PDC	4,019
Interest receivable	-105
TOTAL SURPLUS	**-1,221**

The proposed budgets give a surplus position for 20/21 of £1.221m.

Analysis has been conducted to identify expenditure by subjective code to give a picture of the main expenditure types that the Trust is spending against. The reduction in spend against most subjective expenditure headings

in 2020/21 compared to 2019/20 is due to the transfer of Herefordshire services to Worcestershire Health & Care NHST.

6.2 Table 6: Proposed budget by subjective code

Summary Expenditure budget by subjective

	Combined plan 2019/20 £000s	Combined actual 2019/20 £000s	Budget 2020/21 £000s
Pay costs	177,810	177,660	160,530
Purchase of Healthcare	10,328	10,810	9,664
Purchase of Social care	5,437	6,933	5,928
Supplies and Services	8,038	8,454	6,788
Drugs costs	3,858	4,188	3,527
Premises	11,584	12,325	10,018
Transport	3,009	2,919	2,132
Depreciation	5,859	6,326	5,736
PDC	3,944	3,936	4,019
Education and Training	2,340	2,013	1,660
Lease expenditure	1,423	2,780	1,252
Others	4,968	7,655	8,116
TOTAL	**238,598**	**245,999**	**219,370**

Analysis of the underlying recurring position of the Trust has also been conducted as part of the budget setting process (see table 4 below). This shows that if budgets are spent in line with those planned, and cost improvement plans are delivered then the Trust will have a recurring underlying deficit of £192k, which is a significant improvement on the underlying deficit of £1.556m that the Trust has at the end of 2019/20. This highlights that the Trust's ability to deliver the 19/20 financial control total is due to non-recurring underspends.

6.3 **Table 7: Underlying Financial Position 20/21**

GHC Underlying Financial Position 20/21		£000's	£000's
[2]gether NHSFT	19/20 Surplus excluding PSF	0	
Gloucestershire Care Services	19/20 Surplus excluding PSF	630	
Gloucestershire Health & Care NHSFT	**19/20 Surplus excluding PSF**		**630**
Non delivery recurrent savings			(2,207)
Underlying Deficit from 19/20			**(1,577)**
Pay increase		(4,838)	
Non pay increase		(1,468)	
Tariff uplift		4,873	
Tariff efficiency		(2,233)	
Net inflationary impact			(3,666)
Non recurrent cost pressures			(816)
Impact of Herefordshire transfer			(906)
Recurrent Savings			5,462
Non recurrent savings			2,104
Contingency not used n/r			500
20/21 forecast surplus			**1,101**
Remove Non Recurrent			**(1,293)**
Underlying deficit c/f			**(192)**

7.0 Risks in the Budget

There are a number of potential risks in the proposed budget that should be noted:

Risk	Mitigations	Likelihood	Impact	Risk Score
There is a risk that because CIP plans for the Challenge Schemes are not yet worked up, this may impact on the financial plan.	Non recurrent savings	4	4	16
There is a risk that final depreciation and PDC calculations will lead to cost pressures above the budgets set.	Work will continue to calculate the final impact in March and April to ensure there is sufficient time to address any risks that arise.	4	2	8
There is a risk that the budgets will need to be adjusted due to the complex and condensed nature of this years budget setting process.	Adjustments will be net neutral unless aproved by the Board	4	2	8
There is a risk that different approaches to setting budgets for Maternity leave cover will lead to overspends in some directorates	Non recurrent underspends will be used to support the position in individual budgets. Work will be done to assess the cost of making the approach to budgeting for maternity leave consistent for future years.	2	3	6
There is a risk that controls on agency staffing fail to significantly reduce expenditure on agency staff and the Trust continues to have to use agencies that are outside of national frameworks and/or above national price cap rates, particularly to fill needs in Medical staffing, and Nursing. This leads to the Trust surplus being impacted by agency costs	Agency Management Group Non recurrent savings and establishment budgets	2	3	6
There is a risk that as the Hospitals directorate has not identified funding for cohort 4 trainee nurse associates from the 1st April. If a decision is made to go ahead then savings will need to be identified.	Savings will be required to enable the decision	3	2	6
A vacancy abatement factor has been consistently applied across all budgets (apart for agreed exceptions such as Inpatient units). If services don't have a 2.5% vacancy level then this could lead to overspends.	Close monitoring by budget holders and business partners	1	4	4
There is a risk that becuase the Staff Bank funding model has not been harmonised in budget setting (remains half recurrently and half non-recurrently funded) a recurrrent cost pressure will emerge	Reviewing the overall requirements of the service for the merged organisation.	4	1	4
There is a risk that failure to meet the CQUIN targets leads to reduced income. (For the combined Trust CQUINs are now worth £2.2m.)	Closely monitor performance throughout the year. Non recurring budget to support delivery of the targets.	1	4	4
There is a risk that a Trustwide approach to insuring buildings has not been agreed. There is a risk that it might cost more than the current budget.	A review will be undertaken to ensure consistency across the whole Trust.	2	2	4
There is a risk the Coronavirus will lead to significant additional expenditure that has not been budgeted for in the 20/21 budget.	Monitoring arrangements have set up to ensure capture of any Coronavirus costs are captured so the Trust can be reimbursed by the Dept. of Health and Social Care.	1	3	3
There is a risk that a budget has not been set for the cost of moving different services into Rikenel when the GP Surgery moves out.	The costs will be offset against the savings they release as and when deciisons are made	2	1	2

If these risks materialise then there is also a reputational risk of not meeting the financial control target for the Gloucestershire ICS and partners losing financial support.

8.0 Opportunities

Both organisations have consistently delivered their financial control totals over a number of years even though they have not always met their recurring CIP targets. This has often been due to non-recurring savings made during the year and it is anticipated that the Trust will continue to be able to generate these savings to support the financial position of the Trust. In addition in 2020/21 the Trust will not have to cover the significant non-recurring merger and transition costs of the past two years giving further confidence that non recurring savings will be generated that can be utilised to support the Trust.

The Trust has set budgets to cover cost pressures through CIP delivery. If any of these cost pressures are later resolved through other means, this would be an opportunity to reduce the CIP burden for the year.
Other potential opportunities could be:

- through the Agenda for Change cost pressures for staff not covered by NHS contract income being funded through non-NHS contract income, as well as additional funding from the CCG for pressures highlighted to them.

- Potential additional overage from the sale of the housing on the Westridge site, as these are now in phase 1 of the development.

- Margin benefits from any new developments e.g IAPT or AMHPs as these have not been accounted for in the Trust's financial plans

9.0 Capital Expenditure

During 2020/21 the Trust intends to take forward two major building schemes. A scheme to make the Montpellier Ward Low Secure facility fully en-suite will commence in the early part of 2020/21 and planning work will begin on developing a new four bedded Learning Disabilities Assessment and Treatment facility. In addition the Trust will invest £2.3m on various Information Technology projects as part of the strategic aim to improve care through technology, and a significant project to upgrade and expand clinical and office space at Acorn House will commence to accommodate the expansion of the CYPS service

The overall Capital Plan for the Trust anticipates a spend of £9.945m in 2020/21, which includes £500k on the Forest of Dean new hospital. The breakdown by type of scheme is shown in the table below.

9.1 **Table 8: Capital Plan for 2020/21**

GHC Capital Plan	2020/21
£000s	**£000s**
Land and Buildings	
Buildings	4,259
Backlog Maintenance	1,393
Urgent Care	475
IT	
IT Device and software upgrade	600
IT Infrastructure	1,681
Medical Equipment	1,037
Sub Total	**9,445**
Forest of Dean	500
Total	**9,945**

10.0 Conclusion and Recommendations

It is recommended that the Trust Board:

a) Note the budget-setting process and linkages within business planning and CIP development processes.

b) Note the risks within the financial targets.

c) Approve the budget totals, including capital

Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 13/0320

REPORT TO: Trust Board – 25th March 2020

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

AUTHOR: Philip Baillie/David Smith, Integration/Transition Directors

SUBJECT: **PME CLOSURE REPORT**

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

The purpose of this report is to
Update the Board on the work of PME in overseeing the merger and subsequent integration activities, confirm the arrangements for embedding activities as 'business as usual' and as a consequence seek approval to stand down the PME.

Recommendations and decisions required

The Board is asked to:

- **Endorse** the arrangements for handover and the proposals for assessing future progress and performance towards the strategic intent and Quality Assurance.
- **Note** the status of the programme delivery budget including costs and savings
- **Endorse** the reallocation of outstanding risks to executive directors and consider those identified for inclusion in the BAF, noting the current challenges raised by Covid-19
- **Agree** the proposal to stand down PME with effect from the 1st April 2020

Executive summary

The GHC Board was updated on the work of the PME in January 2020 and in particular the preparation for this task and finish group's activities becoming embedded as business as usual. The purpose of this report is to provide any final detail and to confirm the transition to business as usual which will allow the PME to be stood down.

Key areas include a summary of handover arrangements including ongoing governance via individual executives (and as a collective), as well remaining integration work on key system merges and how these will be managed. The key questions of how progress and performance towards transformation can be assessed are considered with a description of how the Director of Strategy will oversee the collation and presentation of success to the Resources Committee and via the Improving Care Group to the Quality Committee. A summary of the final

programme delivery budget is provided with an explanation as to the variation in originally proposed recurrent savings of £1.265m with the actual recurrent savings of £0.966.

In standing down the PME an allocation of outstanding risks into other governance forums is described, including those strategic risks that could be considered for inclusion within the BAF. Reference is also made to the challenges posed by Covid-19 and its impact on any residual timelines. The paper also focuses on lessons learned, listing a number of successes as well as particular challenges. As a consequence, PME is assured that it will have fully served its purpose by 1st April 2020 and that systems are in place to provide the required future governance and assurance.

Risks associated with meeting the Trust's values

As referred above, risks have either been closed or reallocated and will continue to be overseen. In particular, the challenges posed by Covid-19 over the next few months will reflect the degree to which our values are embedded.

Corporate considerations	
Quality Implications	Considered within the paper
Resource Implications	As above
Equality Implications	

Where has this issue been discussed before?
The GHC Board was updated in January 2020 and PME has been monitoring progress on delivery. The closure report was agreed at the March PME meeting.

Appendices:	N/A

Report authorised by:	**Title:**
Sandra Betney	Joint Deputy CEO and DOF

PME CLOSURE REPORT

1.0 BACKGROUND

1.1 PME is the executive group which historically reported to the Strategic Intent Leadership Group (SILG) and led on delivery of the transaction to merge the two Trusts and the subsequent workforce, culture and system integration. Learning from other transactions identifies significant risk of momentum being merger behaviours. PME has implemented the plan to safely 'hand-over' delivery of the strategic intent to mitigate against this risk.

2.0 HANDOVER

2.1 **Governance**

The PME membership evolved as need changed and currently comprises the GHC executive chaired by the Director of Finance (Co-Deputy CEO) and provides, in effect, a 'ring fenced' and focussed executive team agenda. Post-PME, responsibility for delivery will remain with the executives, both individually and collectively with coordination through the CEO's routine executive meetings as required. Whilst Quality Improvement will become 'business as usual' it will still need some form of governance and championing if it is to compete with the daily operational pressures. This executive leadership and focus will be provided as part of strategy development and implementation by the Director of Strategy and Partnerships reporting to the Resources Committee and through the Improving Care Group to the Quality Committee. The FTC Transition Director role (Dave Smith) has been extended to end of June 2020 to support the executive team with implementation of the final key system integrations and has established a Workforce Data Working Group to ensure effective governance of these specific work streams.

2.2 **Progress and Performance**

The executives have considered how best to set, measure or report performance and progress, primarily as a means of supporting governance. Options considered ranged from the highly directive performance management system advocated by NHSI to the entirely informal option, maximising on colleagues freedom to innovate. The formal option was discounted as being counter-productive, resource intensive, inhibitive on innovation and not in keeping with Trust co-creating and co-production vision. Whilst there was support for the 'hands off' approach note was taken of the experience at NELFT where it was found that some guidance and prioritisation of colleague initiatives had been of significant benefit. PME executives agreed that whilst GHC should do nothing that threatened to stifle innovation it would be helpful to offer colleagues some support and guidance. The CEO and Director of Strategy and Partnerships have outlined the use of strategic themes to help guide (rather than prescribe) GHC development and this along with the desire to be in a position where success can be communicated, led, to the selection of a light touch option. The Director of

Strategy and Partnerships will be the executive responsible for overseeing the collation and presentation of delivery of identified strategic projects to the Resources Committee and through the Improving Care Group to the Quality Committee. The steps will be:

- Revise and collate proof of concept initiatives
- Manual collation of project deliverables contained in PMO sponsored projects
- Manual collation of improvements (delivered or intended) indicated in Life QI
- Grouping of initiatives from above steps to help indicate what is of 'bottom-up' interest to help inform strategy development
- Stored as central resource by the Communications Team
- Over-view report prepared by Director of Strategy and Partnerships. Ad-hoc quantification will be provided, if required (though this will not be the default) by the Business Intelligence function.
- Periodic release as communications items and an intranet update.

2.3 **Finance.** The £1.3m programme delivery budget approved by the Board in 2017 closes on 31 March 2020. The Board is invited to note:

2.4 **Non-Recurrent Costs**

- **Merger Programme Delivery** The merger programme was delivered at £0.341m under budget, driven mostly by underspends in project coordination and support.
- **Transition Costs** Non recurrent transition costs were £0.136m higher than planned due mainly to additional phase 2 exit costs of £0.254m. The planning assumption had been of no redundancy costs during that stage of restructuring.
- The additional non-recurrent transition costs can be more than offset by the £0.341m underspend in the merger cost budget.

2.5 **Recurrent Costs and Savings**

- The measures taken as a result of the merger are expected to deliver a recurrent saving to GHC of £0.996m
- The forecast recurrent savings anticipated in the FBC were in the order of £1.265m.
- The variation of £0.269m is largely attributable to:
    - decisions taken to provide additional capability to the medical structure (£0.323M)
- After investment in Transformation the saving to GHC is £0.780m. This variation is attributable to:
    - Creation of and Organisational Development reserve of £0.1m
    - Funding of the Deputy Director of Strategy and Partnerships of £0.116m

2.6 **Risks and Issues**

The Board will be aware that PME maintained and managed a comprehensive risk and issues register**.** The vast majority of risks have now either failed to materialise or been mitigated to an extent that they can be removed. At the March PME meeting a comprehensive review of all outstanding risks was undertaken. In those few cases where it is felt a risk to GHC remains these have been passed to and discussed with an appropriate risk owner. In practice this means that;

2.7 **Executives** (via the weekly Executive meeting) will monitor current risks relating to:

- Loss of key colleagues
- Gaps occasioned by this or through a failure to appoint in the last phase of organisational restructures
- Ensuring that focus is neither lost nor perceived to have been lost on pre-merger specialisms

2.8 **Directorate of Strategy and Partnerships** (via their internal governance structures and escalation to the broader executive team will monitor risks relating to:

- Changes at a national level relating to health/social care impacting on the planned transformation
- Failing to embed cultural change and alignment within our planned transformation
- Differences in pace between ICS and our strategic intent creating tensions and compromising the delivery of benefits.

The Transition Director will continue to shadow these in the short term, either in conjunction with the appropriate SRO or via the weekly executive meetings. System implementation risks will be managed within the Workforce Data Working Group and escalated to executives as appropriate.

In addition to these reallocated risks, PME considered two other risks which they believe to be very closely linked with the developing Trust strategy and therefore needing to be considered by the ***Board*** for inclusion in the Board Assurance Framework (BAF):

- That we fail to sufficiently manage expectation among internal and external stakeholders regarding merger benefits and stability
- That with the pace no longer set externally, we fail to define and deliver the optimum rate of change with the consequence that we either fail to allow time for recovery and consolidation or we lose momentum and fail to deliver the full benefits of integration and transformation.

2.10 **Quality Assurance**

Changes, improvements and initiatives will be subject to the quality assurance system implemented by the Director of Nursing, Therapies and

Quality. Further guidance as to when and how quality and equality impact assessments should be completed has been issued and compliance will be monitored. Quality assurance reports will be submitted to the Quality Committee and will include the impact of any significant change and Quality Improvement activities. The GHC Board is required to submit its post-transaction quality certificate to NHSI within 6 months of merger (ie by 1 April 2020). The version submitted to NHSI on merger has been updated by the Head of Corporate Affairs for approval and is a separate agenda item for this Board.

2.11 **Obligations and Undertakings**

PME oversaw completion of those items which arose from the advisory recommendations of Grant Thornton and the NHSI or were undertakings given in the FRP or Quality memorandum. The vast majority of items have subsequently been completed as the reporting procedures and quality systems are put in place. Any residual items will continue to be tracked by the executive team with any risks and issues escalated to the Resources and Quality Committees as required.

2.12 **Final Integration**

There are some areas of integration which for technical or procurement reasons won't be completed in this financial year. Whilst their delivery will be the responsibility of the relevant executive there are areas of dependency it was decided to extend the Transition Director post until the end of June 2020. There will be a number of system changes, notably around corporate systems and workforce data (especially finance ledgers and ESR) whose effects will be felt by colleagues in the period from mid-March to end of April 2020. There is a risk that this system go-live period will be as impactful, as Day 1, potentially more so and this was the prime reason for extending the Transition Director in post by way of coordination. Operational colleagues have been fully involved in reviewing both the roll out dates (which have been staggered to mitigate the impact) as well as the training plans - a programme of user familiarisation training, tailored to those that need it, has been developed and a communications and issues management plan similar to that for Day 1 is being put in place to ensure post-implementation support. To date the training has been very well received with colleagues generally impressed with the additional capability and improvements represented by the adopted systems.

2.13 **Culture, Values and Workforce**

PME had been monitoring the impact of merger on the workforce through the Pulse Survey and more recently through workforce reporting. It has not established a direct link, though turbulence does seem to be greatest in the corporate services and a deep dive was held into that aspect. As a result it was decided to provide renewed focus on leadership and personal development through-out the management layers and to review GHC structures on a dynamic basis. Maintaining OD momentum is a key enabler to delivering on the Trust strategic objectives.

2.14 **Covid 19**

It would also be appropriate to recognise at this juncture that the need to ensure an appropriate response to the threat posed by 'Covid 19' and also in safeguarding the continuance of priority services during this period, may well result in some elements of integration being delayed. PME have reviewed this, recognising the dynamic nature of the situation. There are a number of high impact tasks within the integration timeline scheduled for the next quarter and the Transition Director will liaise with individual SRO's in terms of resource allocation and prioritisation, providing weekly updates to the executive team. The system changes referred to above will go ahead because not doing so creates additional longer term risks, however creative solutions will be found to the issues regarding training. The bigger challenges are likely to focus around important but 'discretionary' activity such as the OD interventions described above, particularly where formal development sessions are concerned. The focus will therefore switch to design and readiness to implement at the appropriate point.

2.15 **Lessons Identified**

We have developed a 'Thoughts from our Journey' presentation to support other Trusts in their mergers. The key lessons are summarised in the tables below:

2.16 <u>What We Did Well</u>

- A strong case, aligned to national priorities, passionately owned by the Boards and successfully shared with colleagues
- Done by us, not to us and with co-delivery
- Colleagues believed in the cause and were prepared to 'dig deep'
- Cultural alignment started early and with high profile
- A committed and disciplined approach to 'passing the exam'
- Relationship with NHSI regional team
- Integrating early and visibly, no pause or unravelling post-merger
- Minimal redundancies below Board level
- Merging of best practice, systems and processes
- Phasing in before and after merger rather than big bang
- Preparation for Day 1, Month 1, year-end potential trip hazards
- Maintaining an eye on the real prize – transformation not the merger
- Setting out the Transforming Organisation and proving the concept
- Communications and pulse check – an integral part not just a tool

2.17 <u>Particular Challenges</u>

- We might not know yet – but we are ready
- Simultaneously meeting both BAU and Change pressures
- Communications – 'poor signal zones'
- Allowing for co-development
- Grasping the nettle
- Overcoming the notion of winners and losers
- Individual uncertainty and concerns
- Quantifying benefits

- A tense wait for last minute Ministerial sign-off!!
- Allowing for recovery and consolidation?

3.0 SUMMARY AND RECOMMENDATIONS

3.1 The PME, individually and collectively is assured that it will have fully served its purpose by 1 April 2020, that the appropriate steps have been taken to ensure that any remaining risks and issues have been properly transferred and that systems are in place to provide the required governance and assurance.

3.2 The Board is asked to:

- Endorse the arrangements for handover and the proposals for assessing future progress and performance towards the strategic intent and Quality Assurance,
- Note the status of the programme delivery budget including costs and savings
- Endorse the reallocation of outstanding risks to executive directors and consider those identified for inclusion in the BAF, noting the current challenges raised by Covid-19
- Agree the proposal to stand down PME with effect from the 1st April 2020

with you, for you

Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 13/0320

REPORT TO: Trust Board - 25 Month 2020

PRESENTED BY: Lavinia Rowsell, Head of Governance and Trust Secretary

AUTHOR: Lavinia Rowsell, Head of Governance and Trust Secretary

SUBJECT: **CORPORATE GOVERNANCE CERTIFICATE**

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

The purpose of this report is to

To meet one of the NHS Improvement merger application requirements to submit a revised corporate governance statement within 6 months of the formation of the new Trust.

Recommendations and decisions required

The Board is asked to **approve** the updated corporate governance statement for submission to NHS Improvement.

Executive summary

As part of the merger transaction process the Trust was required to submit a number of statements and certificates to NHS Improvement. One of these was a Corporate Governance Statement which was required as part of the pre-merger due diligence and was approved by the predecessor Boards in August 2019. There is a requirement that this statement be reviewed within six months of the formation of the new Trust i.e. by end March 2020.

The attached statement has been reviewed and updated in discussion with relevant departments/Executive Leads. It is presented to the Board for approval, prior to submission to NHSI by the deadline of 31 March 2020.

Risks associated with meeting the Trust's values
A reputational risk may arise if the Trust does not meet the NHSI post-merger requirements. NHSI may take regulatory action if it believes that post-merger requirements not being met are a breach of license.

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

Where has this issue been discussed before?
Internal discussions with PME programme Director and Director of Finance.

Appendices:	Corporate Governance Statement

Report authorised by: Sandra Betney	**Title:** Director of Finance

CORPORATE GOVERNANCE CERTIFICATE

		Corporate Governance Statement	
Governance Statement	**Evidence for current compliance**	**Unmitigated risks to future compliance, or supporting information**	**Suggested declaration**
The Board is satisfied that GHC 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 • Systems and processes reviewed against principles and standards to ensure in line with good practice and were confirmed and approved as part of the merger process • Engagement programme with stakeholders • Scheduled Board meetings including meeting held in public • Committee structure and Committee meeting programme • Quality Committee, provides focus and challenge on quality and clinical and safety risk issues • Performance dashboards to Resources Committee • Performance exception reports to Board • Quality monitoring and reporting to Quality Committee • CCG observer presence at Quality Committee • Quality Strategy aims translate into service planning objectives • Quality Report and indicators • Financial reporting monthly to Board and Resources Committee	No unmitigated risks identified	Confirmed

	• 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 • Regular update and review of risk register • Implementation of integrated Datix incident reporting system • Council of Governors statutory roles in holding NEDs to account • Service experience function and reports to Board • Patient safety reports to Board and Quality Committee • Patient Stories agenda item at public Board meetings • Meeting evaluation process used at each Board meeting • Mental Health Legislation Scrutiny Committee and Managers' Forum • Whistleblowing/ Freedom to Speak Up and other organisational policies and procedures in place • External auditors appointed • Internal audit programme • Clinical audit programme • Compliance with FT Code of Governance • NHS Improvement approval of post merger arrangements • Constitution for GHC • 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 • Conflicts of Interests policy implemented • Declarations of Interests at all meetings • Single Oversight Framework segmentation predicted 1 at end of 2019/20 • Positive CQC inspection report for 2g and GCS		
The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	• Regular CEO Reports to Board highlight relevant new publications/guidance • Policy and guidance updated as required to Committees • External Auditor Sector development report • NHS I Bulletins received by Exec Directors and Trust Secretary • Annual Reporting Manual guidance • The GHC governance and committee structures assessed and approved by NHSI and external opinion auditors • Compliance with FT Code of Governance confirmed in Annual Report • Legal bulletins and updates received by Trust Secretary and disseminated as appropriate	No unmitigated risks identified	Confirmed
The Board is satisfied that GHC NHS Foundation Trust implements effective board and committee structures	• Committee structures reviewed as part of the process of forming GHC and endorsed by NHSI. • Capital expenditure monitoring at Resources Committee • Triangulation processes between committees through membership • Strengthened Capital Management Group • Clinical presence on Board (Executive and Non-Executive) • Committee summary reports to Board	No unmitigated risks identified	Confirmed

	• Audit Committee annual effectiveness review • Other Committee annual effectiveness reviews planned • Internal audit of Board and Committee effectiveness • Locality Governance structures • Sub-committees mapped		
The Board is satisfied that GHC 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 aligned to strategic priorities • Committee Terms of Reference produced and will be 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 GHC 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 Chief Operating Officer lead on quality and service experience matters • Medical Director is Caldicott Guardian • Deputy CEO is Senior Information Risk Owner • Named Board member leads for Learning From Deaths, Counter Fraud, Security Management, Procurement, Whistleblowing/Freedom to Speak Up, Health and Safety, Equality and Diversity, Safeguarding, Climate Protection, Emergency Planning • Lead Executive for each Committee • Committees reviewed in year	No unmitigated risks identified	Confirmed

	• 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 • Staff appraisals and objectives linked to organisational objectives		
The board is satisfied that GHC NHS Foundation Trust effectively implements systems and/or processes for timely and effective scrutiny and oversight by the board of the licence holder's operations	• Going concern report to Audit Committee • Board Finance Reports • Savings Plans in place • Quality Impact Assessments process in place, overseen by Quality Committee • Budget setting process • Strategic Plan • Capital Programme • Performance dashboard reports to Resources Committee • Performance exceptions reports to Board • Quality reports to Board/Quality Committee Outcomes reporting • Clinical audit programme • Internal audit programme • External auditor in place • CQC registration • Aggregated Learning Reports to Quality Committee • Single Oversight Framework segment 1 rating • Service/business planning process • Service plans include actions for 5 Year Forward View and the Long Term Plan	No unmitigated risks identified	Confirmed
The Board is satisfied that GHC NHS Foundation Trust effectively	• Executive meetings • NED oversight on Board and Committees	No unmitigated risks identified	Confirmed

implements systems and/or processes to ensure compliance with the Licence holder's duty to provide timely and effective scrutiny and oversight	• Mental Health Legislation Scrutiny Committee meeting • Resources Committee meetings • Quality Committee meetings • Audit Committee meetings • Board and Committee agenda planners • Monthly performance dashboards and exception reports • Locality reviews at Resources and Quality Committees • Service performance focus reports to Resources Committee • Meet the Executive/Executive Safety walkabouts • Board NED visits • CQC compliance regular reports to Quality Committee • Overall control total achieved • Identified Cost Improvement Programme for 2020/21		
The Board is satisfied that GHC 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 Resources Committee • Safety/quality oversight by Quality Committee • Board performance exception reports • CQC/Mental Health Act compliance reports • CQC inspection report • Medical/nursing revalidation programmes • Mental Health Legislation Scrutiny Committee oversight • Executive safety walkabouts • Board NED visits • Clinical audit programme • Statutory and mandatory training requirements • Clinical policies • PLACE visits	No unmitigated risks identified	Confirmed

	• Mental Health Act/Mental Capacity Act policies • Mental Health Act Managers in place • Quality Report • Francis processes in place • Regulatory inspection reports/action planning • Inquest reports/action planning • Quality Impact Assessments for efficiency and transformation proposals • QIAs processes reviewed by Medical Director, Director of Nursing, Therapies and Quality and updated in line with revised policy • Workforce and Organisation Development Strategy and implementation plan • Staff Survey action plan		
The Board is satisfied that GHC 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 Resources 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 as required • Counter Fraud Service and annual action plan • Resources Committee oversight of development	No unmitigated risks identified	Confirmed

	opportunities and business cases • Tender submission procedures • Governor approval process for significant transactions • Workforce and 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		
The Board is satisfied that GHC NHS Foundation Trust effectively implements systems and/or processes to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making	• Board/Committee agenda planners • Monthly Finance and Performance reports • Performance Point system to provide up to date high quality data • 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	No unmitigated risks identified	Confirmed
The Board is satisfied that GHC 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 Committee and Board • Board Assurance Map review by Executive Meetings, Audit Committee and Board • Performance early warning reports to Quality/Resources Committee • Internal audit programme • Clinical audit programme • Risk identification as standing Committee agenda item	No unmitigated risks identified	Confirmed

	• Incident Reporting policy and culture • Whistleblowing/Freedom to Speak Up policy and procedure • Quality Impact Assessments process		
The Board is satisfied that GHC 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 where appropriate external assurance on such plans and their delivery	• Annual operational planning process • Service planning process involves service users and Governors • Annual plan/operational plan submission to NHS I • Alignment of service planning and organisational objectives • Plans aligned to commissioners' stated intentions • Resources Committee oversight • Executive oversight • Governor consultation on business plan • Quarterly monitoring reports to Resources Committee • Performance reports • Finance reports • Quality report – external consultation • Lead Exec identified re Healthwatch • External auditors report on Quality report	No unmitigated risks identified	Confirmed
The Board is satisfied that GHC 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 oversight • Audit Committee • Charitable Funds Committee • Information Governance policies and procedures	No unmitigated risks identified	Confirmed

	• 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		
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 Nursing, Therapies and Qualities are clinicians • A number of NEDs are clinicians • Non-Executive Director engagement and review provides rigorous quality challenge	No unmitigated risks identified	Confirmed
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 • 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	• Regular performance dashboard to Resources/Quality Committee • Performance Exception reports to Board • Quarterly update reports on Quality Report • Regular 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	• Regular performance dashboard to Resources/Quality Committees • Performance Exception reports to Board • Quarterly update reports on Quality Report • Monthly Patient Safety report to Board • Monthly performance reports to Resources 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 GHC 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 • Update reports on Quality Report shared with stakeholders including Clinical Commissioning Groups, HealthWatch and Overview and Scrutiny Committees, and feedback encouraged • Governors engaged with Quality Report audit processes • Engagement & Communication processes • Patient surveys • Staff Survey • Complaints and Comments process • Patient and Staff Friends & Family Tests • Patient Story is regular agenda item at public Board meetings • Service Experience function and reports to Board • Stakeholder groups as required • 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” ICS Clinical and non-clinical workstreams	No unmitigated risks identified	Confirmed

	• Triangle of Care • Co-production of new care pathways involving service users and stakeholders, • Ongoing QI system		
The Board is satisfied that systems and processes in place ensure that there is clear accountability for quality of care throughout GHC 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	• Quality Governance assigned to Exec Directors • Non-Exec Director oversight of Quality • Clinical Directors • Service Directors • Heads of Profession • Lead Nurses • Board Committee and sub-committee structure • Locality Committees have reporting line to Board through the Quality Committee		
The Board of GHC 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	• Board recruitment processes (including Fit and Proper Person Test requirements) • Governor appointment of Non Exec Directors • Appointment & Terms of Service Committee for Executive recruitment • Budgeted establishment • Delegated recruitment processes • Recruitment and selection policy	No unmitigated risks identified	Confirmed

compliance with the conditions of this Licence.	• Appraisal and revalidation policies • Ward staffing levels information		

Submitted for and on behalf of Gloucestershire NHS Foundation Trust Board 6 months after Trust formation following merger

Signed on behalf of the Board:

Paul Roberts
Chief Executive Officer
Dated: 26 March 2020

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 14/0320

REPORT TO: Trust Board - 25 March 2020

PRESENTED BY: Neil Savage, Director of HR & OD

AUTHOR: Linda Gabaldoni, Head of OD
Neil Savage, Director of HR & OD

SUBJECT: **2019 NHS NATIONAL STAFF SURVEY REPORT**

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

The purpose of this report

This report presents a summary of the 2019 Annual Staff Survey published in February 2020.

The National Office required the Trust to compete two separate surveys – one for the former 2gether NHSFT (2g) and another former Gloucestershire Care Services NHST (GCS). The survey was completed between October and November 2019. All staff in post on 1st September 2019 were invited to take part in the confidential online survey.

Further changes were made to the 2019 survey. An additional eleventh Theme was introduced on "team working".

Recommendations and decisions required

The Board of Directors is asked to **note**:

- the findings and recommendations from the two 2019 surveys
- that the majority of Themes had no statistically significant improvement or deterioration at a time of merger and major change
- a rating of overall significant assurance on Staff Engagement for the former 2G and the highest score of the past five years in the former GCS
- the statistically significant improvements in three GCS Themes
- the statistically significant reductions in two 2G Themes
- that the relevant outcomes in the survey are being taken forward within the Workforce Disability Equality Standard and Workforce Race Equality Standard Action Plans, for 2020.

Executive summary

A summary the results is attached as a PowerPoint presentation as appendix 1. This includes comparisons with other organisations in Gloucestershire, more widely and also

with other recently merged Trusts. The national benchmark report summaries are available in the reading room or via links set out below.

Key headlines include:

- A performance to be proud of given context of merger
- GCS services show some marked & sustained improvements
- 2G services largely maintained position with a few exceptions & remained in top half of MH Trusts in England
- GCS, 3rd best Community Trust for colleagues recommending the Trust as a place to receive care
- 2G, 4th best MH/LD Trust for colleagues recommending Trust both as (A) a place to receive care and (B) an organisation to work for
- 2G 6/11 Themes above benchmark cluster average
- GCS 8/11 Themes improved
- Staff engagement rating for GCS improved to 7.1, the highest score in 5 years, while 2G remained at 7.2, in top half of MH/LD Trusts

Given that the surveys were completed at the time of the merger with its heightened workload and communications, alongside the point that a number of related Phase 2 and Phase 3 Management of Change processes had just completed or were still in the process of being worked through, the overarching results are generally positive, with some exceptions for example for 2G generally in terms of morale and immediate managers, alongside some notable corporate teams.

GCS's response rate was 36%, down from 40% the previous year. The usual comparator group of Community trusts' average response rate was 58%. 2G's response was 33%, down from 40% the previous year. The usual comparator group of Mental Health and Learning Disability trusts' average response rate was 54%. This will need to be a prime area of focus for the 2020 survey.

While the lower responses are disappointing, there was an expectation that these would be lower in view of the timing of the survey. It was sent out at peak merger time with a high level of corporate communications, an anecdotal "survey overload" reported by many colleagues alongside an internal IT issue which blocked the distribution of the surveys for a number of colleagues. However, as 6 reminders with links to the survey were sent to those not completing the survey, this latter issue was believed to have been mitigated against.

Risks associated with meeting the Trust's values

The results of the Survey are published nationally and locally. Perception and knowledge of results may impact the view service users, carers and other stakeholders have of the Trust. In addition, the results can impact the Trust's ability to demonstrate that it is an employer of choice with the resultant effect on recruitment and retention.

Corporate considerations	
Quality Implications	The results are part of a range of feedback that reflect how staff view the Trust, including the quality of the services it provides and of the Trust as an employer.
Resource Implications	The delivery of actions arising will be managed within existing resources.
Equality Implications	The surveys' limited equalities monitoring across all protected characteristics reduces the usefulness of the evidence to support actions to reduce barriers and improve staff experience particularly regarding race. However, it provides some useful pointers which will be taken forwards in actions.

Where has this issue been discussed before?	
Executive Committee	27 January & 11 February 2020
Workforce Management Group	February 2020
Senior HR/OD Directorate Team Meeting	February 2020
Resources Committee	February 2020

Explanation of acronyms used:	GCS – Gloucestershire Care Services 2G – 2gether NHS Foundation Trust MHLDT – Mental Health/Learning Disability Trusts QH – Quality Health ESR – Electronic Staff Record NHSE – NHS England

Appendices:	The Staff Survey Results summary for both GCS and 2gether are available for viewing in the Reading Room on Diligent and/or by following the below links: http://www.nhsstaffsurveyresults.com/wp-content/uploads/2020/02/NHS_staff_survey_2019_RTQ_summary.pdf http://www.nhsstaffsurveyresults.com/wp-content/uploads/2020/02/NHS_staff_survey_2019_R1J_summary.pdf This paper is accompanied by a presentation, in the event of the meeting being held by teleconference this can also be found in the Diligent Reading Room.

Report authorised by: Neil Savage	**Title:** Director of HR & OD

2019 NHS National Staff Survey

1.0 Introduction

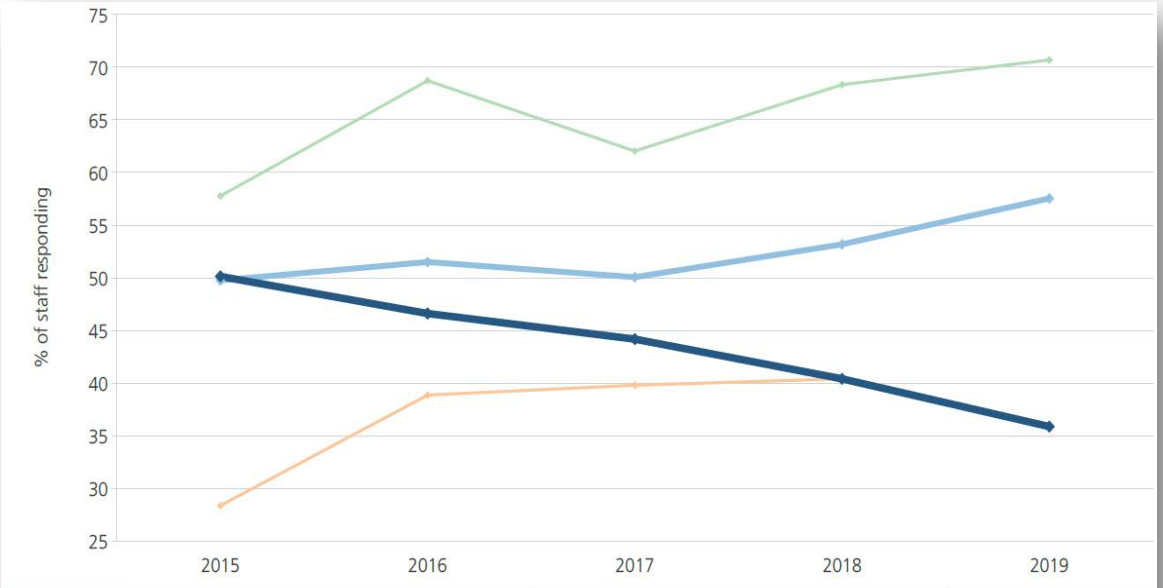
The Trust participates in the NHS Annual Staff Survey, a requirement of the Department of Health. The Survey is carried out by our independent contractor Quality Health (QH). The Trust provided a full staff listing extracted from the Electronic Staff Record (ESR).

All colleagues in post with ESR on 1st September 2019 were invited to take part. All responses were returned directly to QH who confidentially held, managed the data and sent up to 6 reminders to colleagues about completing the survey. The Trust does not know who responded to the survey.

2.0 Response to the Survey

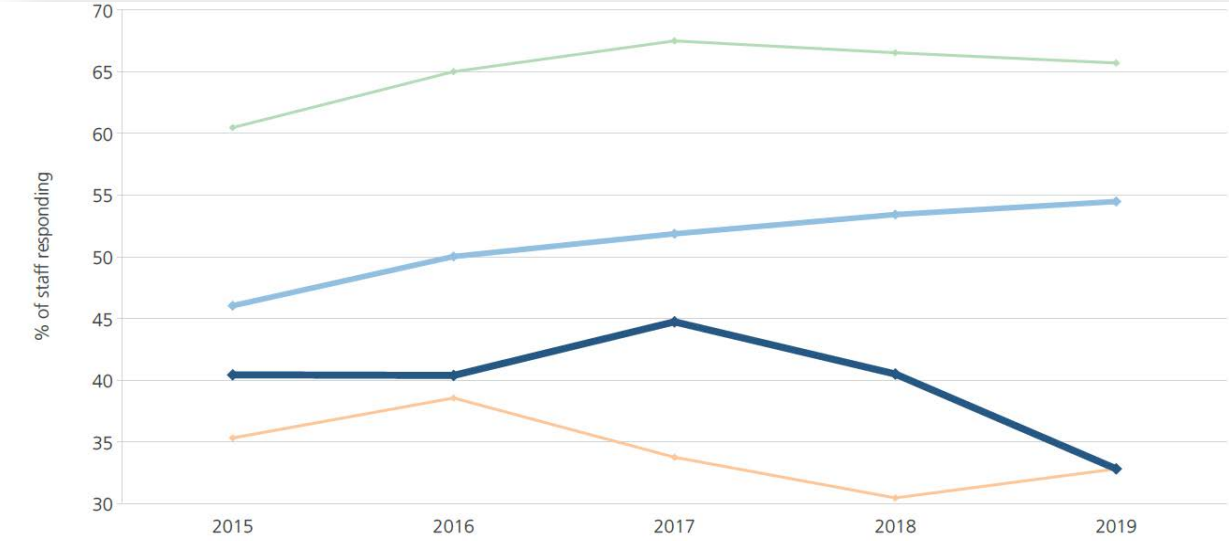
The survey was responded to by 1,596 colleagues in total -- 887 former GCS colleagues (36%), and 709 former 2G colleagues (33%). This marked a decrease for both former Trusts' response rates. The 2019 Survey took place between October and November 2019. Table 1 shows the comparative response rate for GCS over 5 years and Table 2 shows the same data for 2G.

Table 1 -GCS



	2015	2016	2017	2018	2019
Best	57.8%	68.7%	62.0%	68.3%	70.7%
Your org	50.1%	46.6%	44.2%	40.4%	35.9%
Median	49.8%	51.5%	50.1%	53.2%	57.5%
Worst	28.4%	38.9%	39.8%	40.4%	35.9%

Table 2 – 2G



	2015	2016	2017	2018	2019
Best	60.5%	65.0%	67.5%	66.5%	65.7%
Your org	40.4%	40.4%	44.7%	40.5%	32.8%
Median	46.0%	50.0%	51.9%	53.4%	54.5%
Worst	35.3%	38.6%	33.8%	30.5%	32.8%

3.0 Changes

3.1 Further changes were made to Staff Survey reporting for 2019. The report is now shown through a series of 11 rather than 10 Themes instead of the Key Findings of all the pre 2018 surveys. The new 11th Theme is "Teamworking" in light of Professor Michael West's findings on the importance of teamworking. His research found significant relationships between team working, staff and patient satisfaction. The research has subsequently been further validated by the more recent 2016 survey "Saving Lives: A Meta-Analysis of Team Training in Healthcare", albeit that both studies focussed on acute hospitals.

3.2 The 11 Themes have been designed to provide a balanced overview of organisational performance on staff experience and are benchmarked against our comparator groups of MHLD and Community trusts. The Themes are again scored consistently on a scale of 1-10, which last year replaced the previous and occasionally confusing mix of percentages, scores on a 1 to 5 scale, scores on a 1 to 10 scale and weighted summary scores.

3.3 In both the attached summary reports Theme and question level data have been benchmarked with comparator trusts.

3.4 Similarly, in more detailed QH unweighted reports, the Theme results are available for Staff Groups and Directorates and are benchmarked against the overall trust ratings. These are being provided to directorates to choose their priorities for 2020.

3.5 All results are displayed graphically and show trends that have developed over the previous 5 annual surveys. The intent is that readers can see at a glance how colleagues have viewed the Trust over this period and to highlight whether there have been significant developments or year on year fluctuations.

3.6 The purpose of this report is to draw out some of the more significant findings. The summary reports are attached as appendices 2 and 3.

4.0 Themes and Headlines

4.1 Tables 3 (GCS) and 4 (2G) have been extracted from the benchmark reports and shows the 11 Themes with the latest scores compared with the 2018 surveys.

Table 3 - GCS

Theme	2018 score	2018 respondents	2019 score	2019 respondents	Statistically significant change?
Equality, diversity & inclusion	**9.3**	991	**9.3**	868	Not significant
Health & wellbeing	**5.9**	991	**6.0**	881	Not significant
Immediate managers	**6.9**	993	**7.2**	882	↑
Morale	**6.0**	975	**6.2**	878	Not significant
Quality of appraisals	**5.3**	877	**5.5**	780	Not significant
Quality of care	**7.2**	860	**7.4**	745	↑
Safe environment - Bullying & harassment	**8.1**	986	**8.3**	878	Not significant
Safe environment - Violence	**9.7**	990	**9.7**	875	Not significant
Safety culture	**6.7**	986	**7.0**	876	↑
Staff engagement	**6.9**	1002	**7.1**	886	Not significant
Team working	**6.8**	990	**6.6**	865	Not significant

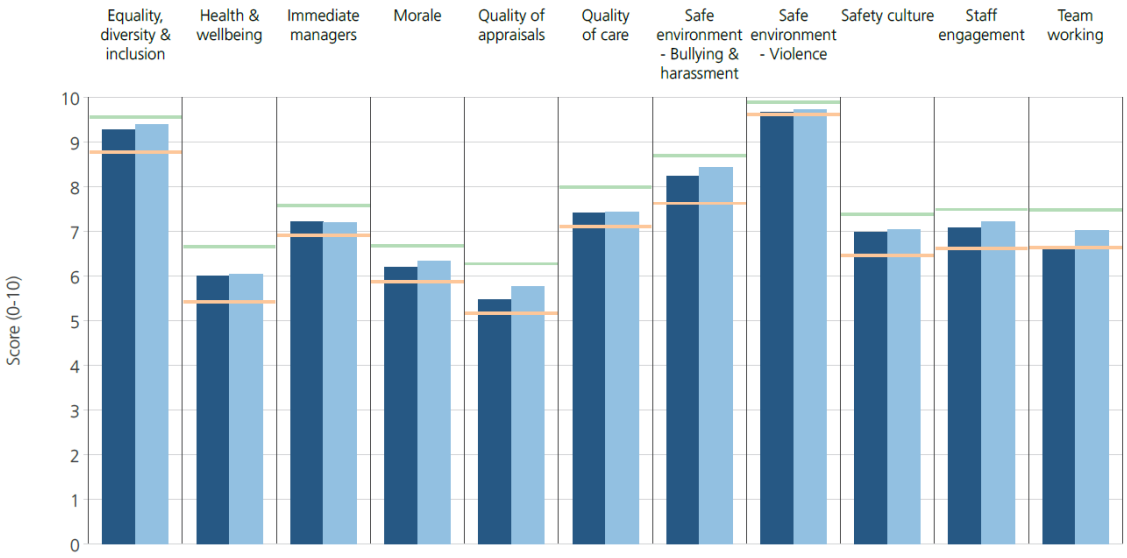
Table 4 – 2G

Theme	2018 score	2018 respondents	2019 score	2019 respondents	Statistically significant change?
Equality, diversity & inclusion	**9.2**	851	**9.1**	691	Not significant
Health & wellbeing	**6.2**	855	**6.0**	698	Not significant
Immediate managers	**7.5**	857	**7.2**	702	↓
Morale	**6.6**	845	**6.4**	694	↓
Quality of appraisals	**5.4**	741	**5.5**	593	Not significant
Quality of care	**7.3**	672	**7.2**	536	Not significant
Safe environment - Bullying & harassment	**8.0**	849	**8.2**	695	Not significant
Safe environment - Violence	**9.4**	845	**9.4**	694	Not significant
Safety culture	**6.9**	852	**6.9**	693	Not significant
Staff engagement	**7.2**	862	**7.2**	708	Not significant
Team working	**7.1**	843	**6.9**	698	Not significant

4.2 The Theme of 'Morale' was new for 2018 and the colleague ratings in 2019 showed a statistically insignificant improvement for GCS and a statistically significant deteriorating for 2G colleagues.

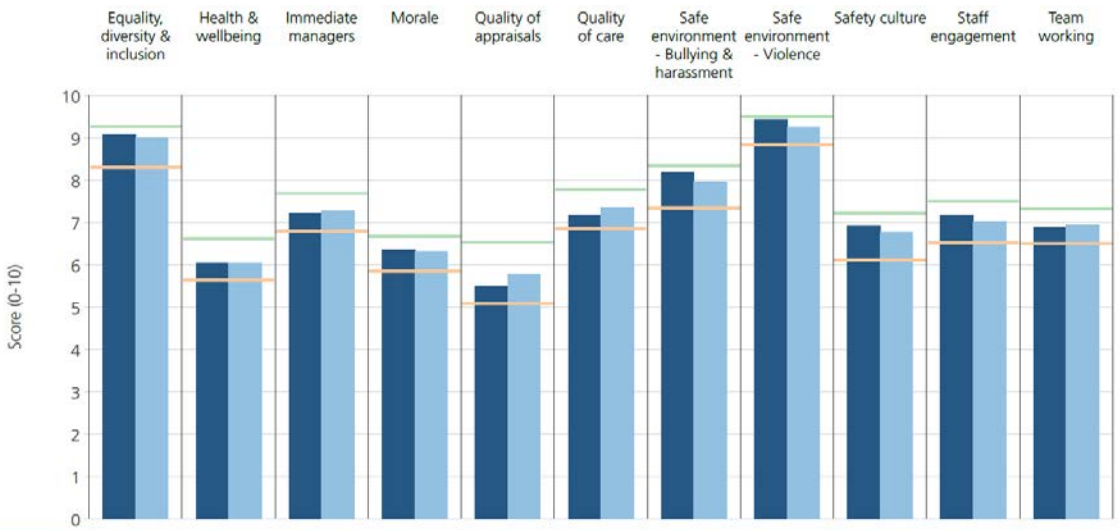
4.3 Tables 5 (GCS) and 6 (2G) below highlight the overall results of each Theme benchmarked against the best, worst and average scores from the comparator group

Table 5 – GCS



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.6	6.7	7.6	6.7	6.3	8.0	8.7	9.9	7.4	7.5	7.5
Your org	9.3	6.0	7.2	6.2	5.5	7.4	8.3	9.7	7.0	7.1	6.6
Average	9.4	6.0	7.2	6.3	5.8	7.4	8.4	9.7	7.0	7.2	7.0
Worst	8.8	5.4	6.9	5.9	5.2	7.1	7.6	9.6	6.5	6.6	6.6
Responses	868	881	882	878	780	745	878	875	876	886	865

Table 6 – 2g



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.3	6.6	7.7	6.7	6.5	7.8	8.3	9.5	7.2	7.5	7.3
Your org	9.1	6.0	7.2	6.4	5.5	7.2	8.2	9.4	6.9	7.2	6.9
Average	9.0	6.0	7.3	6.3	5.8	7.4	8.0	9.3	6.8	7.0	7.0
Worst	8.3	5.6	6.8	5.9	5.1	6.9	7.4	8.8	6.1	6.5	6.5
Responses	691	698	702	694	593	536	695	694	693	708	698

4.4 Of the 11 GCS colleague rated Themes:-

- GCS was average in 4 and below average in 7.
- The 3 Themes where the Trust scored highest in were “Equality, Diversity & Inclusion”, “Safe Environment – Violence” “Safe environment - Bullying & Harassment”.
- The 3 lowest scoring Themes were “Health and well-being”, “Morale” and “Quality of Appraisals” although colleague rating improved over both 2017 and 2018’s rating for appraisals
- One Theme, “Teamworking” scored the lowest in the community Trust benchmarking class.
- Staff engagement rating improved to 7.1, the highest score in 5 years.

4.5 Of the GCS survey Themes:

- 8 had improved over 2018 (73%)
- 2 remained the same as 2018 (18%)
- 1 had reduced over 2018 (9%)

4.6 Of the GCS survey questions circa 40% showed improvement, 52% maintained and 8% deteriorated.

4.7 Of the 2G 11 Themes:

- 2G was better than average in 6, average in 1 and below average in 4.
- As with GCS, the 3 Themes where the Trust scored highest in were “Equality, Diversity & Inclusion”, “Safe Environment – Violence” “Safe environment - Bullying & Harassment”, with all three being close to the best in class.
- The lowest scoring 3 Themes were, as with GCS, “Health and Well-being”, “Moral” and the “Quality of Appraisals” although again on the latter, colleague rating improved over last year.
- There were no Themes were the Trust was rated in the lowest score amongst MH/LD benchmarking trusts.
- Staff engagement received a just below top quartile score of 7.2, against a best in class score of 7.5.

4.8 Of the 2G survey Themes:

- 2 had improved over 2018 (18%)
- 3 remained the same as 2018 (27%)
- 6 had reduced over 2018 (55%)

4.9 Of the 2G survey questions circa 5% showed improvement, 64% maintained and 31% deteriorated.

4.10 For the Workforce Race Equality Standard (WRES)

- The former 2G was rated above average on all 4 questions.

- The former GCS was rated above average for 2 questions and below for 2 (experiencing harassment, bullying, abuse from staff and provision of equal opportunities for career development and promotion)

4.11 For the Workforce Disability Equality Standard (WDES)

- The former 2G was rated above average on 6 out of 9 questions (67%). The 3 questions it scored below average in were reporting incidents, provision of equal opportunities for career development and promotion, and, feeling pressure from managers to come to work when unwell.
- The former GCS was rated below average on all 9 questions (100%)

4.12 The Staff Friends and Family ratings from both former organisations are shown in Table 7 below. There were statistically significant improvements for the former GCS and minor and statistically insignificant reductions in the former 2G ratings:

Table 7

Question	GCS 2018	GCS 2019	²g 2018	²g 2019
I would recommend my organisation as a place to work	56%	62% ↑	72%	70% ↓
If a friend or relative needed treatment, respondents being happy with the standard of care provided by the organisation	76%	82% ↑	75%	74% ↓

4.13 GCS increased in both these areas whilst 2g showed a small and insignificant change of 2% or less. As a new Trust it is promising that former GCS responses have increased regarding recommending the Trust as a place to work, inching closer to former 2g in this respect, although former 2g are still significantly ahead.

4.14 It is also worth mentioning that there has been a significant increase from former GCS respondents being happy with the standard of care provided, which is 8% above former 2g's rating.

5.0 Demographics

5.1 The benchmark report also presents a picture of the organisations' colleagues based on the background of the survey respondents.

5.2 For the former GCS:

- 87% of respondents were female
- 40% of respondents were aged between 51 and 65
- 96% were white
- 91% were heterosexual
- 50% were Christian

- 20% reported that they had a disability of which 75% felt the Trust had made adequate adjustments to enable them to carry out their roles
- 26% had more than 15 years' service

5.3 For the former 2G:

- 73% of respondents were female
- 40% of respondents were aged between 51 and 65
- 95% were white
- 87% were heterosexual
- 45% were Christian
- 25% reported that they had a disability of which 81% felt the Trust had made adequate adjustments to enable them to carry out their roles
- 29% had more than 15 years' service

5.4 A study of the demographics and questions linked to protected characteristics are being analysed as part of the 2020 WRES (Workforce Race Equality Standard) submission and the WDES (Workforce Disability Equality Standard).

6.0 The Combined Survey

6.1 The scores of the two organisation's results have been combined below and weighted to present an alternative representation of the results based against the Combined Community / Mental Health Trust benchmark group.

	GHC	Combined Comm / MH Trust Average	Better/	Worse than average
Equality	9.2	9.1	↑	↓
Health & Wellbeing	6.0	6.1	↓	
Immediate Managers	7.2	7.2		
Moral	6.3	6.3		
Appraisal	5.5	5.7	↓	↑
Quality of Care	7.3	7.4	↓	↑
Safe – B&H	8.3	8.2	↑	↑
Safe – Violence	9.6	9.5	↑	
Safety Culture	7.0	6.8	↑	↑
Staff Engagement	7.1	7.1	↑	
Teamwork	6.7	6.9	↓	↓

6.2 Further comparisons of the Trust within Gloucestershire NHS organisations, Trusts on the Gloucestershire border, and Trusts which have recently merged, is provided within the attached Staff Survey presentation.

7.0 Conclusions

7.1 <u>Summary conclusions & focus areas</u>:

This is a survey outcome which the Trust should be proud of. The results demonstrate that at a peak time of the merger and the accompanying major

organisational changes, the vast majority of ratings did not change on a statistically significant basis.

7.2 Positively, for 2019, colleagues said that the former GCS had significantly improved in three areas - safety culture, quality of care and immediate managers.

7.3 Staff engagement also improved for the former GCS and reached the highest rating in the previous 5 years. The former 2gether maintained its position as a strong Mental Health trust on safe environment – violence and aggression, safe environment – harassment and bullying, and also staff engagement but also saw reductions in the Themes of immediate managers and morale. We think some of this relates to the focus on the merger and some of the management and structure changes, but we need to understand more fully the reduction in these two areas so as we can address them.

7.4 Importantly, colleagues reported that they would be happy for their family to receive treatment from both Trusts – in fact both organisations scored above the national average on this particular question. In terms of recommending the organisation as a place of work, former 2g staff rated the Trust higher than the national average, and former GCS colleagues rated the organisation 6% higher than in 2018. Both Trusts also generally scored well in terms of equality, diversity and inclusion, which is also important.

7.5 Following our successful merger in October 2019, leaders and managers must continue to work hard throughout 2020 to ensure that GHC continues to improve as an employer, being a place in which we are proud to work and which helps us to be fulfilled in improving the health and well-being of our local communities.

7.6 As with last year's survey results, we should not be complacent about the size of the task ahead. Whilst the 2019 survey results are generally pleasing given the context of the merger, we must do better going forwards if we are to realise our full ambitions.

7.7 In terms of proposed actions, subject to wider engagement over the next month, it is proposed that the following four focus areas:

- **Health and wellbeing –** a focus on supporting teams, individual resilience, stress and sleep and implementing the Health and Wellbeing strategy and action plan. Communicating the health and wellbeing elements of the new Staff Benefits offer alongside existing offers such as our web resources, counselling and self-referral musculo-skeletal physiotherapy services.

- **Engagement, response rates and embedding our values and behaviours –** focus on improving response rates; acknowledging results and thanking employees for highlighting areas for improvement and how we aim to make changes going forward based on the findings; celebrating

the good; involving colleagues in coming up with ideas and solutions (e.g. launching our new monthly Your Voice survey; embedding values and behaviours. Revised Staff Forum, new Executive Director Walkabout programme.

- **Communications - Responding and acting on feedback from colleagues and people who use our services –** wider publication of Freedom to Speak Up activity, patient and staff FFT outcomes, Datix incidents, complaints and compliments. More related news stories, Team Talk topics, blogs and social media on this. Make an explicit expectation that local managers refer to the surveys and feedback in team meetings. We may wish to do a short video to colleagues about the outcomes of the survey and next steps. An easy-read graphical communication on the survey will be circulated.

- **Improving our leadership and management skills, behaviours and approaches** – implementing our "Leading Better Care Together" leadership development programmes, communicating their development, progress and outcome. Team working will play a key component in this. Improving the quality of appraisals and supervision with our new paperwork and the roll out of Totara. Using the recent OD investment as one of a number of "You Said, We Did" communications example.

7.8 It is clear that quantum improvements will not be possible without a significant focus, improved "you said, we did" communications, and arguably an organisational social movement which makes the survey and responsive actions the responsibility of every director, line manager and colleague.

7.9 Response rates:

The 2019 survey received a lower response rate than in the previous year but still provides a sizeable and representative data set that presents a reasonably accurate view of our predecessor Trusts. However, both Trusts' response rates were below average in the respective benchmark groups. The higher the response rate the more representative the ratings are. Again, it is recommended that actions are taken to encourage line managers to own the response rate and to encourage all staff to complete the next survey. This will be need to be supported by communications and personal objective setting for line managers.

7.10 Local ownership:

The updated survey format for 2019 can be used to enable the operational service directorates, heads of profession and corporate teams to review results in their own areas, informing local action plans. It is proposed that each operational directorate area will be asked to come up with 2 or 3 local actions and to report on these.

7.11 Next steps:

The results will be communicated via Senior Leadership Network, JNCF, LNC and Team Talk with drop in presentation and engagement events to inform an approach and action plan. This will need to be supported via colourful and graphical easy read presentation on the results, using examples of best practice from within the NHS and local government. Communications and OD colleagues are working on this now. Executive and Resources Committee will be asked to consider and agree an approach and action plan in April, with this being reported to the Board of Directors meeting.

7.12 Going forward, the 2019 results can be used in association with the emerging responses from the updated monthly Your Voice Survey and the 2020 Staff Friends and Family Tests to formulate a wider view of the Trust and enable additional improvement actions to be taken.

8.0 Recommendations

8.1 The Board of Directors is asked to:

- the findings and recommendations from the two 2019 surveys in this paper and the attached presentation
- that the majority of Themes had no statistically significant improvement or deterioration at a time of merger and major change
- a rating of overall significant assurance on Staff Engagement for the former 2G and the highest score of the past five years in the former GCS
- the statistically significant improvements in three GCS Themes
- the statistically significant reductions in two 2G Themes
- that the relevant outcomes in the survey are being taken forward within the Workforce Disability Equality Standard and Workforce Race Equality Standard Action Plans, for 2020.

8.2 In considering these, the Board will need to be mindful of the high impact and focus that the emerging response to emergency planning and business continuity for COVID-19 will have on the depth of response likely to be available for the next few months.

with you, for you

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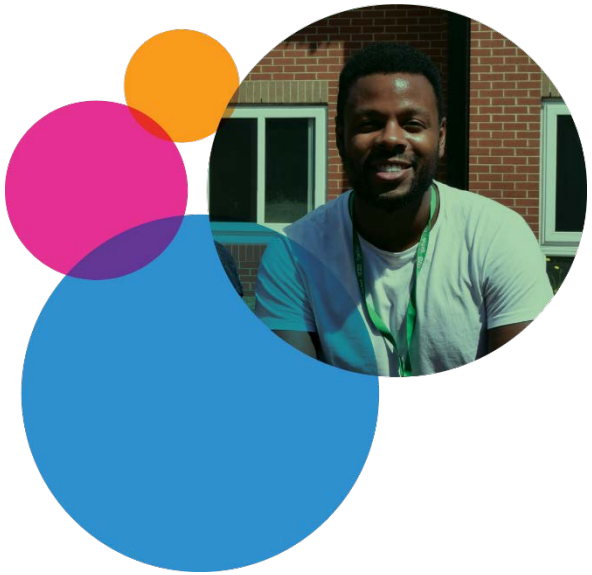

Board of Directors Staff Survey 2019

March 2020

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

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Gloucestershire Health and Care
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Our 2019 Staff Survey

Key headlines:

- A performance to be proud of given context of merger
- GCS services show some marked & sustained improvements
- 2G services largely maintained position with a few exceptions & remained in top half of MH Trusts in England
- GCS, **3rd best** Community Trust **for colleagues recommending the Trust as a place to receive care**
- 2G, **4th best** MH/LD Trust for colleagues recommending Trust both as (A) **a place to receive care** and (B) an organisation **to work for**
- 2G **6/11 Themes above benchmark** cluster average
- GCS **8/11 Themes improved**
- Staff engagement rating for GCS improved to 7.1, **the highest score in 5 years**, while 2G remained at 7.2, **in top half of MH/LD Trusts**

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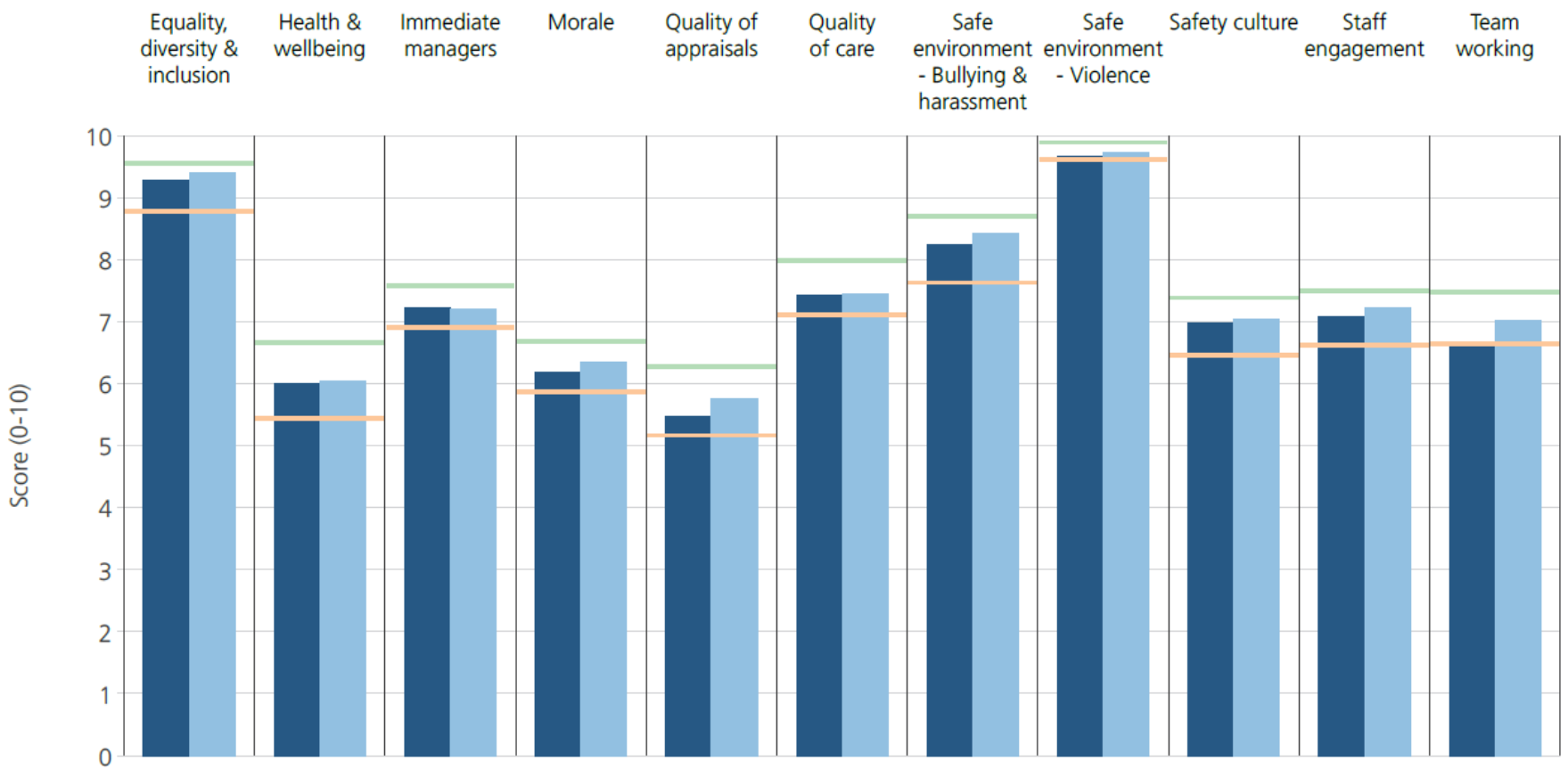
GCS



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.6	6.7	7.6	6.7	6.3	8.0	8.7	9.9	7.4	7.5	7.5
Your org	9.3	6.0	7.2	6.2	5.5	7.4	8.3	9.7	7.0	7.1	6.6
Average	9.4	6.0	7.2	6.3	5.8	7.4	8.4	9.7	7.0	7.2	7.0
Worst	8.8	5.4	6.9	5.9	5.2	7.1	7.6	9.6	6.5	6.6	6.6
Responses	868	881	882	878	780	745	878	875	876	886	865

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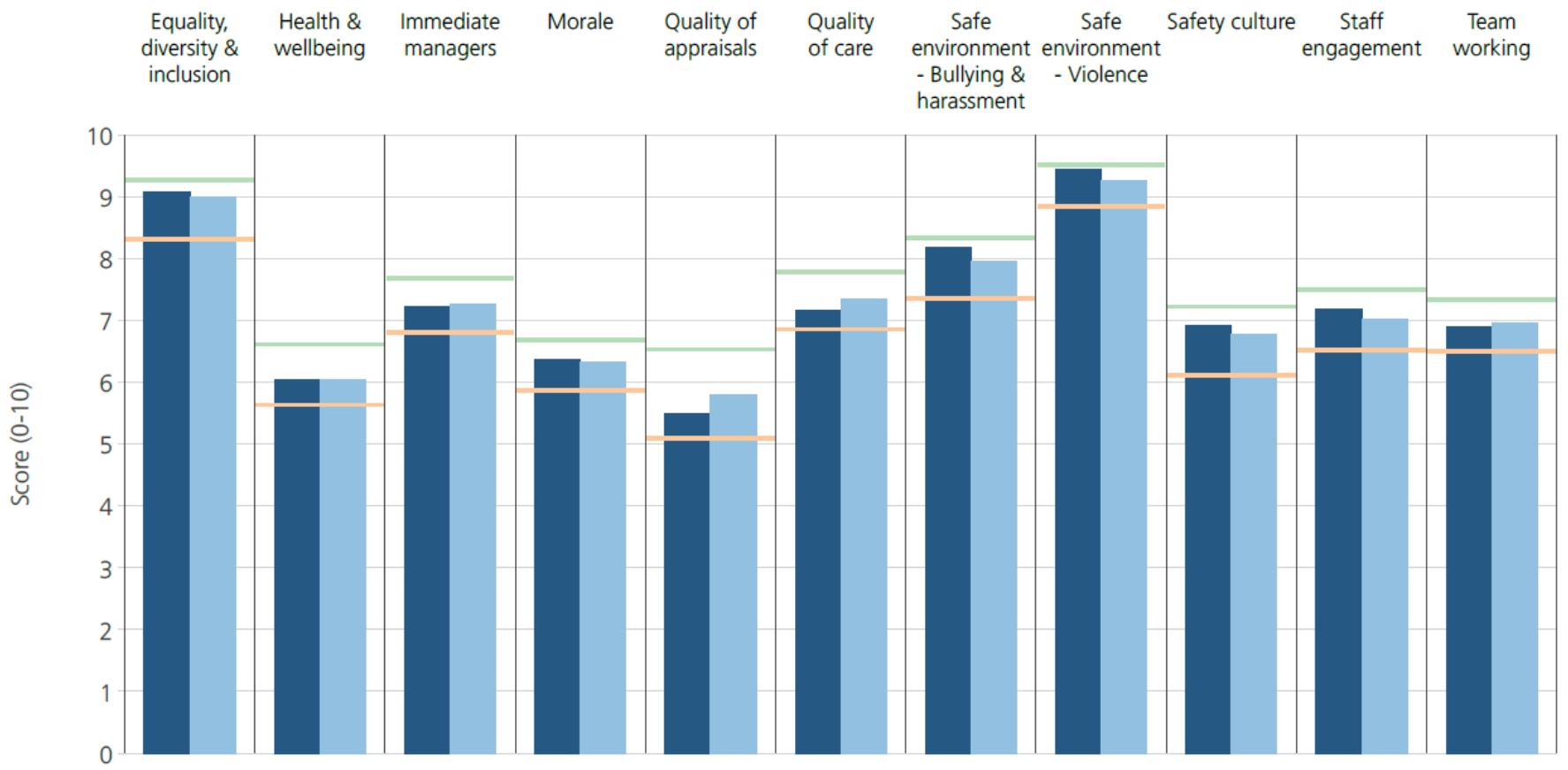
2G



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.3	6.6	7.7	6.7	6.5	7.8	8.3	9.5	7.2	7.5	7.3
Your org	9.1	6.0	7.2	6.4	5.5	7.2	8.2	9.4	6.9	7.2	6.9
Average	9.0	6.0	7.3	6.3	5.8	7.4	8.0	9.3	6.8	7.0	7.0
Worst	8.3	5.6	6.8	5.9	5.1	6.9	7.4	8.8	6.1	6.5	6.5
Responses	691	698	702	694	593	536	695	694	693	708	698

2019 NHS Staff Survey:
Results Summary

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All of the eleven themes are scored on 0-10 scale, where a higher score is more positive then a lower score. The scores have been calculated with weighting from converting former 2g and GCS 2019 Staff Survey results. These theme scores are created by scoring question results and grouping these results together.

You can see how we have scored on each of the themes compared to average below. Both Trusts had the lowest response rate for five years - 36% for former GCS, 33% for former 2g.

Equality diversity & inclusion
2019 GHC Score
9.2
Average Community and MH Trust Score - 9.1

Health & Wellbeing
2019 GHC Score
6.0
Average Community and MH Trust Score - 6.1

Immediate managers
2019 GHC Score
7.2
Average Community and MH Trust Score - 7.2

Morale
2019 GHC Score
6.3
Average Community and MH Trust Score - 6.3

Quality of appraisals
2019 GHC Score
5.5
Average Community and MH Trust Score - 5.7

Quality of care
2019 GHC Score
7.3
Average Community and MH Trust Score - 7.4

Safe environment - Bullying & harassment
2019 GHC Score
8.3
Average Community and MH Trust Score - 8.2

Safe environment - Violence
2019 GHC Score
9.6
Average Community and MH Trust Score - 9.5

Safety culture
2019 GHC Score
7.0
Average Community and MH Trust Score - 6.8

Staff engagement
2019 GHC Score
7.1
Average Community and MH Trust Score - 7.1

Team working
2019 GHC Score
6.7
Average Community and MH Trust Score - 6.9

How our scores compare to other community and mental health benchmarking groups.
Same or better than
Worse than

2019 Staff Survey - GLOUCESTERSHIRE

(calculated with weighting for GHC from 2g and GCS results)

Gloucestershire Health and Care
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	EDI	H&W	Immediate Managers	Morale	Appraisals	Qual of Care	Safe: B&H	Safe: Violence	Safety Culture	Staff Eng	Team Work
GHC	9.2	6.0	7.2	6.3	5.5	7.3	8.3	9.6	7.0	7.1	6.7
Combined Comm/MH Trust Average	9.1	6.1	7.2	6.3	5.7	7.4	8.2	9.5	6.8	7.1	6.9
Better/ Worse than Ave	↑	↓			↓	↓	↑	↑	↑	↑	↓
Improved /worse	↓				↑	↑	↑		↑		↓
GHT	9.1	5.8	6.8	6.1	5.2	7.3	8.0	9.4	6.5	6.9	6.5
GCCG	9.3	6.9	6.9	6.4	5.2	7.2	8.7	10	6.7	7.0	6.4

Compared with GHT – GHC had 10 Higher. 0 Lower. 1 Same.
Compared with GCCG – GHC had 6 Higher. 5 Lower. 0 Same.

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Staff survey
Some common ground

GCS achieved its highest ratings for:
- Equality, Diversity and Inclusion
- Safe Environment – Violence
- Safe Environment – Bullying and Harassment

2g achieved its highest ratings for:
- Equality, Diversity and Inclusion
- Safe Environment – Violence
- Safe Environment – Bullying and Harassment

GCS achieved its lowest ratings for:
- Health and Wellbeing
- Morale
- Quality of Appraisals

2g achieved its lowest ratings for:
- Health and Wellbeing
- Morale
- Quality of Appraisals

Response Rates

Both Trusts had **lowest response rates for 5 years** – 36% for GCS and 33% for 2g.

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Gloucestershire Health and Care
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Staff survey
Some differences

Of the **GCS** survey themes:

- 8 had improved over 2018
- 2 remained the same as 2018
- 1 had reduced over 2018

GCS was average in 5 themes and below average in 6

Of the **2g** survey themes:

- 2 had improved over 2018
- 3 remained the same as 2018
- 6 had reduced over 2018

2g was better than average in 6 themes, average in 1 and below average in 4

Workforce Race Equality Standard	Workforce Disability Standard
2g rated above average on all 4 questions.	2g rated above average for 6 out of 9 questions.
GCS rated above average for 2 questions and below for 2.	GCS rated below average on all 9 questions.

2019 Staff Survey - OTHER LOCAL TRUSTS

(calculated for GHC from 2g and GCS results)

NHS
Gloucestershire Health and Care
NHS Foundation Trust

	EDI	H&W	Immediate Managers	Morale	Appraisals	Qual of Care	Safe: B&H	Safe: Violence	Safety Culture	Staff Eng	Team Work
GHC	9.2	6.0	7.2	6.3	5.5	7.3	8.3	9.6	7.0	7.1	6.7
Combined Comm/MH Trust Average	9.1	6.1	7.2	6.3	5.7	7.4	8.2	9.5	6.8	7.1	6.9
AWP	*9.0*	*5.9*	*7.3*	*6.1*	*5.3*	*7.0*	*7.7*	*9.3*	*6.4*	*6.8*	*6.8*
WHCT	*9.3*	*6.4*	*7.5*	*6.5*	*5.7*	*7.4*	*8.3*	*9.5*	*7.1*	*7.2*	*6.9*
WVT	*9.1*	*6.0*	*7.0*	*6.4*	*5.5*	*7.6*	*8.0*	*9.5*	*6.7*	*7.2*	*6.9*
WAHT	*9.2*	*5.7*	*6.8*	*6.1*	*5.2*	*7.5*	*7.9*	*9.5*	*6.6*	*6.9*	*6.7*

Other key highlights:

- Compared with AWP – GHC had 9 scoring higher, 2 lower & 0 the same.
- Compared with WHCT – GHC only had 1 higher, 9 lower & 1 the same. Sarah Dugan focus on culture & engagement.
- Compared with WVT – GHC had 5 higher, 4 lower & 2 the same.
- Compared with WHAT – GHC had 8 higher, 1 lower & 2 the same.

2019 Staff Survey - OTHER RECENTLY MERGED TRUSTS

(calculated for GHC from 2g and GCS results)

Gloucestershire Health and Care
NHS Foundation Trust

	EDI	H&W	Immediate Managers	Morale	Appraisals	Qual of Care	Safe: B&H	Safe: Violence	Safety Culture	Staff Eng	Team Work
GHC	9.2	6.0	7.2	6.3	5.5	7.3	8.3	9.6	7.0	7.1	6.7
Combined Comm/MH Trust Average	9.1	6.1	7.2	6.3	5.7	7.4	8.2	9.5	6.8	7.1	6.9
UHB	*8.9*	*5.6*	*6.7*	*5.9*	*5.4*	*7.4*	*8.0*	*9.5*	*6.5*	*6.9*	*6.3*
BWC	*9.1*	*5.8*	*7.0*	*6.1*	*5.5*	*7.2*	*8.2*	*9.7*	*6.8*	*7.1*	*6.6*
ESNE	*9.1*	*5.7*	*6.6*	*6.0*	*4.9*	*7.3*	*7.8*	*9.4*	*6.5*	*6.8*	*6.3*
STS	*9.3*	*5.9*	*6.8*	*6.1*	*5.3*	*7.6*	*8.3*	*9.5*	*6.8*	*6.9*	*6.5*
CPT	*9.4*	*6.1*	*7.4*	*6.4*	*5.3*	*7.3*	*8.2*	*9.5*	*6.7*	*7.1*	*7.0*

Other key highlights:

- Compared with UHB – GHC had 10 higher, 1 lower & 0 same.
- Compared with BWC – GHC had 8 higher, 1 lower & 2 same.
- Compared with ESNE – GHC had 10 higher, 0 lower & 1 same.
- Compared with STS – GHC had 8 higher, 2 lower & 1 same.
- Compared with CPT – GHC had 4 higher, 5 lower & 2 same.

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Our 2019 Staff Survey

Suggested key focus areas:

- Deep dive into available data to understand it
- Share & discuss with colleagues
- Improve (1) health & wellbeing, (2) Engagement, (3) Communications & (4) Leadership skills, values & behaviour
- Ensure Team Working is core element of new OD Leadership Development offer
- Target improvement in response rates
- Understand the differences in WDES and WRES ratings & take identified actions
- Consider our approaches with ex 2G colleagues generally & some ex GCS teams – there are examples of corporate and operational teams who have been impacted by the merger
- Identify good practice from other Trusts

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

Survey Coordination Centre

NHS England

2Gether NHS Foundation Trust

2019 NHS Staff Survey

Summary Benchmark Report

Organisation details

2Gether NHS Foundation Trust

2019 NHS Staff Survey

Organisation details

Completed questionnaires	709
2019 response rate	33%

See response rate trend for the last 5 years

Survey details

Survey mode	Online
Sample type	Census

This organisation is benchmarked against:

Mental Health / Learning Disability Trusts

2019 benchmarking group details

Organisations in group: **23**

Median response rate: **54%**

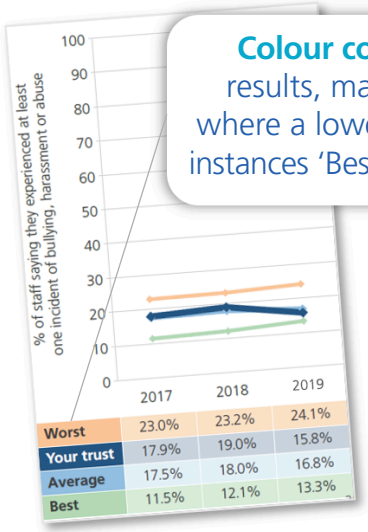
No. of completed questionnaires: **38,413**

Using the report

Key features

Question number and text (or the theme) specified at the top of each slide

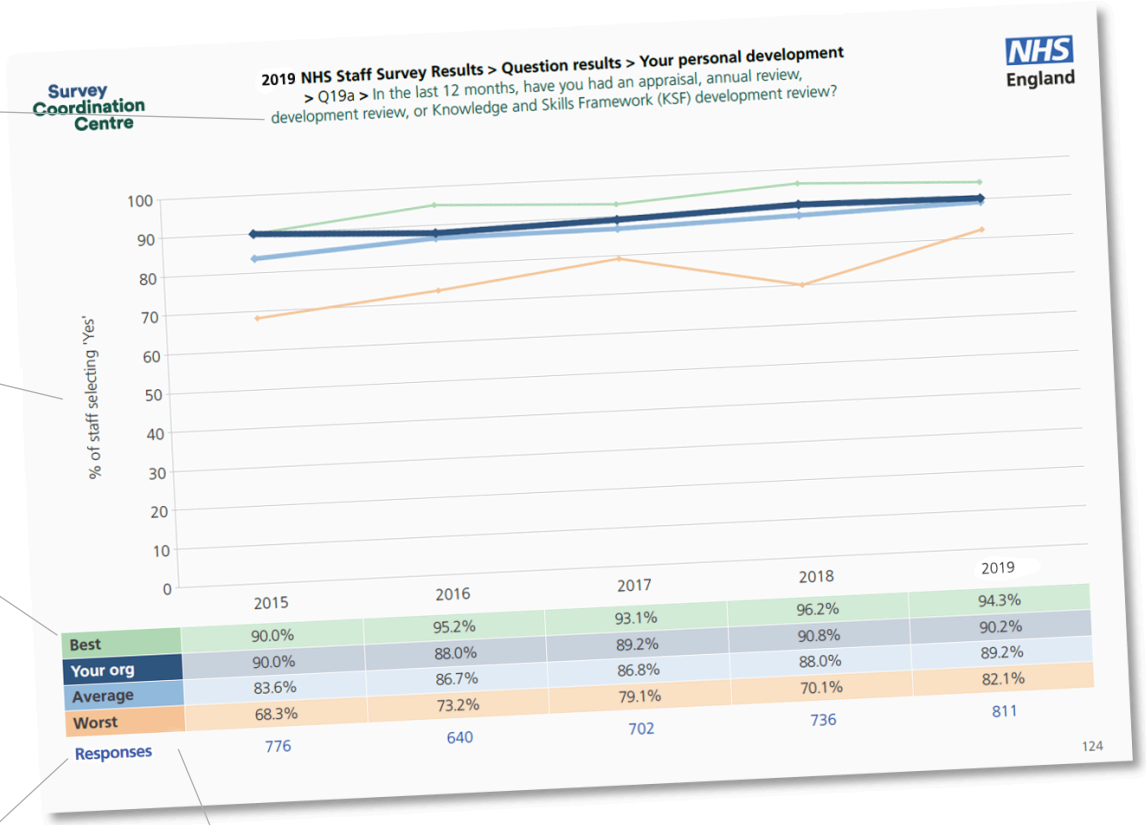
Question-level results are always reported as percentages; the **meaning of the value** is outlined along the axis. Themes are always on a 0-10pt scale where 10 is the best score attainable



Colour coding highlights best / worst results, making it easy to spot questions where a lower percentage is better – in such instances 'Best' is the bottom line in the table

Keep an eye out!

Number of responses for the organisation for the given question



'Best', 'Average', and 'Worst' refer to the **benchmarking group's** best, average and worst **results**

Full details on how the scores are calculated are provided in the **Technical Document**, under the Supporting Documents section of our results page

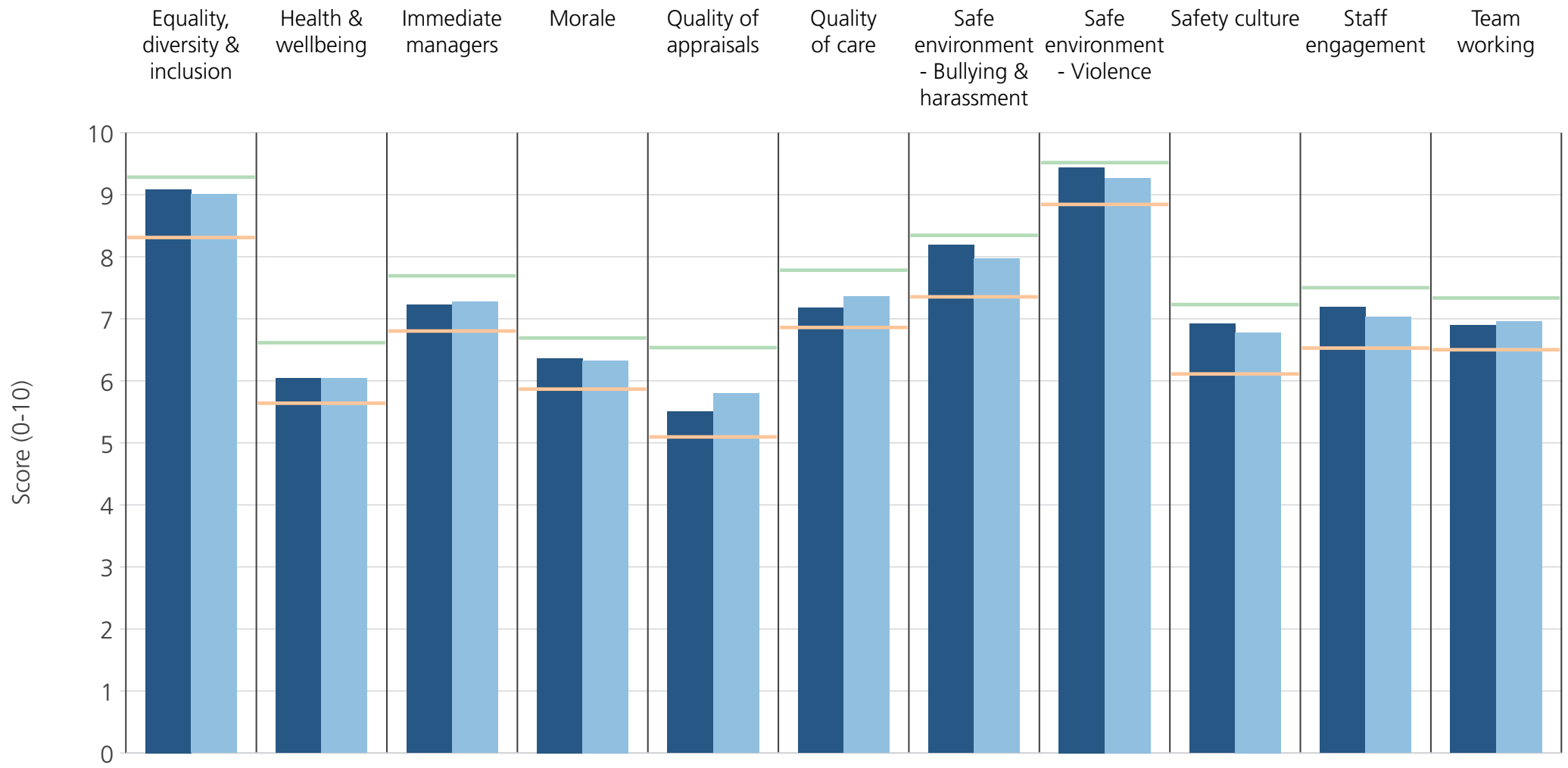
Survey Coordination Centre

NHS England

Theme results

2Gether NHS Foundation Trust

2019 NHS Staff Survey Results



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.3	6.6	7.7	6.7	6.5	7.8	8.3	9.5	7.2	7.5	7.3
Your org	9.1	6.0	7.2	6.4	5.5	7.2	8.2	9.4	6.9	7.2	6.9
Average	9.0	6.0	7.3	6.3	5.8	7.4	8.0	9.3	6.8	7.0	7.0
Worst	8.3	5.6	6.8	5.9	5.1	6.9	7.4	8.8	6.1	6.5	6.5
Responses	691	698	702	694	593	536	695	694	693	708	698

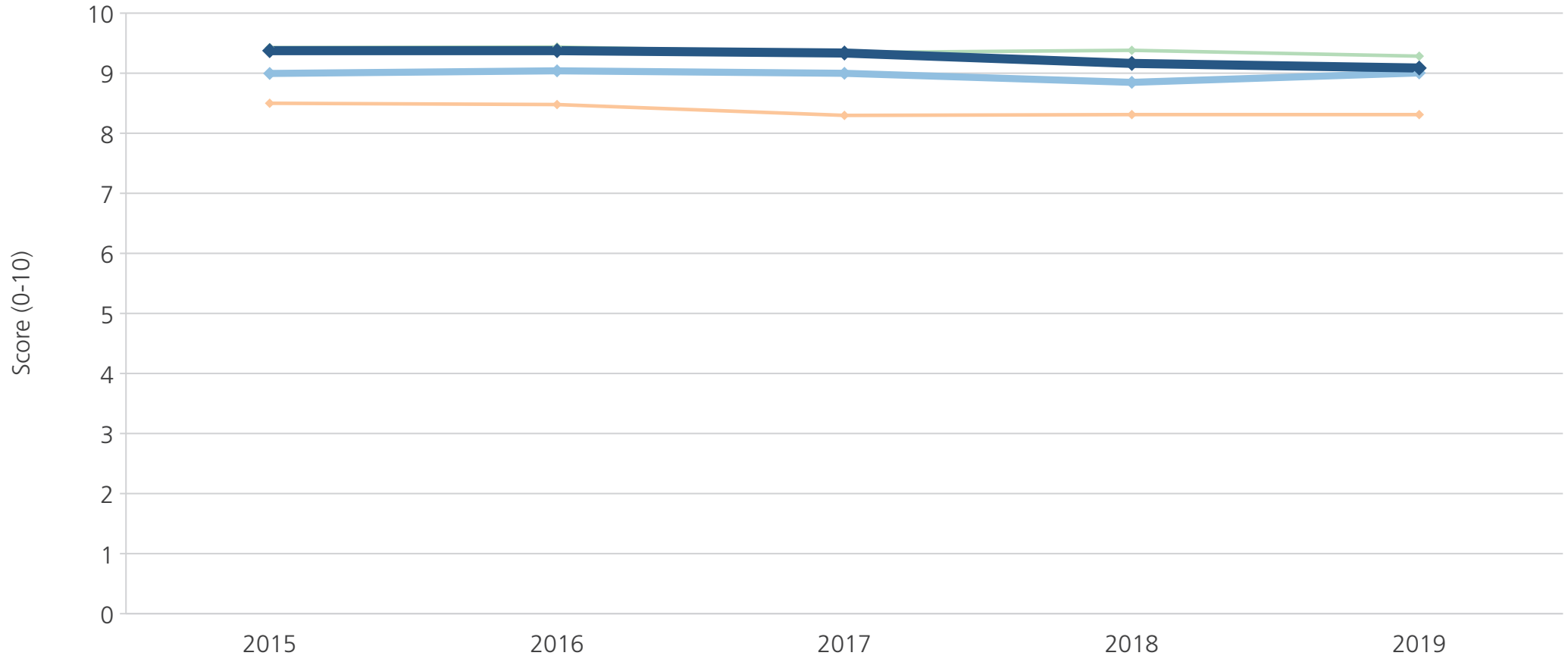
Survey Coordination Centre

NHS England

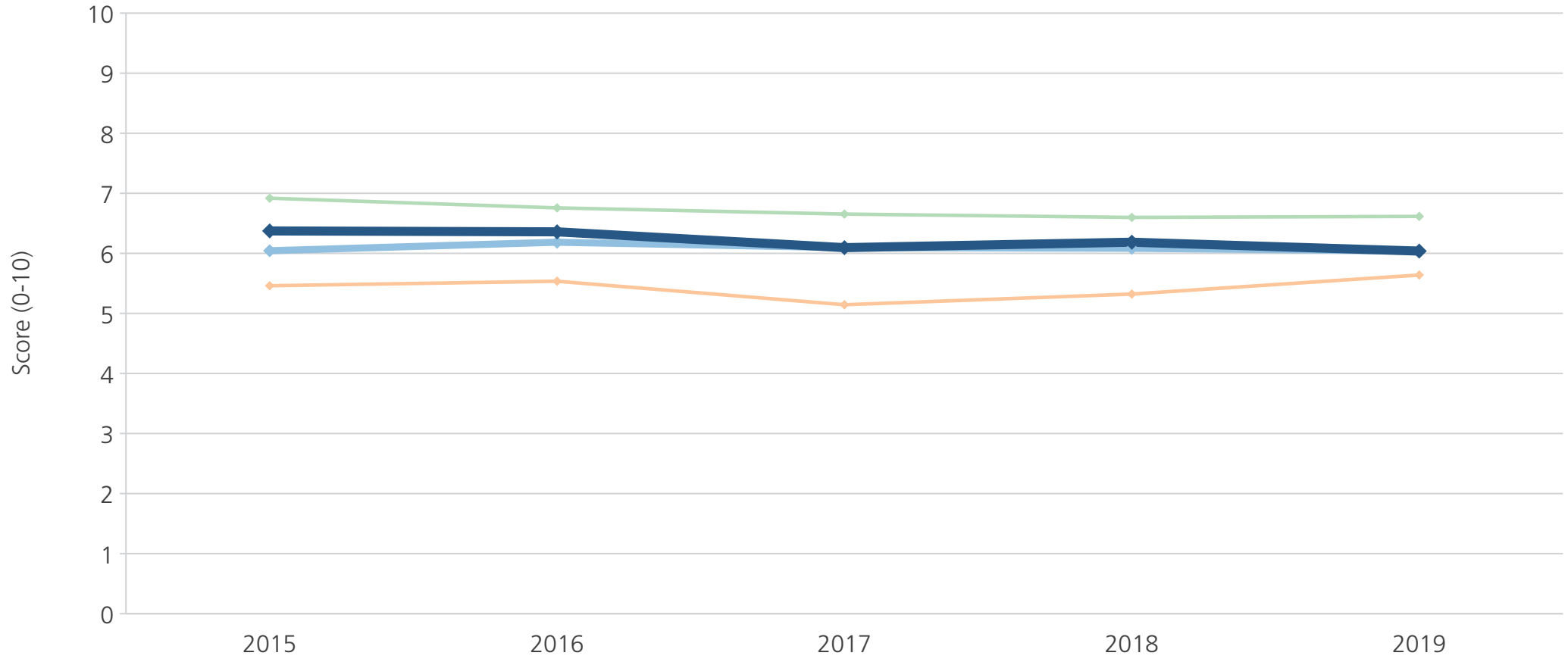
Theme results – Trends

2Gether NHS Foundation Trust

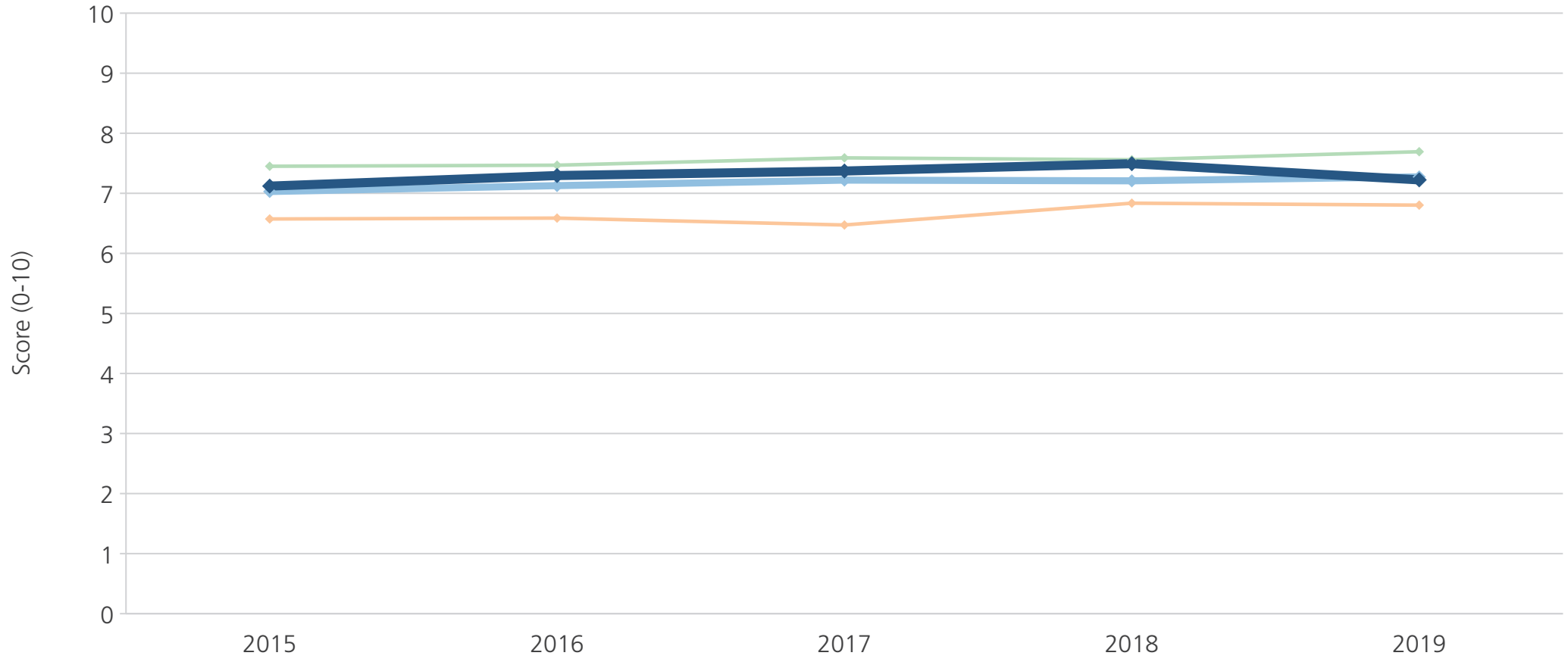
2019 NHS Staff Survey Results



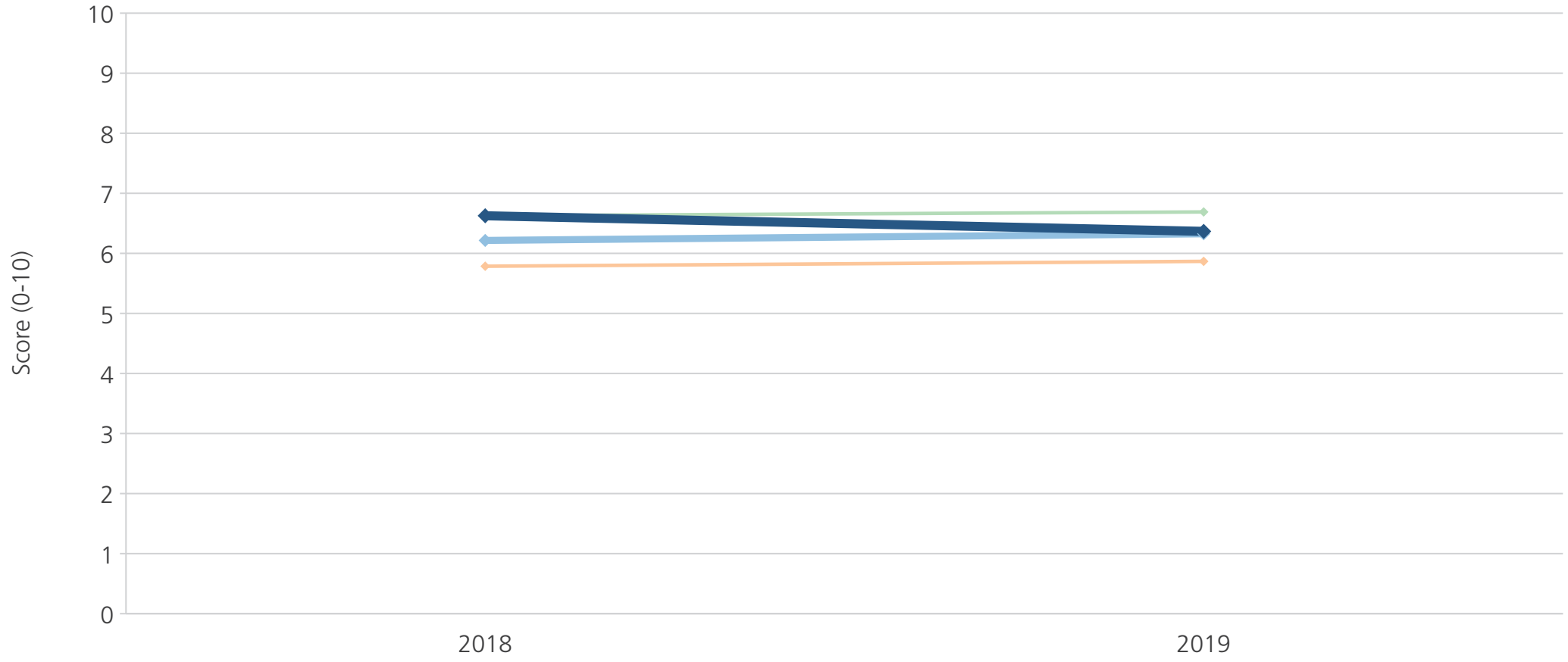
	2015	2016	2017	2018	2019
Best	9.4	9.4	9.3	9.4	9.3
Your org	9.4	9.4	9.3	9.2	9.1
Average	9.0	9.0	9.0	8.8	9.0
Worst	8.5	8.5	8.3	8.3	8.3
Responses	296	765	903	851	691



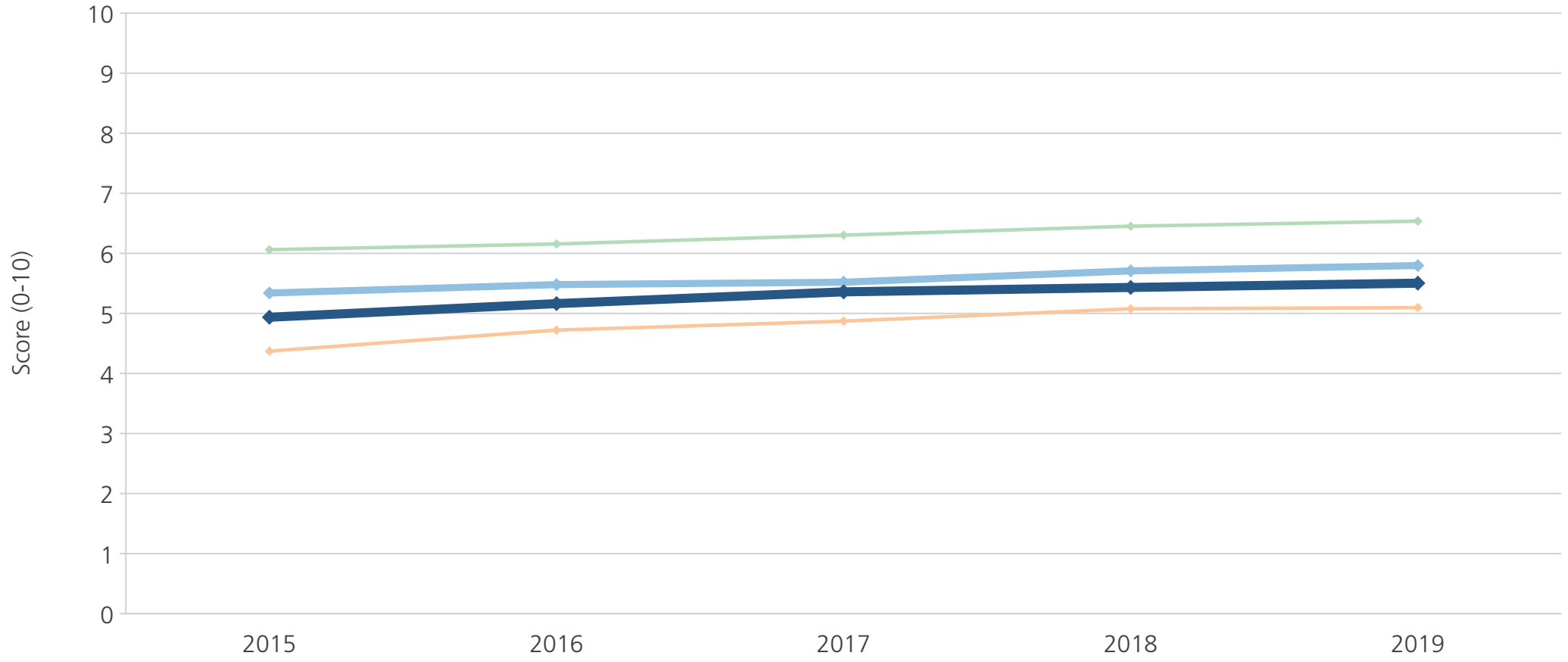
	2015	2016	2017	2018	2019
Best	6.9	6.8	6.7	6.6	6.6
Your org	6.4	6.4	6.1	6.2	6.0
Average	6.0	6.2	6.1	6.1	6.0
Worst	5.5	5.5	5.1	5.3	5.6
Responses	296	773	911	855	698



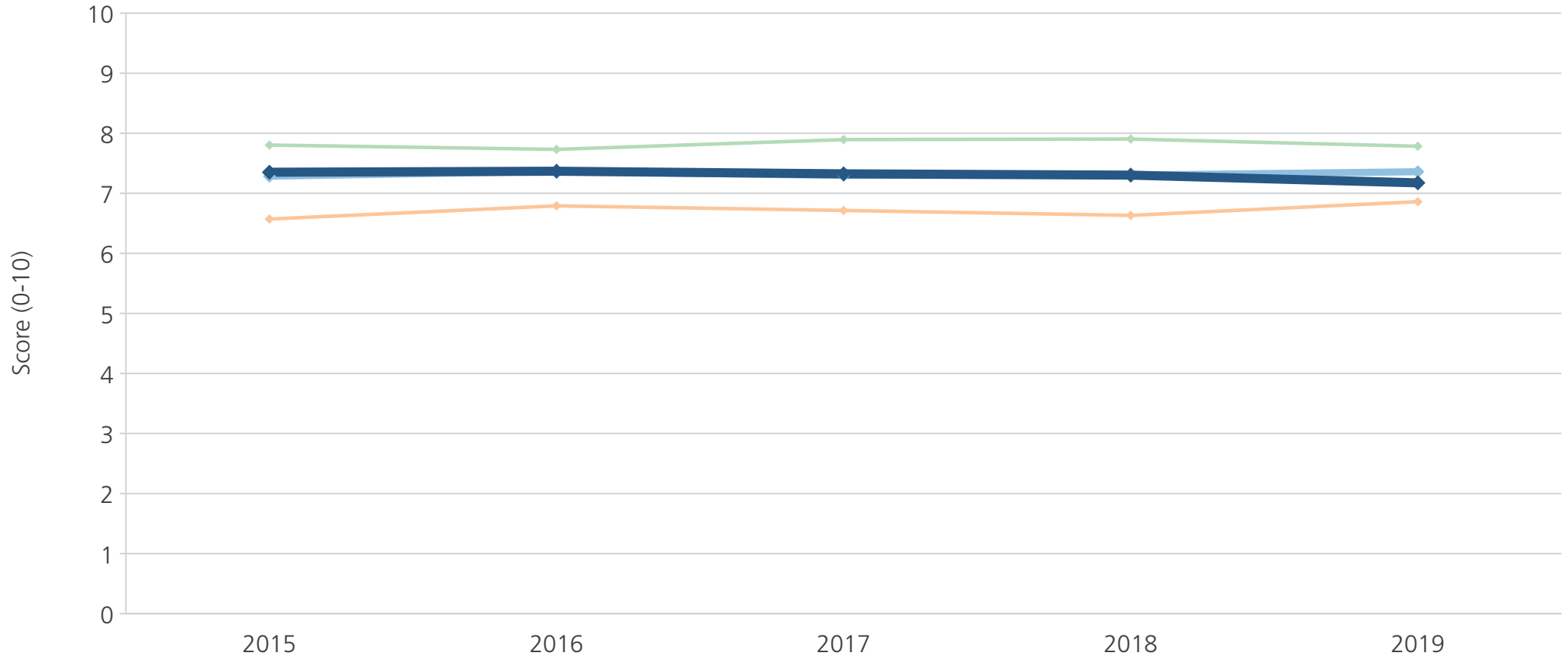
	2015	2016	2017	2018	2019
Best	7.5	7.5	7.6	7.6	7.7
Your org	7.1	7.3	7.4	7.5	7.2
Average	7.0	7.1	7.2	7.2	7.3
Worst	6.6	6.6	6.5	6.8	6.8
Responses	295	771	911	857	702



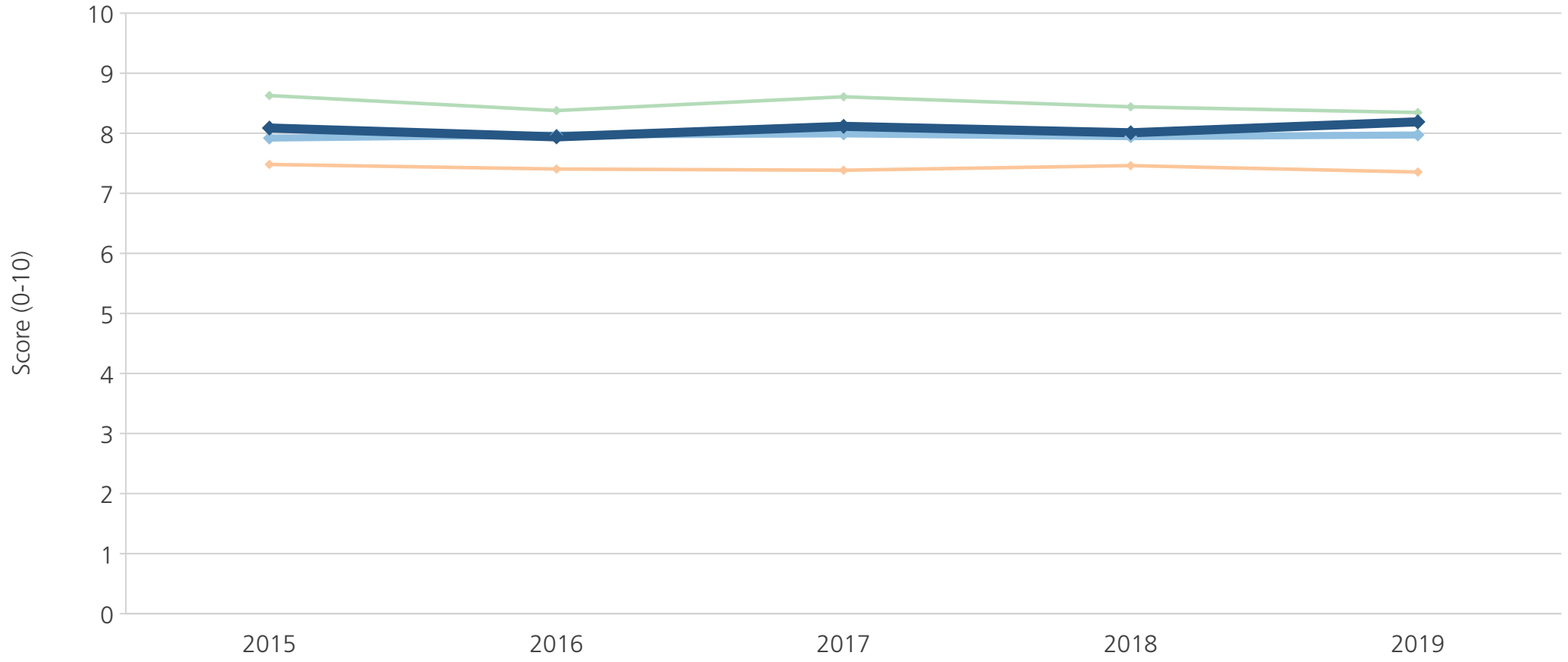
	2018	2019
Best	6.6	6.7
Your org	6.6	6.4
Average	6.2	6.3
Worst	5.8	5.9
Responses	845	694



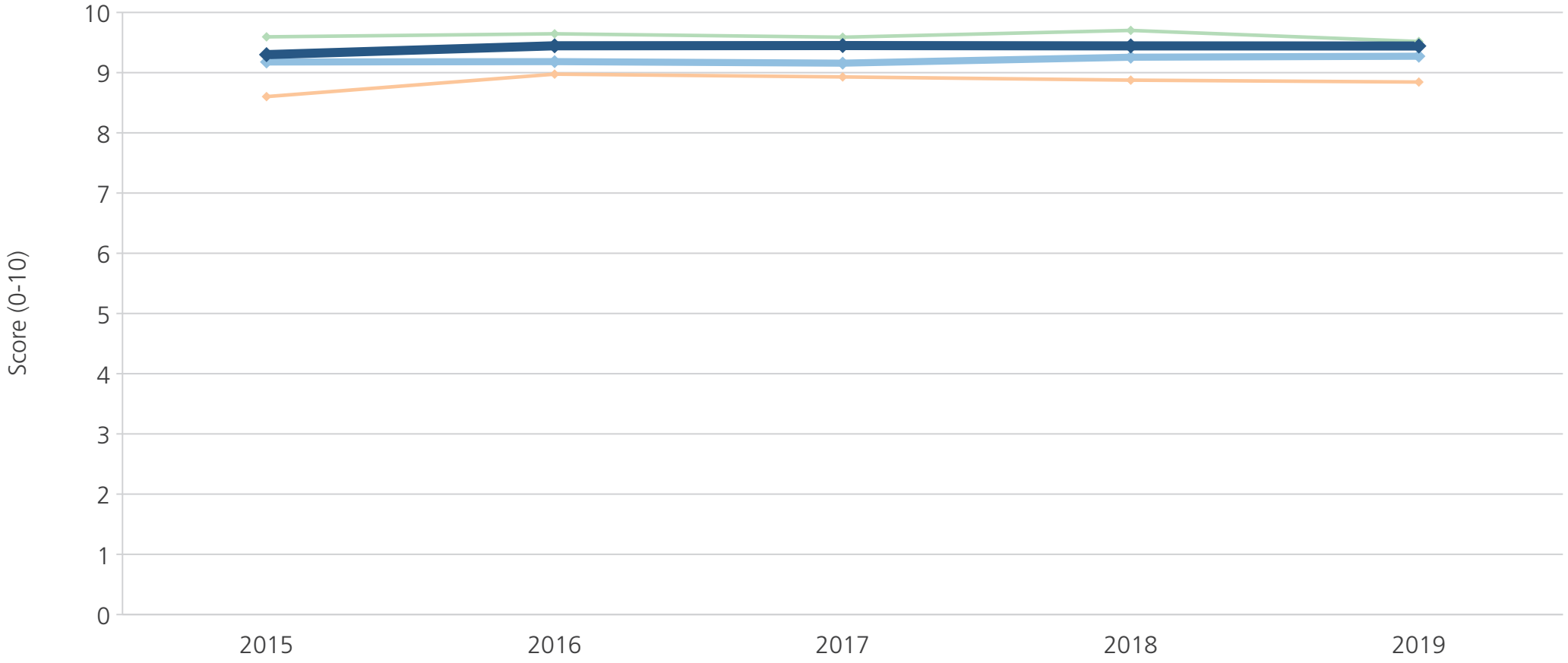
	2015	2016	2017	2018	2019
Best	6.1	6.2	6.3	6.5	6.5
Your org	4.9	5.2	5.4	5.4	5.5
Average	5.3	5.5	5.5	5.7	5.8
Worst	4.4	4.7	4.9	5.1	5.1
Responses	255	677	803	741	593



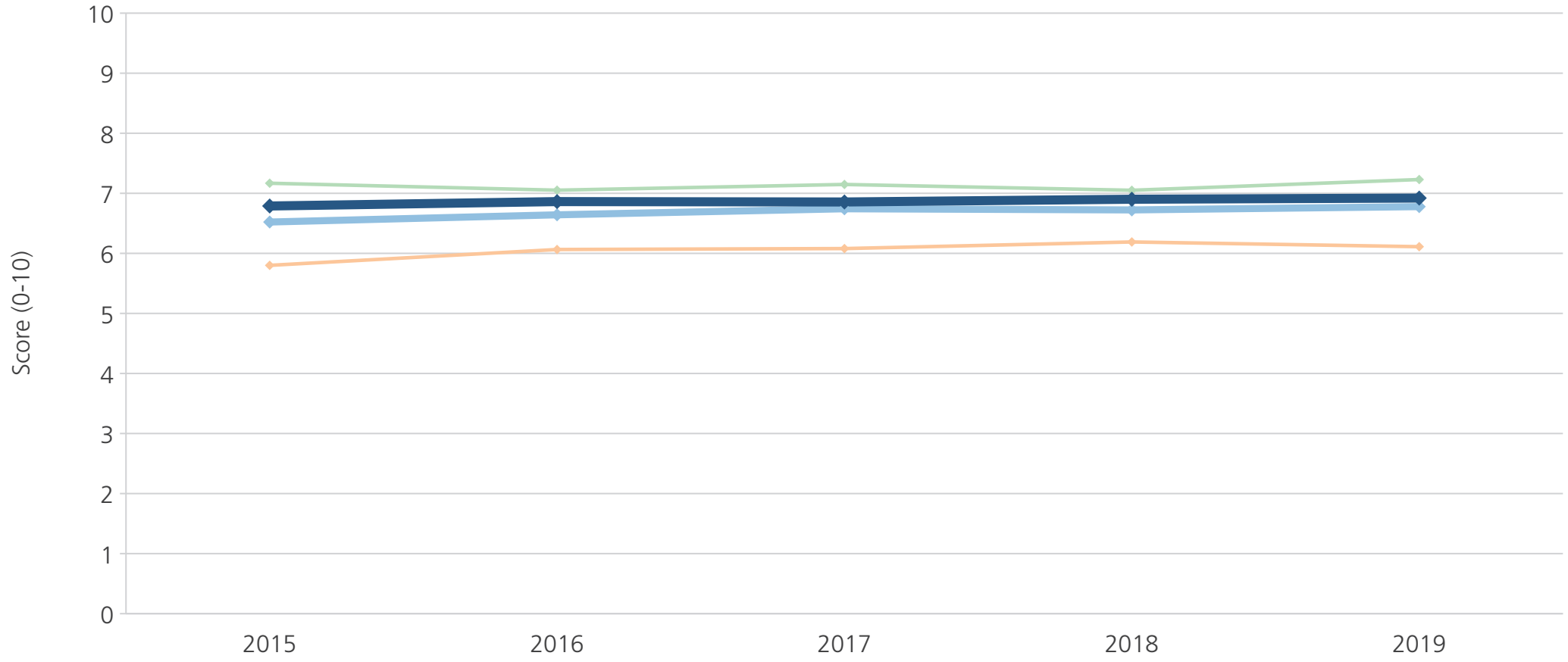
	2015	2016	2017	2018	2019
Best	7.8	7.7	7.9	7.9	7.8
Your org	7.4	7.4	7.3	7.3	7.2
Average	7.3	7.4	7.3	7.3	7.4
Worst	6.6	6.8	6.7	6.6	6.9
Responses	235	596	723	672	536



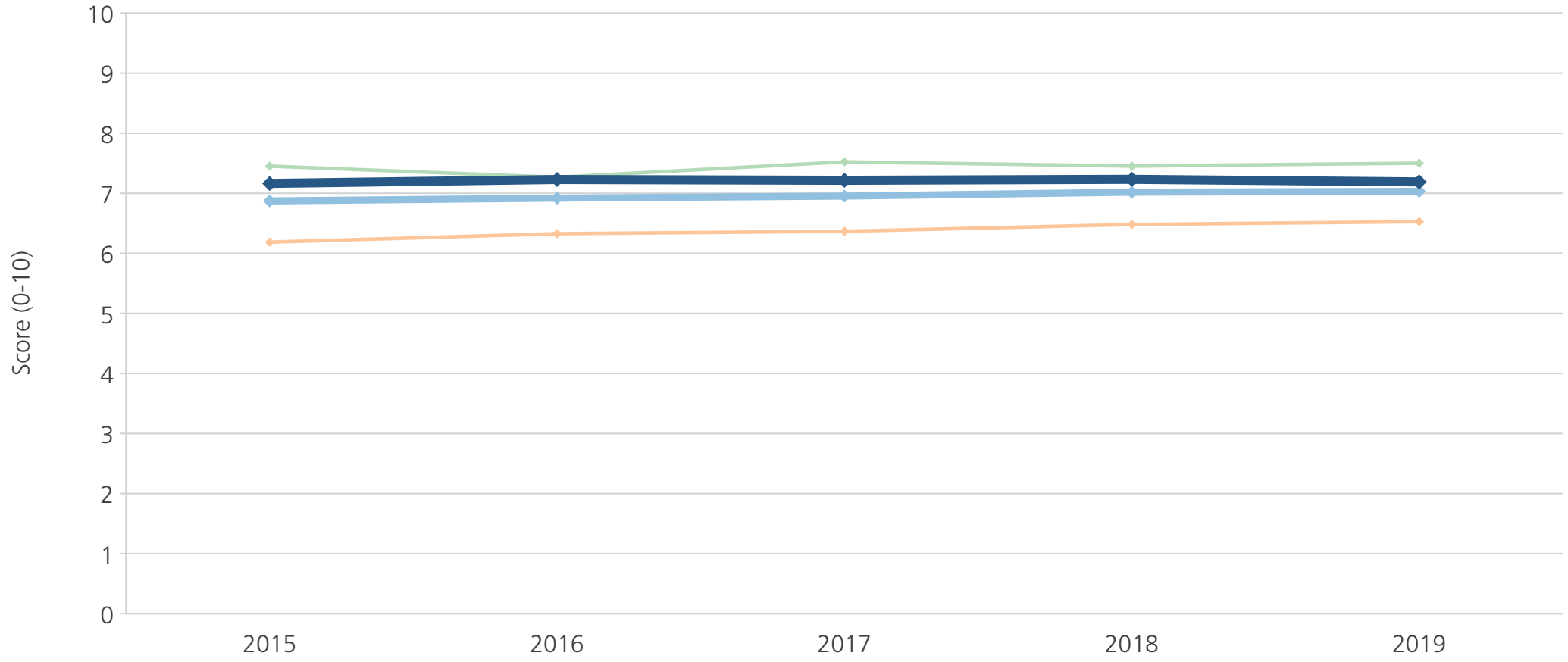
	2015	2016	2017	2018	2019
Best	8.6	8.4	8.6	8.4	8.3
Your org	8.1	7.9	8.1	8.0	8.2
Average	7.9	8.0	8.0	7.9	8.0
Worst	7.5	7.4	7.4	7.5	7.4
Responses	291	766	904	849	695



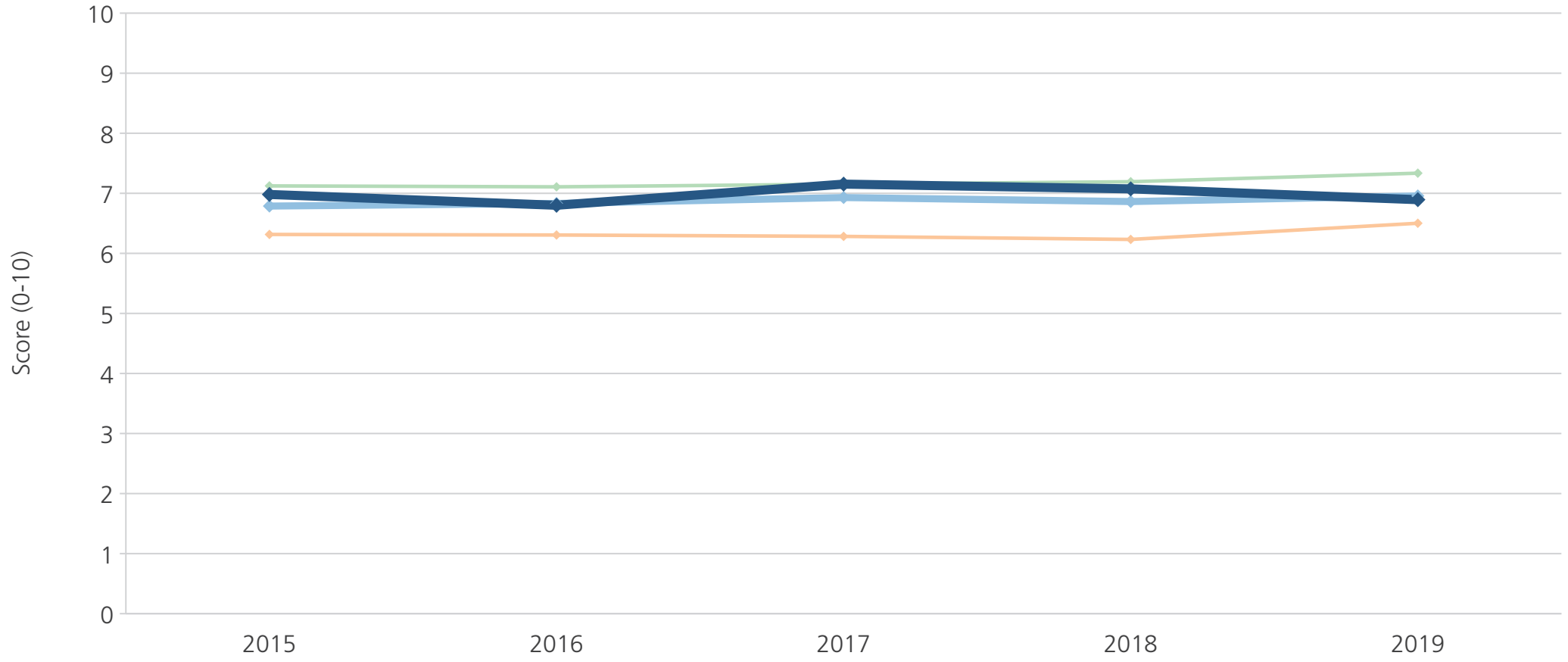
	2015	2016	2017	2018	2019
Best	9.6	9.6	9.6	9.7	9.5
Your org	9.3	9.4	9.4	9.4	9.4
Average	9.2	9.2	9.2	9.3	9.3
Worst	8.6	9.0	8.9	8.9	8.8
Responses	293	768	907	845	694



	2015	2016	2017	2018	2019
Best	7.2	7.1	7.1	7.1	7.2
Your org	6.8	6.9	6.9	6.9	6.9
Average	6.5	6.6	6.7	6.7	6.8
Worst	5.8	6.1	6.1	6.2	6.1
Responses	294	770	910	852	693



	2015	2016	2017	2018	2019
Best	7.5	7.3	7.5	7.5	7.5
Your org	7.2	7.2	7.2	7.2	7.2
Average	6.9	6.9	7.0	7.0	7.0
Worst	6.2	6.3	6.4	6.5	6.5
Responses	297	776	918	862	708



	2015	2016	2017	2018	2019
Best	7.1	7.1	7.2	7.2	7.3
Your org	7.0	6.8	7.2	7.1	6.9
Average	6.8	6.8	6.9	6.9	7.0
Worst	6.3	6.3	6.3	6.2	6.5
Responses	289	765	907	843	698

Survey Coordination Centre

NHS England

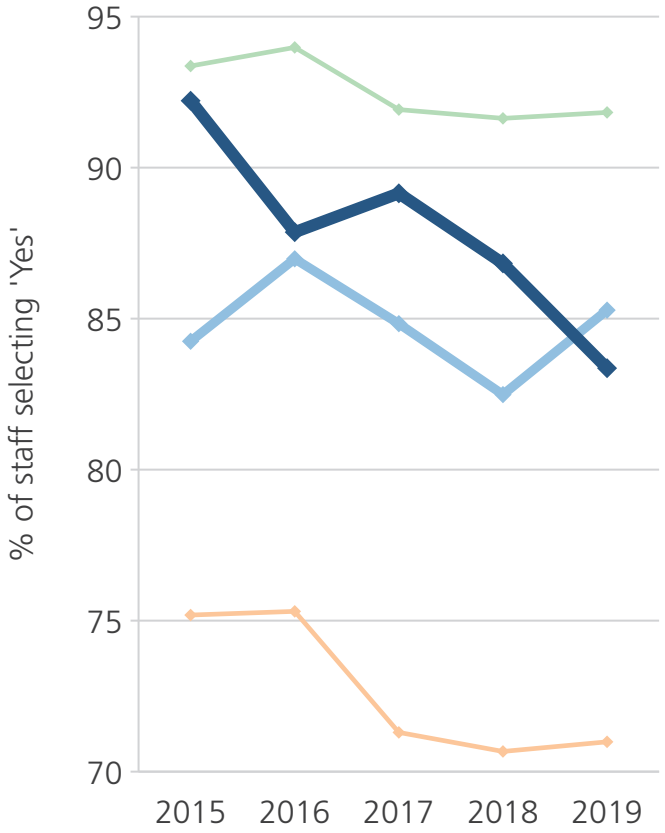
Theme results – Detailed information

2Gether NHS Foundation Trust

2019 NHS Staff Survey Results

Q14

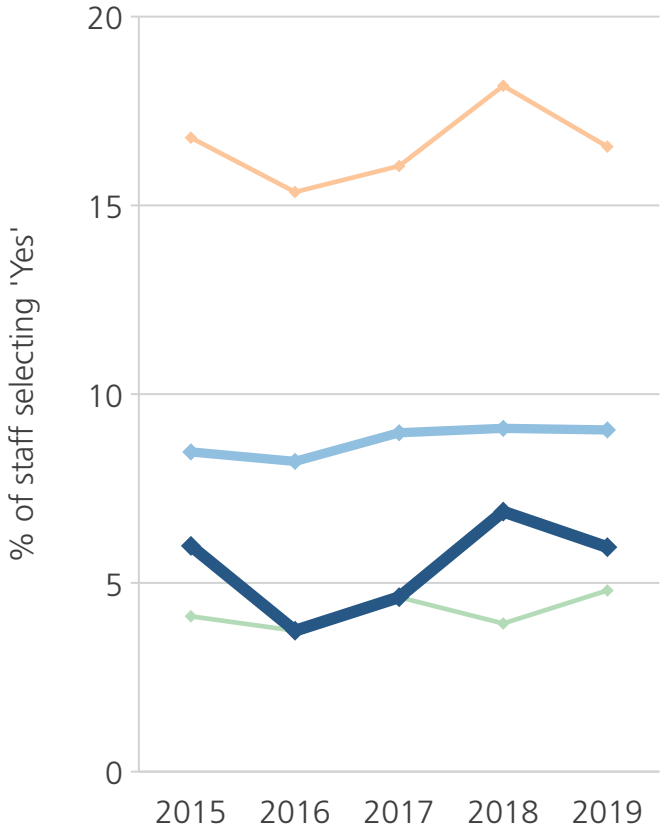
Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?



	2015	2016	2017	2018	2019
Best	93.4%	94.0%	91.9%	91.6%	91.8%
Your org	92.2%	87.9%	89.1%	86.8%	83.4%
Average	84.2%	87.0%	84.8%	82.5%	85.3%
Worst	75.2%	75.3%	71.3%	70.7%	71.0%

Q15a

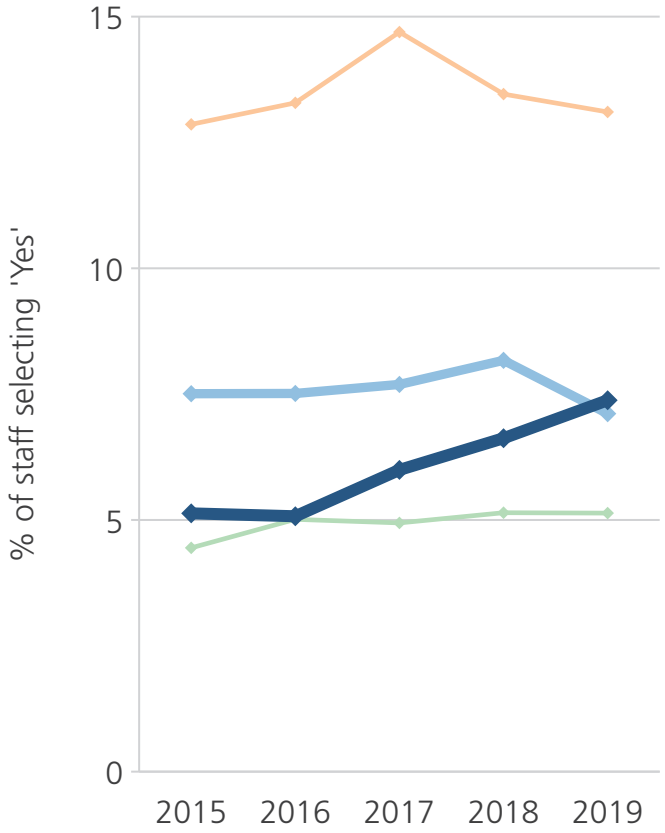
In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public?



	2015	2016	2017	2018	2019
Worst	16.8%	15.4%	16.0%	18.2%	16.6%
Your org	6.0%	3.7%	4.6%	6.9%	5.9%
Average	8.5%	8.2%	9.0%	9.1%	9.1%
Best	4.1%	3.7%	4.6%	3.9%	4.8%

Q15b

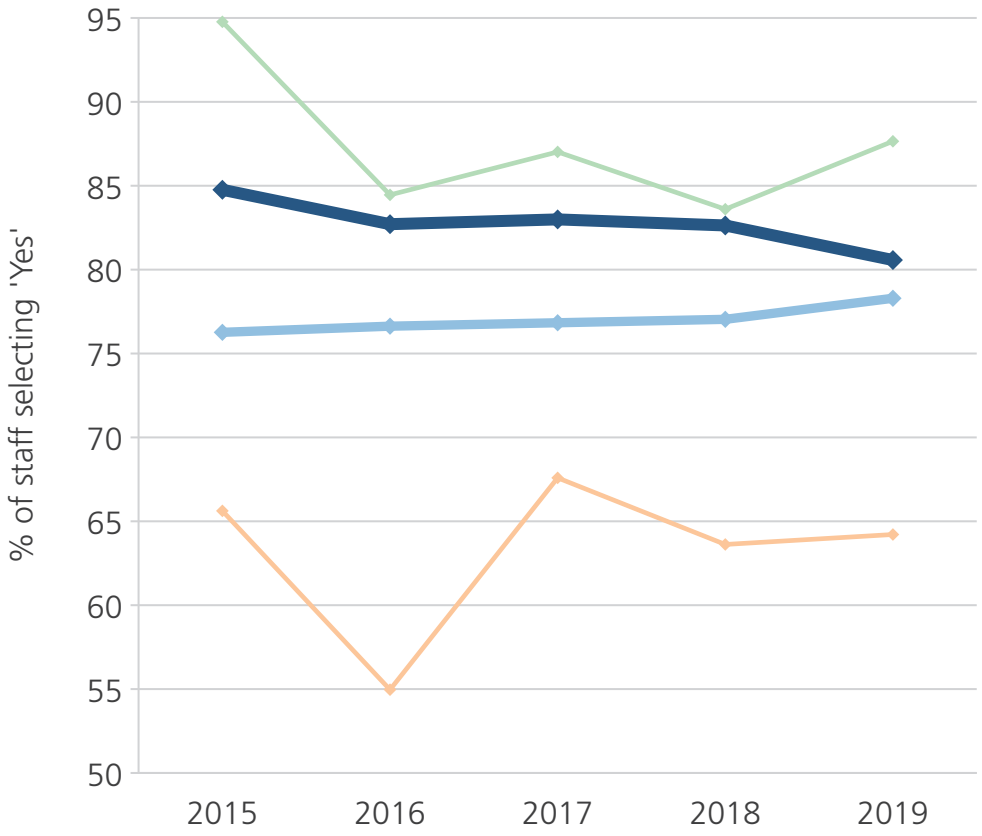
In the last 12 months have you personally experienced discrimination at work from manager / team leader or other colleagues?



	2015	2016	2017	2018	2019
Worst	12.9%	13.3%	14.7%	13.5%	13.1%
Your org	5.1%	5.1%	6.0%	6.6%	7.4%
Average	7.5%	7.5%	7.7%	8.2%	7.1%
Best	4.4%	5.0%	4.9%	5.1%	5.1%

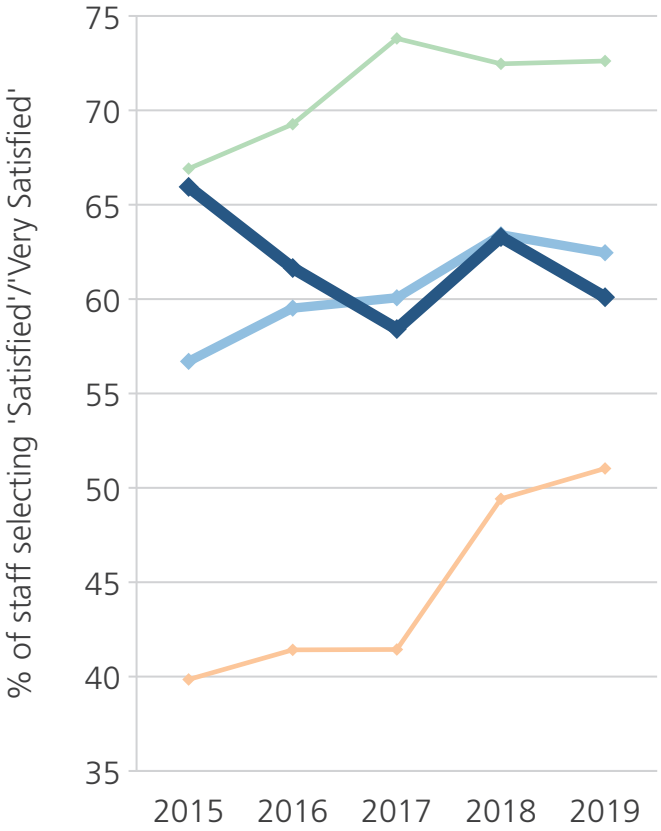
Q28b

Has your employer made adequate adjustment(s) to enable you to carry out your work?



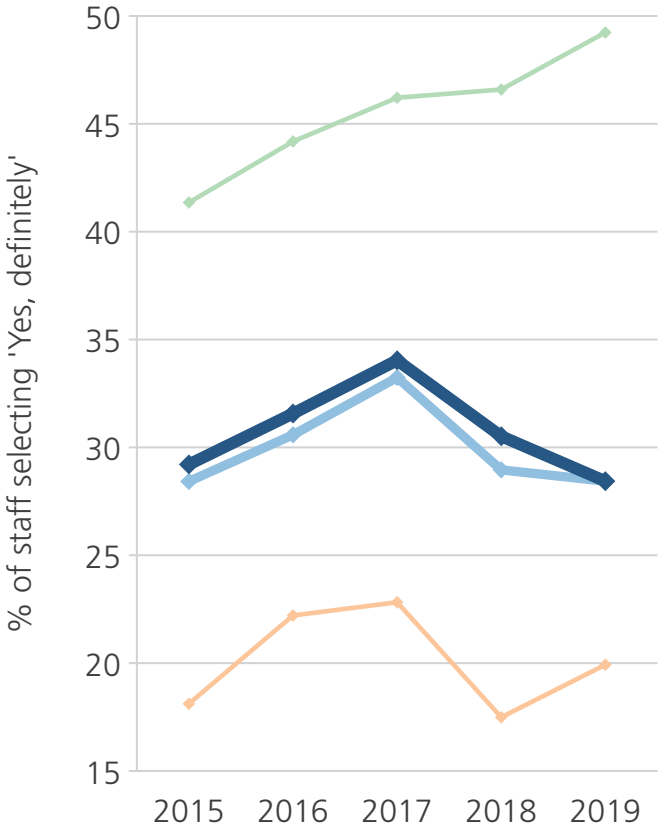
	2015	2016	2017	2018	2019
Best	94.8%	84.5%	87.0%	83.6%	87.7%
Your org	84.8%	82.7%	83.0%	82.6%	80.6%
Average	76.3%	76.6%	76.8%	77.0%	78.3%
Worst	65.6%	55.0%	67.6%	63.6%	64.2%

Q5h
The opportunities for flexible working patterns



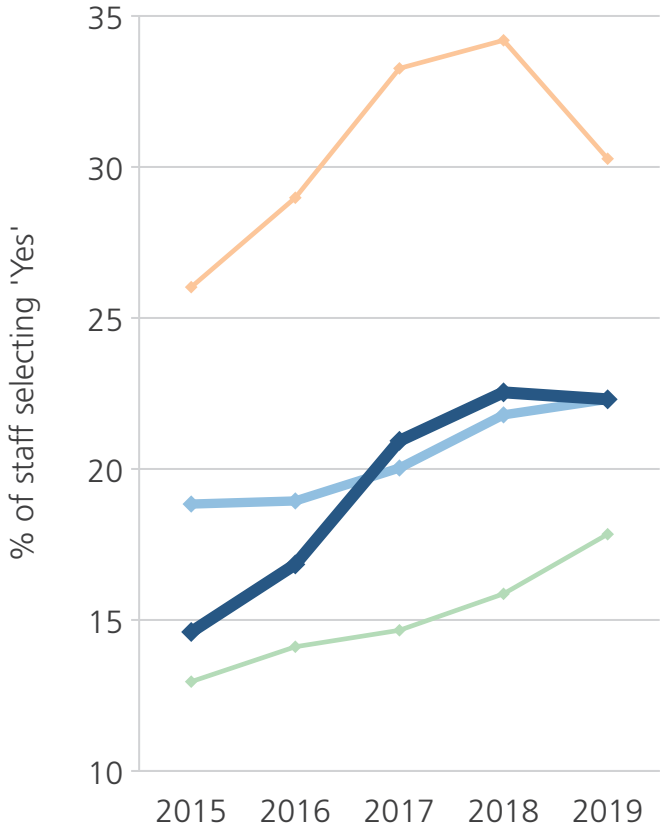
	2015	2016	2017	2018	2019
Best	66.9%	69.3%	73.8%	72.5%	72.6%
Your org	65.9%	61.6%	58.4%	63.3%	60.1%
Average	56.7%	59.5%	60.1%	63.4%	62.5%
Worst	39.8%	41.4%	41.4%	49.4%	51.0%

Q11a
Does your organisation take positive action on health and well-being?



	2015	2016	2017	2018	2019
Best	41.4%	44.2%	46.2%	46.6%	49.2%
Your org	29.2%	31.6%	34.0%	30.5%	28.4%
Average	28.4%	30.6%	33.2%	29.0%	28.4%
Worst	18.1%	22.2%	22.8%	17.5%	19.9%

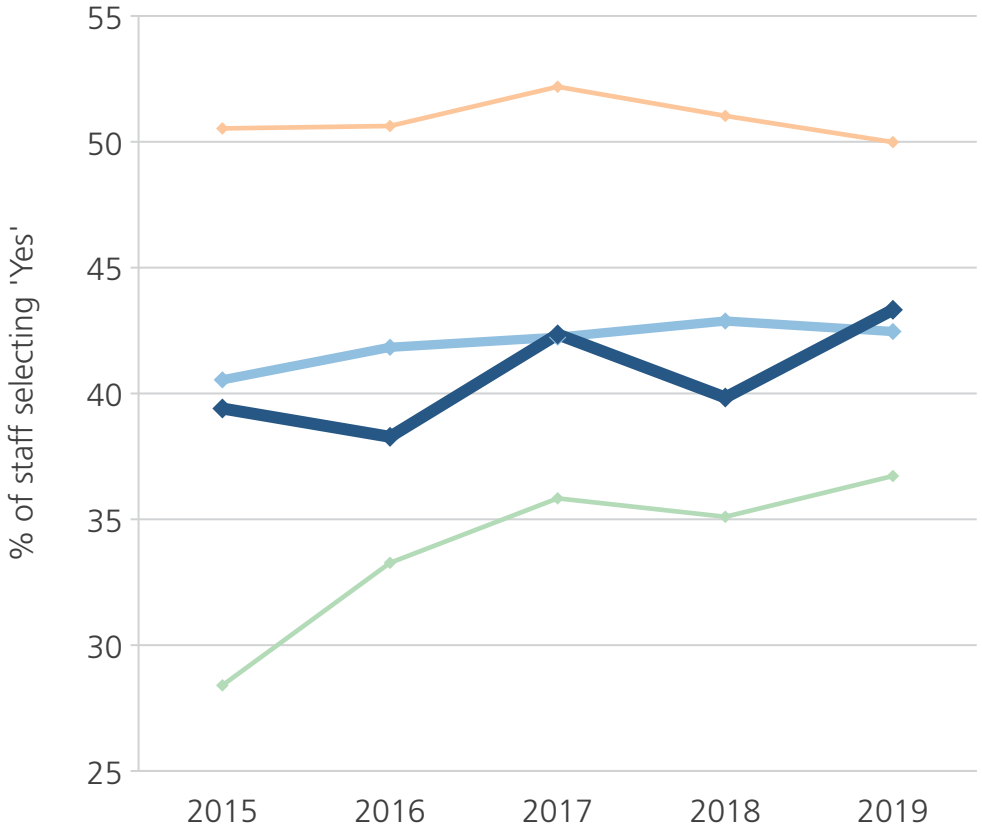
Q11b
In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?



	2015	2016	2017	2018	2019
Worst	26.0%	29.0%	33.3%	34.2%	30.3%
Your org	14.6%	16.8%	20.9%	22.5%	22.3%
Average	18.8%	18.9%	20.0%	21.8%	22.3%
Best	13.0%	14.1%	14.7%	15.9%	17.8%

Q11c

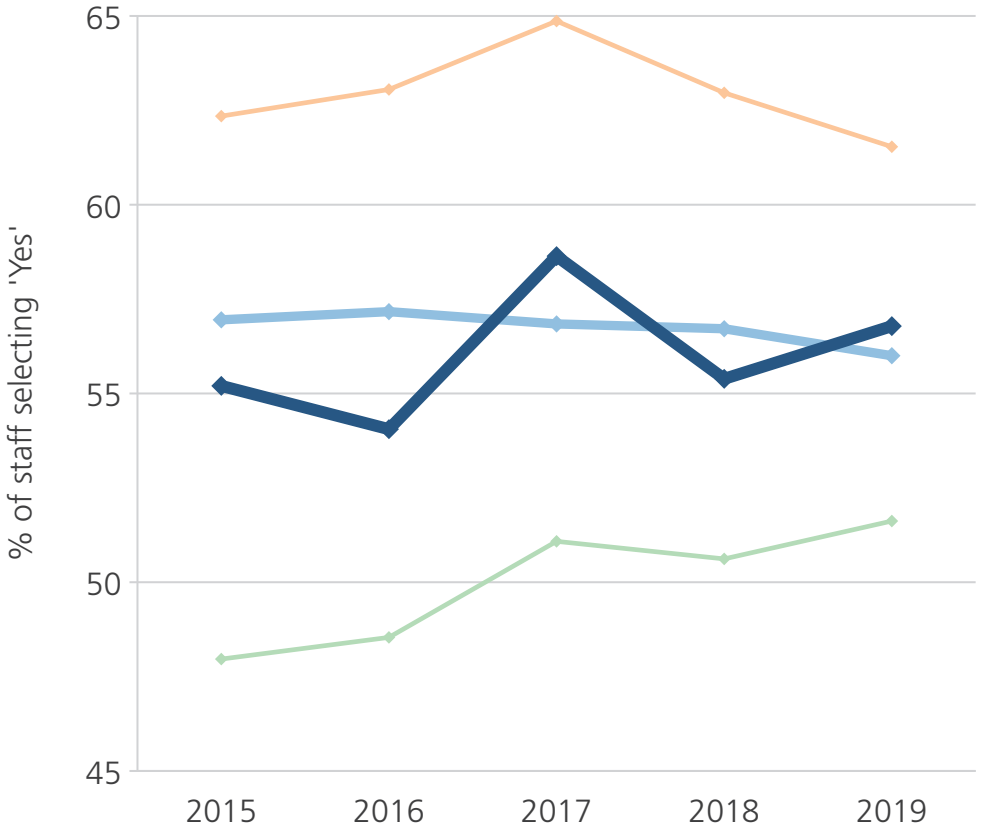
During the last 12 months have you felt unwell as a result of work related stress?



	2015	2016	2017	2018	2019
Worst	50.5%	50.6%	52.2%	51.0%	50.0%
Your org	39.4%	38.3%	42.3%	39.8%	43.3%
Average	40.5%	41.8%	42.2%	42.9%	42.5%
Best	28.4%	33.3%	35.8%	35.1%	36.7%

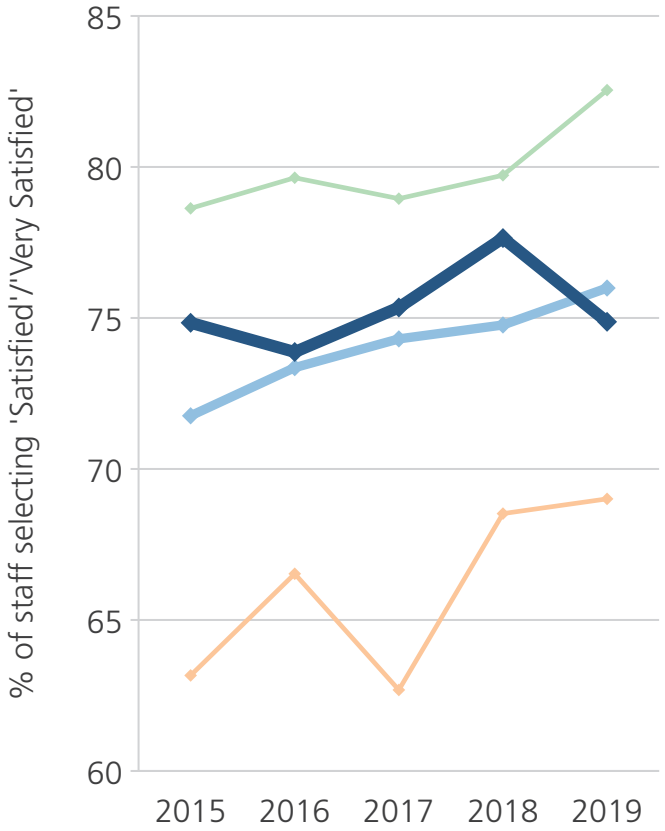
Q11d

In the last three months have you ever come to work despite not feeling well enough to perform your duties?



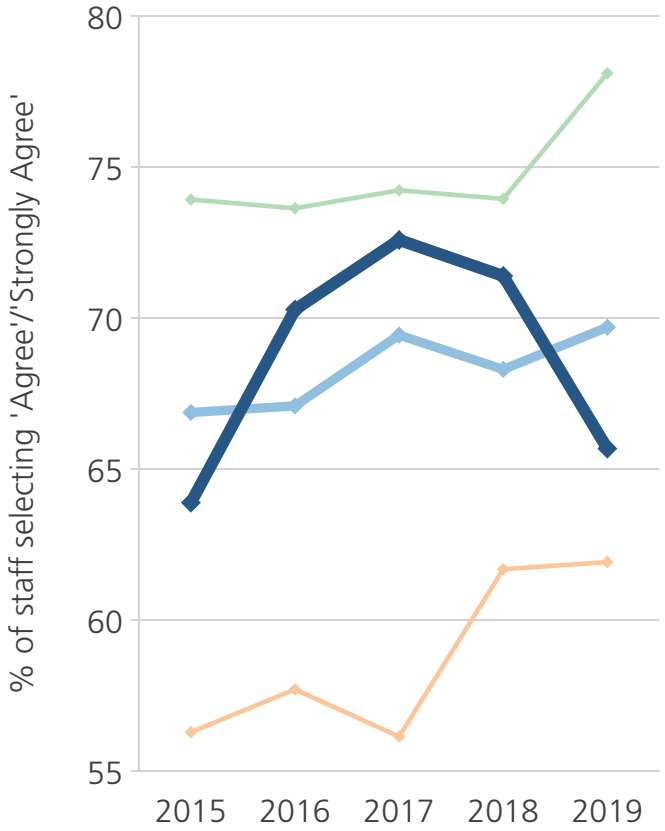
	2015	2016	2017	2018	2019
Worst	62.3%	63.1%	64.9%	63.0%	61.5%
Your org	55.2%	54.1%	58.6%	55.4%	56.8%
Average	57.0%	57.2%	56.8%	56.7%	56.0%
Best	48.0%	48.5%	51.1%	50.6%	51.6%

Q5b
The support I get from my immediate manager



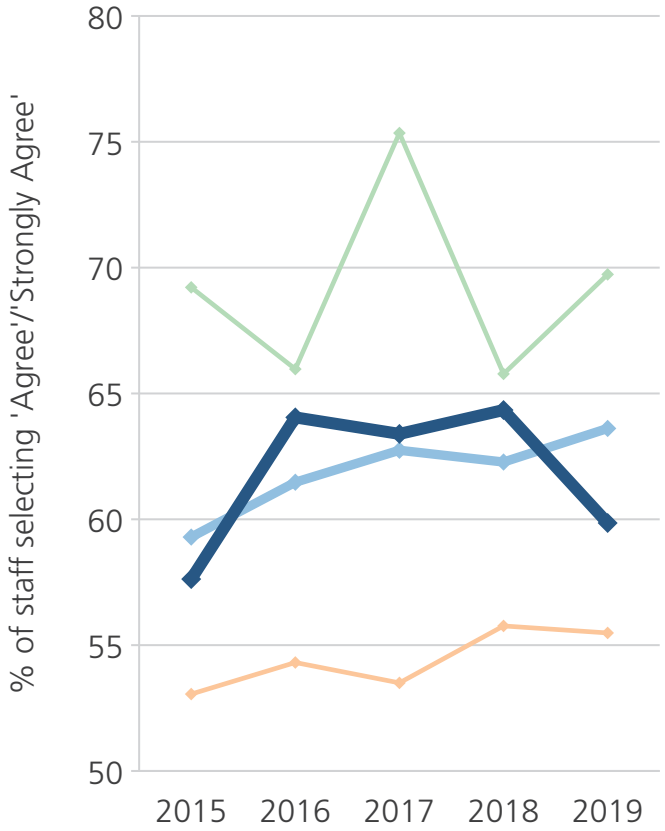
	2015	2016	2017	2018	2019
Best	78.6%	79.6%	79.0%	79.7%	82.5%
Your org	74.8%	73.9%	75.3%	77.6%	74.9%
Average	71.8%	73.4%	74.3%	74.8%	76.0%
Worst	63.2%	66.5%	62.7%	68.5%	69.0%

Q8c
My immediate manager gives me clear feedback on my work



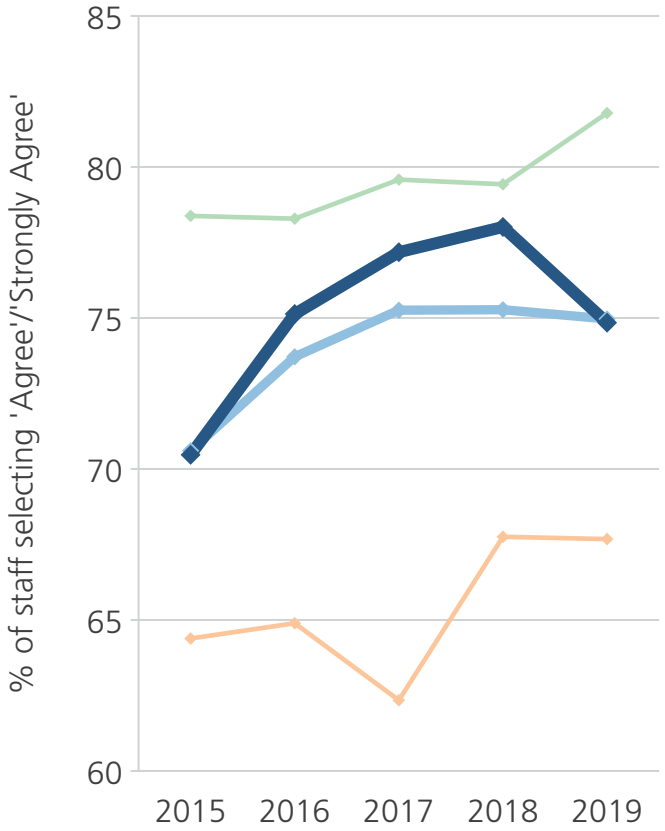
	2015	2016	2017	2018	2019
Best	73.9%	73.6%	74.2%	73.9%	78.1%
Your org	63.9%	70.3%	72.6%	71.4%	65.7%
Average	66.9%	67.1%	69.4%	68.3%	69.7%
Worst	56.3%	57.7%	56.1%	61.7%	61.9%

Q8d
My immediate manager asks for my opinion before making decisions that affect my work



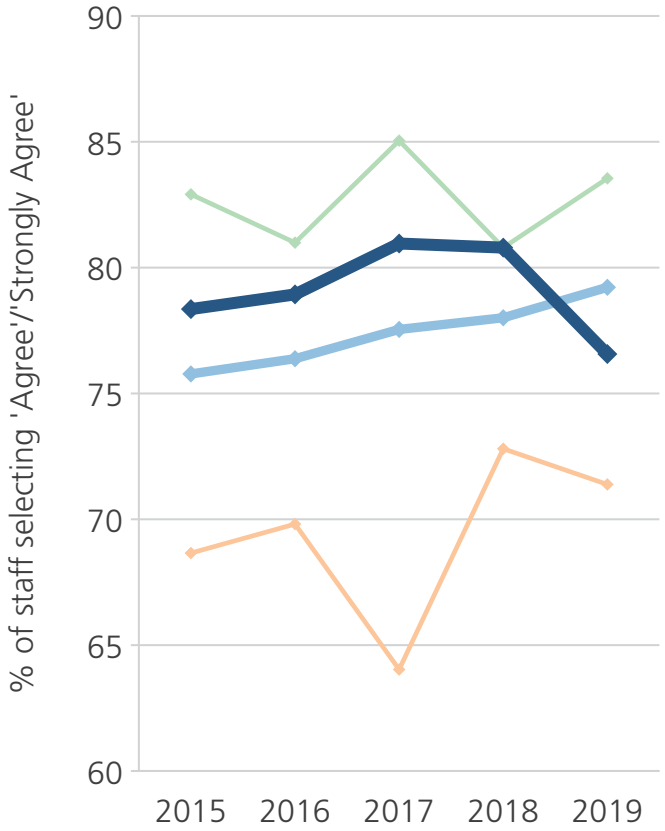
	2015	2016	2017	2018	2019
Best	69.2%	66.0%	75.3%	65.8%	69.7%
Your org	57.6%	64.0%	63.4%	64.3%	59.9%
Average	59.3%	61.5%	62.7%	62.3%	63.6%
Worst	53.1%	54.3%	53.5%	55.8%	55.5%

Q8f
My immediate manager takes a positive interest in my health and well-being



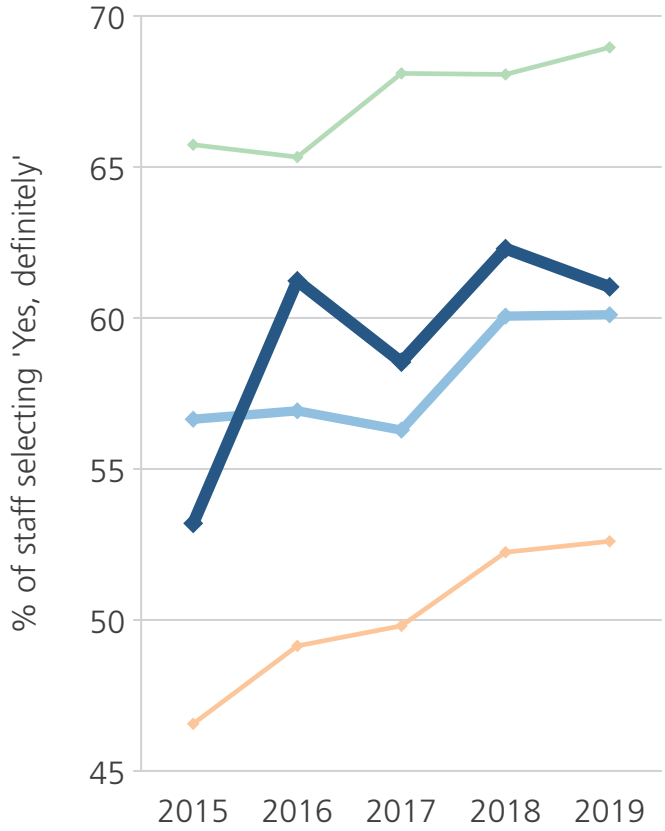
	2015	2016	2017	2018	2019
Best	78.4%	78.3%	79.6%	79.4%	81.8%
Your org	70.5%	75.1%	77.2%	78.0%	74.8%
Average	70.6%	73.7%	75.3%	75.3%	75.0%
Worst	64.4%	64.9%	62.3%	67.8%	67.7%

Q8g
My immediate manager values my work



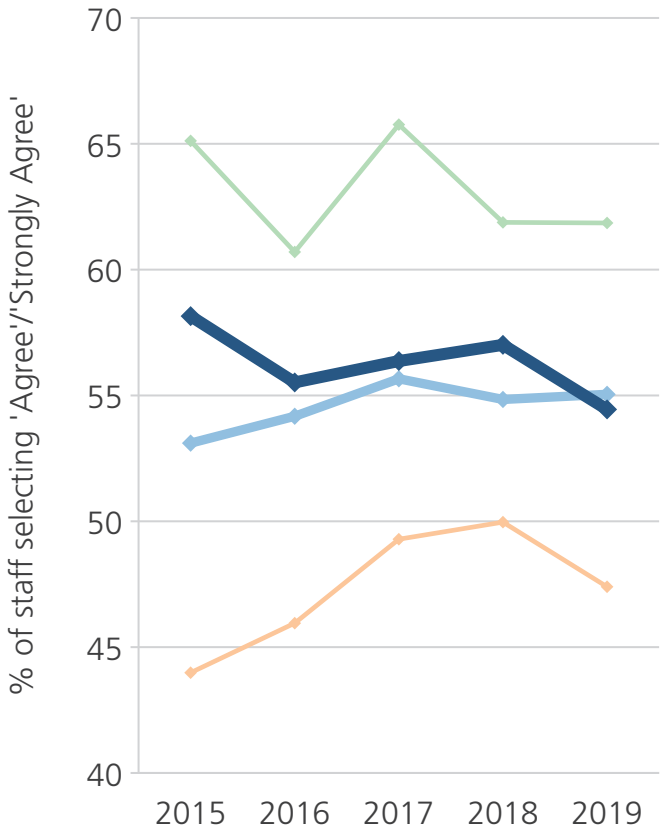
	2015	2016	2017	2018	2019
Best	82.9%	81.0%	85.0%	80.8%	83.5%
Your org	78.4%	78.9%	81.0%	80.8%	76.6%
Average	75.8%	76.4%	77.5%	78.0%	79.2%
Worst	68.7%	69.8%	64.0%	72.8%	71.4%

Q19g
My manager supported me to receive this training, learning or development



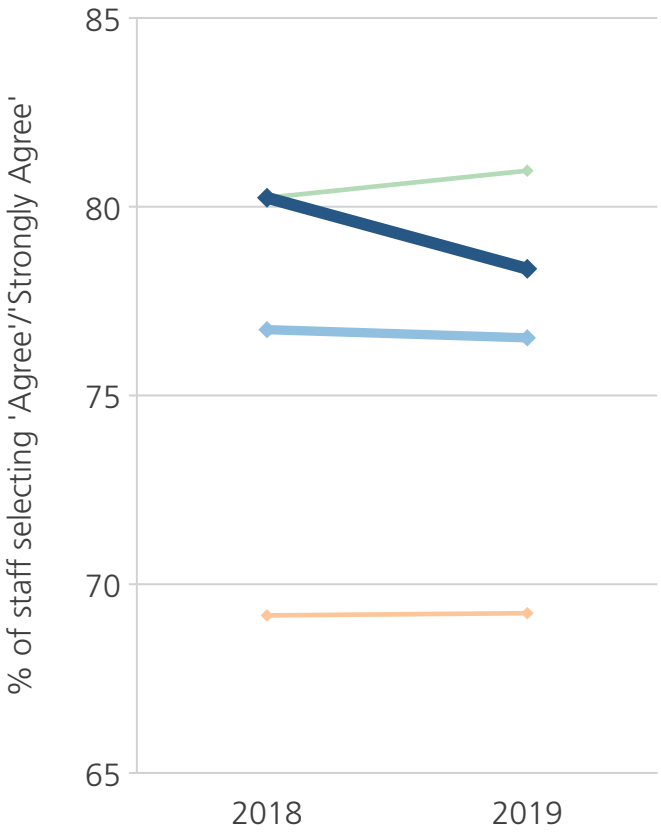
	2015	2016	2017	2018	2019
Best	65.7%	65.3%	68.1%	68.1%	69.0%
Your org	53.2%	61.2%	58.5%	62.3%	61.0%
Average	56.6%	56.9%	56.3%	60.1%	60.1%
Worst	46.6%	49.1%	49.8%	52.2%	52.6%

Q4c
I am involved in deciding on changes introduced that affect my work area / team / department



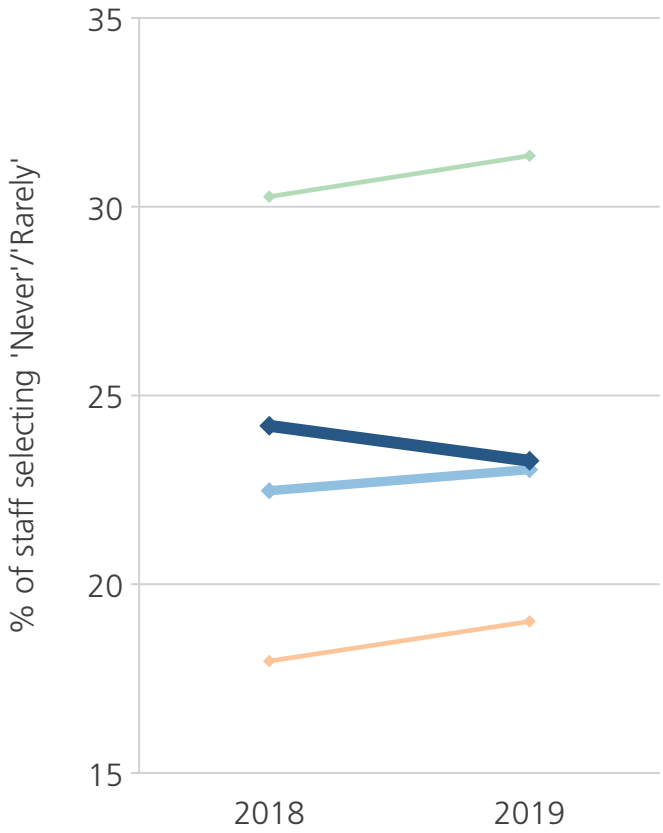
	2015	2016	2017	2018	2019
Best	65.1%	60.7%	65.8%	61.9%	61.9%
Your org	58.2%	55.5%	56.4%	57.0%	54.4%
Average	53.1%	54.2%	55.7%	54.8%	55.0%
Worst	44.0%	46.0%	49.3%	50.0%	47.4%

Q4j
I receive the respect I deserve from my colleagues at work



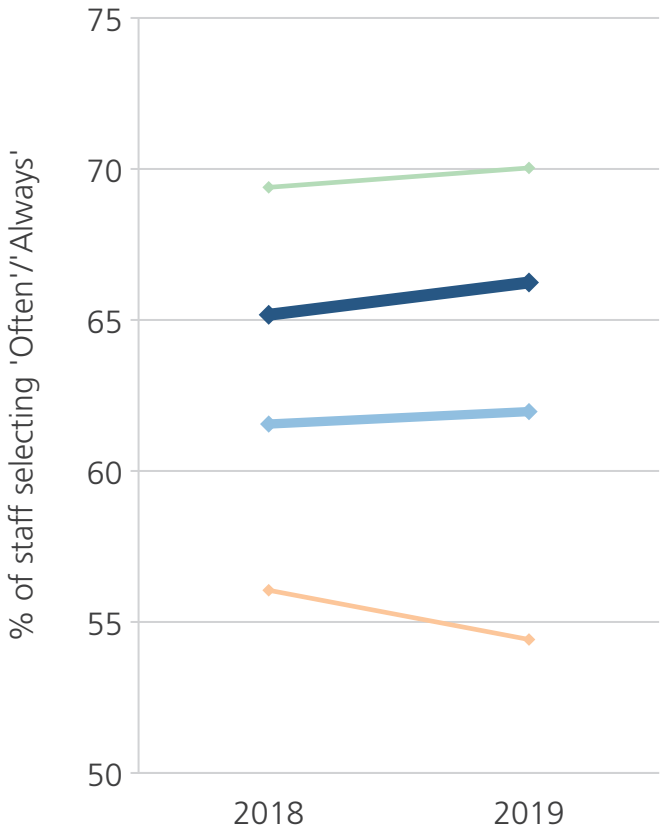
	2018	2019
Best	80.2%	81.0%
Your org	80.2%	78.4%
Average	76.7%	76.5%
Worst	69.2%	69.2%

Q6a
I have unrealistic time pressures



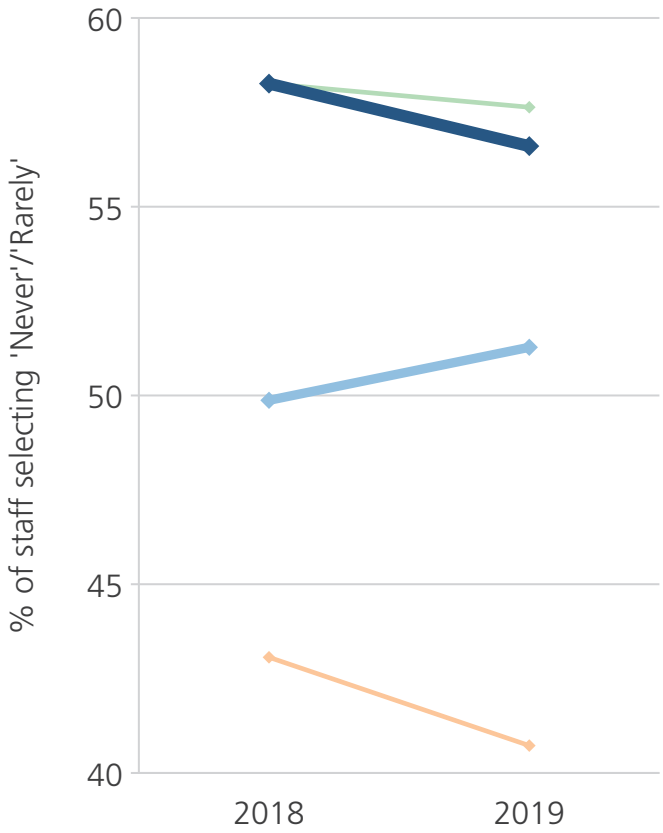
	2018	2019
Best	30.3%	31.4%
Your org	24.2%	23.3%
Average	22.5%	23.0%
Worst	18.0%	19.0%

Q6b
I have a choice in deciding how to do my work



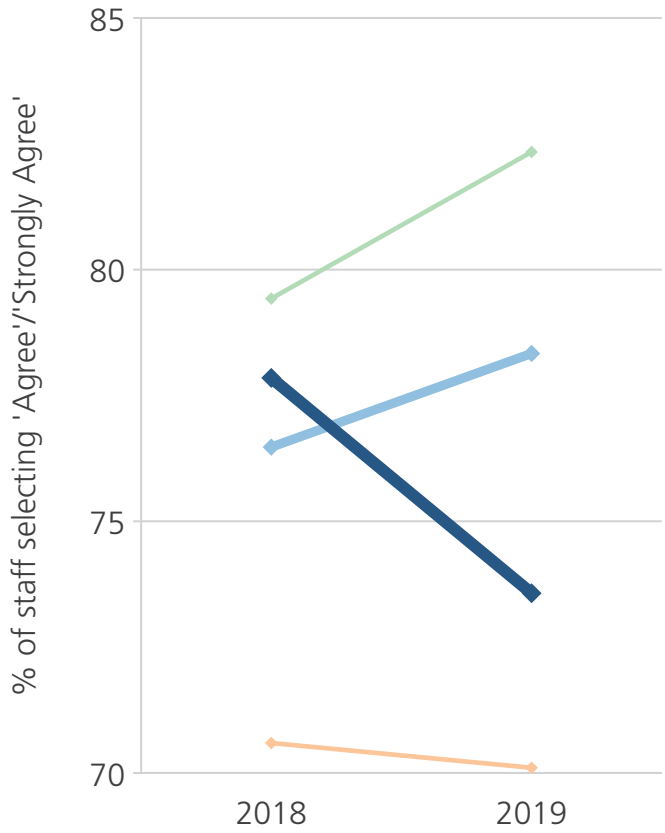
	2018	2019
Best	69.4%	70.0%
Your org	65.2%	66.2%
Average	61.6%	62.0%
Worst	56.1%	54.4%

Q6c
Relationships at work are strained



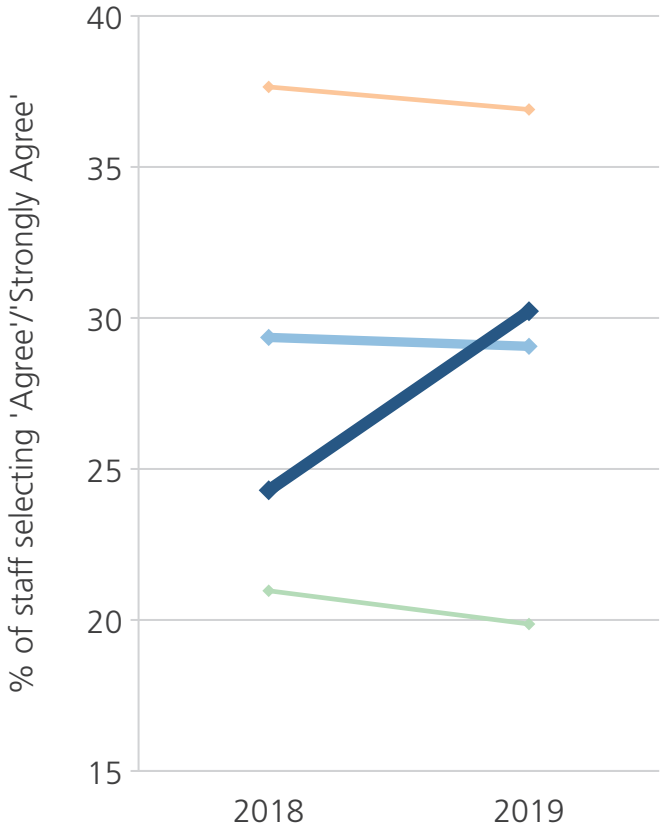
	2018	2019
Best	58.3%	57.6%
Your org	58.3%	56.6%
Average	49.9%	51.3%
Worst	43.1%	40.7%

Q8a
My immediate manager encourages me at work



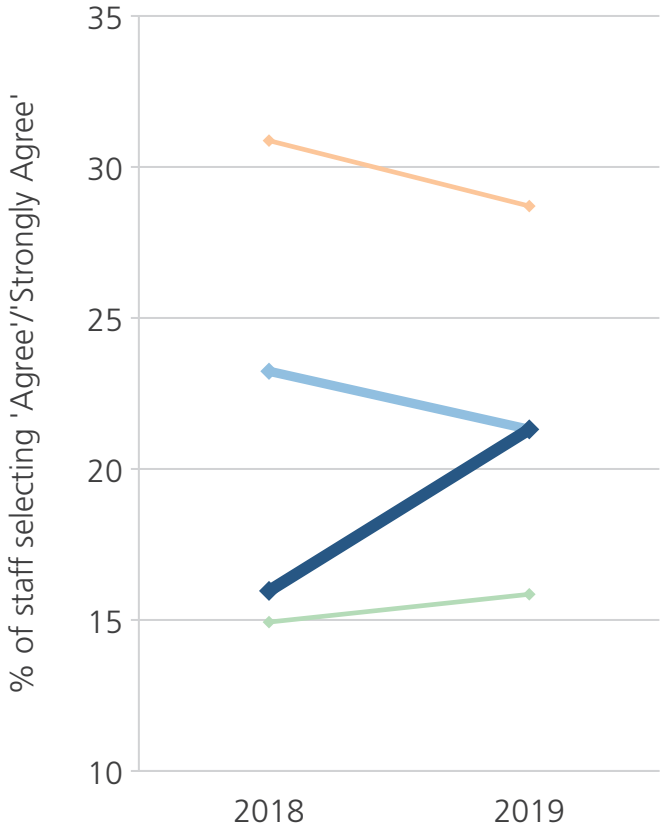
	2018	2019
Best	79.4%	82.3%
Your org	77.8%	73.6%
Average	76.5%	78.3%
Worst	70.6%	70.1%

Q23a
I often think about leaving this organisation



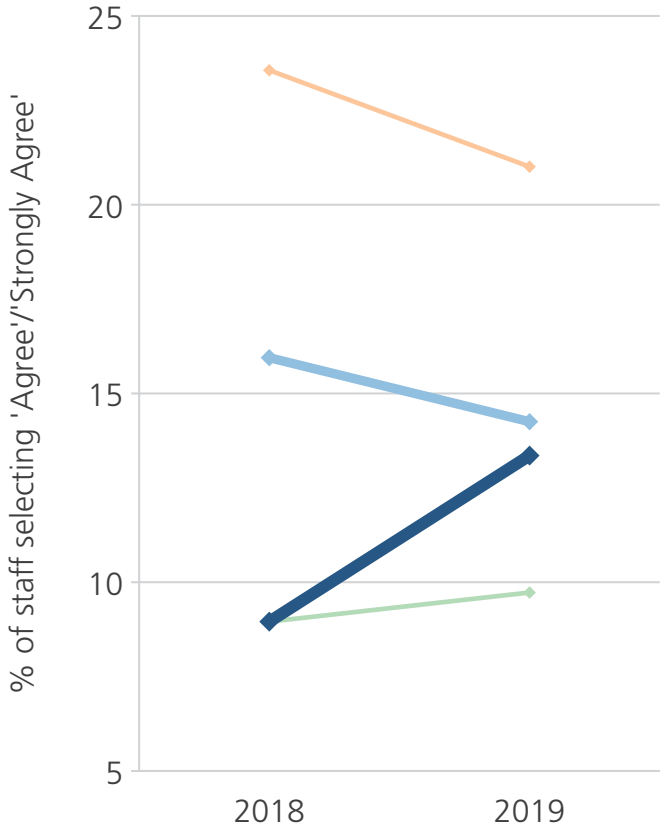
	2018	2019
Worst	37.6%	36.9%
Your org	24.3%	30.2%
Average	29.4%	29.1%
Best	21.0%	19.9%

Q23b
I will probably look for a job at a new organisation in the next 12 months



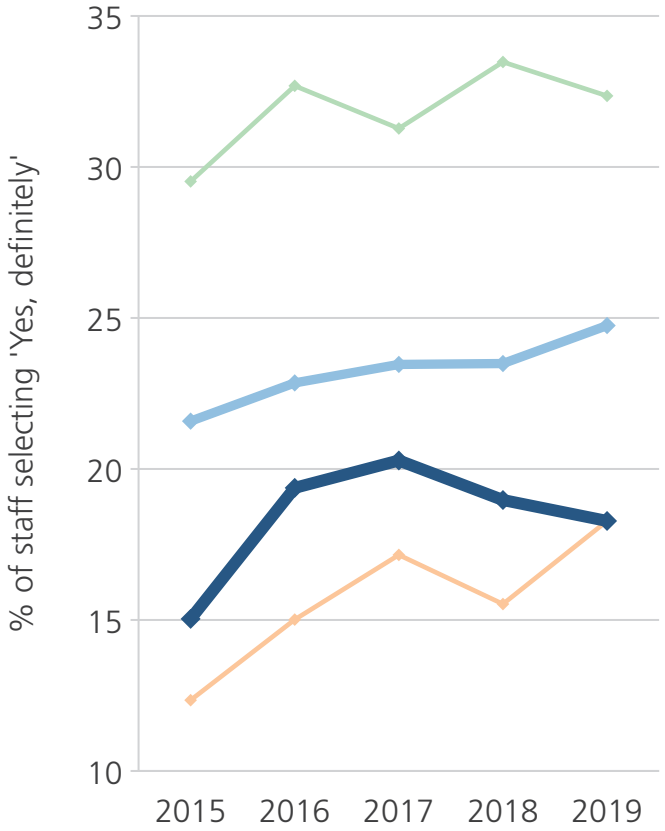
	2018	2019
Worst	30.9%	28.7%
Your org	16.0%	21.3%
Average	23.2%	21.3%
Best	14.9%	15.9%

Q23c
As soon as I can find another job, I will leave this organisation



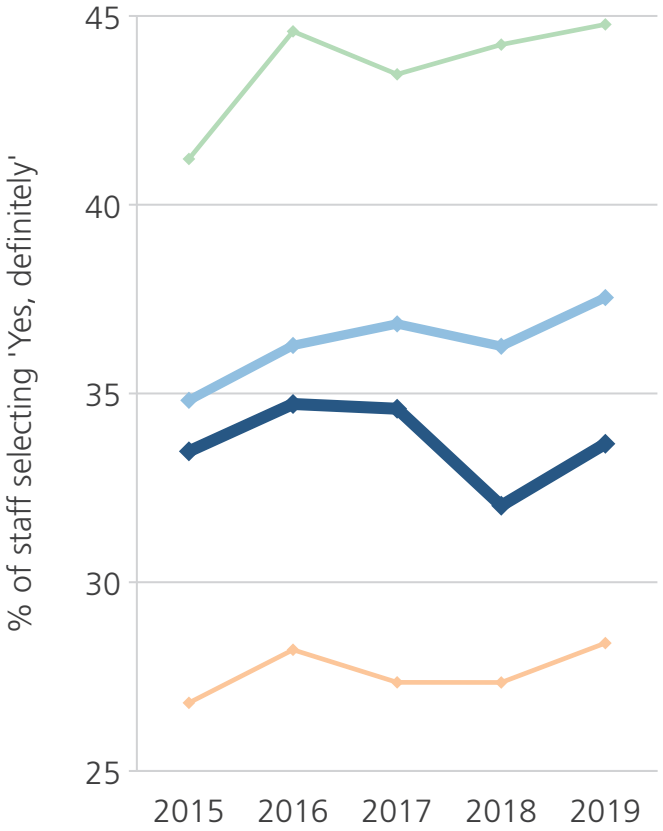
	2018	2019
Worst	23.6%	21.0%
Your org	9.0%	13.4%
Average	15.9%	14.3%
Best	9.0%	9.7%

Q19b
It helped me to improve how I do my job



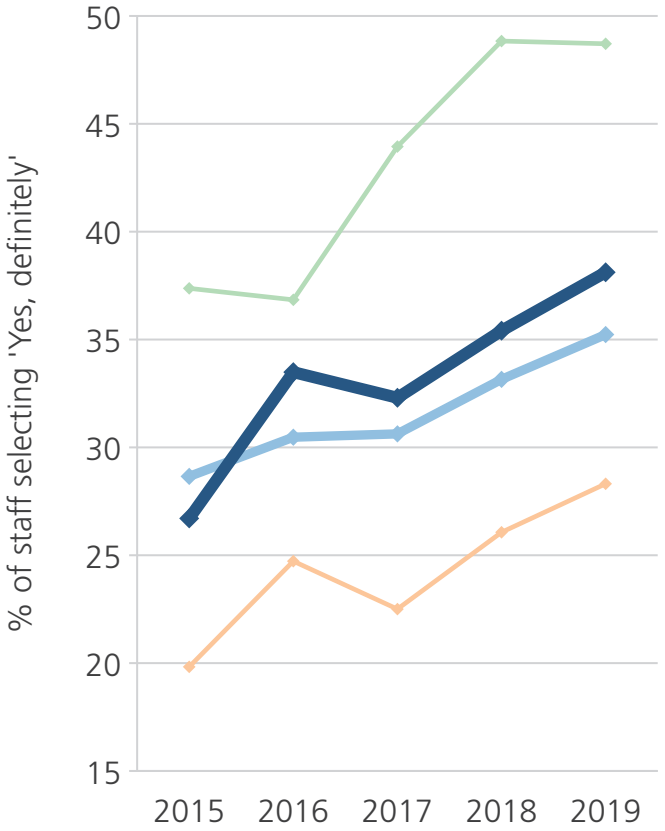
	2015	2016	2017	2018	2019
Best	29.5%	32.7%	31.3%	33.5%	32.4%
Your org	15.0%	19.4%	20.3%	19.0%	18.3%
Average	21.6%	22.8%	23.5%	23.5%	24.7%
Worst	12.3%	15.0%	17.2%	15.5%	18.3%

Q19c
It helped me agree clear objectives for my work



	2015	2016	2017	2018	2019
Best	41.2%	44.6%	43.5%	44.2%	44.8%
Your org	33.5%	34.7%	34.6%	32.0%	33.7%
Average	34.8%	36.3%	36.8%	36.3%	37.5%
Worst	26.8%	28.2%	27.3%	27.3%	28.4%

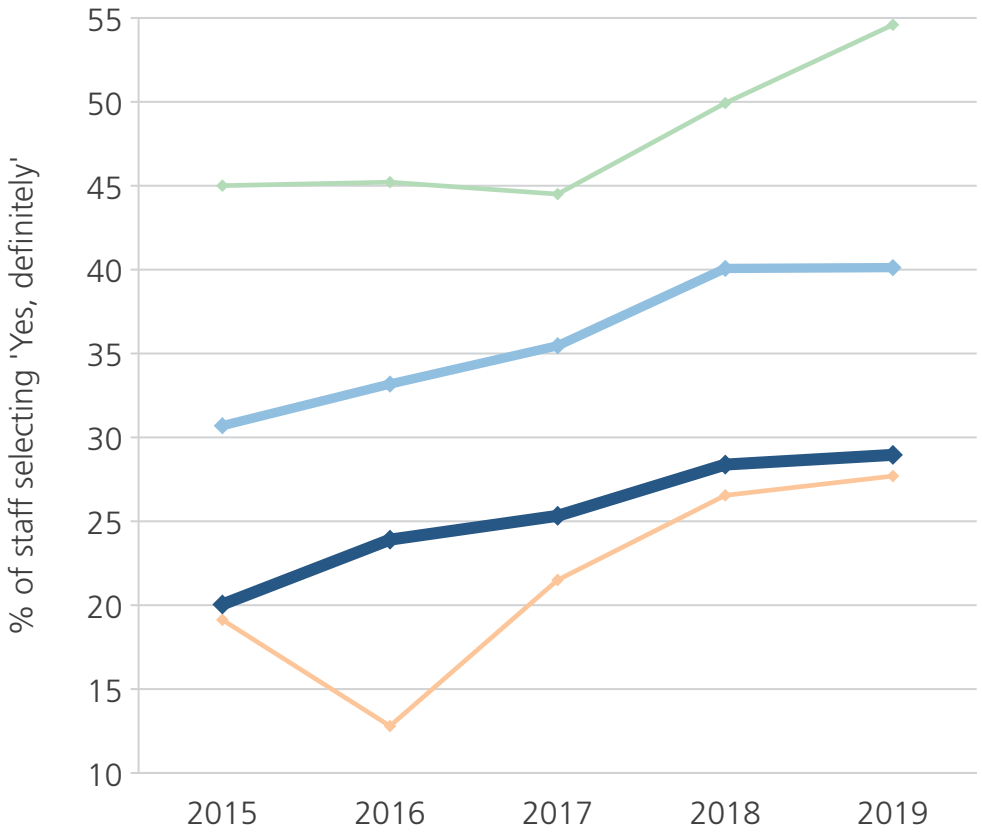
Q19d
It left me feeling that my work is valued by my organisation



	2015	2016	2017	2018	2019
Best	37.4%	36.8%	43.9%	48.8%	48.7%
Your org	26.7%	33.5%	32.3%	35.4%	38.1%
Average	28.7%	30.5%	30.6%	33.2%	35.2%
Worst	19.8%	24.7%	22.5%	26.1%	28.3%

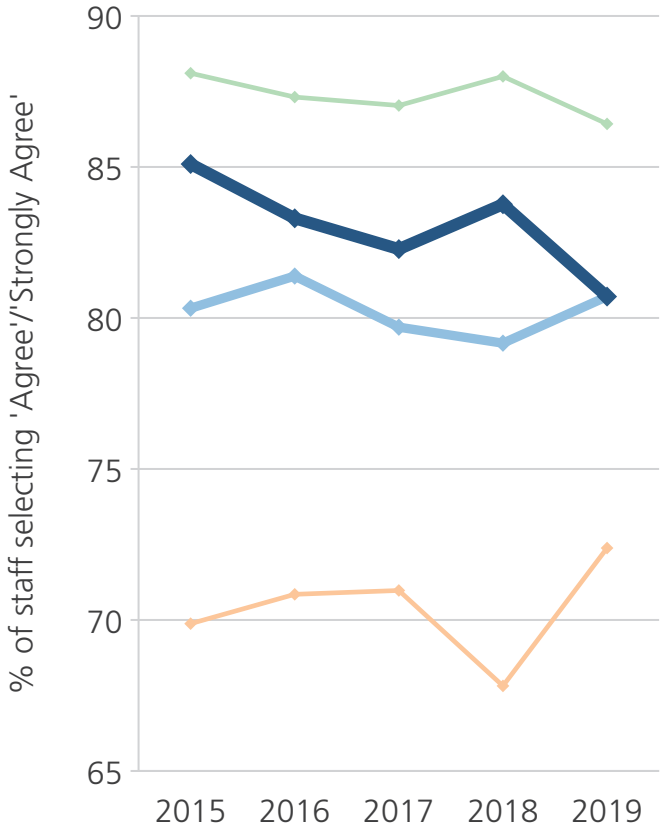
Q19e

The values of my organisation were discussed as part of the appraisal process



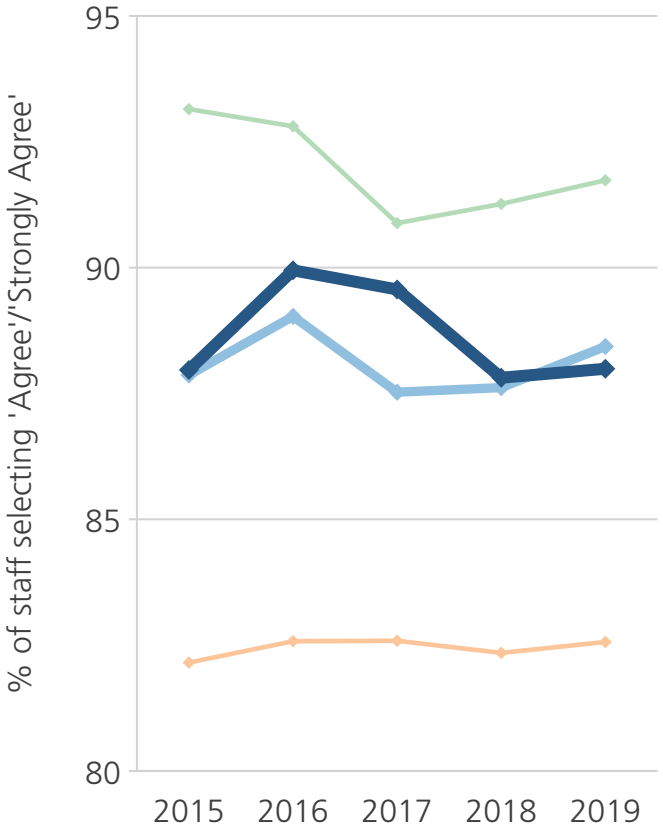
	2015	2016	2017	2018	2019
Best	45.0%	45.2%	44.5%	49.9%	54.6%
Your org	20.0%	23.9%	25.3%	28.4%	29.0%
Average	30.7%	33.2%	35.5%	40.1%	40.1%
Worst	19.1%	12.8%	21.5%	26.5%	27.7%

Q7a
I am satisfied with the quality of care I give to patients / service users



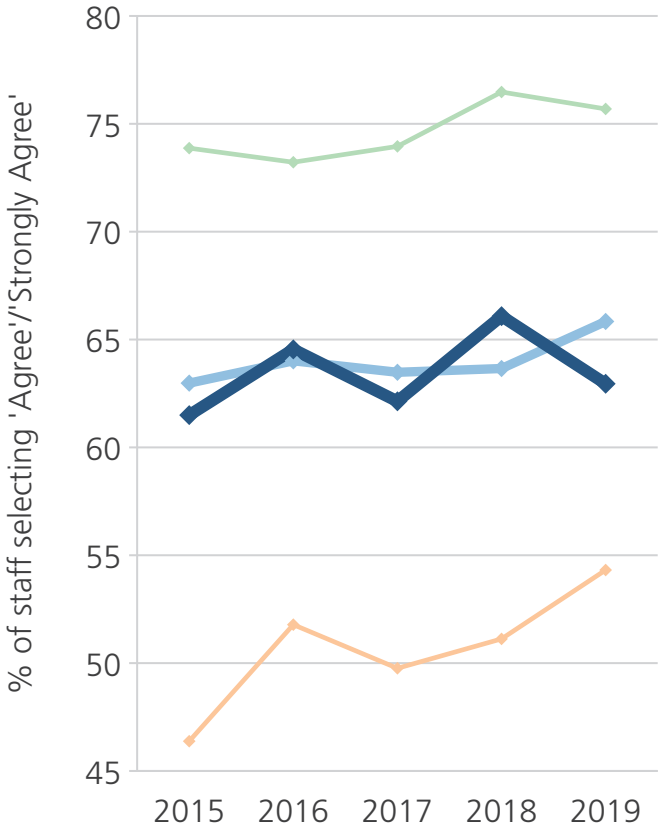
	2015	2016	2017	2018	2019
Best	88.1%	87.3%	87.0%	88.0%	86.4%
Your org	85.1%	83.3%	82.3%	83.8%	80.7%
Average	80.3%	81.4%	79.7%	79.2%	80.7%
Worst	69.9%	70.8%	71.0%	67.8%	72.4%

Q7b
I feel that my role makes a difference to patients / service users



	2015	2016	2017	2018	2019
Best	93.1%	92.8%	90.9%	91.3%	91.7%
Your org	88.0%	89.9%	89.6%	87.8%	88.0%
Average	87.9%	89.0%	87.5%	87.6%	88.4%
Worst	82.2%	82.6%	82.6%	82.3%	82.6%

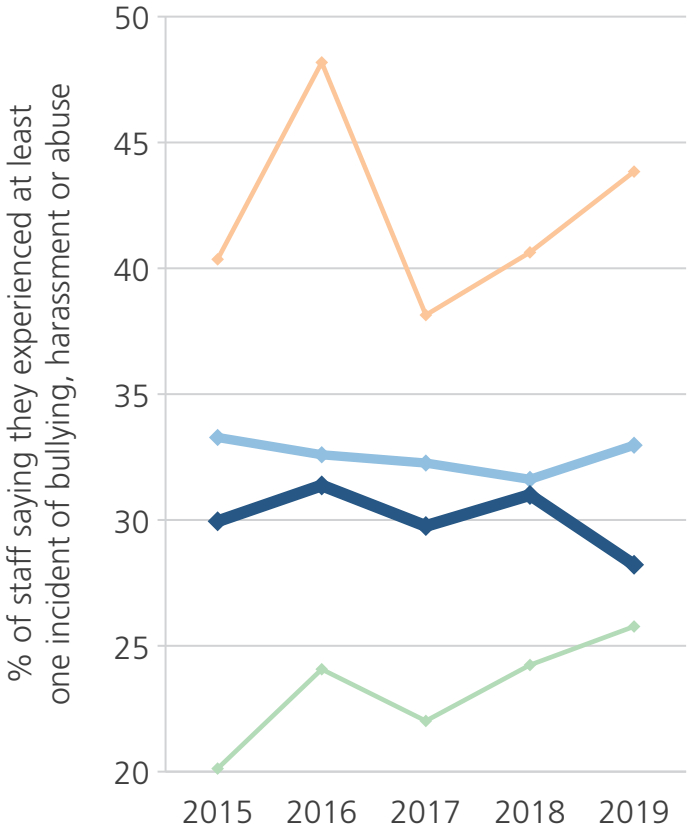
Q7c
I am able to deliver the care I aspire to



	2015	2016	2017	2018	2019
Best	73.9%	73.2%	74.0%	76.5%	75.7%
Your org	61.5%	64.5%	62.1%	66.1%	63.0%
Average	63.0%	64.0%	63.5%	63.7%	65.8%
Worst	46.4%	51.8%	49.8%	51.1%	54.3%

Q13a

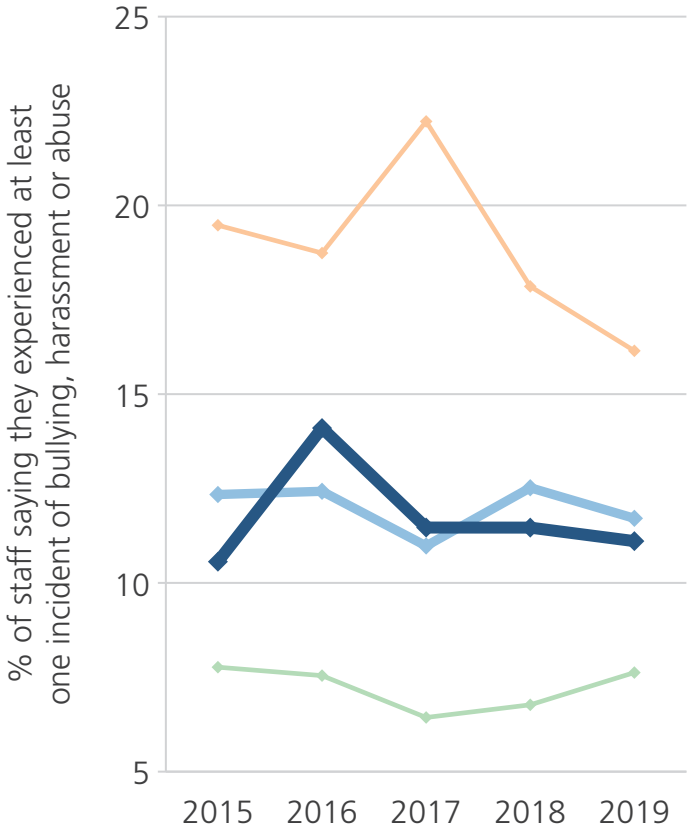
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public?



	2015	2016	2017	2018	2019
Worst	40.4%	48.2%	38.1%	40.6%	43.8%
Your org	29.9%	31.4%	29.8%	31.0%	28.2%
Average	33.3%	32.6%	32.3%	31.6%	33.0%
Best	20.1%	24.1%	22.0%	24.2%	25.8%

Q13b

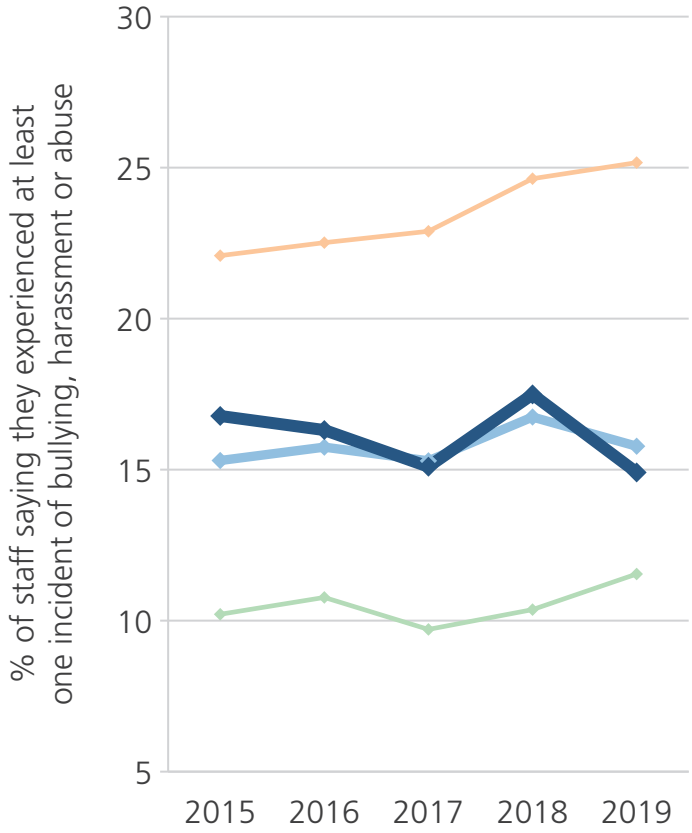
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from managers?



	2015	2016	2017	2018	2019
Worst	19.5%	18.7%	22.2%	17.9%	16.1%
Your org	10.6%	14.1%	11.5%	11.5%	11.1%
Average	12.3%	12.4%	11.0%	12.5%	11.7%
Best	7.8%	7.5%	6.4%	6.8%	7.6%

Q13c

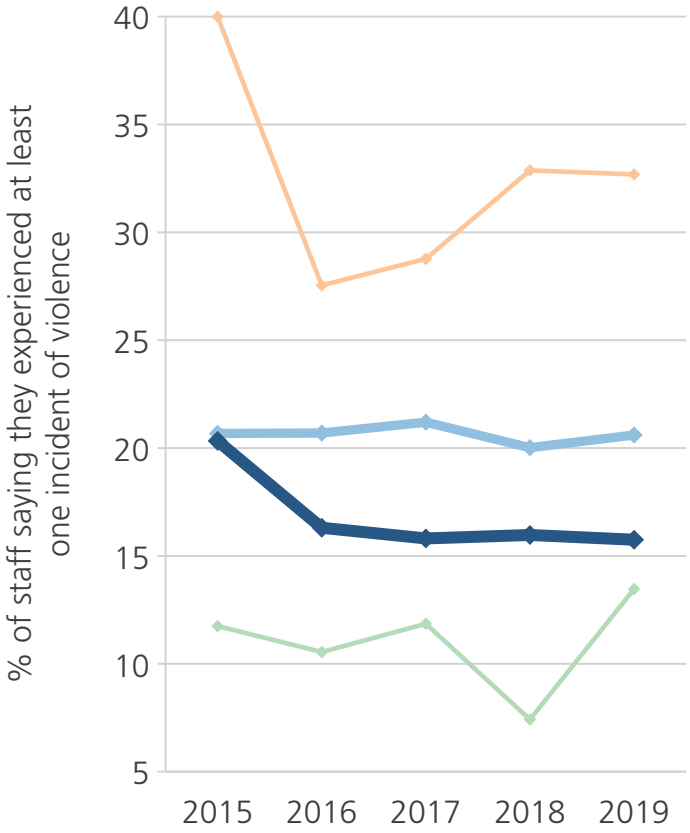
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from other colleagues?



	2015	2016	2017	2018	2019
Worst	22.1%	22.5%	22.9%	24.6%	25.2%
Your org	16.8%	16.3%	15.1%	17.5%	14.9%
Average	15.3%	15.7%	15.3%	16.7%	15.8%
Best	10.2%	10.8%	9.7%	10.4%	11.5%

Q12a

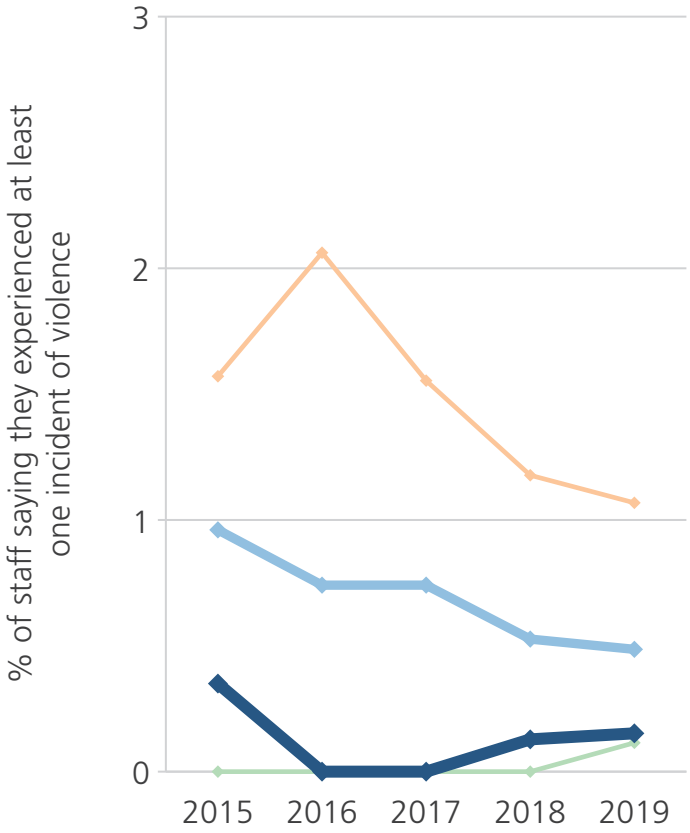
In the last 12 months how many times have you personally experienced physical violence at work from patients / service users, their relatives or other members of the public?



	2015	2016	2017	2018	2019
Worst	40.0%	27.5%	28.8%	32.9%	32.7%
Your org	20.3%	16.3%	15.8%	16.0%	15.8%
Average	20.7%	20.7%	21.2%	20.0%	20.6%
Best	11.7%	10.5%	11.9%	7.4%	13.5%

Q12b

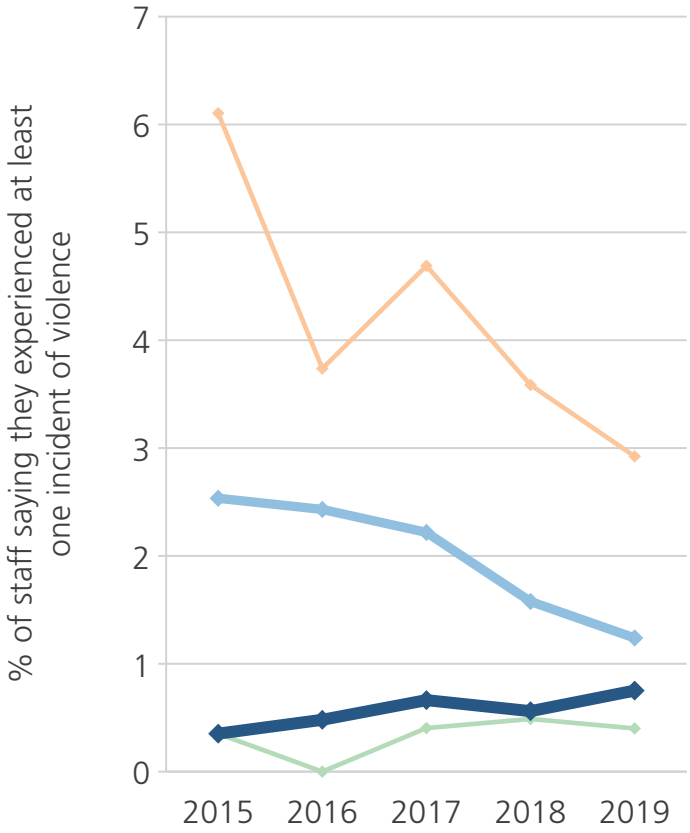
In the last 12 months how many times have you personally experienced physical violence at work from managers?



	2015	2016	2017	2018	2019
Worst	1.6%	2.1%	1.6%	1.2%	1.1%
Your org	0.3%	0.0%	0.0%	0.1%	0.2%
Average	1.0%	0.7%	0.7%	0.5%	0.5%
Best	0.0%	0.0%	0.0%	0.0%	0.1%

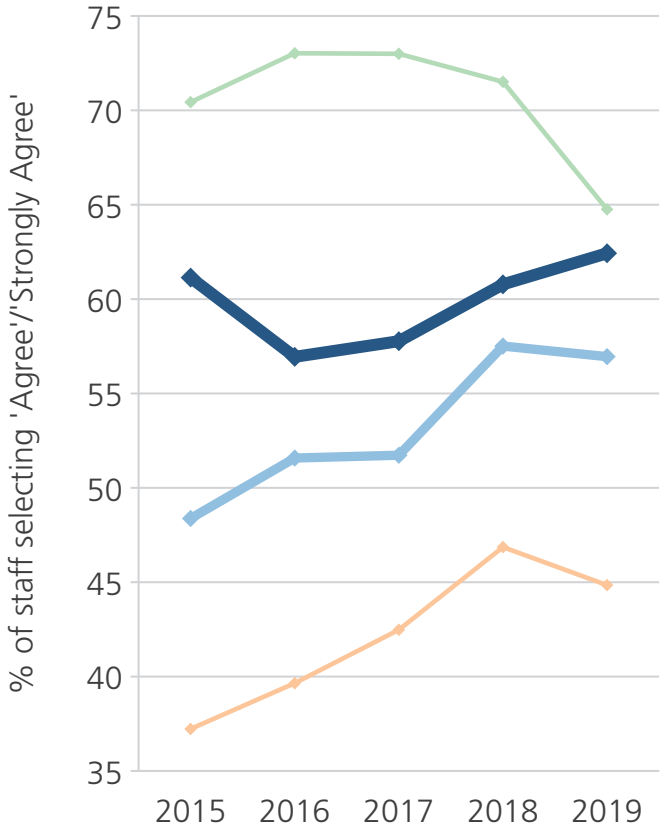
Q12c

In the last 12 months how many times have you personally experienced physical violence at work from other colleagues?



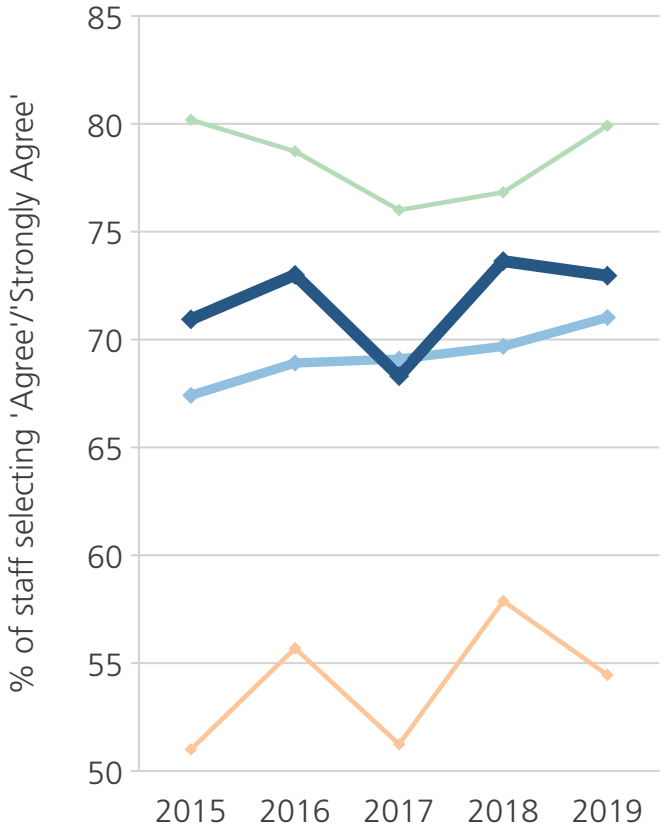
	2015	2016	2017	2018	2019
Worst	6.1%	3.7%	4.7%	3.6%	2.9%
Your org	0.4%	0.5%	0.7%	0.6%	0.8%
Average	2.5%	2.4%	2.2%	1.6%	1.2%
Best	0.4%	0.0%	0.4%	0.5%	0.4%

Q17a
My organisation treats staff who are involved in an error, near miss or incident fairly



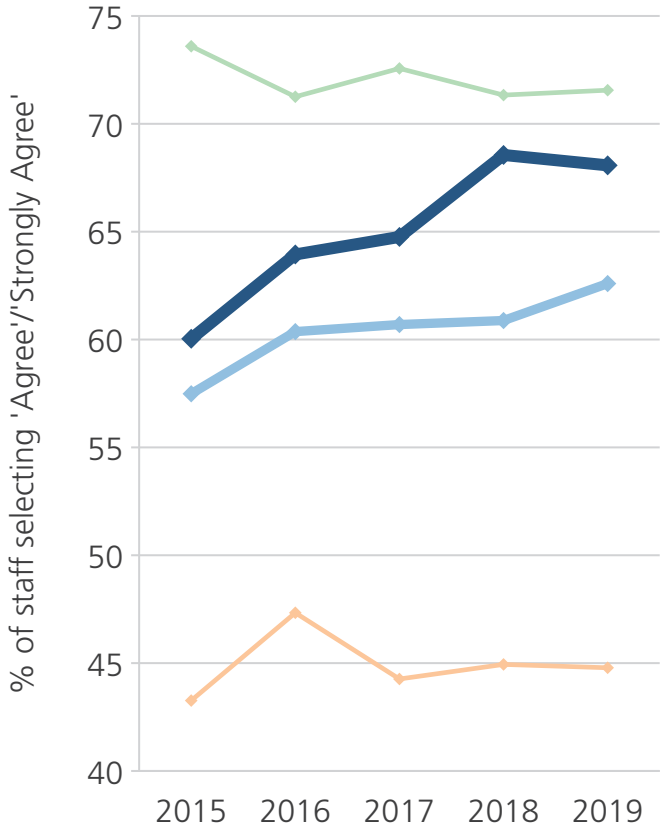
	2015	2016	2017	2018	2019
Best	70.4%	73.0%	73.0%	71.5%	64.8%
Your org	61.1%	56.9%	57.8%	60.8%	62.4%
Average	48.4%	51.6%	51.7%	57.5%	57.0%
Worst	37.2%	39.7%	42.5%	46.9%	44.8%

Q17c
When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again



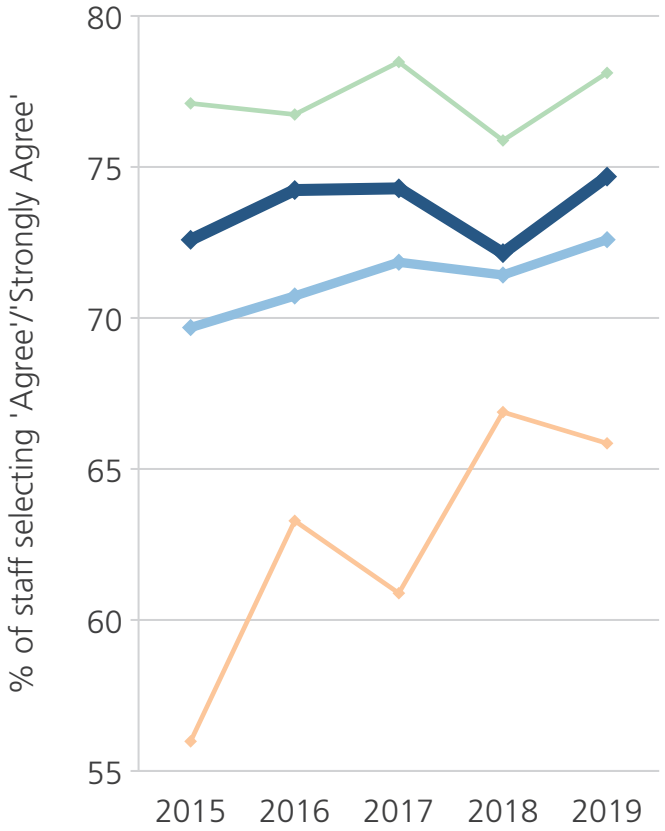
	2015	2016	2017	2018	2019
Best	80.2%	78.7%	76.0%	76.8%	79.9%
Your org	70.9%	73.0%	68.3%	73.6%	73.0%
Average	67.4%	68.9%	69.1%	69.7%	71.0%
Worst	51.0%	55.7%	51.2%	57.9%	54.5%

Q17d
We are given feedback about changes made in response to reported errors, near misses and incidents



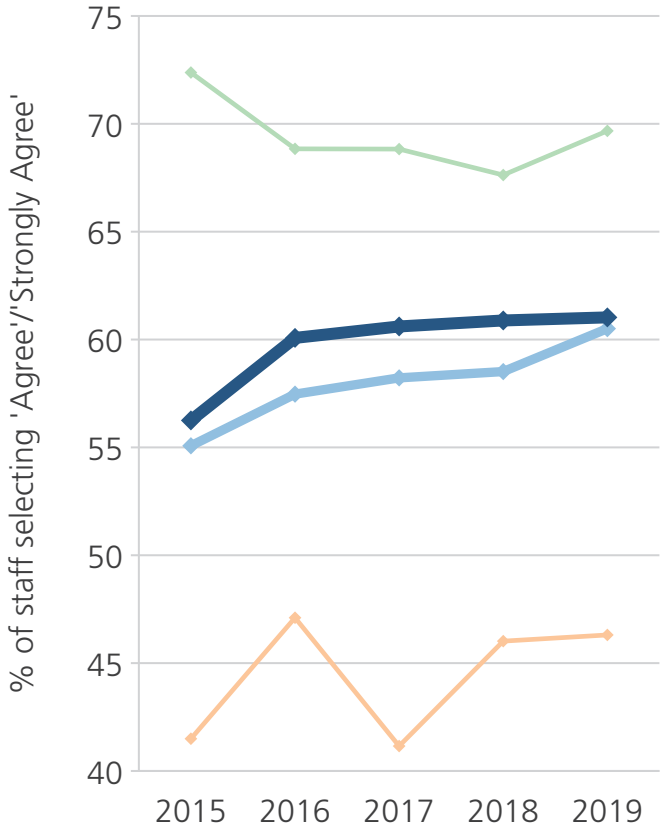
	2015	2016	2017	2018	2019
Best	73.6%	71.3%	72.6%	71.3%	71.6%
Your org	60.0%	63.9%	64.8%	68.6%	68.1%
Average	57.5%	60.4%	60.7%	60.9%	62.6%
Worst	43.3%	47.3%	44.3%	44.9%	44.8%

Q18b
I would feel secure raising concerns about unsafe clinical practice



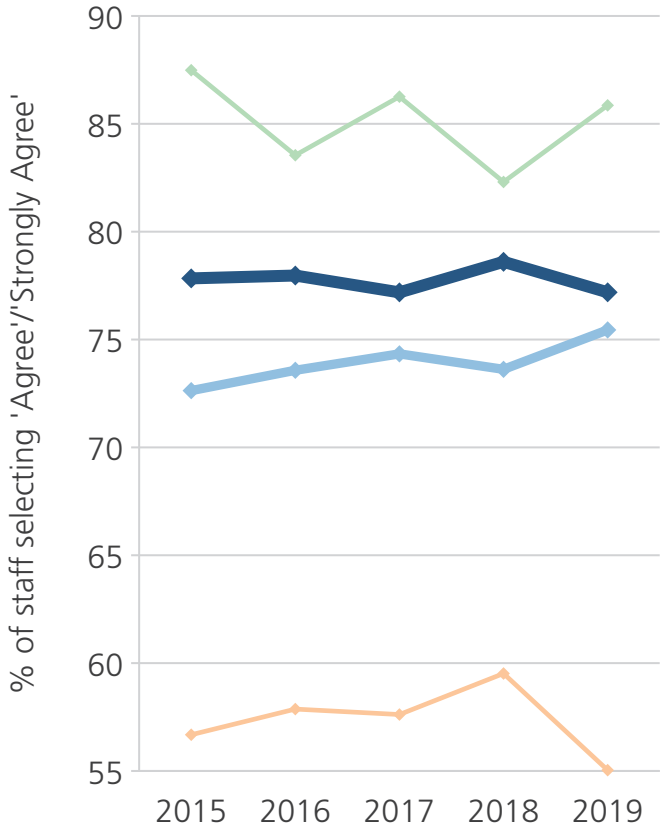
	2015	2016	2017	2018	2019
Best	77.1%	76.7%	78.5%	75.9%	78.1%
Your org	72.6%	74.2%	74.3%	72.1%	74.7%
Average	69.7%	70.7%	71.8%	71.4%	72.6%
Worst	56.0%	63.3%	60.9%	66.9%	65.8%

Q18c
I am confident that my organisation would address my concern



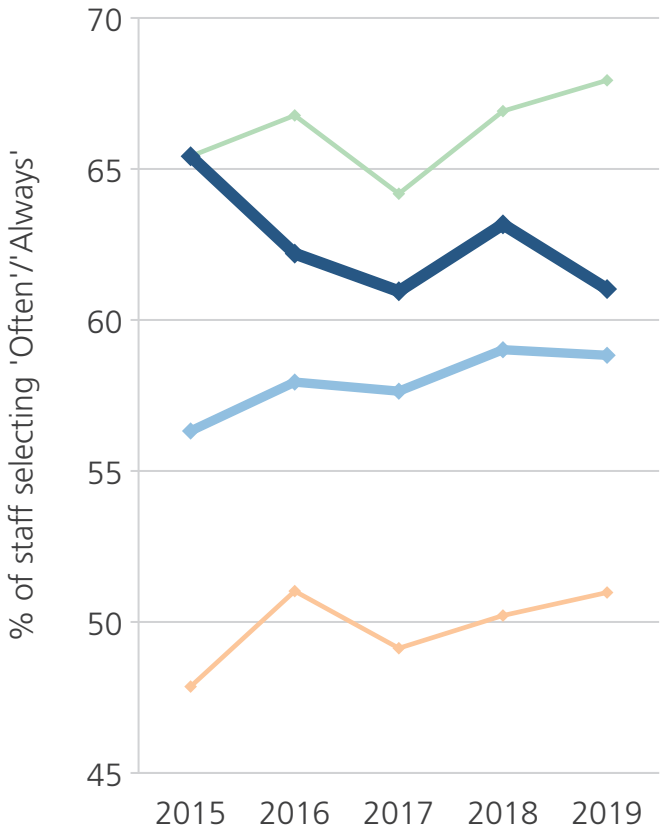
	2015	2016	2017	2018	2019
Best	72.4%	68.8%	68.8%	67.6%	69.7%
Your org	56.3%	60.1%	60.6%	60.9%	61.0%
Average	55.1%	57.5%	58.2%	58.5%	60.5%
Worst	41.5%	47.1%	41.2%	46.0%	46.3%

Q21b
My organisation acts on concerns raised by patients / service users



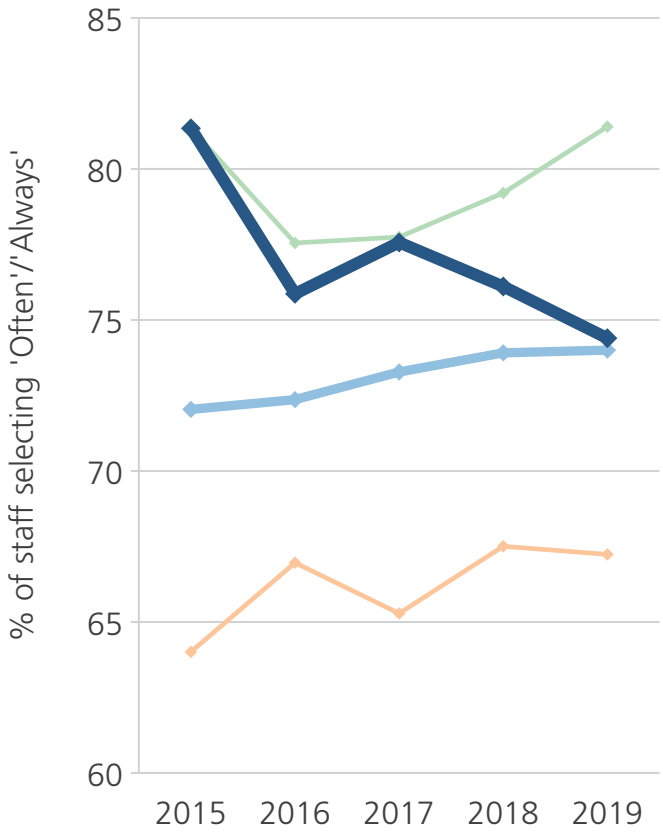
	2015	2016	2017	2018	2019
Best	87.5%	83.5%	86.3%	82.3%	85.9%
Your org	77.8%	78.0%	77.2%	78.6%	77.2%
Average	72.6%	73.6%	74.3%	73.6%	75.4%
Worst	56.7%	57.9%	57.6%	59.5%	55.0%

Q2a
I look forward to going to work



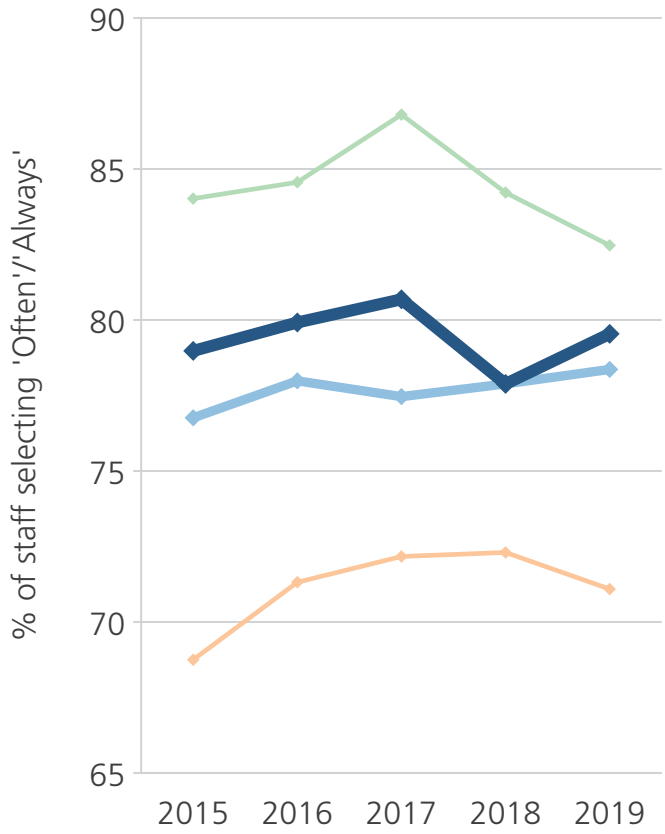
	2015	2016	2017	2018	2019
Best	65.4%	66.8%	64.2%	66.9%	67.9%
Your org	65.4%	62.2%	61.0%	63.2%	61.0%
Average	56.3%	57.9%	57.6%	59.0%	58.8%
Worst	47.9%	51.0%	49.1%	50.2%	51.0%

Q2b
I am enthusiastic about my job



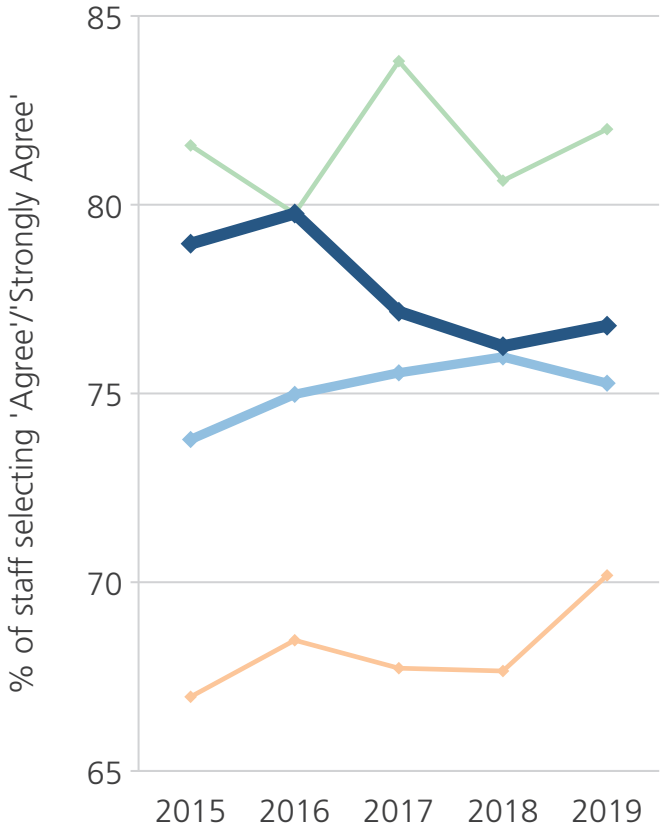
	2015	2016	2017	2018	2019
Best	81.3%	77.5%	77.7%	79.2%	81.4%
Your org	81.3%	75.9%	77.6%	76.1%	74.4%
Average	72.0%	72.4%	73.3%	73.9%	74.0%
Worst	64.0%	67.0%	65.3%	67.5%	67.2%

Q2c
Time passes quickly when I am working



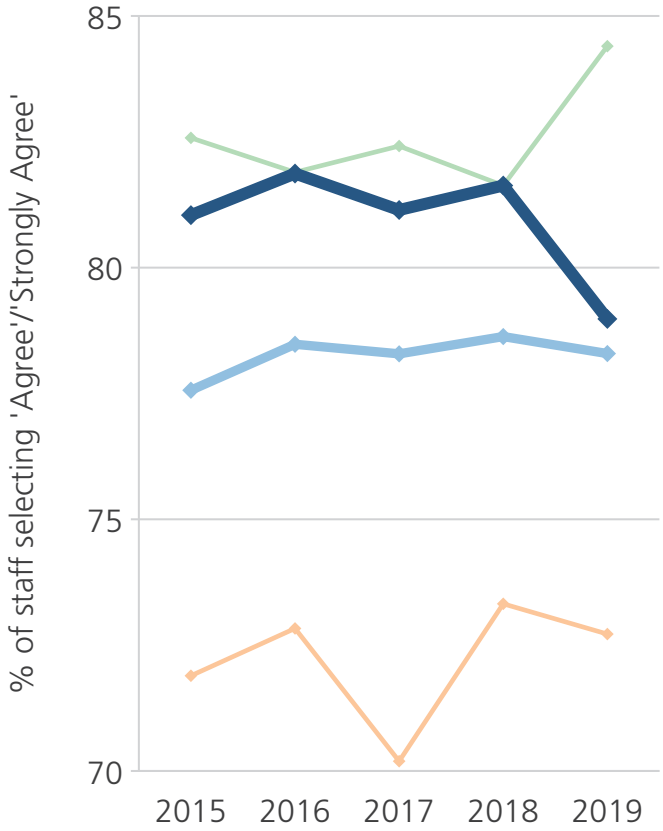
	2015	2016	2017	2018	2019
Best	84.0%	84.6%	86.8%	84.2%	82.5%
Your org	79.0%	79.9%	80.7%	77.9%	79.5%
Average	76.8%	78.0%	77.5%	77.9%	78.4%
Worst	68.7%	71.3%	72.2%	72.3%	71.1%

Q4a
There are frequent opportunities for me to show initiative in my role



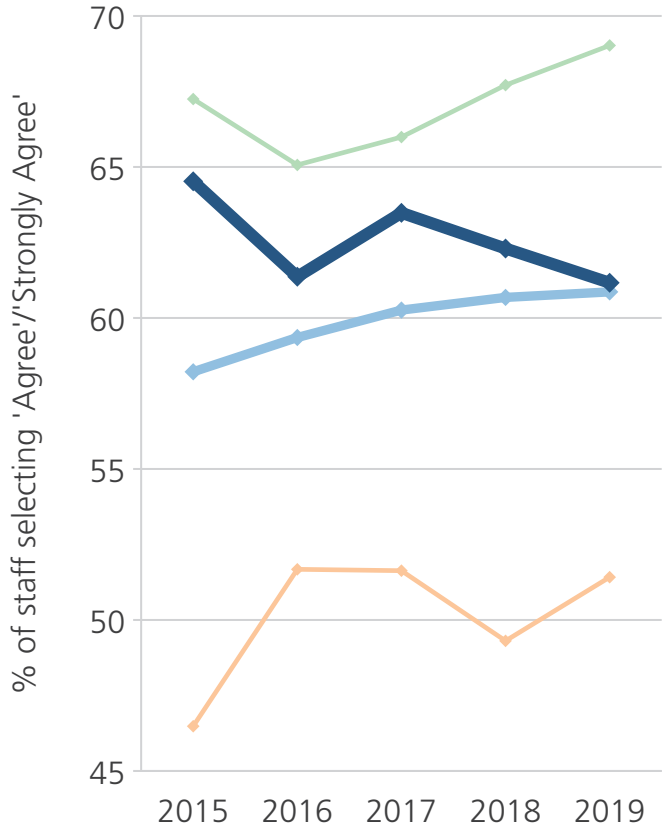
	2015	2016	2017	2018	2019
Best	81.6%	79.8%	83.8%	80.6%	82.0%
Your org	79.0%	79.8%	77.2%	76.3%	76.8%
Average	73.8%	75.0%	75.5%	76.0%	75.3%
Worst	67.0%	68.5%	67.7%	67.6%	70.2%

Q4b
I am able to make suggestions to improve the work of my team / department



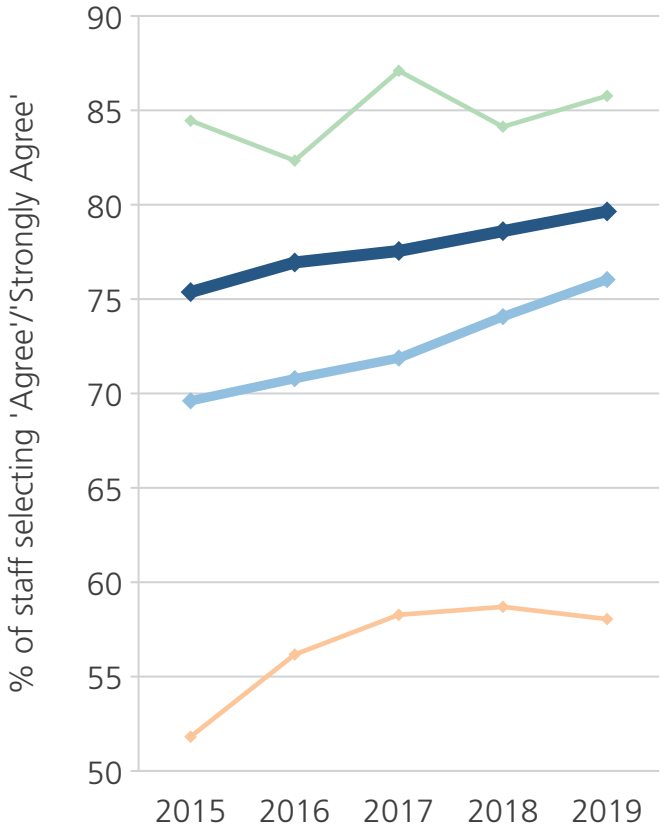
	2015	2016	2017	2018	2019
Best	82.6%	81.9%	82.4%	81.6%	84.4%
Your org	81.0%	81.9%	81.1%	81.6%	79.0%
Average	77.6%	78.5%	78.3%	78.6%	78.3%
Worst	71.9%	72.8%	70.2%	73.3%	72.7%

Q4d
I am able to make improvements happen in my area of work



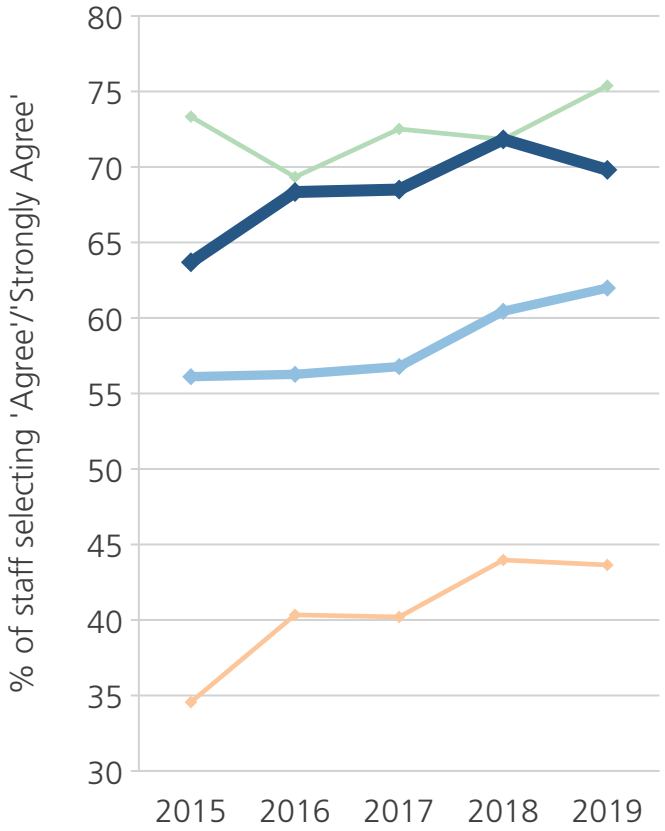
	2015	2016	2017	2018	2019
Best	67.2%	65.1%	66.0%	67.7%	69.0%
Your org	64.5%	61.4%	63.5%	62.3%	61.2%
Average	58.2%	59.4%	60.3%	60.7%	60.9%
Worst	46.5%	51.7%	51.6%	49.3%	51.4%

Q21a
Care of patients / service users is my organisation's top priority



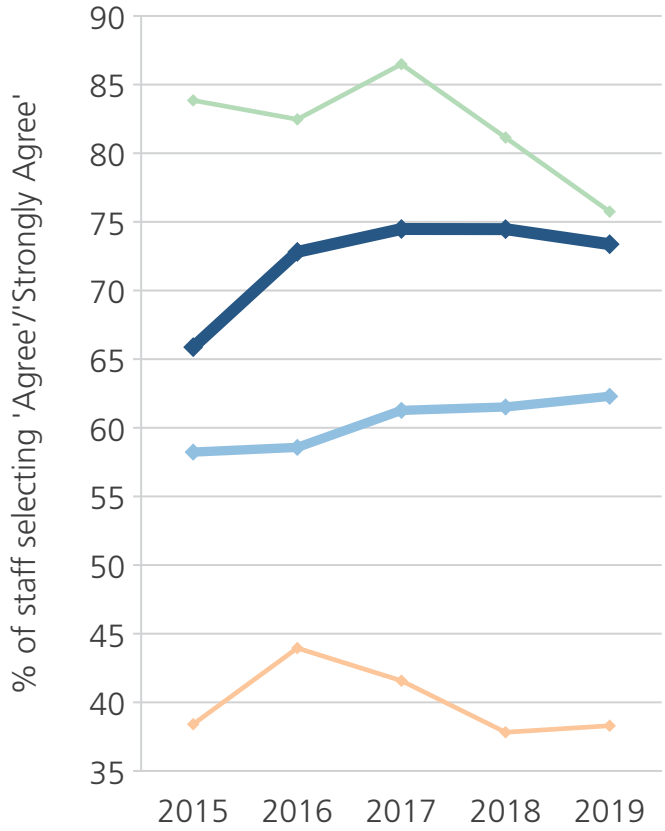
	2015	2016	2017	2018	2019
Best	84.5%	82.3%	87.1%	84.1%	85.8%
Your org	75.4%	76.9%	77.5%	78.6%	79.6%
Average	69.6%	70.8%	71.9%	74.1%	76.0%
Worst	51.8%	56.2%	58.3%	58.7%	58.0%

Q21c
I would recommend my organisation as a place to work



	2015	2016	2017	2018	2019
Best	73.3%	69.3%	72.5%	71.8%	75.4%
Your org	63.7%	68.3%	68.5%	71.8%	69.8%
Average	56.1%	56.3%	56.8%	60.4%	62.0%
Worst	34.6%	40.3%	40.2%	44.0%	43.6%

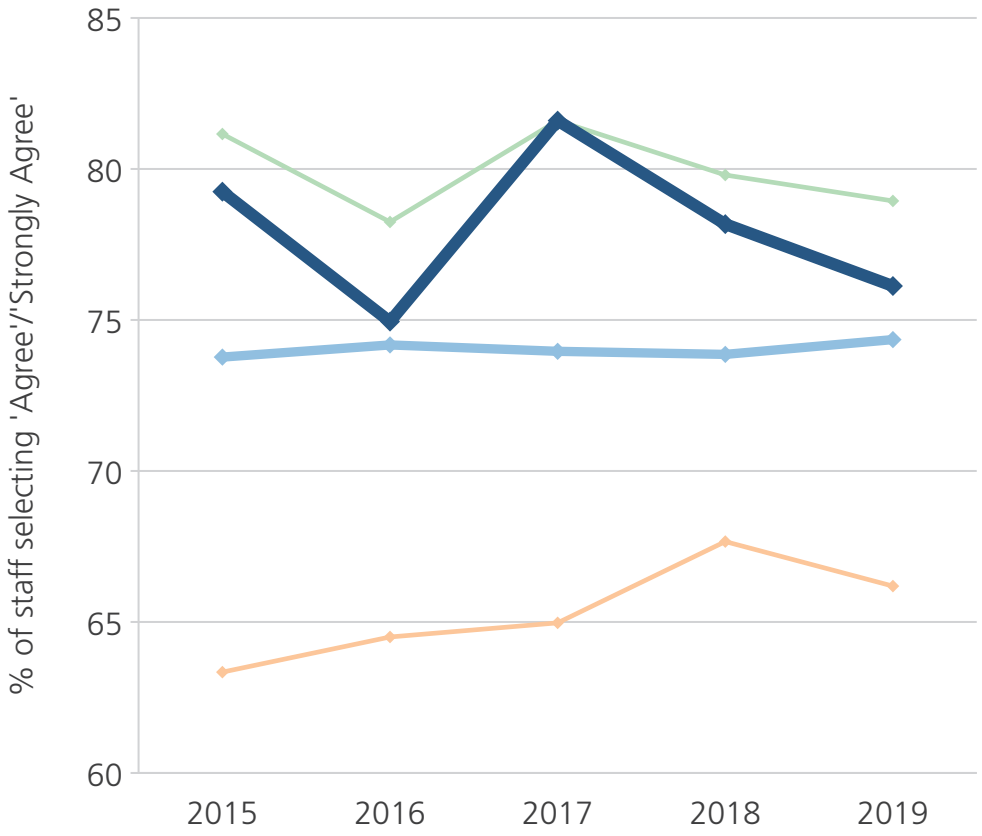
Q21d
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation



	2015	2016	2017	2018	2019
Best	83.8%	82.5%	86.5%	81.1%	75.7%
Your org	65.9%	72.8%	74.5%	74.5%	73.4%
Average	58.2%	58.6%	61.3%	61.5%	62.3%
Worst	38.4%	44.0%	41.6%	37.8%	38.3%

Q4h

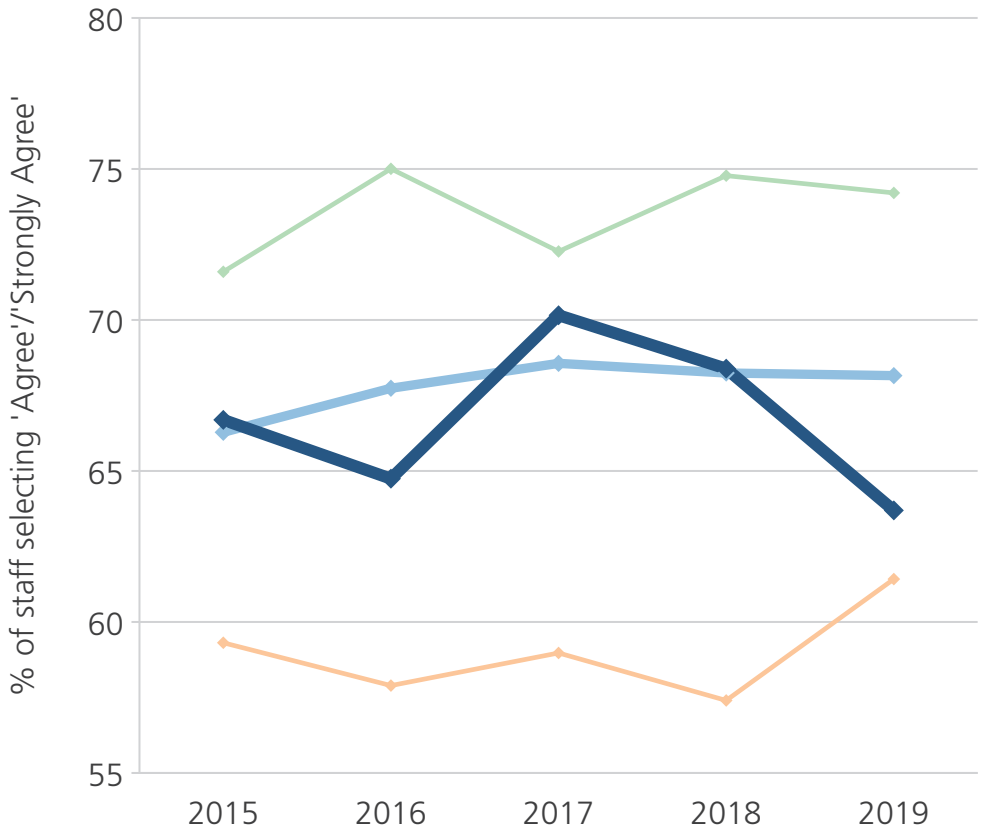
The team I work in has a set of shared objectives



	2015	2016	2017	2018	2019
Best	81.2%	78.2%	81.6%	79.8%	78.9%
Your org	79.2%	74.9%	81.6%	78.2%	76.1%
Average	73.8%	74.2%	74.0%	73.9%	74.4%
Worst	63.3%	64.5%	65.0%	67.7%	66.2%

Q4i

The team I work in often meets to discuss the team's effectiveness



	2015	2016	2017	2018	2019
Best	71.6%	75.0%	72.3%	74.8%	74.2%
Your org	66.7%	64.7%	70.2%	68.4%	63.7%
Average	66.3%	67.7%	68.6%	68.2%	68.2%
Worst	59.3%	57.9%	59.0%	57.4%	61.4%

Survey Coordination Centre

NHS England

Workforce Equality Standards

2Gether NHS Foundation Trust

2019 NHS Staff Survey Results

Workforce Equality Standards

This section contains data required for the NHS Staff Survey indicators used in the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES). Data presented in this section are unweighted.

Full details of how the data are calculated are included in the Technical Document, available to download from our results website.

Workforce Race Equality Standard (WRES)

- This contains data for each organisation required for the NHS Staff Survey indicators used in the Workforce Race Equality Standard (WRES). It includes the 2017, 2018 and 2019 trust/CCG and benchmarking group median results for q13a, q13b&c combined, q14, and q15b split by ethnicity (by white / BME staff).

Workforce Disability Equality Standard (WDES)

- This contains data for each organisation required for the NHS Staff Survey indicators used in the Workforce Disability Equality Standard (WDES). It includes the 2018 and 2019 trust/CCG and benchmarking group median results for q5f, q11e, q13, and q14 split by disabled staff compared to non-disabled staff. It also shows results for q28b (for disabled staff only), and the staff engagement score for disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.

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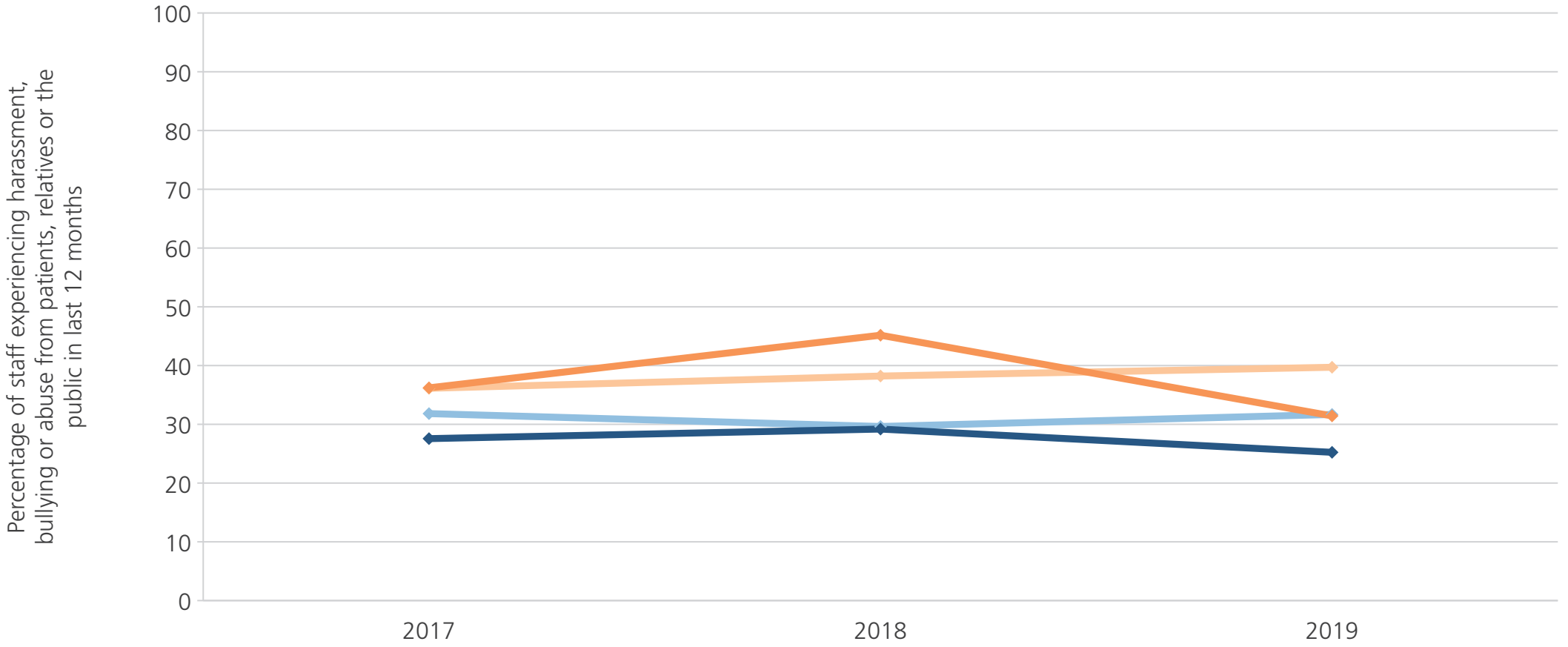
NHS England

Workforce Race Equality Standard (WRES)

2Gether NHS Foundation Trust

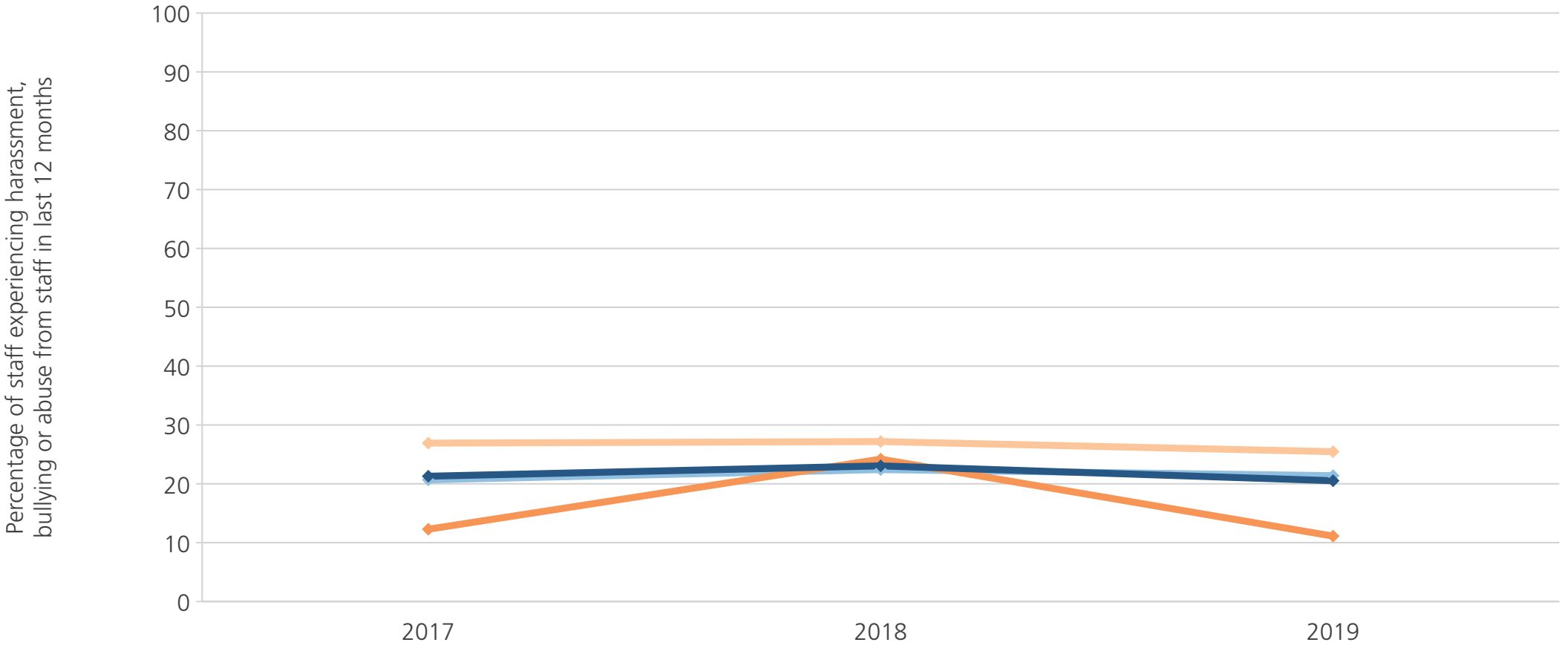
2019 NHS Staff Survey Results



	2017	2018	2019
White: Your org	27.6%	29.2%	25.2%
BME: Your org	36.2%	45.2%	31.4%
White: Average	31.8%	29.6%	31.7%
BME: Average	36.1%	38.2%	39.7%

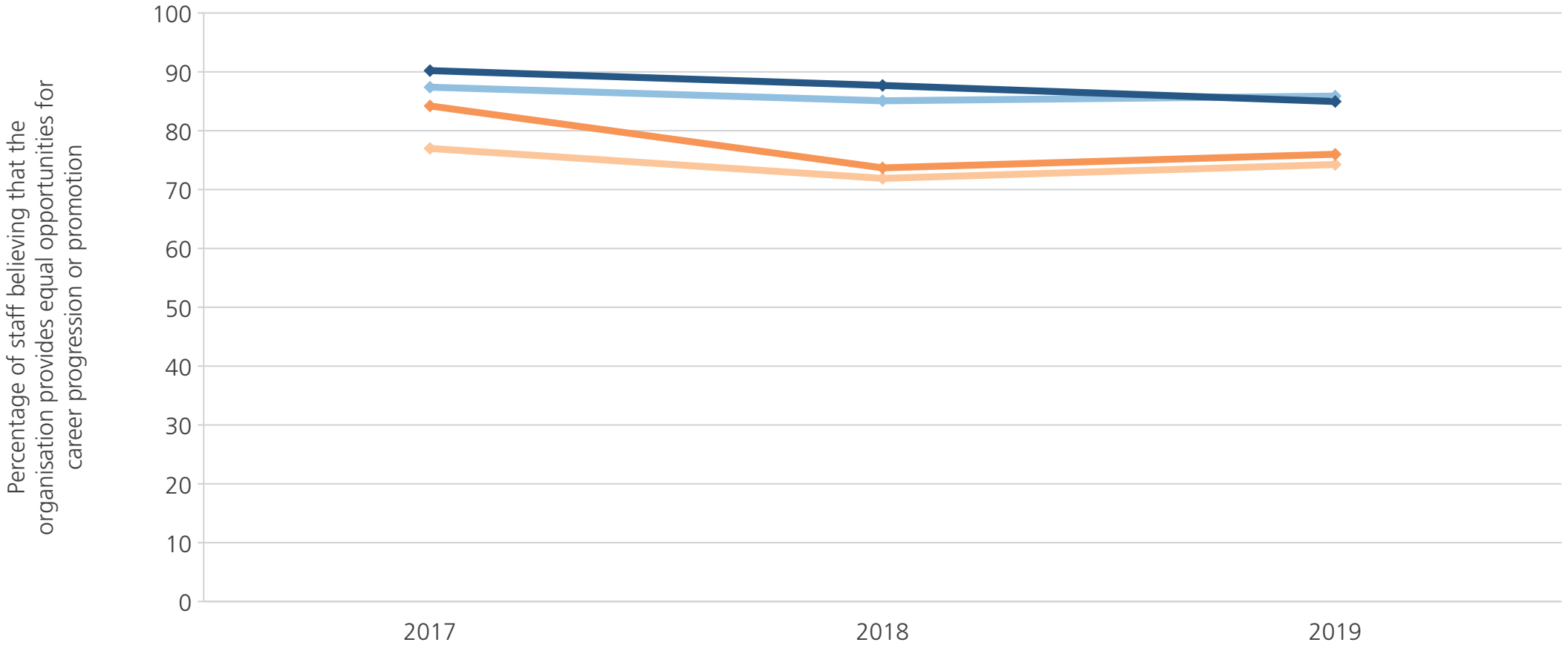
White: Responses	820	764	646
BME: Responses	58	62	35

Average calculated as the median for the benchmark group



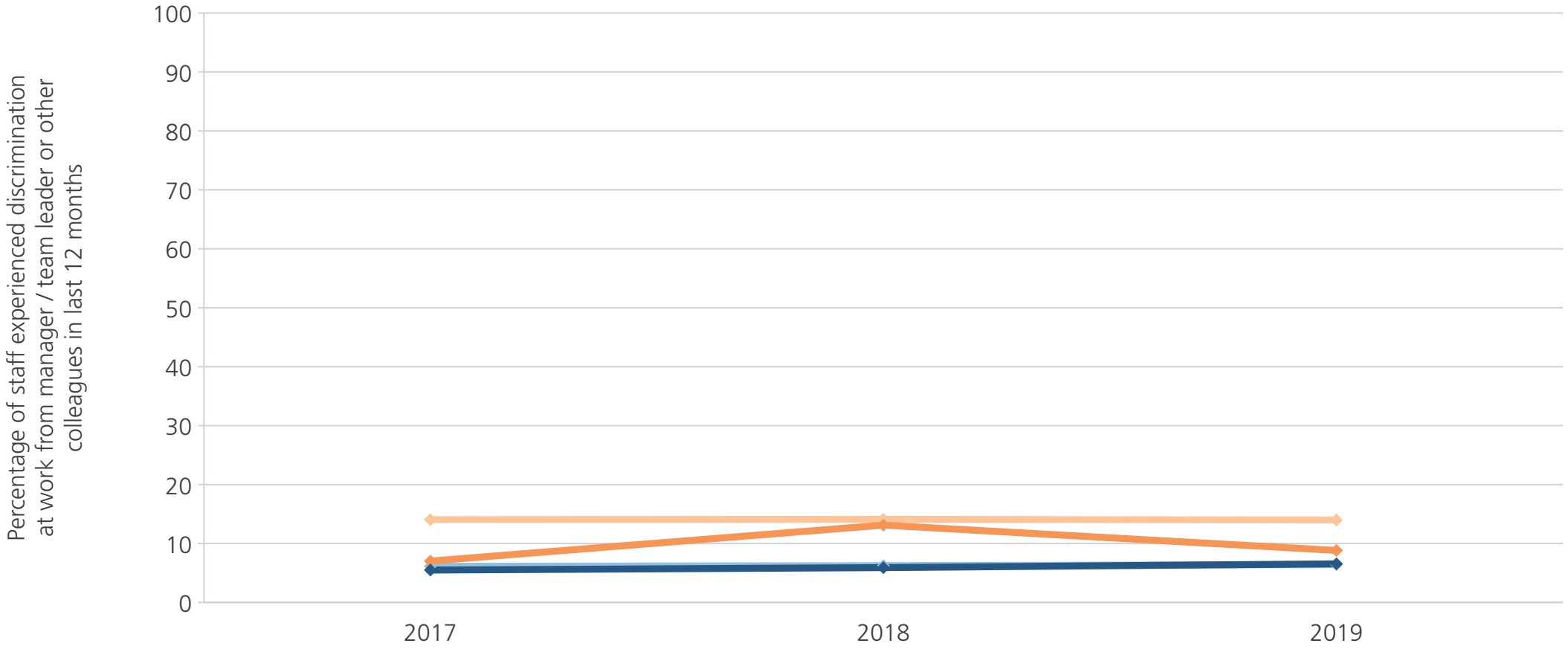
	2017	2018	2019
White: Your org	21.3%	23.0%	20.5%
BME: Your org	12.3%	24.2%	11.1%
White: Average	20.7%	22.4%	21.4%
BME: Average	26.9%	27.2%	25.5%
White: Responses	822	768	648
BME: Responses	57	62	36

Average calculated as the median for the benchmark group



	2017	2018	2019
White: Your org	90.2%	87.7%	85.0%
BME: Your org	84.2%	73.7%	76.0%
White: Average	87.4%	85.1%	85.9%
BME: Average	77.0%	71.9%	74.3%
White: Responses	562	512	399
BME: Responses	38	38	25

Average calculated as the median for the benchmark group



	2017	2018	2019
White: Your org	5.5%	5.9%	6.6%
BME: Your org	7.0%	13.1%	8.8%
White: Average	6.1%	6.2%	6.4%
BME: Average	14.0%	14.1%	14.0%
White: Responses	819	762	641
BME: Responses	57	61	34

Average calculated as the median for the benchmark group

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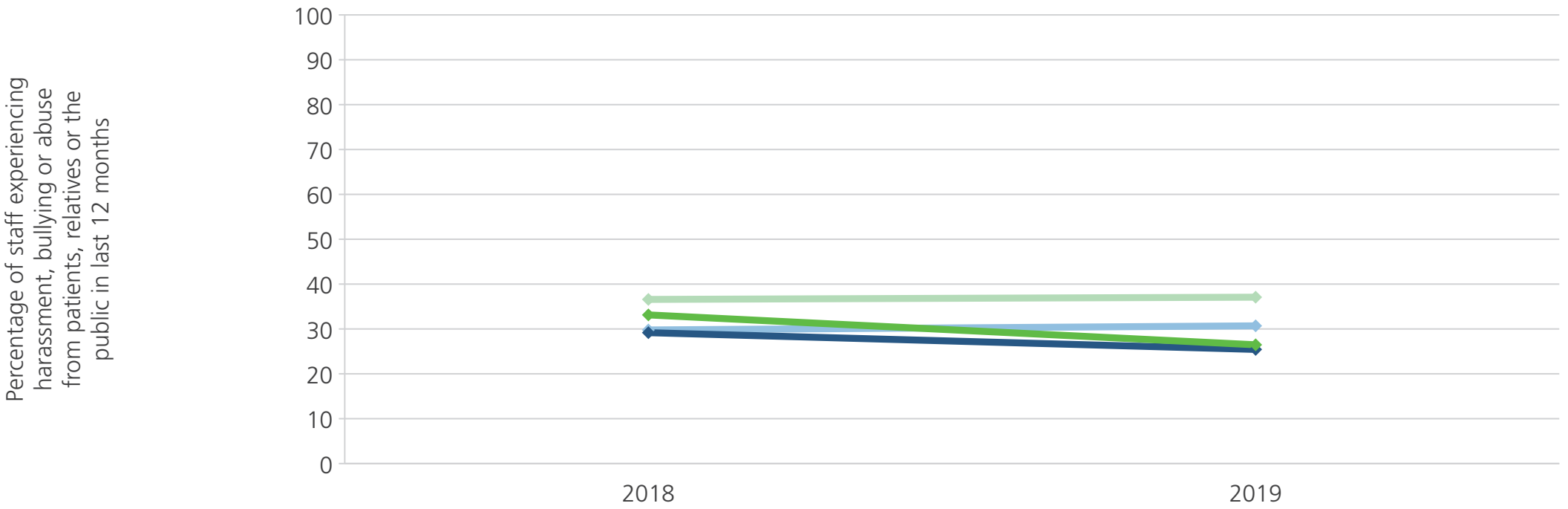
NHS England

Workforce Disability Equality Standard (WDES)

2Gether NHS Foundation Trust

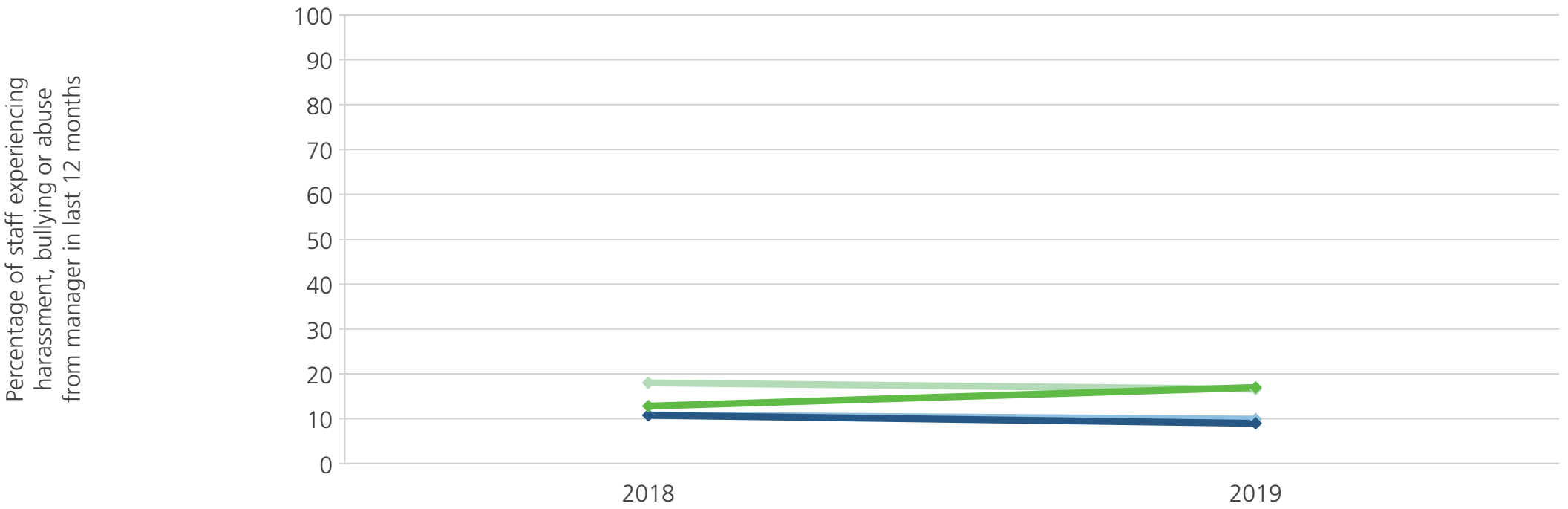
2019 NHS Staff Survey Results



Disabled staff: Your org	33.1%	26.5%
Non-disabled staff: Your org	29.2%	25.4%
Disabled staff: Average	36.6%	37.1%
Non-disabled staff: Average	29.8%	30.7%

Disabled staff: Responses	166	170
Non-disabled staff: Responses	665	515

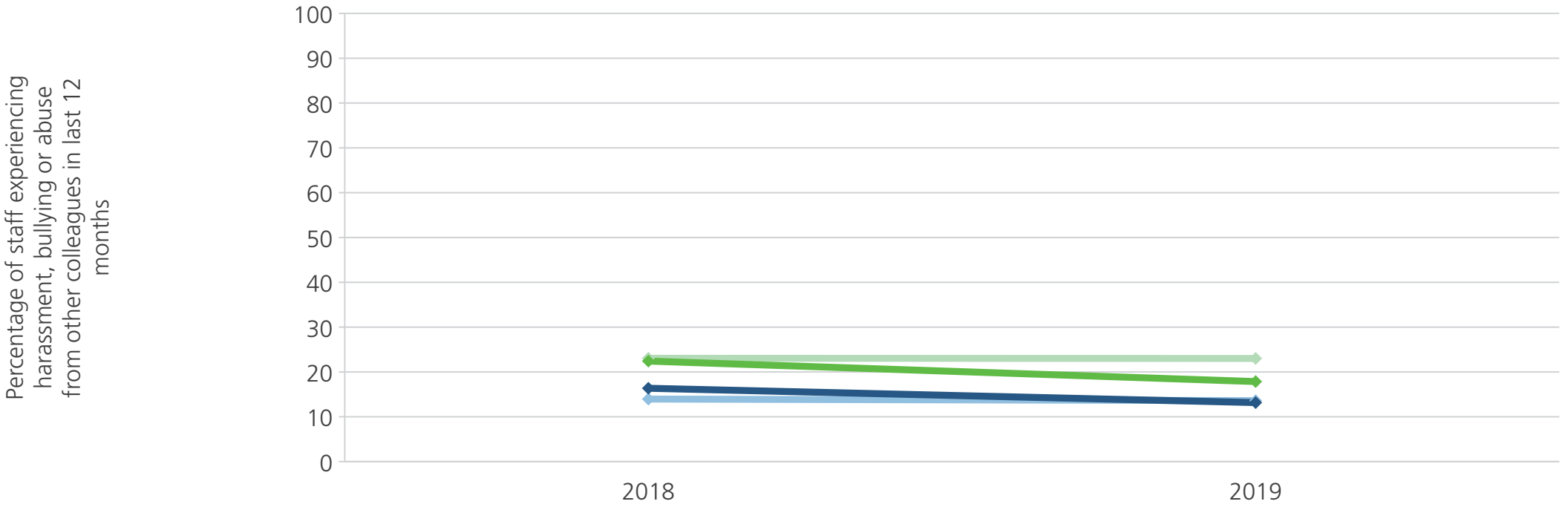
Average calculated as the median for the benchmark group



	2018	2019
Disabled staff: Your org	12.8%	17.0%
Non-disabled staff: Your org	10.8%	9.0%
Disabled staff: Average	18.0%	16.6%
Non-disabled staff: Average	10.8%	9.9%

Disabled staff: Responses	164	171
Non-disabled staff: Responses	660	513

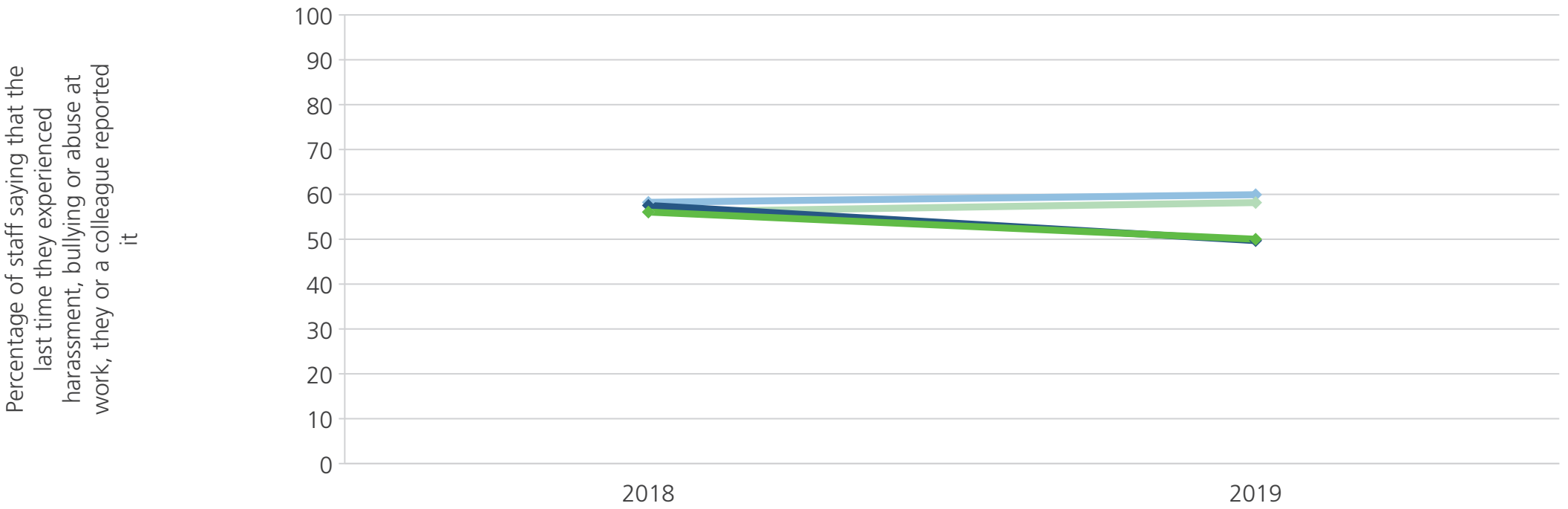
Average calculated as the median for the benchmark group



	2018	2019
Disabled staff: Your org	22.4%	17.9%
Non-disabled staff: Your org	16.4%	13.2%
Disabled staff: Average	23.1%	23.0%
Non-disabled staff: Average	14.0%	13.6%

Disabled staff: Responses	165	168
Non-disabled staff: Responses	660	509

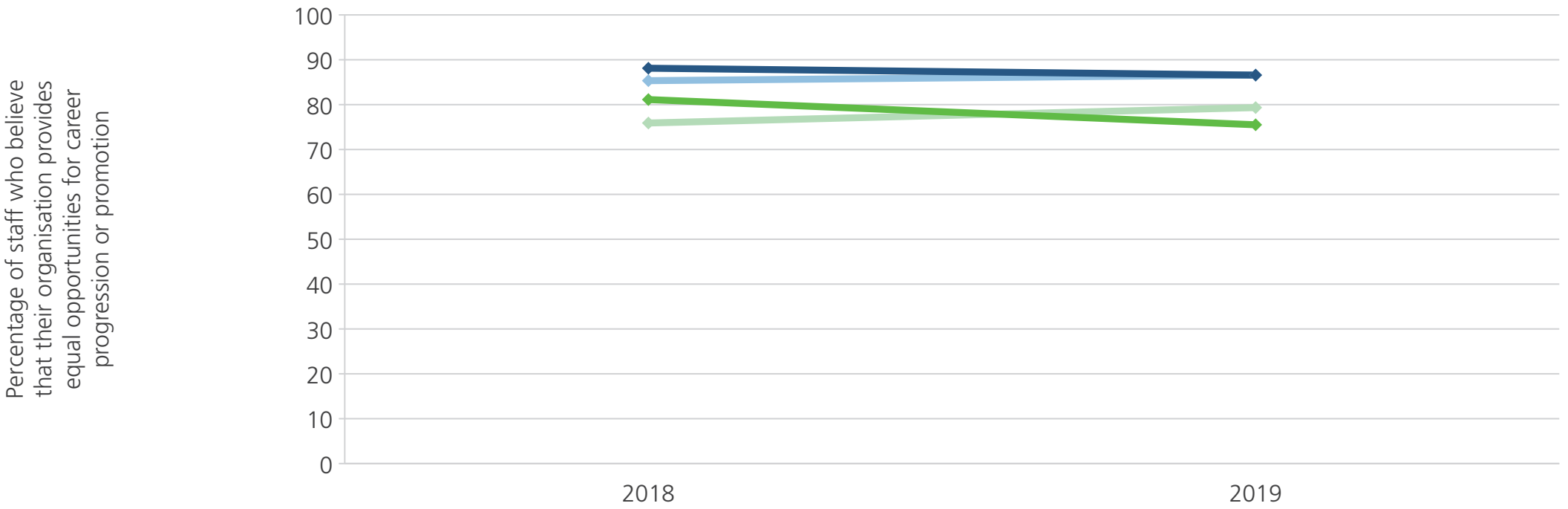
Average calculated as the median for the benchmark group



Disabled staff: Your org	56.1%	50.0%
Non-disabled staff: Your org	57.5%	49.7%
Disabled staff: Average	56.1%	58.2%
Non-disabled staff: Average	58.2%	59.9%

Disabled staff: Responses	66	62
Non-disabled staff: Responses	219	161

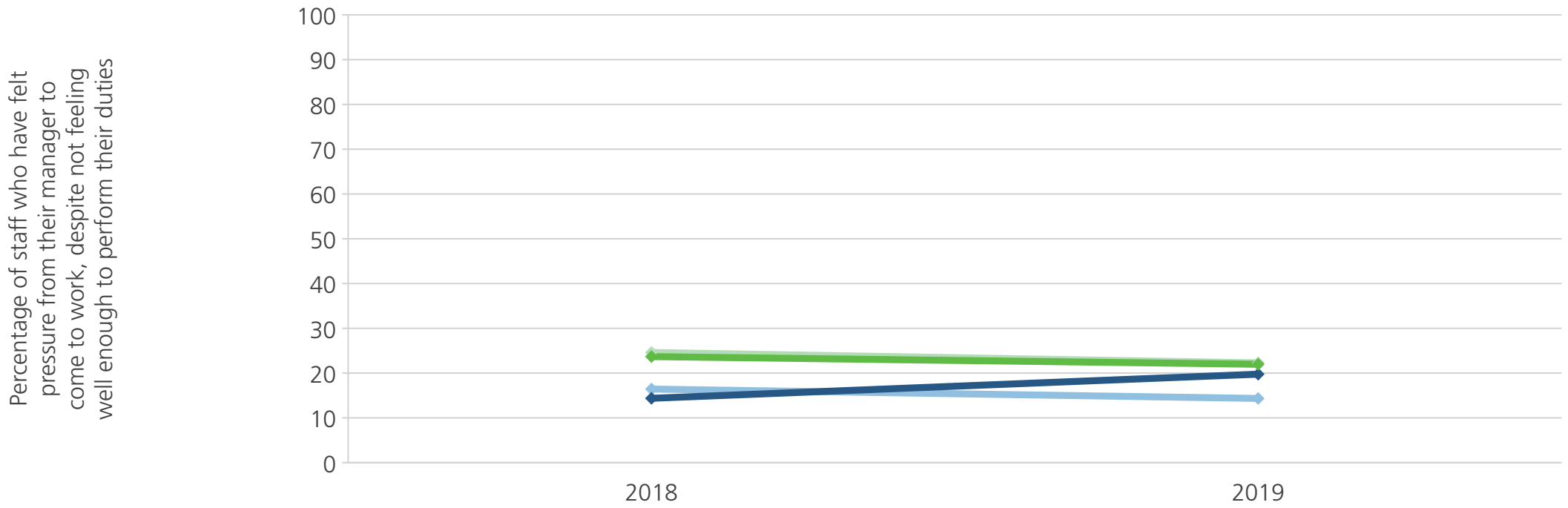
Average calculated as the median for the benchmark group



	2018	2019
Disabled staff: Your org	81.1%	75.5%
Non-disabled staff: Your org	88.1%	86.6%
Disabled staff: Average	75.9%	79.3%
Non-disabled staff: Average	85.3%	86.6%

Disabled staff: Responses	106	98
Non-disabled staff: Responses	446	328

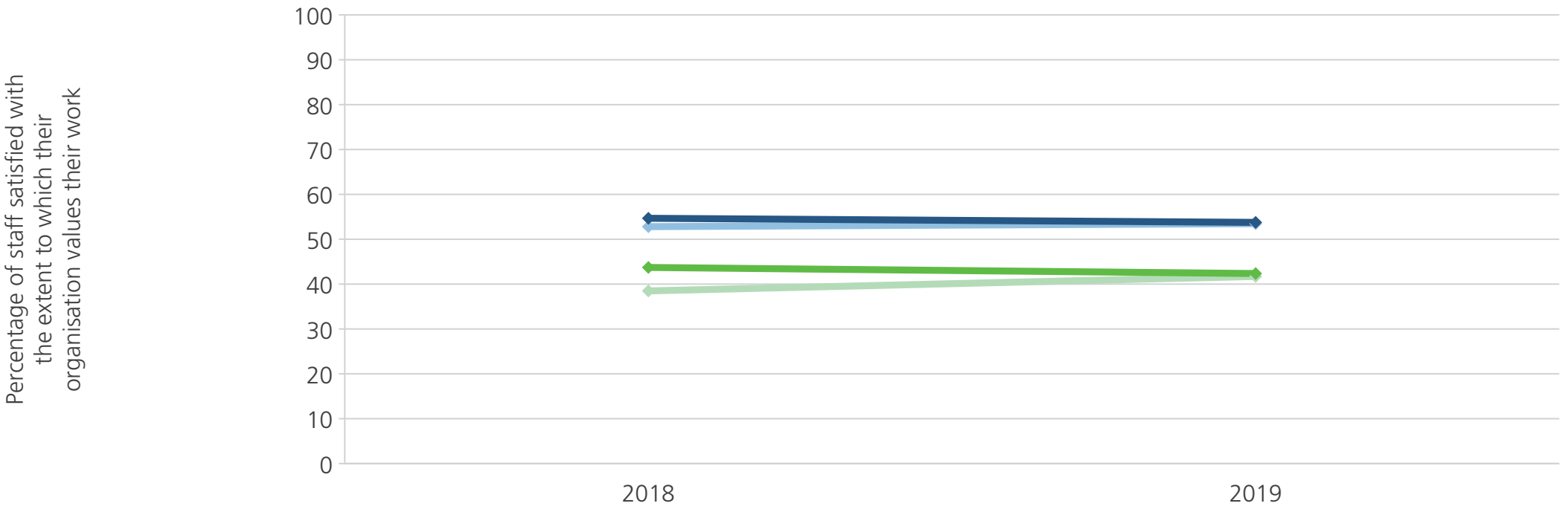
Average calculated as the median for the benchmark group



Disabled staff: Your org	23.7%	22.0%
Non-disabled staff: Your org	14.4%	19.8%
Disabled staff: Average	24.6%	22.3%
Non-disabled staff: Average	16.4%	14.3%

Disabled staff: Responses	114	132
Non-disabled staff: Responses	341	248

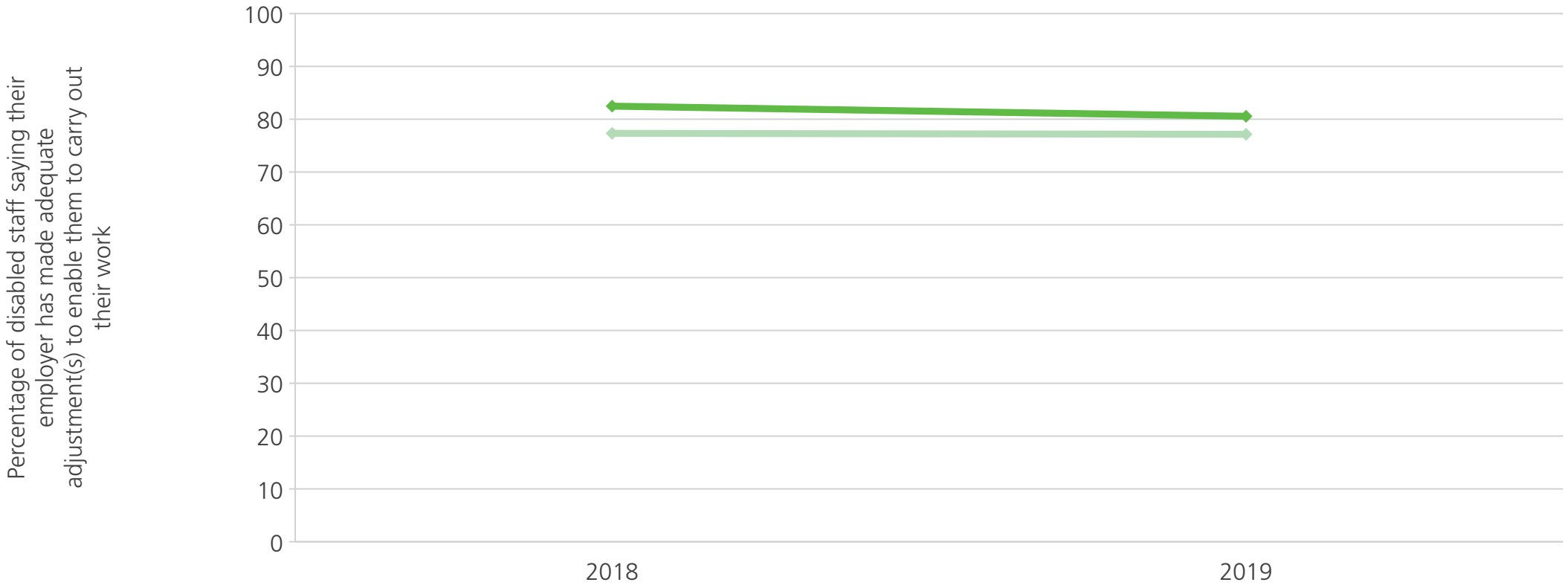
Average calculated as the median for the benchmark group



Disabled staff: Your org	43.7%	42.4%
Non-disabled staff: Your org	54.7%	53.8%
Disabled staff: Average	38.5%	41.7%
Non-disabled staff: Average	52.8%	53.5%

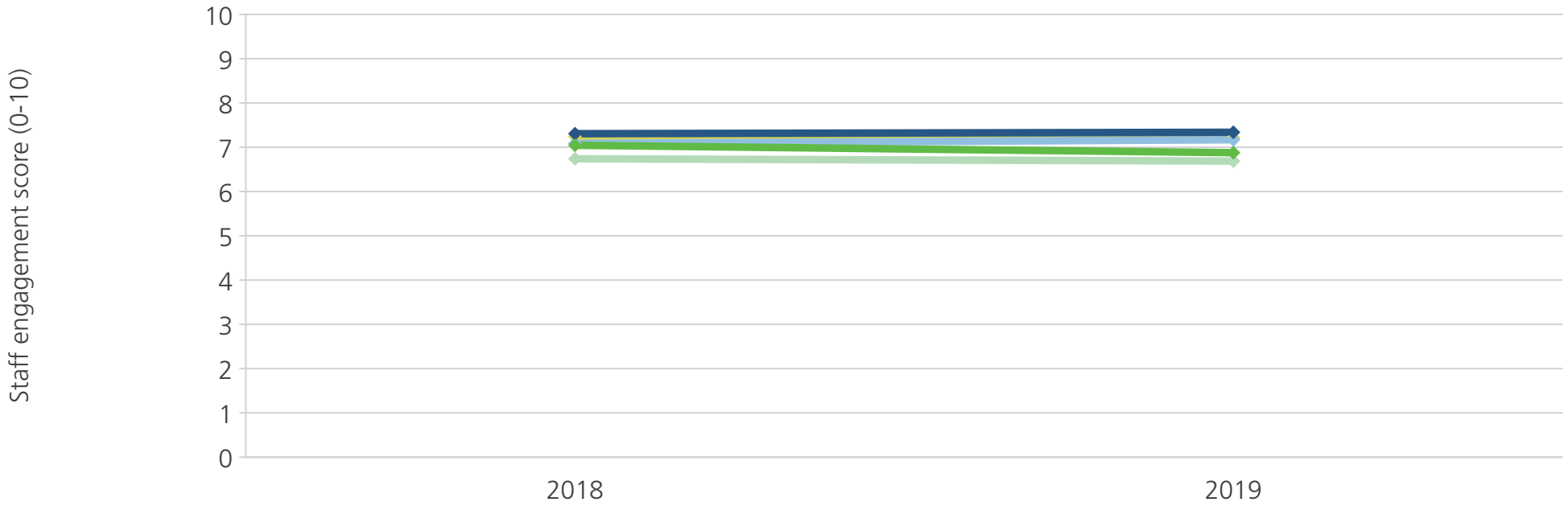
Disabled staff: Responses	167	170
Non-disabled staff: Responses	664	519

Average calculated as the median for the benchmark group



Disabled staff: Your org	82.5%	80.6%
Disabled staff: Average	77.3%	77.1%
Disabled staff: Responses	97	108

Average calculated as the median for the benchmark group



	2018	2019
Organisation average	7.2	7.2
Disabled staff: Your org	7.0	6.9
Non-disabled staff: Your org	7.3	7.3
Disabled staff: Average	6.7	6.7
Non-disabled staff: Average	7.1	7.2

Organisation Responses	862	708
Disabled staff: Responses	168	172
Non-disabled staff: Responses	671	519

Average calculated as the median for the benchmark group

Survey Coordination Centre

NHS England

Appendices

2Gether NHS Foundation Trust

2019 NHS Staff Survey Results

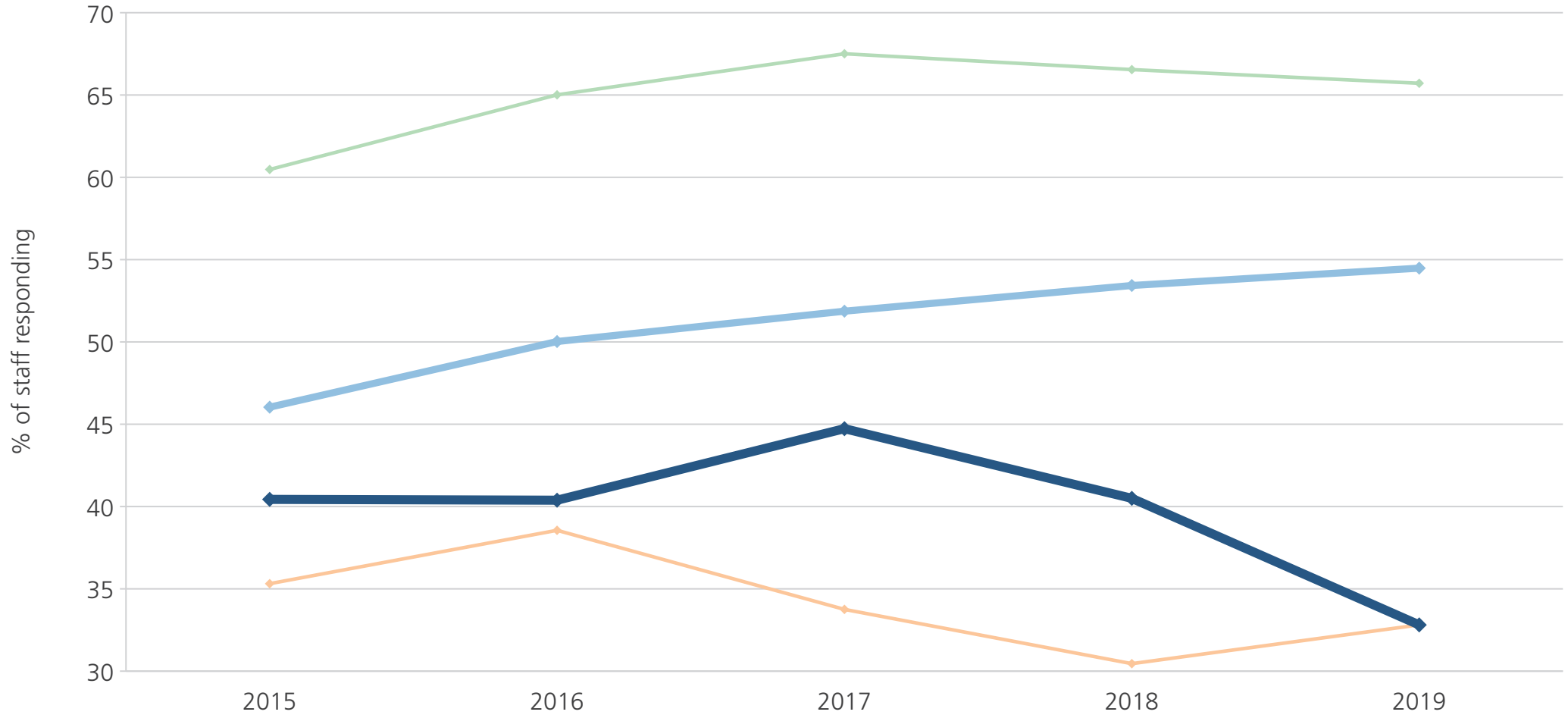
Survey Coordination Centre

NHS England

Appendix A: Response rate

2Gether NHS Foundation Trust

2019 NHS Staff Survey Results



	2015	2016	2017	2018	2019
Best	60.5%	65.0%	67.5%	66.5%	65.7%
Your org	40.4%	40.4%	44.7%	40.5%	32.8%
Median	46.0%	50.0%	51.9%	53.4%	54.5%
Worst	35.3%	38.6%	33.8%	30.5%	32.8%

Survey Coordination Centre

NHS England

Appendix B: Significance testing - 2018 v 2019 theme results

2Gether NHS Foundation Trust

2019 NHS Staff Survey Results

The table below presents the results of significance testing conducted on this year's theme scores and those from last year*. It details the organisation's theme scores for both years and the number of responses each of these are based on.

The final column contains the outcome of the significance testing: ↑ indicates that the 2019 score is significantly higher than last year's, whereas ↓ indicates that the 2019 score is significantly lower. If there is no statistically significant difference, you will see 'Not significant'. When there is no comparable data from the past survey year, you will see 'N/A'.

Theme	2018 score	2018 respondents	2019 score	2019 respondents	Statistically significant change?
Equality, diversity & inclusion	**9.2**	851	**9.1**	691	Not significant
Health & wellbeing	**6.2**	855	**6.0**	698	Not significant
Immediate managers	**7.5**	857	**7.2**	702	↓
Morale	**6.6**	845	**6.4**	694	↓
Quality of appraisals	**5.4**	741	**5.5**	593	Not significant
Quality of care	**7.3**	672	**7.2**	536	Not significant
Safe environment - Bullying & harassment	**8.0**	849	**8.2**	695	Not significant
Safe environment - Violence	**9.4**	845	**9.4**	694	Not significant
Safety culture	**6.9**	852	**6.9**	693	Not significant
Staff engagement	**7.2**	862	**7.2**	708	Not significant
Team working	**7.1**	843	**6.9**	698	Not significant

* Statistical significance is tested using a two-tailed t-test with a 95% level of confidence.

Survey Coordination Centre

NHS England

Gloucestershire Care Services NHS Trust

2019 NHS Staff Survey

Summary Benchmark Report

Organisation details

Gloucestershire Care Services NHS Trust

2019 NHS Staff Survey

Organisation details

Completed questionnaires	887
2019 response rate	36%

See response rate trend for the last 5 years

Survey details

Survey mode	Online
Sample type	Census

This organisation is benchmarked against:

Community Trusts

2019 benchmarking group details

Organisations in group: **16**

Median response rate: **58%**

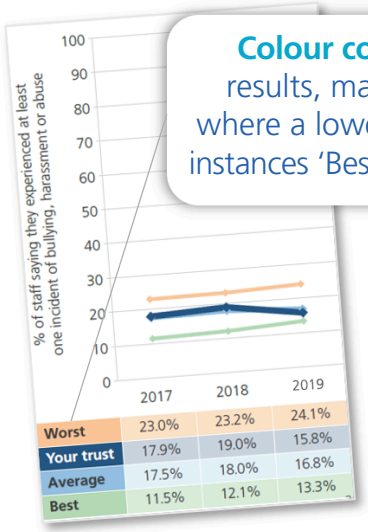
No. of completed questionnaires: **22,887**

Using the report

Key features

Question number and text (or the theme) specified at the top of each slide

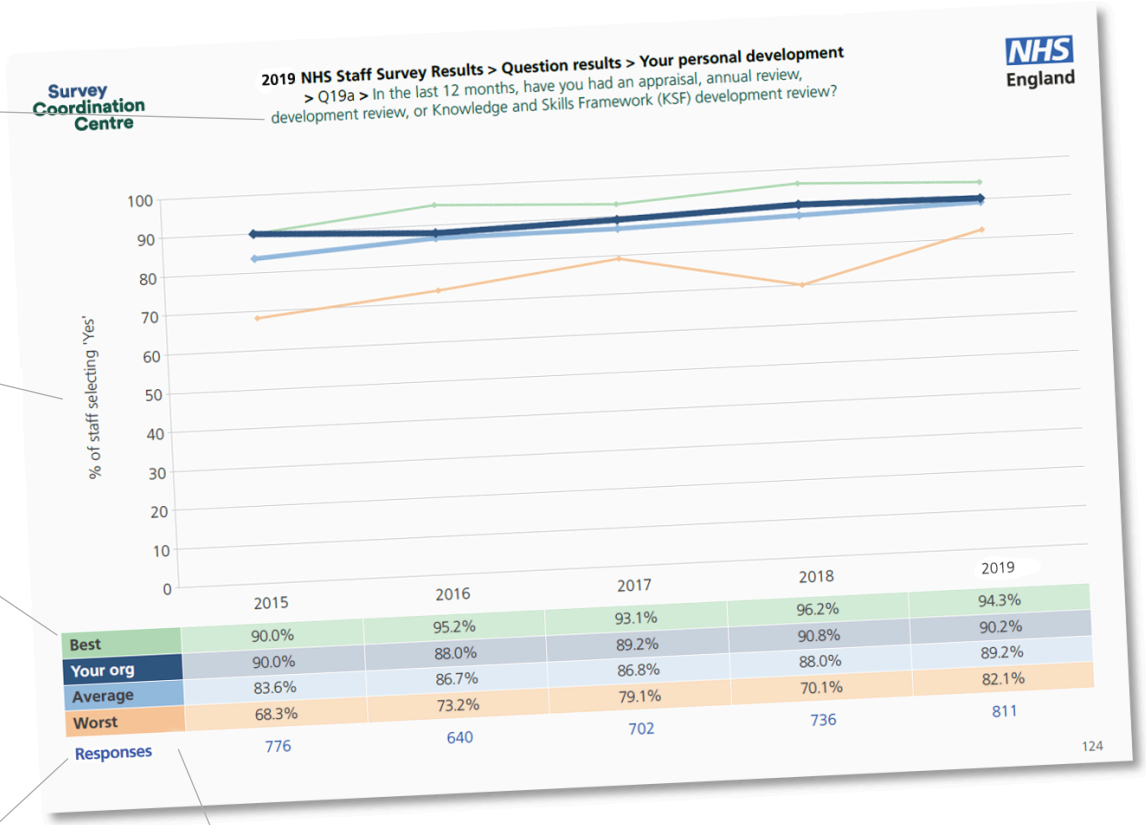
Question-level results are always reported as percentages; the **meaning of the value** is outlined along the axis. Themes are always on a 0-10pt scale where 10 is the best score attainable



Colour coding highlights best / worst results, making it easy to spot questions where a lower percentage is better – in such instances 'Best' is the bottom line in the table

Keep an eye out!

Number of responses for the organisation for the given question



'Best', 'Average', and 'Worst' refer to the **benchmarking group's** best, average and worst **results**

Full details on how the scores are calculated are provided in the **Technical Document**, under the Supporting Documents section of our results page

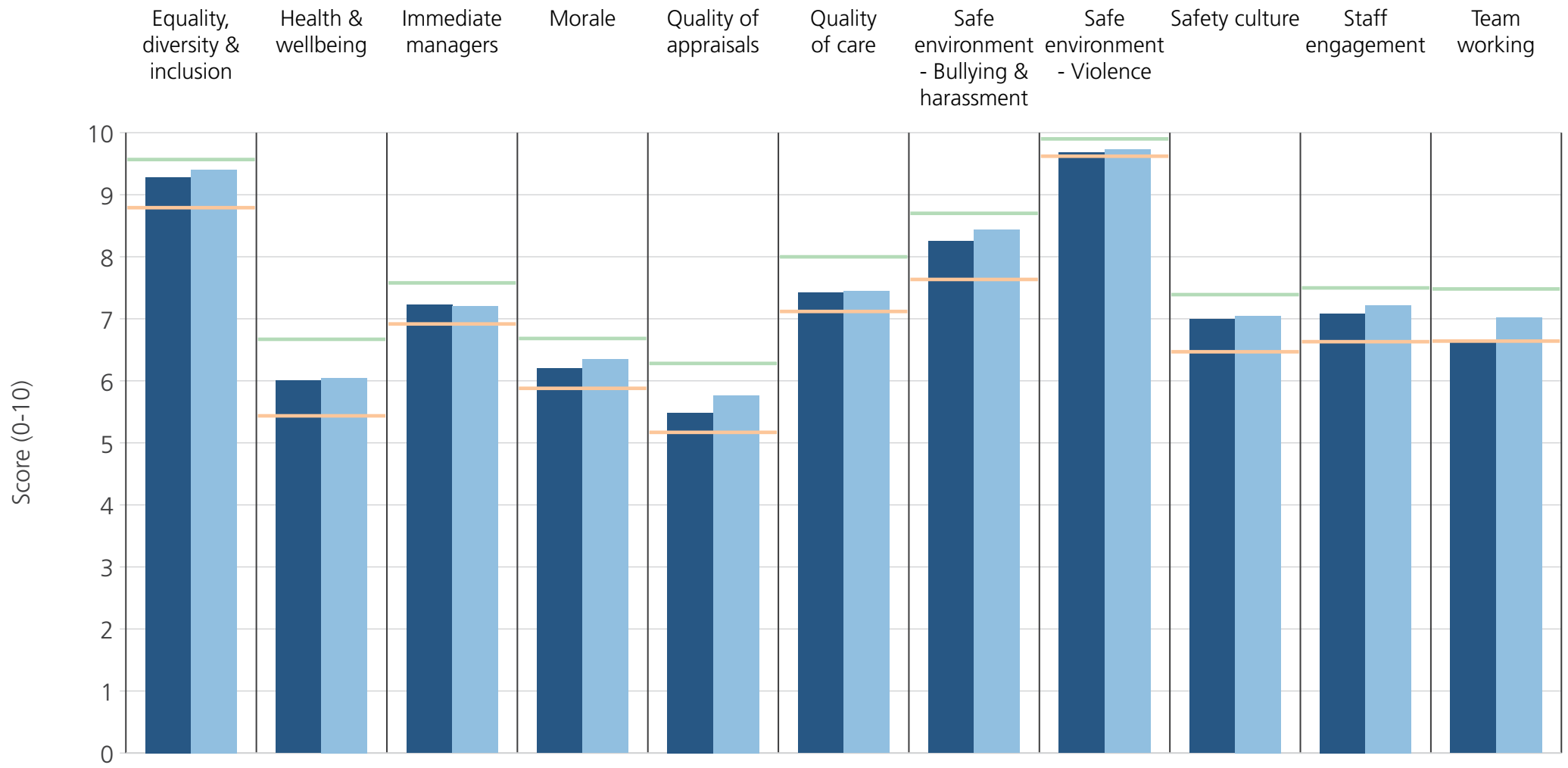
Survey Coordination Centre

NHS England

Theme results

Gloucestershire Care Services NHS Trust

2019 NHS Staff Survey Results



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.6	6.7	7.6	6.7	6.3	8.0	8.7	9.9	7.4	7.5	7.5
Your org	9.3	6.0	7.2	6.2	5.5	7.4	8.3	9.7	7.0	7.1	6.6
Average	9.4	6.0	7.2	6.3	5.8	7.4	8.4	9.7	7.0	7.2	7.0
Worst	8.8	5.4	6.9	5.9	5.2	7.1	7.6	9.6	6.5	6.6	6.6
Responses	868	881	882	878	780	745	878	875	876	886	865

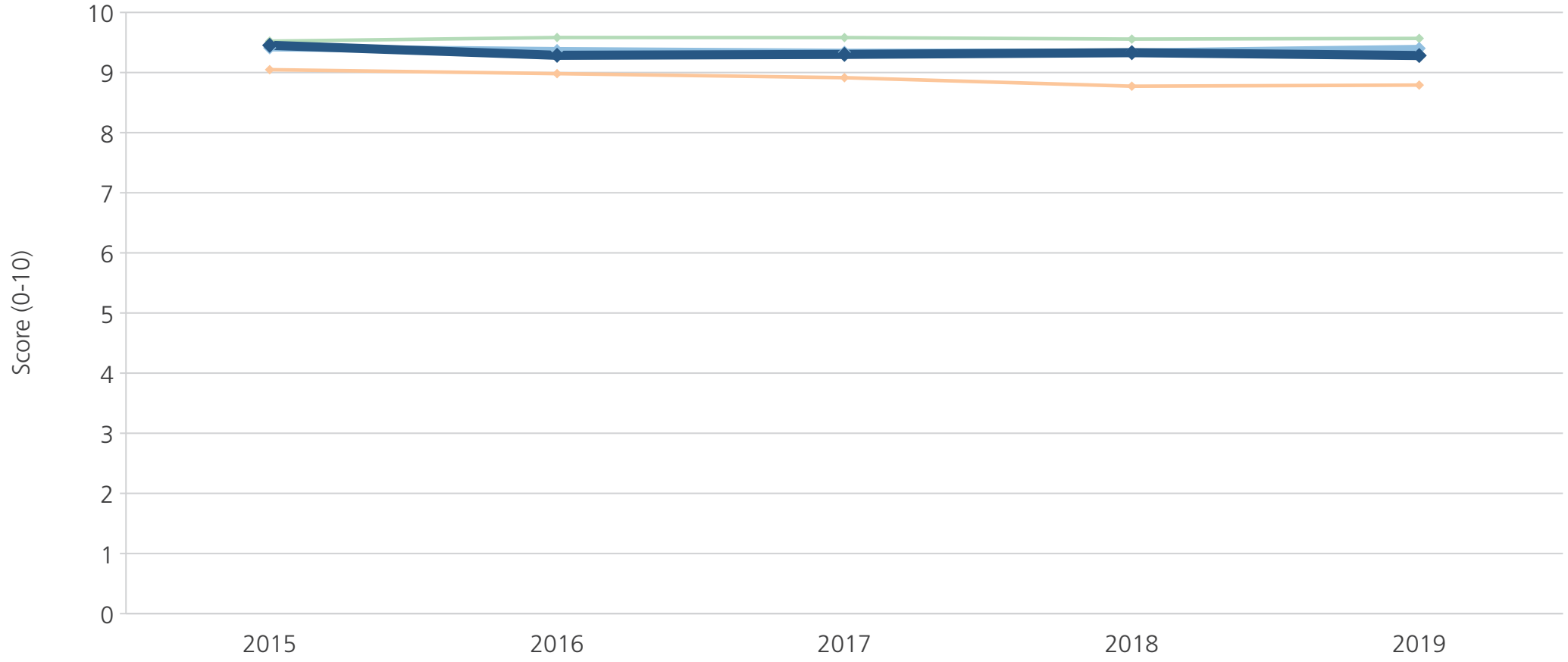
Survey Coordination Centre

NHS England

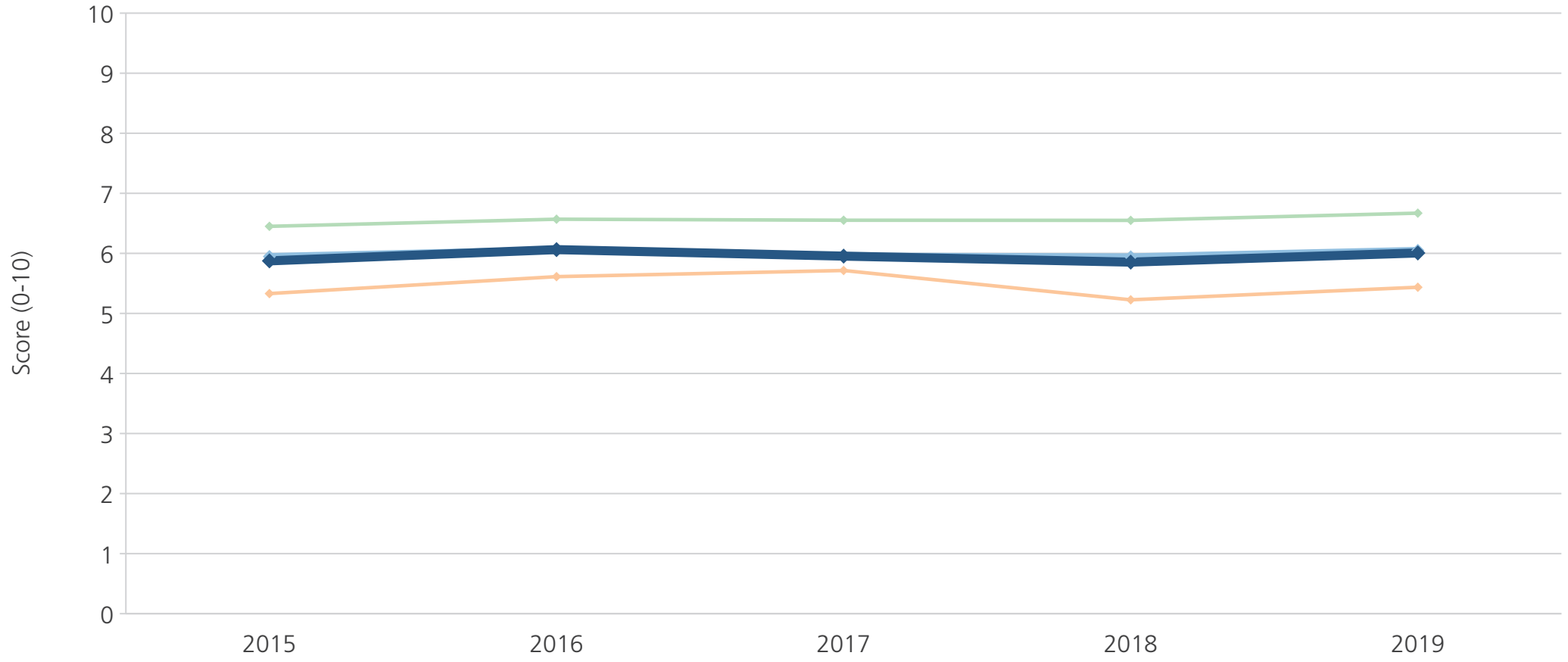
Theme results – Trends

Gloucestershire Care Services NHS Trust

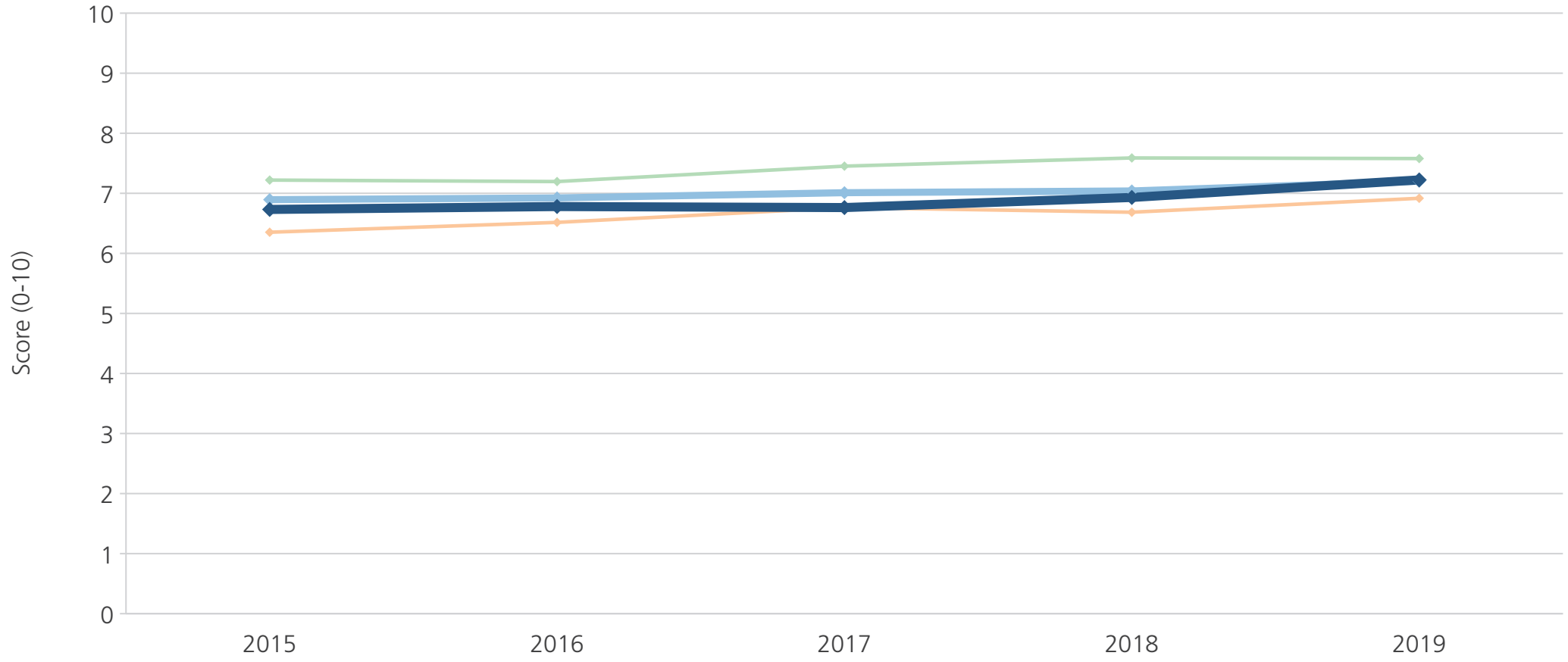
2019 NHS Staff Survey Results



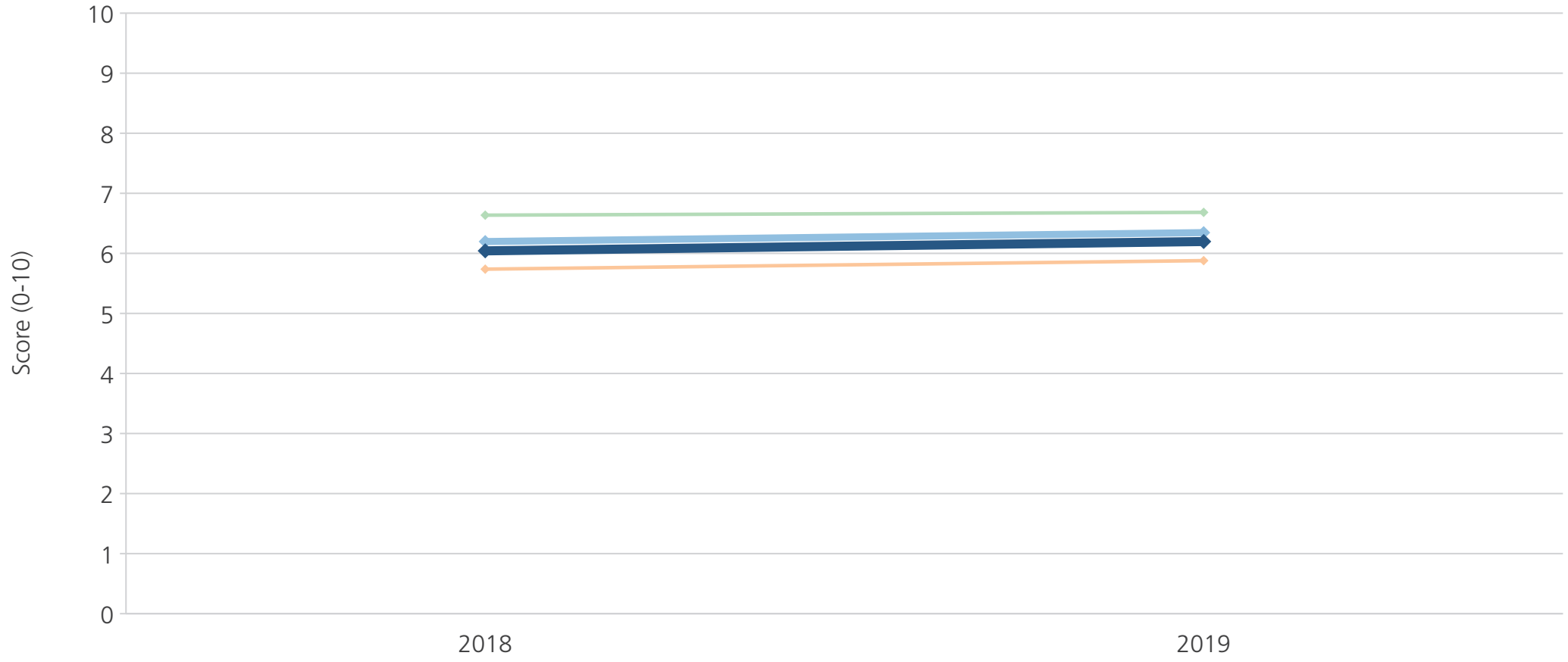
	2015	2016	2017	2018	2019
Best	9.5	9.6	9.6	9.6	9.6
Your org	9.5	9.3	9.3	9.3	9.3
Average	9.4	9.4	9.3	9.3	9.4
Worst	9.0	9.0	8.9	8.8	8.8
Responses	385	1,186	1,103	991	868



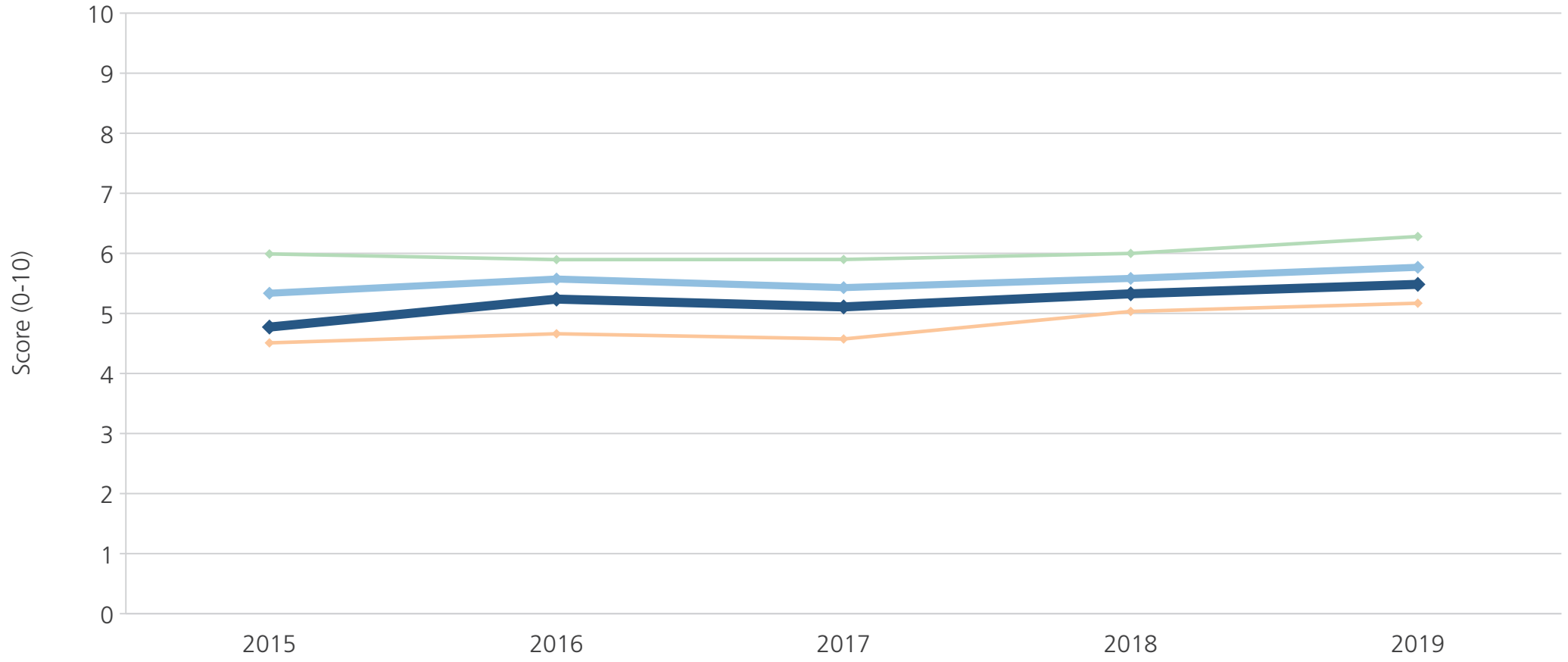
	2015	2016	2017	2018	2019
Best	6.4	6.6	6.6	6.5	6.7
Your org	5.9	6.1	6.0	5.9	6.0
Average	5.9	6.1	6.0	5.9	6.0
Worst	5.3	5.6	5.7	5.2	5.4
Responses	390	1,198	1,108	991	881



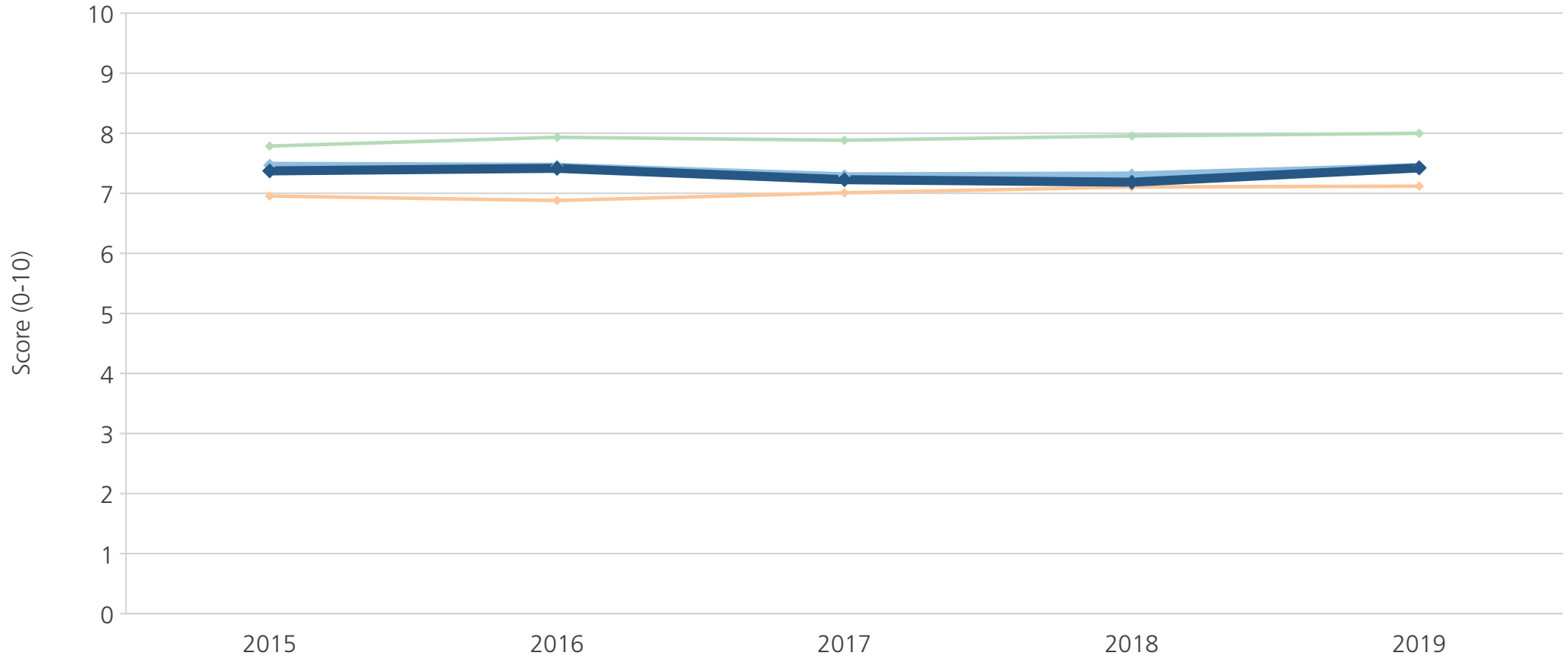
	2015	2016	2017	2018	2019
Best	7.2	7.2	7.5	7.6	7.6
Your org	6.7	6.8	6.8	6.9	7.2
Average	6.9	6.9	7.0	7.0	7.2
Worst	6.4	6.5	6.8	6.7	6.9
Responses	388	1,199	1,106	993	882



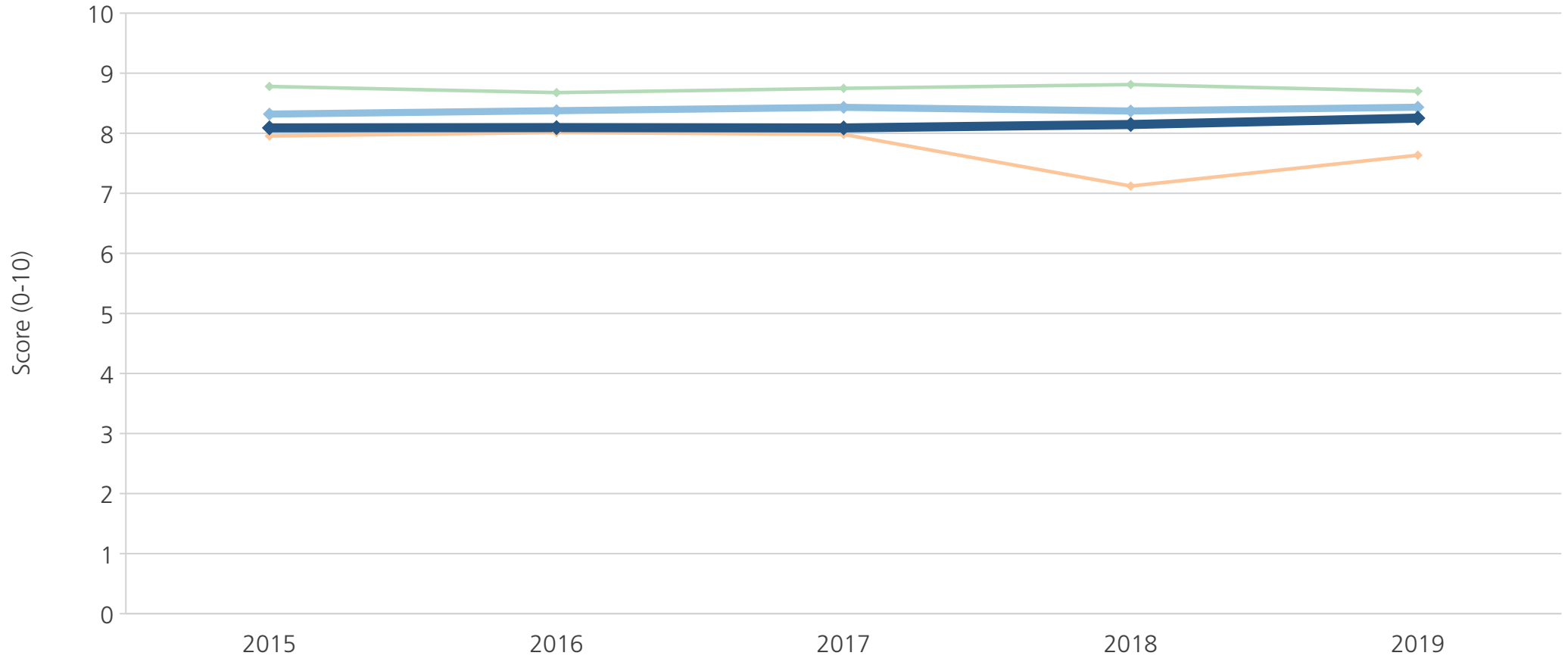
	2018	2019
Best	6.6	6.7
Your org	6.0	6.2
Average	6.2	6.3
Worst	5.7	5.9
Responses	975	878



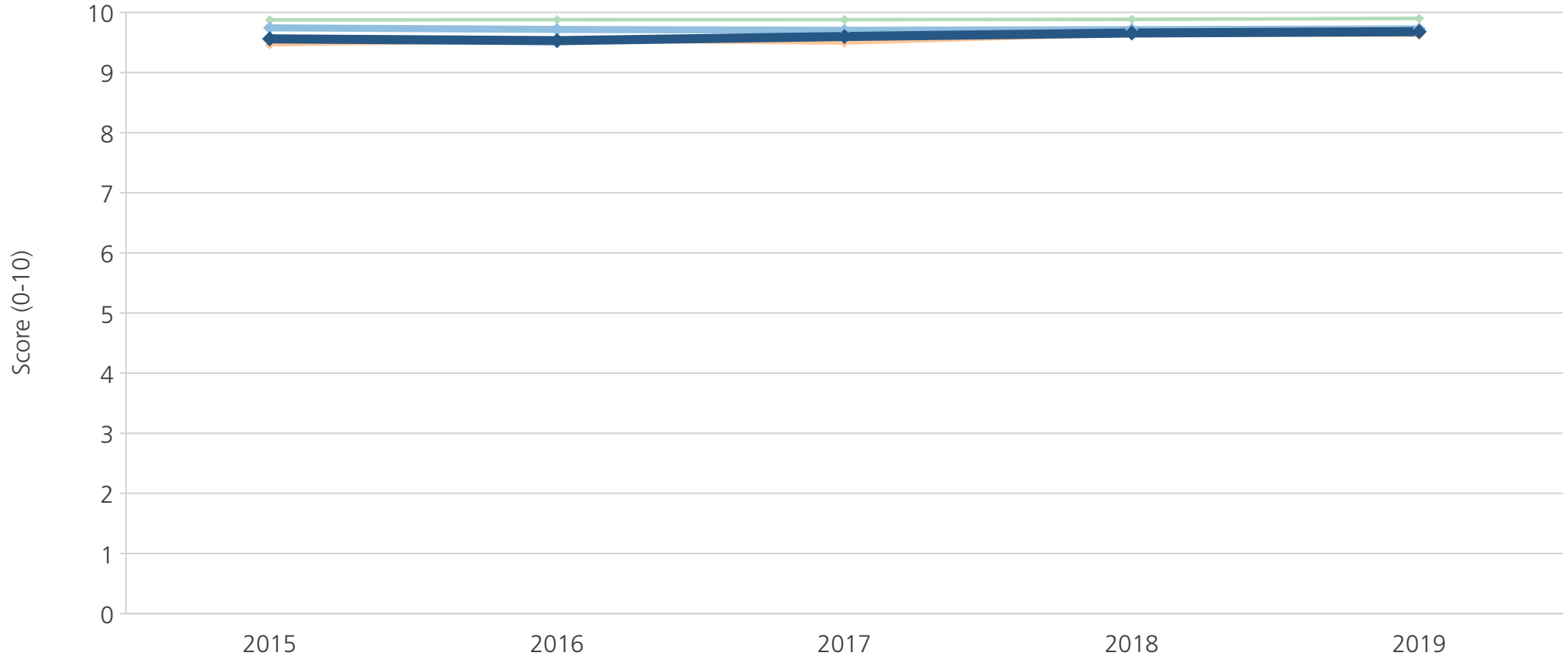
	2015	2016	2017	2018	2019
Best	6.0	5.9	5.9	6.0	6.3
Your org	4.8	5.2	5.1	5.3	5.5
Average	5.3	5.6	5.4	5.6	5.8
Worst	4.5	4.7	4.6	5.0	5.2
Responses	337	1,018	963	877	780



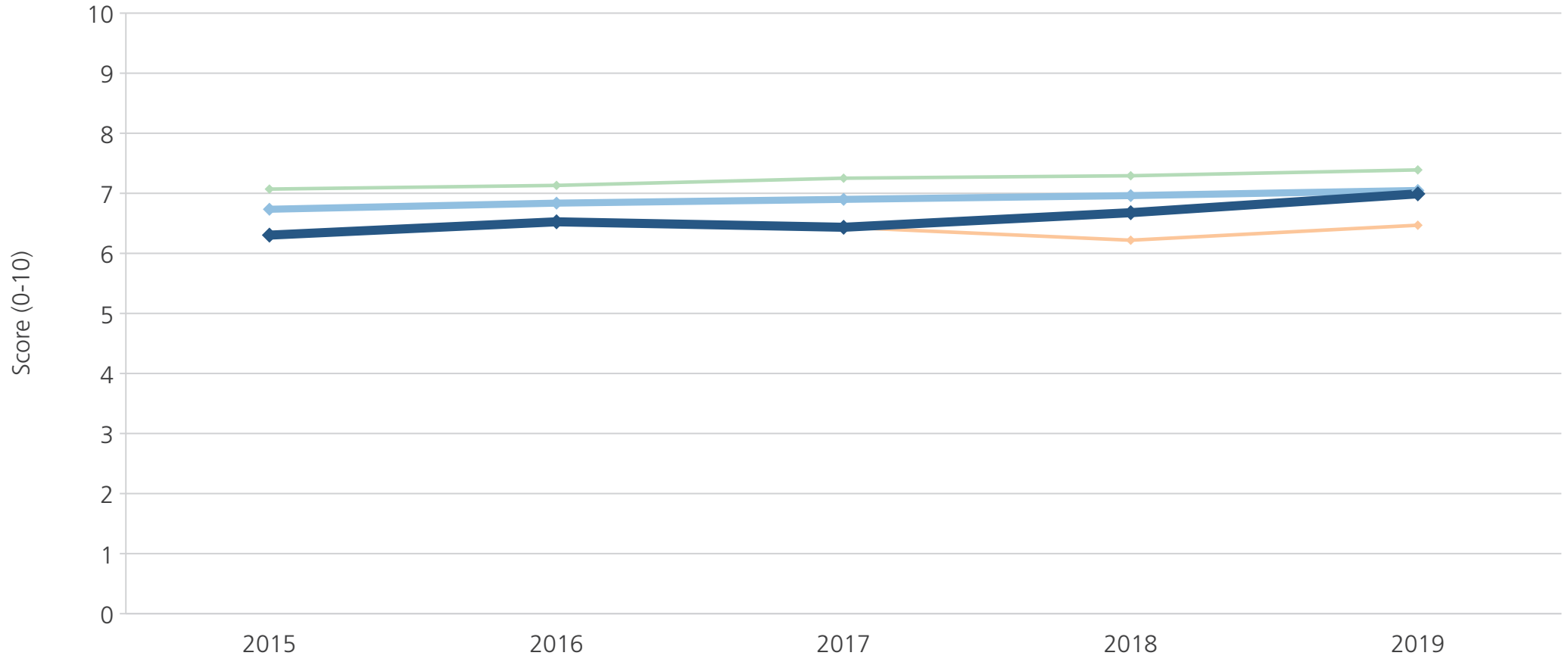
	2015	2016	2017	2018	2019
Best	7.8	7.9	7.9	8.0	8.0
Your org	7.4	7.4	7.2	7.2	7.4
Average	7.5	7.5	7.3	7.3	7.4
Worst	7.0	6.9	7.0	7.1	7.1
Responses	346	1,061	988	860	745



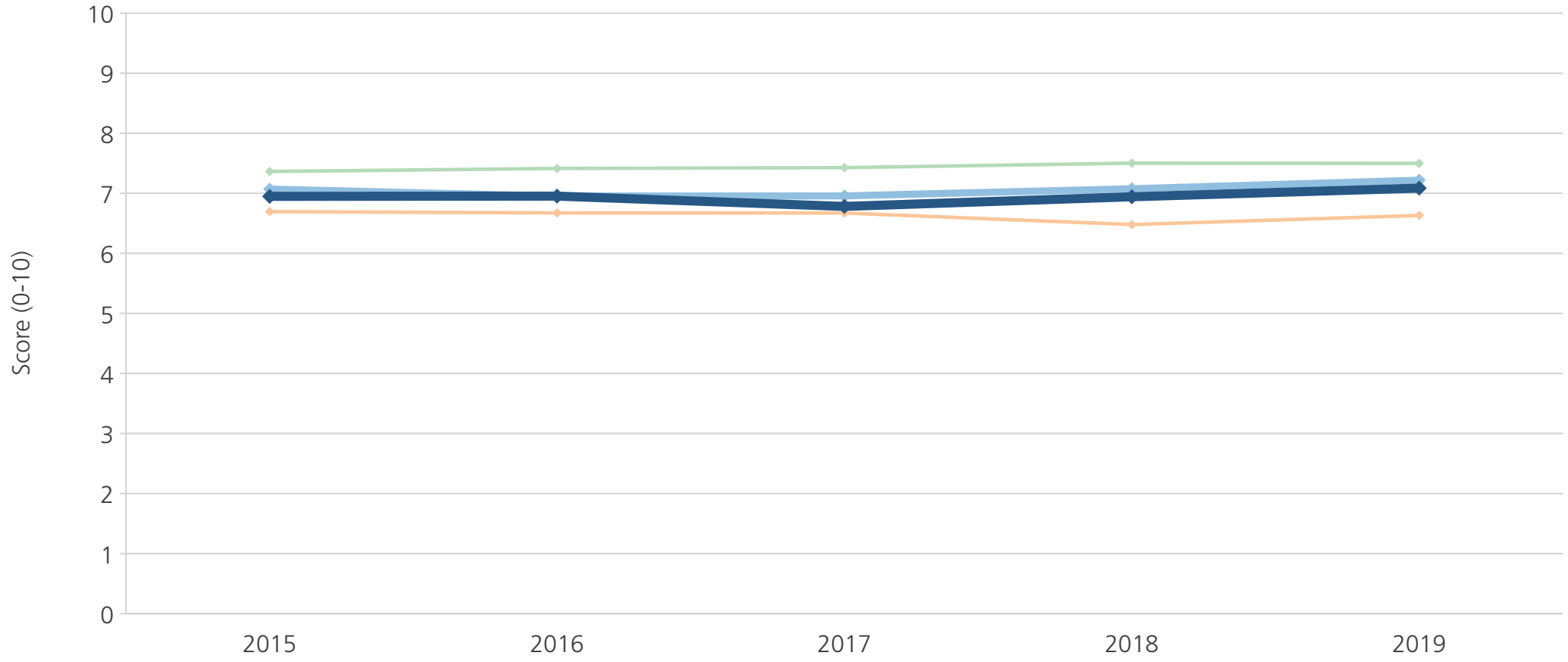
	2015	2016	2017	2018	2019
Best	8.8	8.7	8.7	8.8	8.7
Your org	8.1	8.1	8.1	8.1	8.3
Average	8.3	8.4	8.4	8.4	8.4
Worst	8.0	8.0	8.0	7.1	7.6
Responses	385	1,181	1,095	986	878



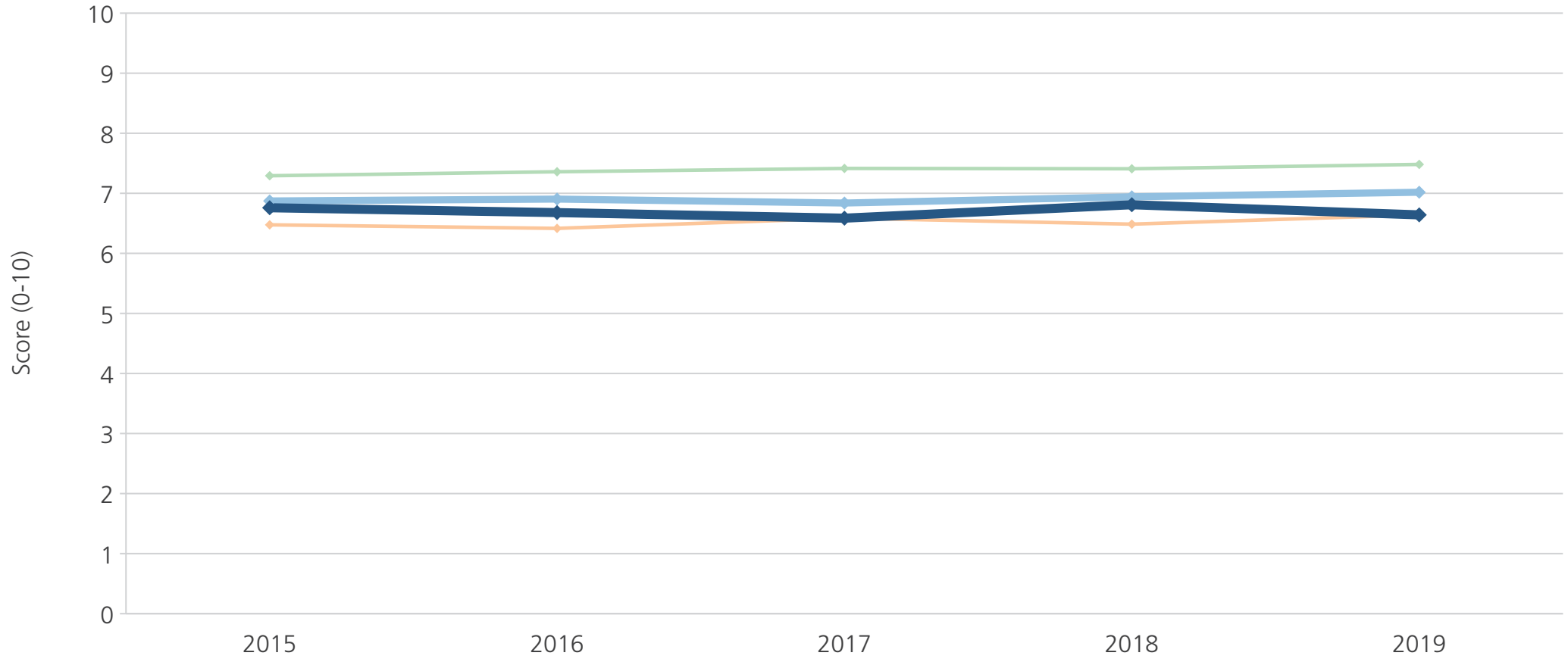
	2015	2016	2017	2018	2019
Best	9.9	9.9	9.9	9.9	9.9
Your org	9.6	9.5	9.6	9.7	9.7
Average	9.7	9.7	9.7	9.7	9.7
Worst	9.5	9.5	9.5	9.6	9.6
Responses	382	1,175	1,096	990	875



	2015	2016	2017	2018	2019
Best	7.1	7.1	7.3	7.3	7.4
Your org	6.3	6.5	6.4	6.7	7.0
Average	6.7	6.8	6.9	7.0	7.0
Worst	6.3	6.5	6.4	6.2	6.5
Responses	388	1,191	1,100	986	876



	2015	2016	2017	2018	2019
Best	7.4	7.4	7.4	7.5	7.5
Your org	6.9	7.0	6.8	6.9	7.1
Average	7.1	7.0	7.0	7.1	7.2
Worst	6.7	6.7	6.7	6.5	6.6
Responses	389	1,200	1,107	1,002	886



	2015	2016	2017	2018	2019
Best	7.3	7.4	7.4	7.4	7.5
Your org	6.8	6.7	6.6	6.8	6.6
Average	6.9	6.9	6.8	6.9	7.0
Worst	6.5	6.4	6.6	6.5	6.6
Responses	387	1,190	1,102	990	865

Survey Coordination Centre

NHS England

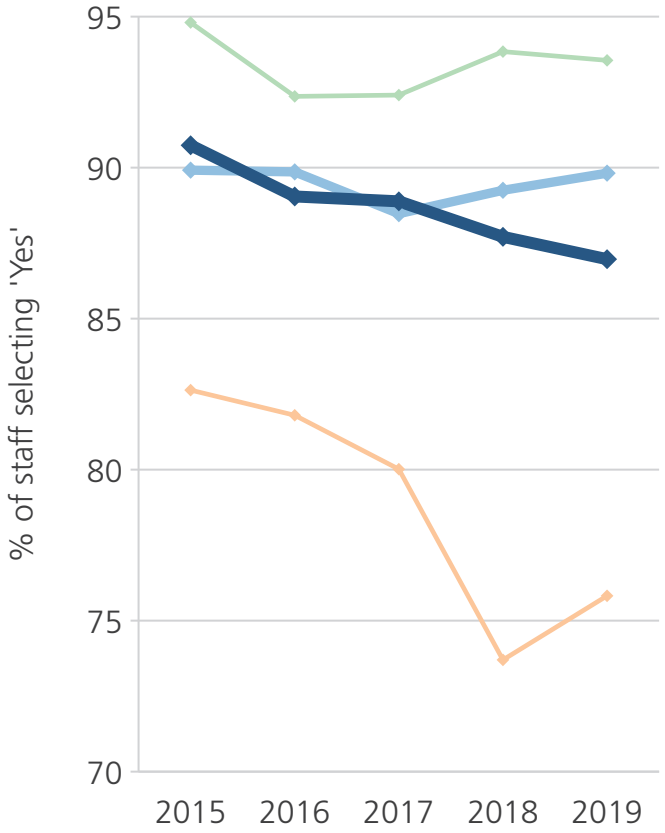
Theme results – Detailed information

Gloucestershire Care Services NHS Trust

2019 NHS Staff Survey Results

Q14

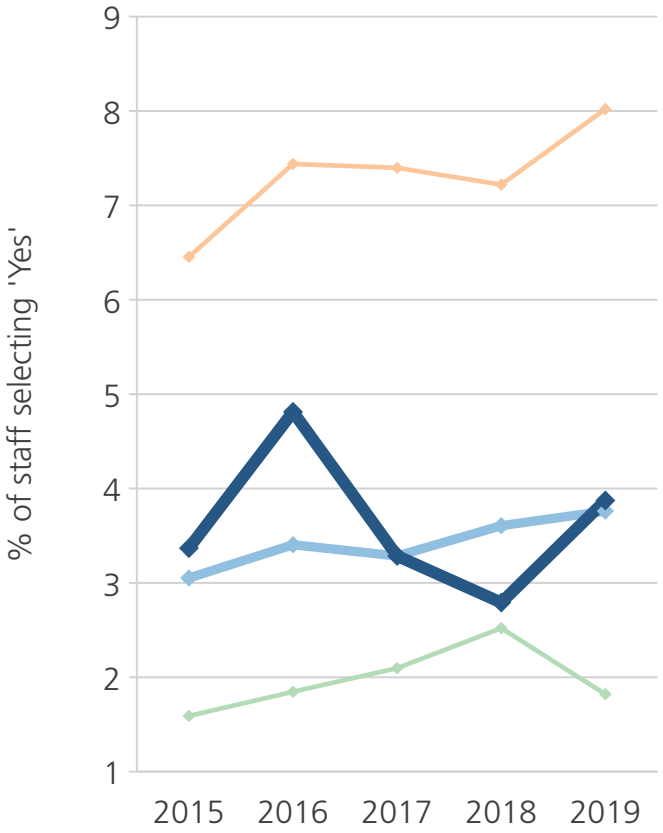
Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?



	2015	2016	2017	2018	2019
Best	94.8%	92.4%	92.4%	93.8%	93.6%
Your org	90.7%	89.0%	88.9%	87.7%	87.0%
Average	89.9%	89.9%	88.5%	89.2%	89.8%
Worst	82.6%	81.8%	80.0%	73.7%	75.8%

Q15a

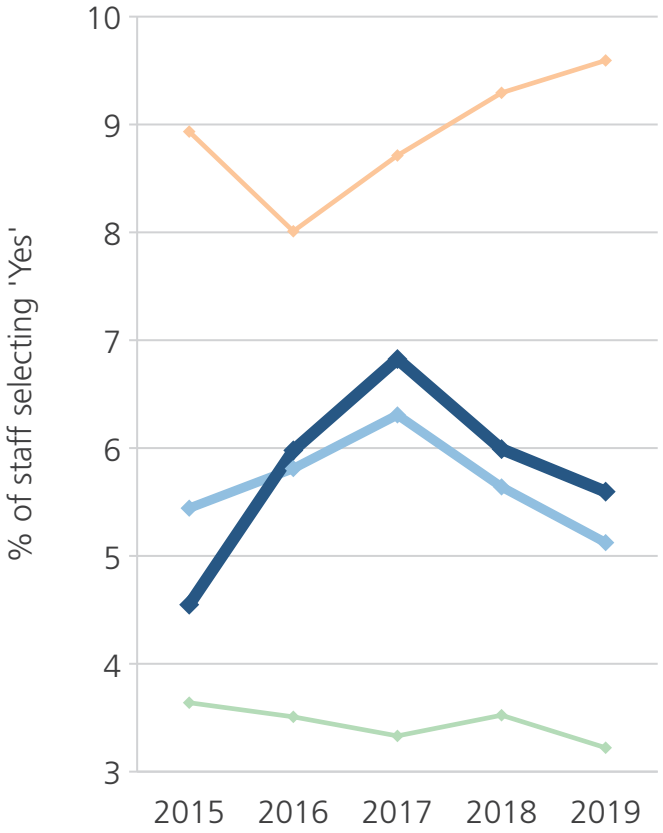
In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public?



	2015	2016	2017	2018	2019
Worst	6.5%	7.4%	7.4%	7.2%	8.0%
Your org	3.4%	4.8%	3.3%	2.8%	3.9%
Average	3.1%	3.4%	3.3%	3.6%	3.8%
Best	1.6%	1.8%	2.1%	2.5%	1.8%

Q15b

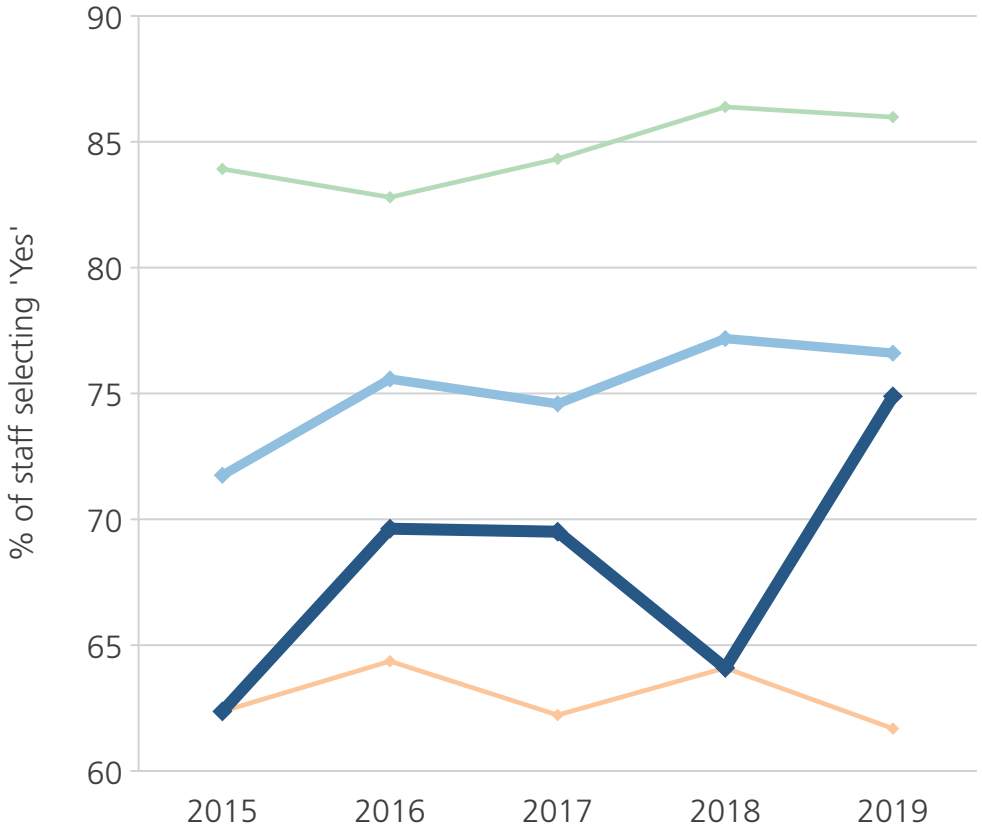
In the last 12 months have you personally experienced discrimination at work from manager / team leader or other colleagues?



	2015	2016	2017	2018	2019
Worst	8.9%	8.0%	8.7%	9.3%	9.6%
Your org	4.5%	6.0%	6.8%	6.0%	5.6%
Average	5.4%	5.8%	6.3%	5.6%	5.1%
Best	3.6%	3.5%	3.3%	3.5%	3.2%

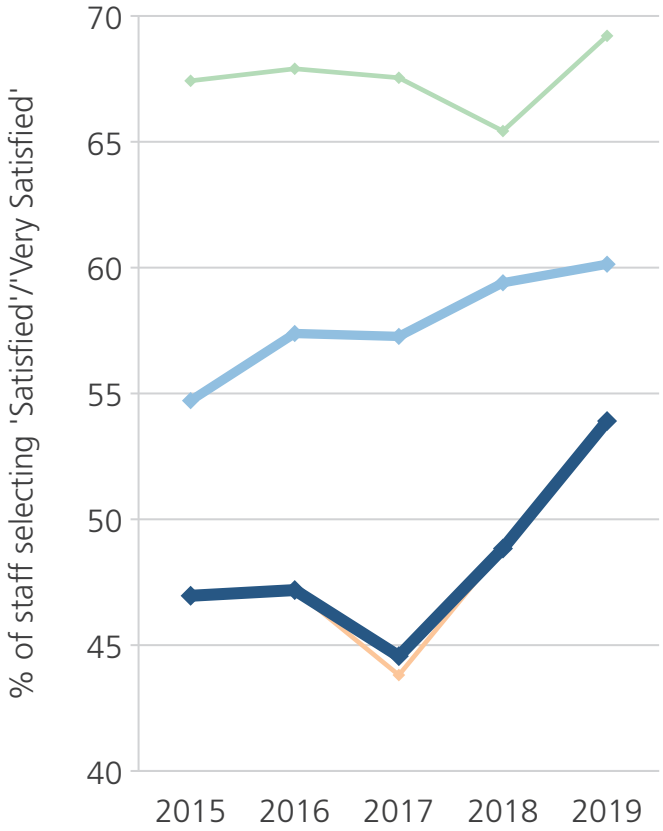
Q28b

Has your employer made adequate adjustment(s) to enable you to carry out your work?



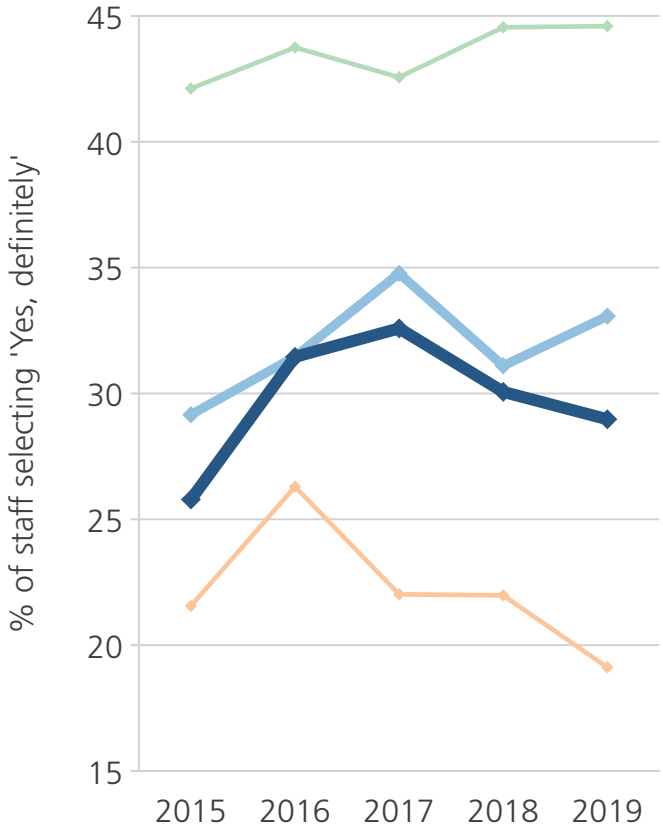
	2015	2016	2017	2018	2019
Best	83.9%	82.8%	84.3%	86.4%	86.0%
Your org	62.4%	69.6%	69.5%	64.1%	74.9%
Average	71.8%	75.6%	74.6%	77.2%	76.6%
Worst	62.4%	64.4%	62.2%	64.1%	61.7%

Q5h
The opportunities for flexible working patterns



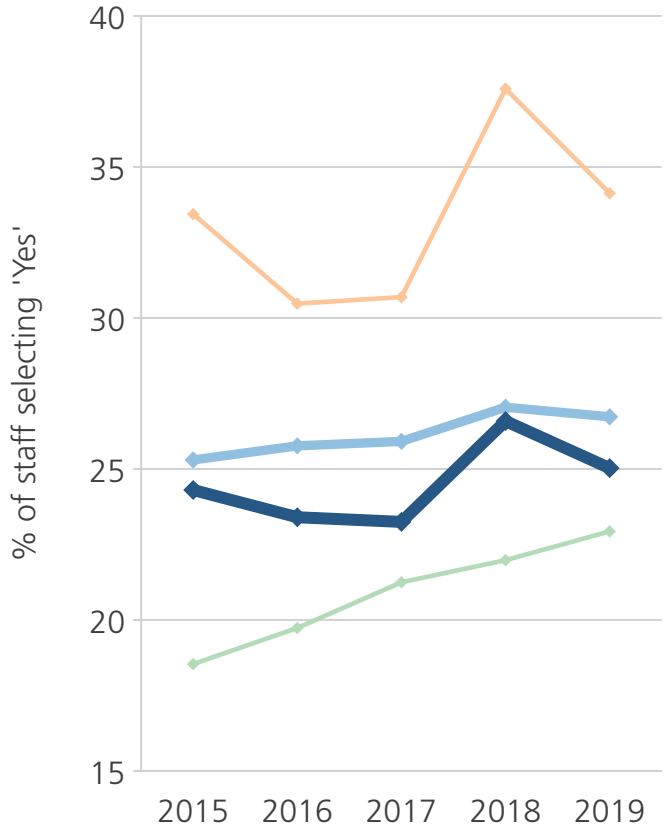
	2015	2016	2017	2018	2019
Best	67.4%	67.9%	67.5%	65.4%	69.2%
Your org	47.0%	47.2%	44.6%	48.8%	53.9%
Average	54.7%	57.4%	57.3%	59.4%	60.1%
Worst	47.0%	47.2%	43.8%	48.8%	53.9%

Q11a
Does your organisation take positive action on health and well-being?



	2015	2016	2017	2018	2019
Best	42.1%	43.7%	42.6%	44.6%	44.6%
Your org	25.8%	31.5%	32.6%	30.1%	29.0%
Average	29.2%	31.5%	34.8%	31.1%	33.1%
Worst	21.6%	26.3%	22.0%	22.0%	19.1%

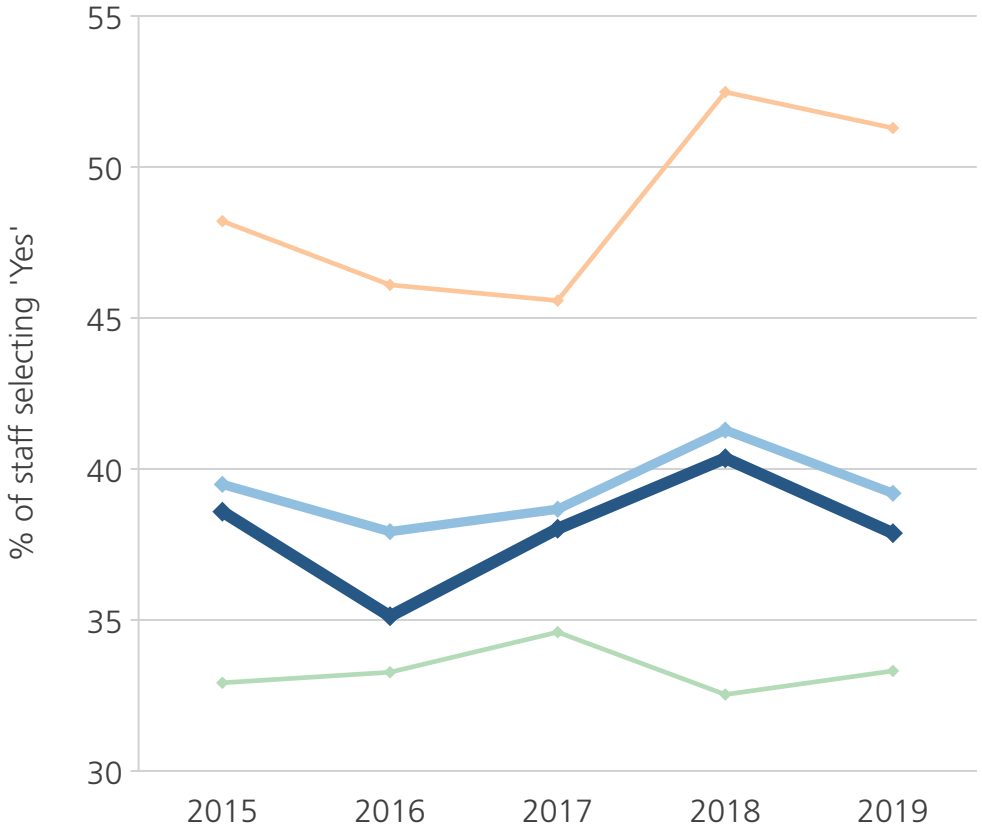
Q11b
In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?



	2015	2016	2017	2018	2019
Worst	33.4%	30.5%	30.7%	37.6%	34.1%
Your org	24.3%	23.4%	23.2%	26.6%	25.0%
Average	25.3%	25.8%	25.9%	27.0%	26.7%
Best	18.5%	19.7%	21.2%	22.0%	22.9%

Q11c

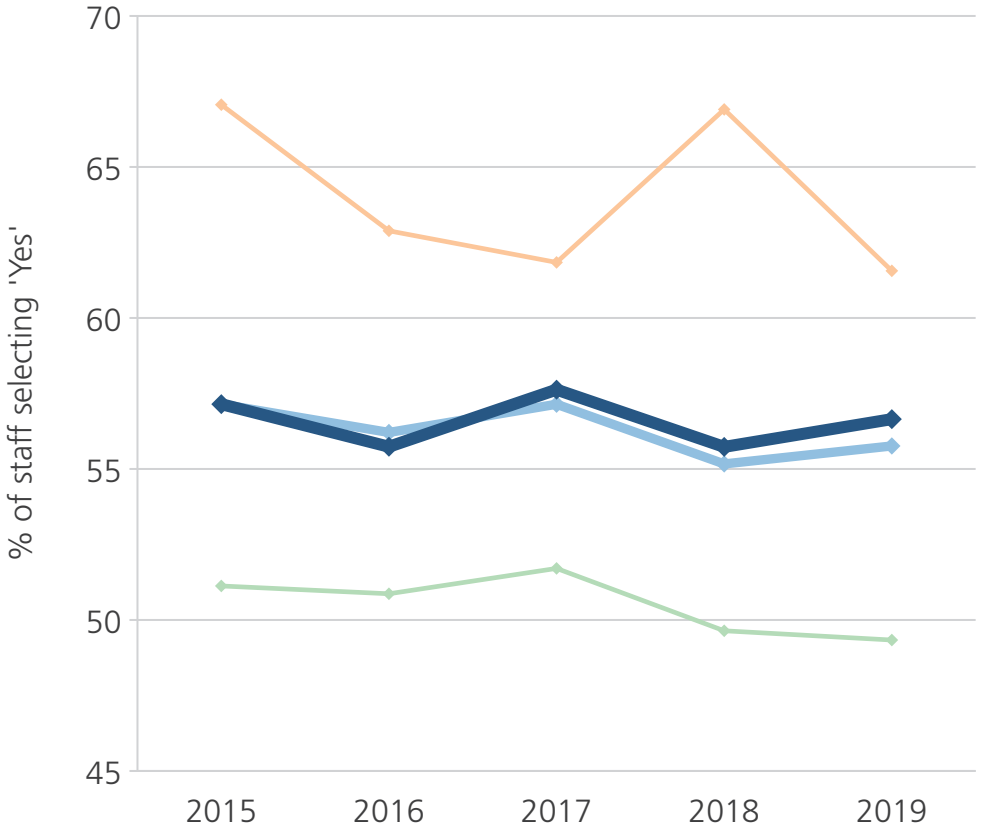
During the last 12 months have you felt unwell as a result of work related stress?



	2015	2016	2017	2018	2019
Worst	48.2%	46.1%	45.6%	52.5%	51.3%
Your org	38.6%	35.1%	38.0%	40.4%	37.9%
Average	39.5%	37.9%	38.7%	41.3%	39.2%
Best	32.9%	33.3%	34.6%	32.5%	33.3%

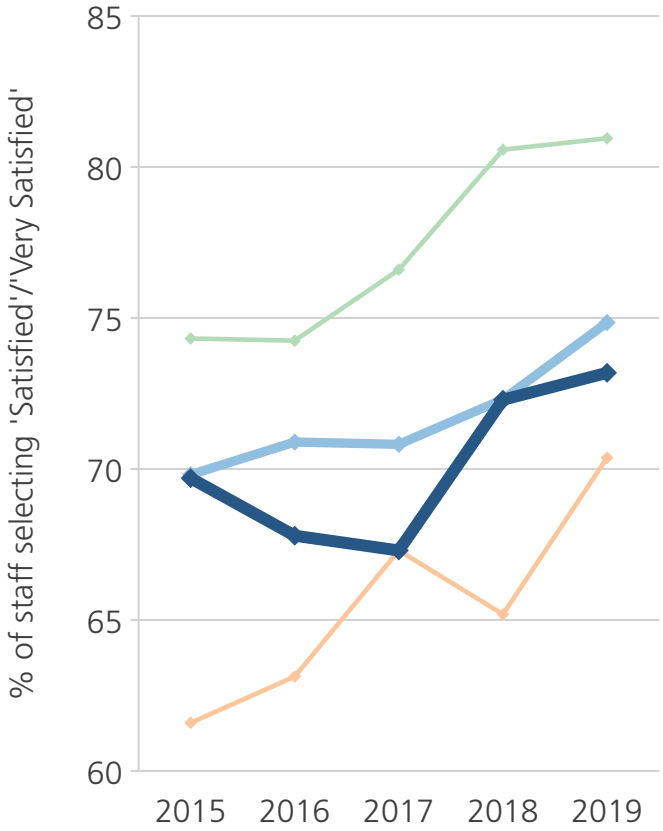
Q11d

In the last three months have you ever come to work despite not feeling well enough to perform your duties?



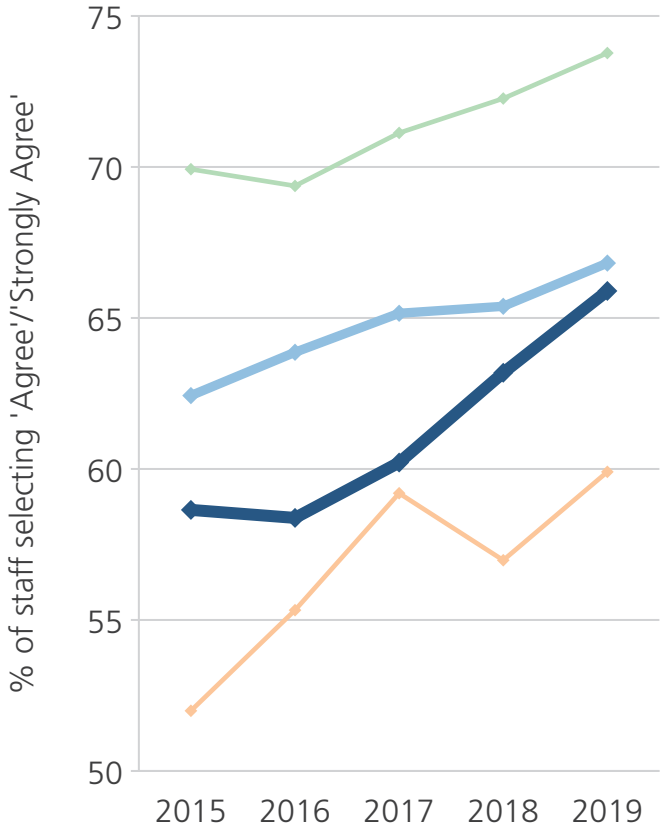
	2015	2016	2017	2018	2019
Worst	67.1%	62.9%	61.8%	66.9%	61.6%
Your org	57.1%	55.7%	57.6%	55.7%	56.6%
Average	57.1%	56.2%	57.1%	55.2%	55.8%
Best	51.1%	50.9%	51.7%	49.6%	49.3%

Q5b
The support I get from my immediate manager



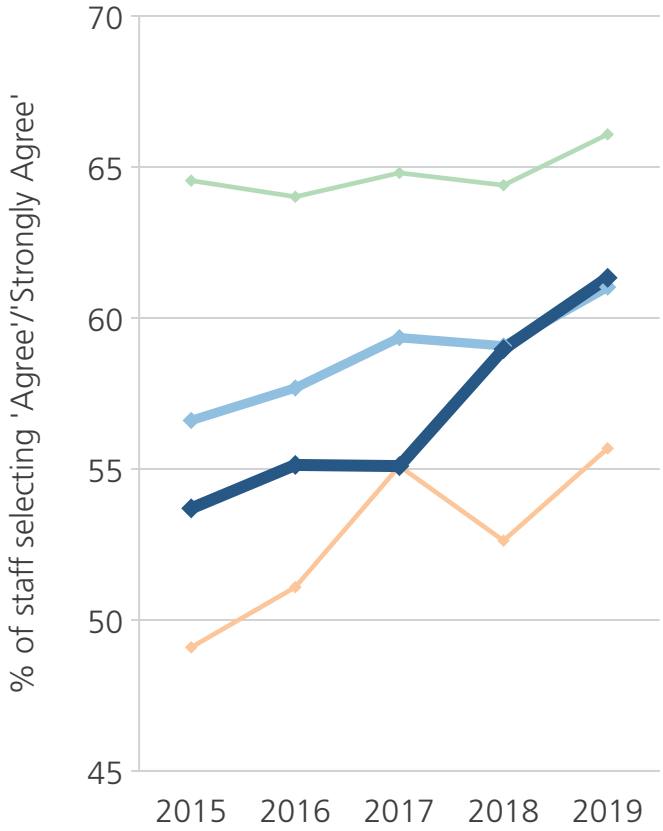
	2015	2016	2017	2018	2019
Best	74.3%	74.2%	76.6%	80.6%	81.0%
Your org	69.7%	67.8%	67.3%	72.3%	73.2%
Average	69.8%	70.9%	70.8%	72.3%	74.8%
Worst	61.6%	63.1%	67.3%	65.2%	70.4%

Q8c
My immediate manager gives me clear feedback on my work



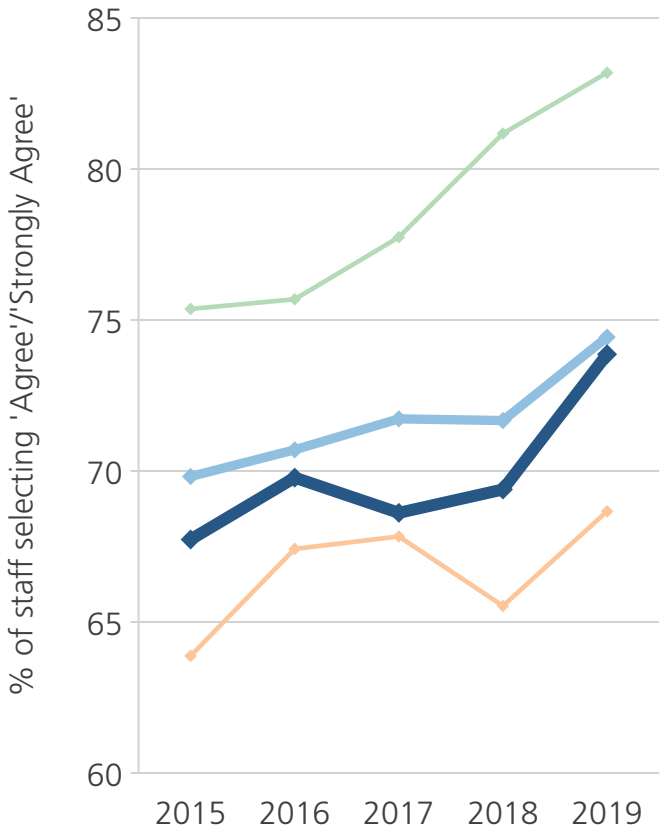
	2015	2016	2017	2018	2019
Best	69.9%	69.4%	71.1%	72.3%	73.8%
Your org	58.6%	58.4%	60.2%	63.2%	65.9%
Average	62.4%	63.9%	65.2%	65.4%	66.8%
Worst	52.0%	55.3%	59.2%	57.0%	59.9%

Q8d
My immediate manager asks for my opinion before making decisions that affect my work



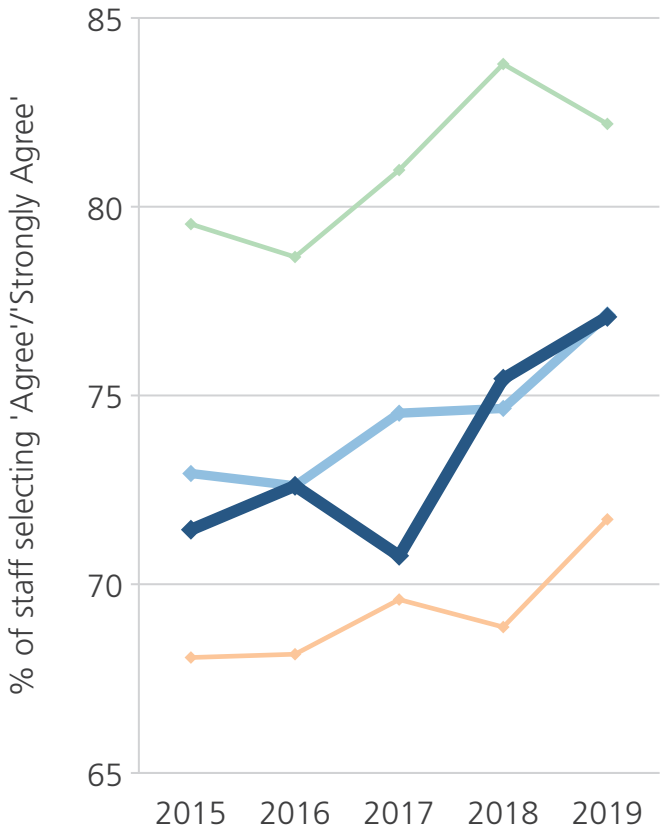
	2015	2016	2017	2018	2019
Best	64.5%	64.0%	64.8%	64.4%	66.1%
Your org	53.7%	55.1%	55.1%	59.0%	61.3%
Average	56.6%	57.7%	59.3%	59.1%	61.0%
Worst	49.1%	51.1%	55.1%	52.6%	55.7%

Q8f
My immediate manager takes a positive interest in my health and well-being



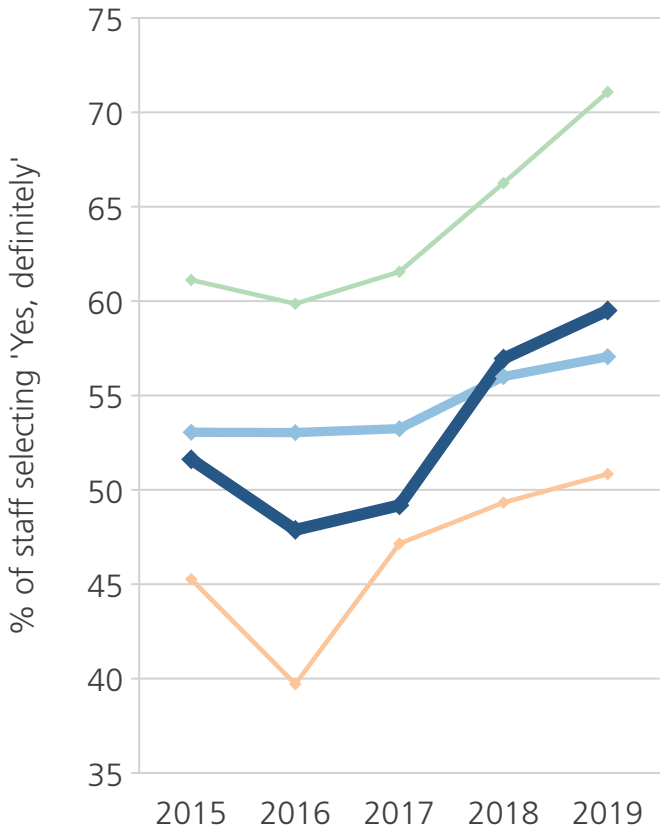
	2015	2016	2017	2018	2019
Best	75.4%	75.7%	77.7%	81.2%	83.2%
Your org	67.7%	69.8%	68.6%	69.4%	73.9%
Average	69.8%	70.7%	71.7%	71.7%	74.4%
Worst	63.9%	67.4%	67.8%	65.5%	68.7%

Q8g
My immediate manager values my work



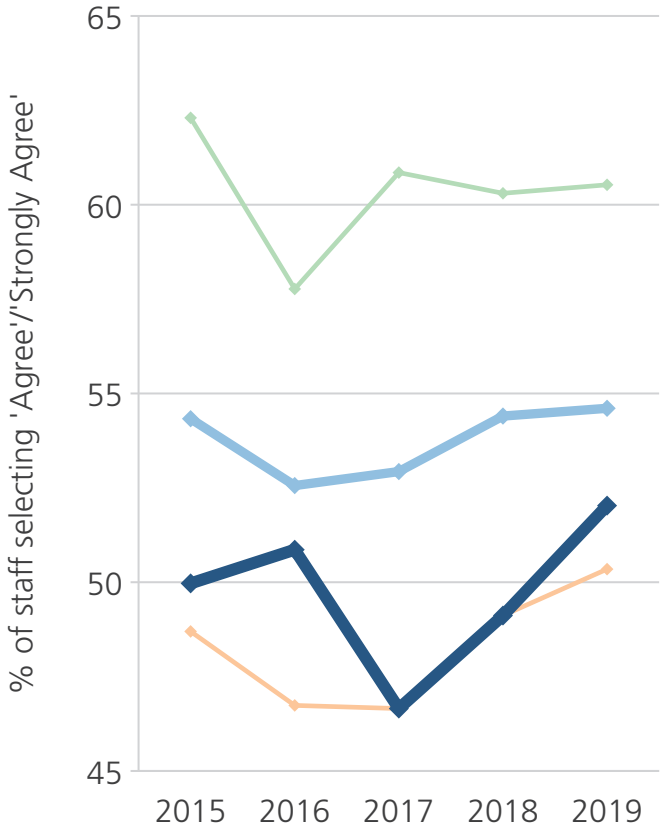
	2015	2016	2017	2018	2019
Best	79.5%	78.7%	81.0%	83.8%	82.2%
Your org	71.4%	72.6%	70.8%	75.4%	77.1%
Average	72.9%	72.6%	74.5%	74.7%	77.1%
Worst	68.1%	68.1%	69.6%	68.9%	71.7%

Q19g
My manager supported me to receive this training, learning or development



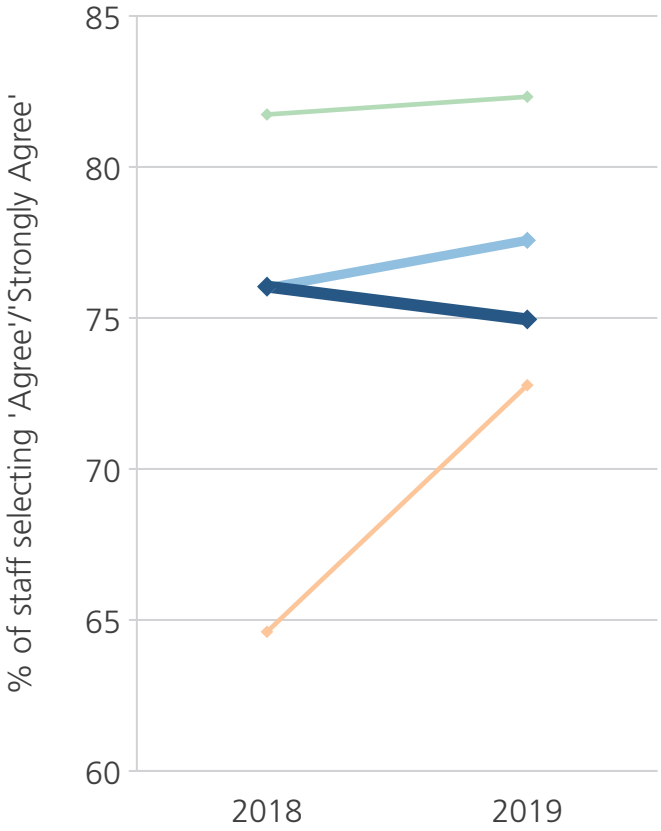
	2015	2016	2017	2018	2019
Best	61.1%	59.9%	61.6%	66.3%	71.1%
Your org	51.6%	47.9%	49.2%	57.0%	59.5%
Average	53.1%	53.0%	53.2%	56.0%	57.1%
Worst	45.3%	39.7%	47.1%	49.3%	50.8%

Q4c
I am involved in deciding on changes introduced that affect my work area / team / department



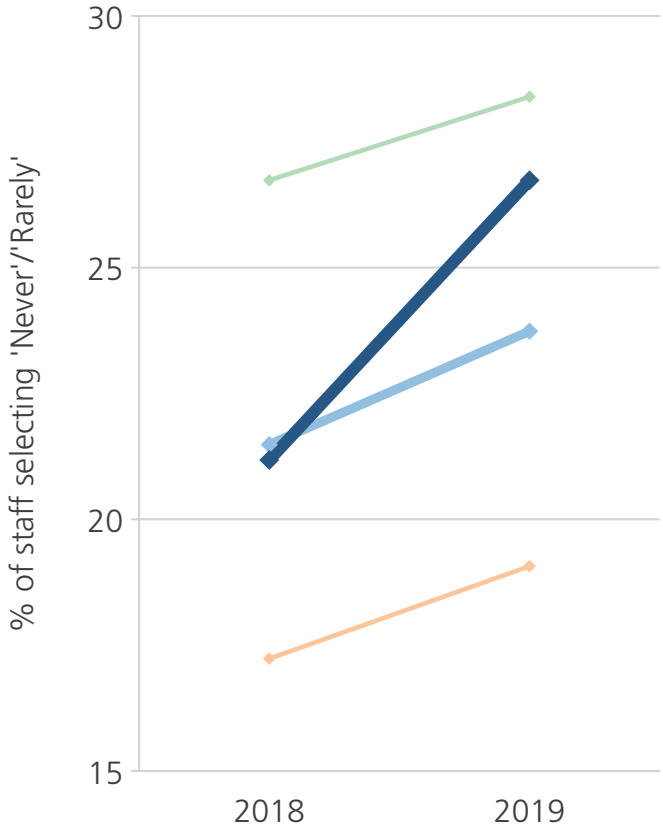
	2015	2016	2017	2018	2019
Best	62.3%	57.8%	60.9%	60.3%	60.5%
Your org	50.0%	50.9%	46.7%	49.1%	52.0%
Average	54.3%	52.6%	52.9%	54.4%	54.6%
Worst	48.7%	46.7%	46.7%	49.1%	50.3%

Q4j
I receive the respect I deserve from my colleagues at work



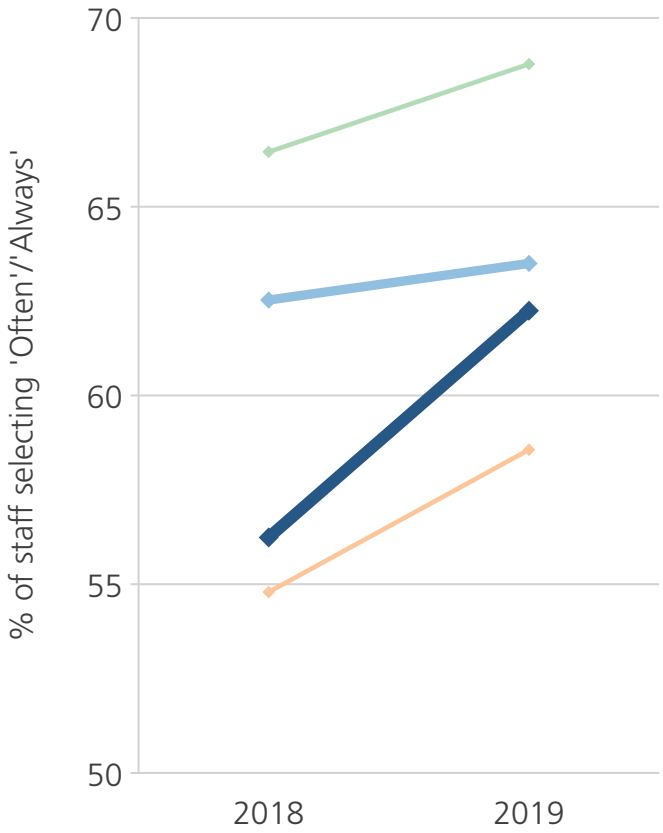
	2018	2019
Best	81.7%	82.3%
Your org	76.0%	75.0%
Average	76.0%	77.6%
Worst	64.6%	72.8%

Q6a
I have unrealistic time pressures



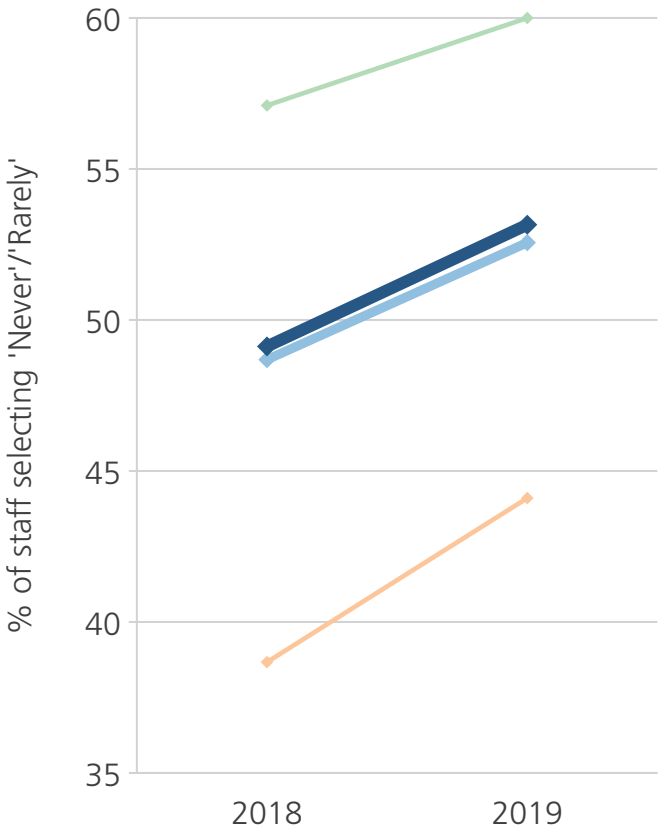
	2018	2019
Best	26.7%	28.4%
Your org	21.2%	26.7%
Average	21.5%	23.7%
Worst	17.2%	19.1%

Q6b
I have a choice in deciding how to do my work



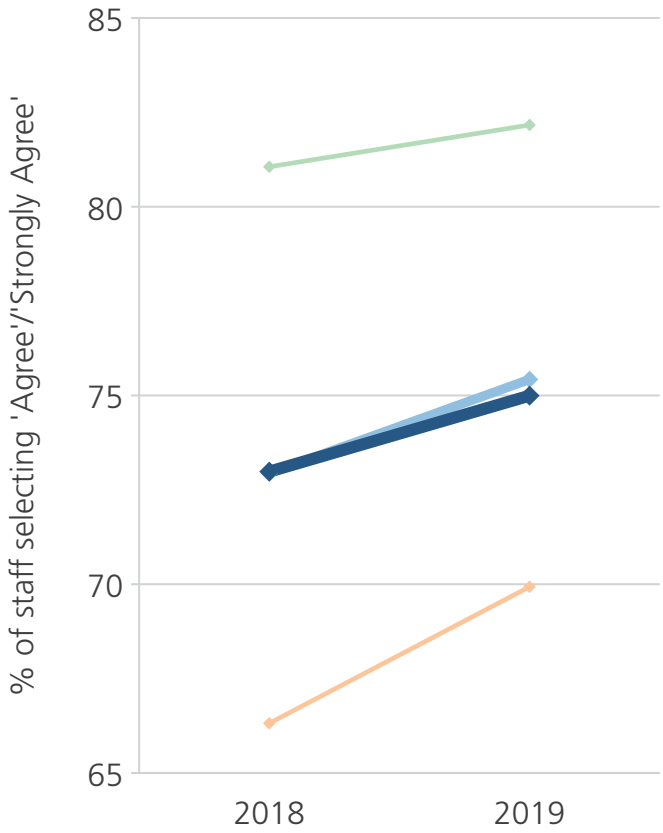
Best	66.5%	68.8%
Your org	56.2%	62.2%
Average	62.5%	63.5%
Worst	54.8%	58.6%

Q6c
Relationships at work are strained



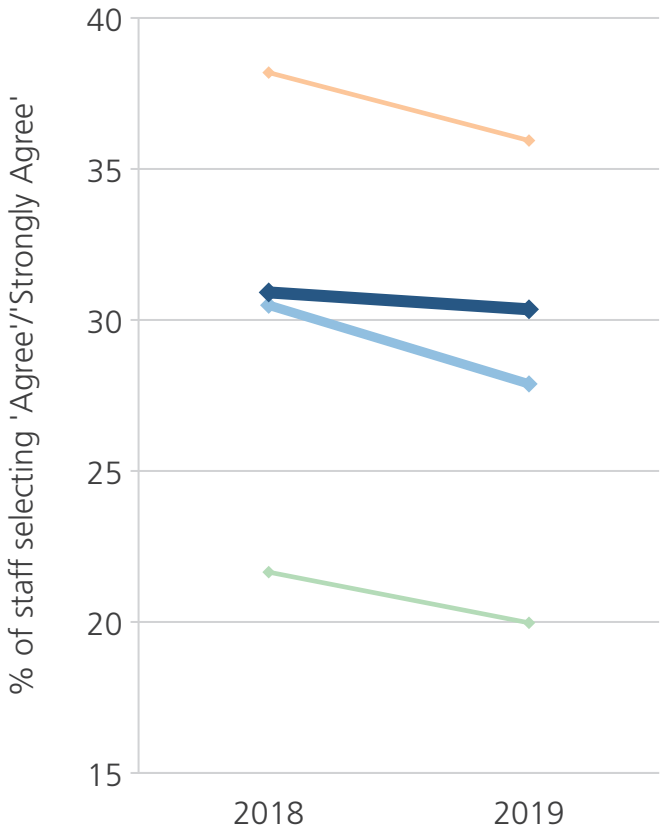
Best	57.1%	60.0%
Your org	49.1%	53.2%
Average	48.7%	52.6%
Worst	38.7%	44.1%

Q8a
My immediate manager encourages me at work



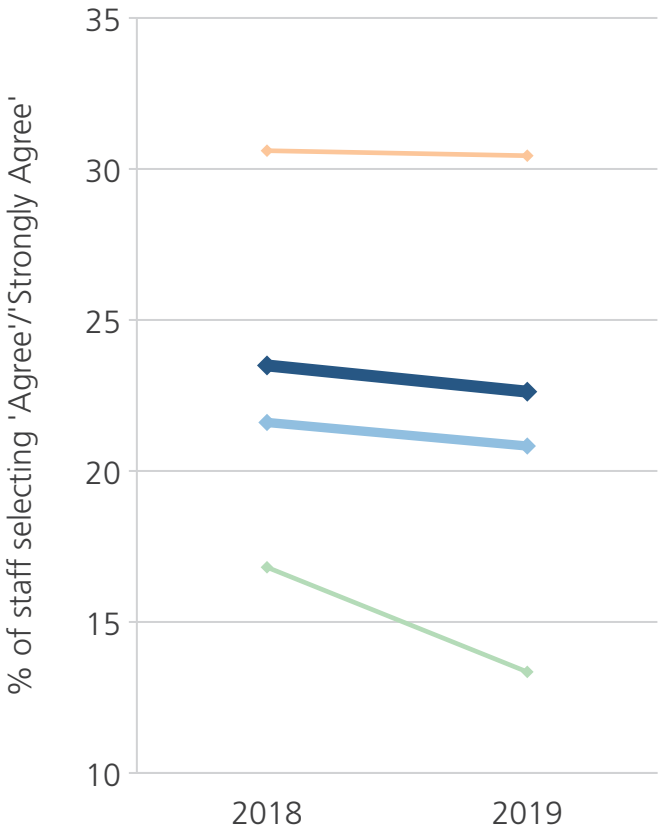
Best	81.1%	82.2%
Your org	73.0%	75.0%
Average	72.9%	75.4%
Worst	66.3%	69.9%

Q23a
I often think about leaving this organisation



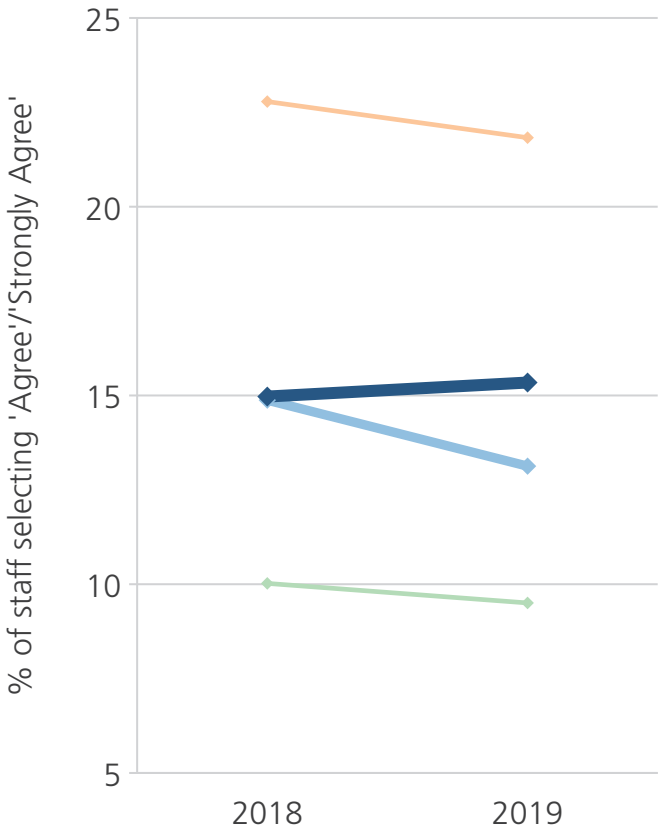
	2018	2019
Worst	38.2%	35.9%
Your org	30.9%	30.4%
Average	30.5%	27.9%
Best	21.7%	20.0%

Q23b
I will probably look for a job at a new organisation in the next 12 months



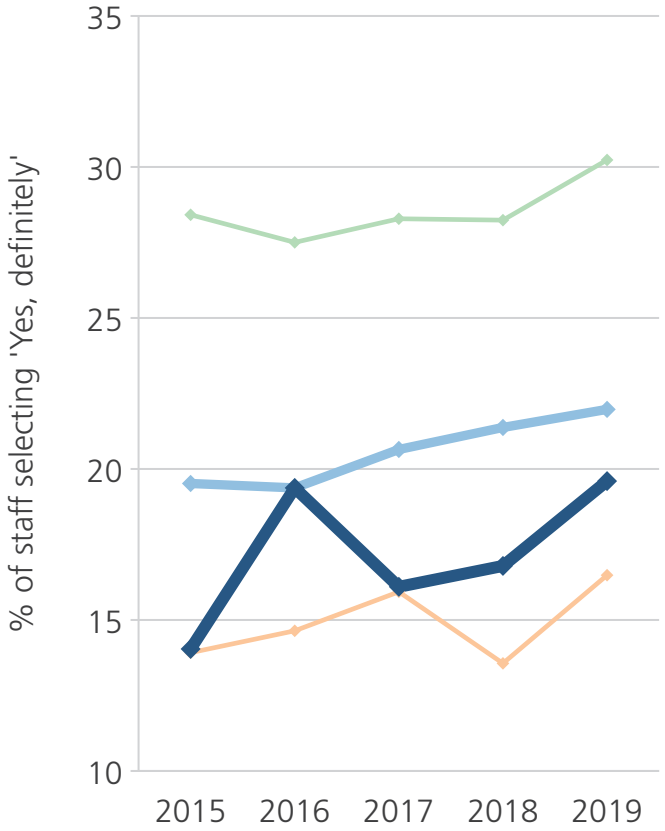
	2018	2019
Worst	30.6%	30.4%
Your org	23.5%	22.6%
Average	21.6%	20.8%
Best	16.8%	13.3%

Q23c
As soon as I can find another job, I will leave this organisation



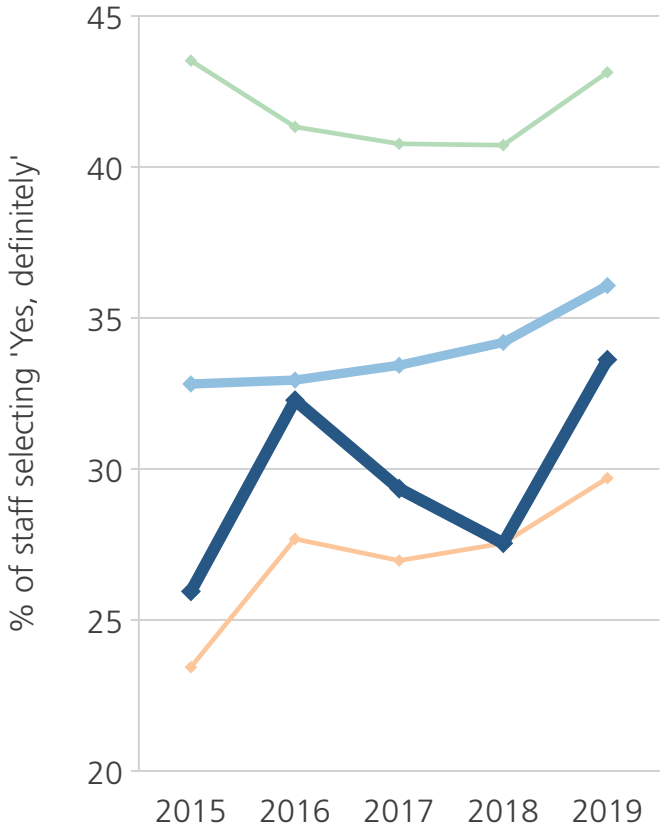
	2018	2019
Worst	22.8%	21.8%
Your org	15.0%	15.3%
Average	14.9%	13.1%
Best	10.0%	9.5%

Q19b
It helped me to improve how I do my job



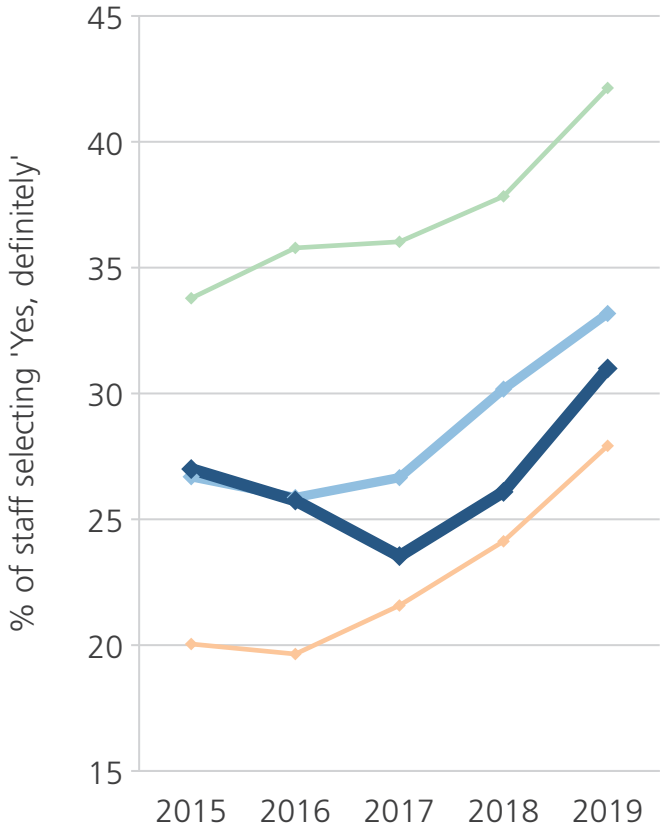
	2015	2016	2017	2018	2019
Best	28.4%	27.5%	28.3%	28.2%	30.2%
Your org	14.0%	19.4%	16.1%	16.8%	19.6%
Average	19.5%	19.4%	20.6%	21.4%	22.0%
Worst	13.9%	14.6%	15.9%	13.6%	16.5%

Q19c
It helped me agree clear objectives for my work



	2015	2016	2017	2018	2019
Best	43.5%	41.3%	40.8%	40.7%	43.1%
Your org	25.9%	32.3%	29.3%	27.5%	33.6%
Average	32.8%	32.9%	33.4%	34.2%	36.1%
Worst	23.4%	27.7%	27.0%	27.5%	29.7%

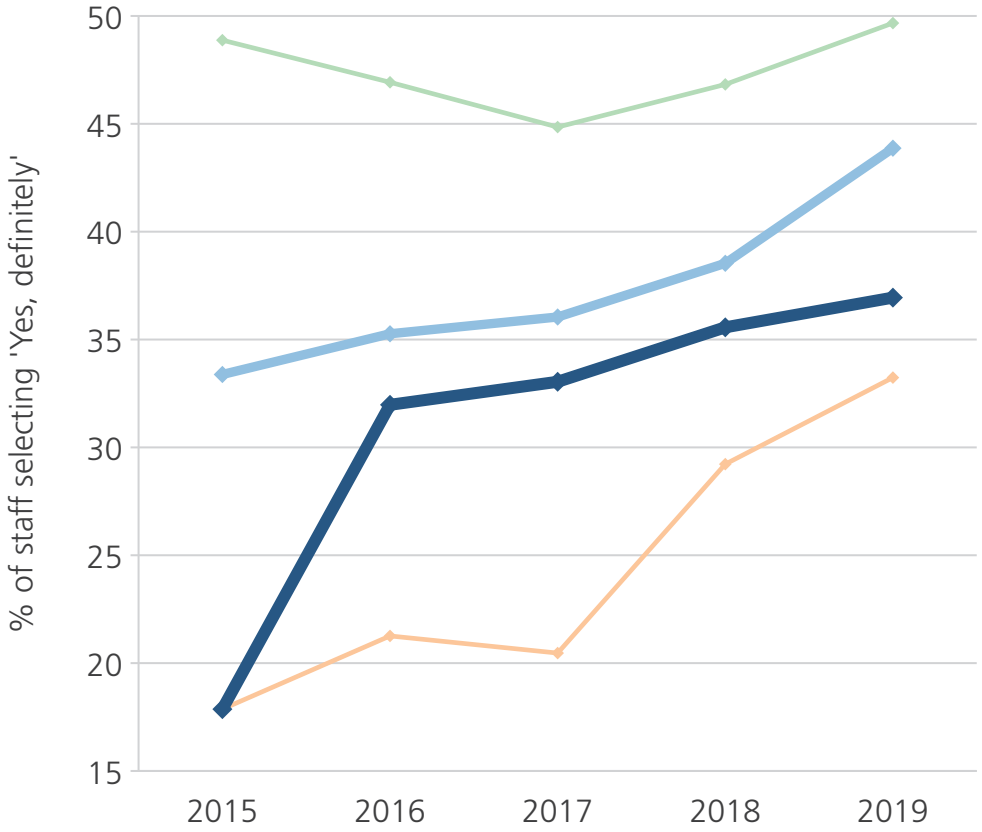
Q19d
It left me feeling that my work is valued by my organisation



	2015	2016	2017	2018	2019
Best	33.8%	35.8%	36.0%	37.8%	42.1%
Your org	27.0%	25.7%	23.5%	26.1%	31.0%
Average	26.7%	25.9%	26.7%	30.2%	33.2%
Worst	20.0%	19.6%	21.6%	24.1%	27.9%

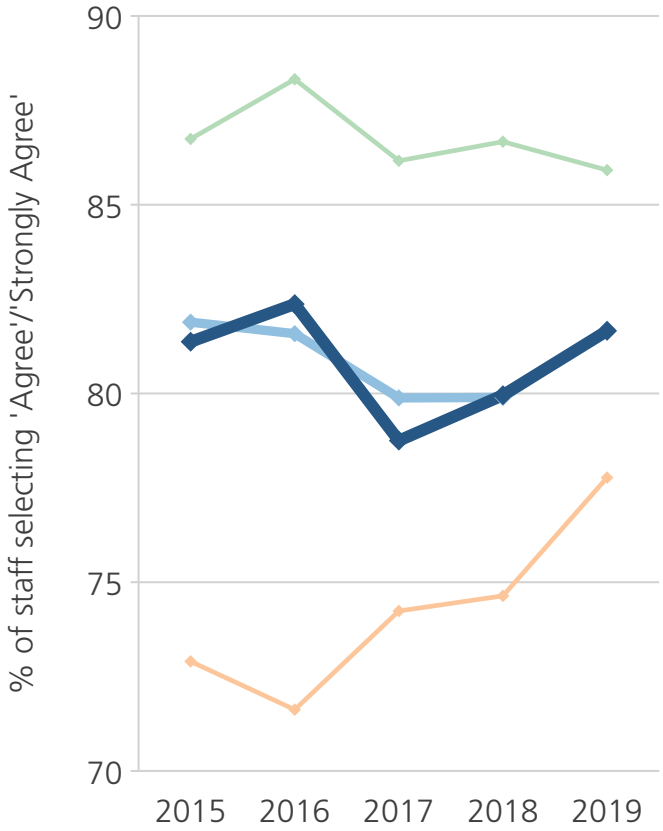
Q19e

The values of my organisation were discussed as part of the appraisal process



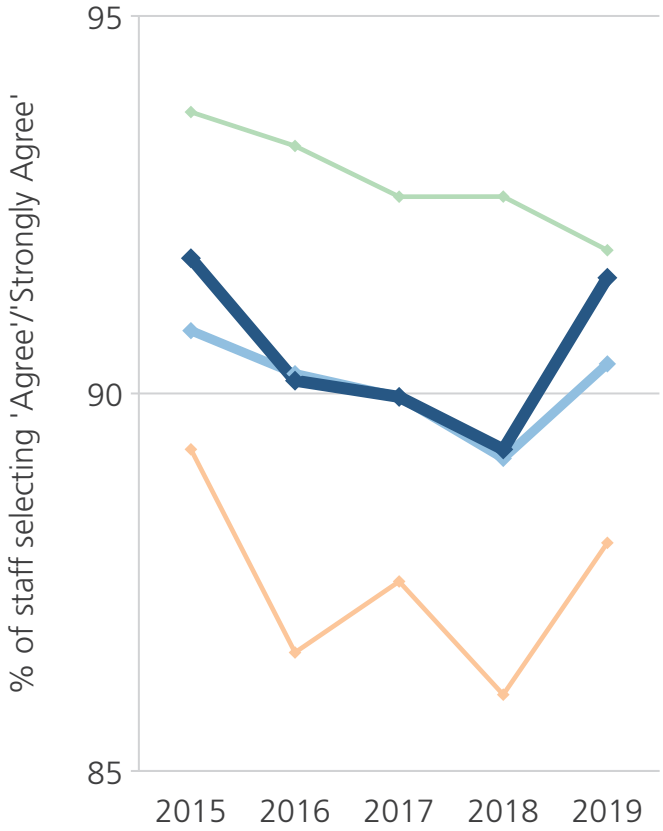
	2015	2016	2017	2018	2019
Best	48.9%	46.9%	44.8%	46.8%	49.7%
Your org	17.9%	32.0%	33.0%	35.6%	36.9%
Average	33.4%	35.3%	36.0%	38.5%	43.9%
Worst	17.9%	21.3%	20.5%	29.2%	33.2%

Q7a
I am satisfied with the quality of care I give to patients / service users



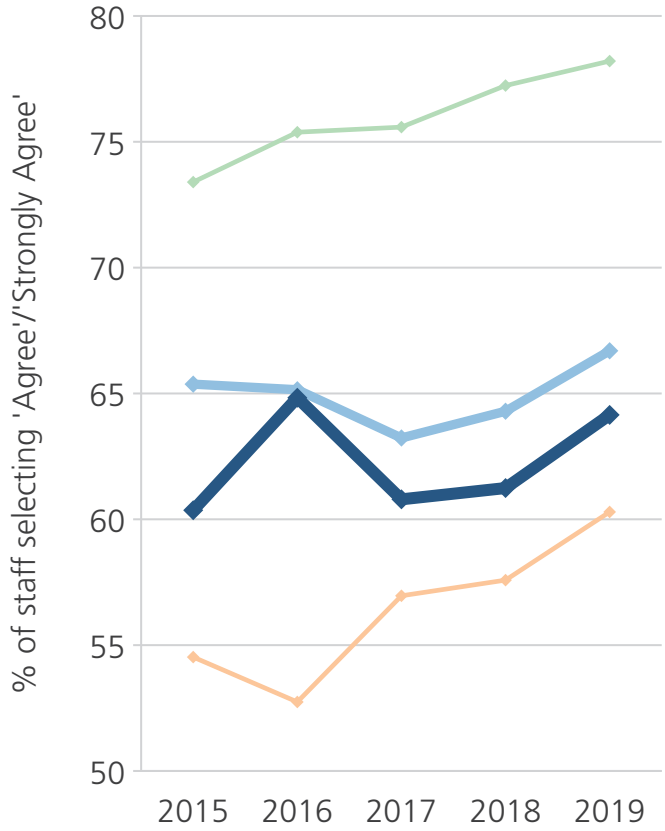
	2015	2016	2017	2018	2019
Best	86.7%	88.3%	86.2%	86.7%	85.9%
Your org	81.4%	82.4%	78.8%	80.0%	81.7%
Average	81.9%	81.6%	79.9%	79.9%	81.7%
Worst	72.9%	71.6%	74.2%	74.6%	77.8%

Q7b
I feel that my role makes a difference to patients / service users



	2015	2016	2017	2018	2019
Best	93.7%	93.3%	92.6%	92.6%	91.9%
Your org	91.8%	90.2%	90.0%	89.3%	91.5%
Average	90.8%	90.3%	90.0%	89.1%	90.4%
Worst	89.3%	86.6%	87.5%	86.0%	88.0%

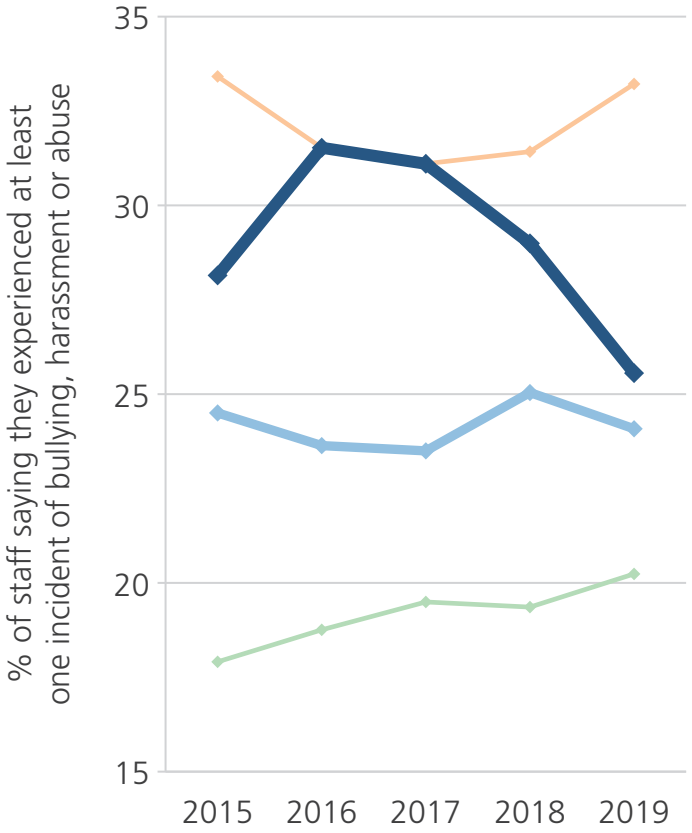
Q7c
I am able to deliver the care I aspire to



	2015	2016	2017	2018	2019
Best	73.4%	75.4%	75.6%	77.2%	78.2%
Your org	60.4%	64.8%	60.8%	61.2%	64.1%
Average	65.4%	65.1%	63.2%	64.3%	66.7%
Worst	54.5%	52.7%	57.0%	57.6%	60.3%

Q13a

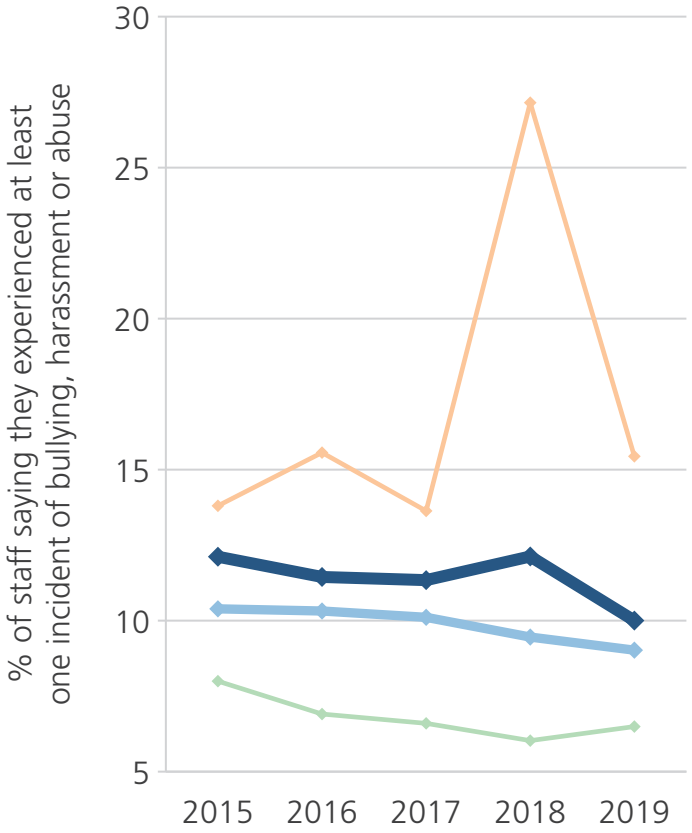
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public?



	2015	2016	2017	2018	2019
Worst	33.4%	31.5%	31.1%	31.4%	33.2%
Your org	28.1%	31.5%	31.1%	29.0%	25.6%
Average	24.5%	23.6%	23.5%	25.0%	24.1%
Best	17.9%	18.8%	19.5%	19.4%	20.2%

Q13b

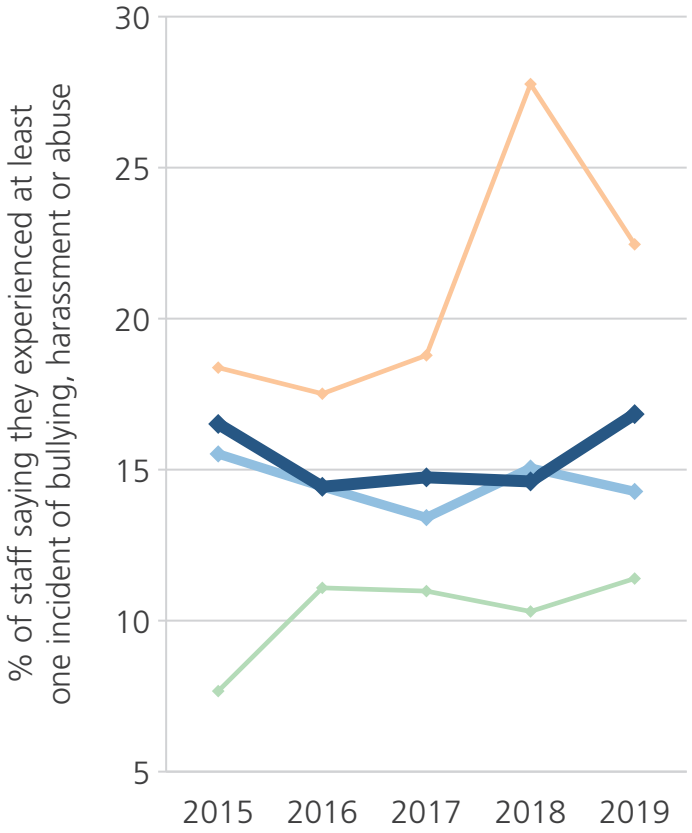
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from managers?



	2015	2016	2017	2018	2019
Worst	13.8%	15.6%	13.6%	27.2%	15.4%
Your org	12.1%	11.4%	11.3%	12.1%	10.0%
Average	10.4%	10.3%	10.1%	9.5%	9.0%
Best	8.0%	6.9%	6.6%	6.0%	6.5%

Q13c

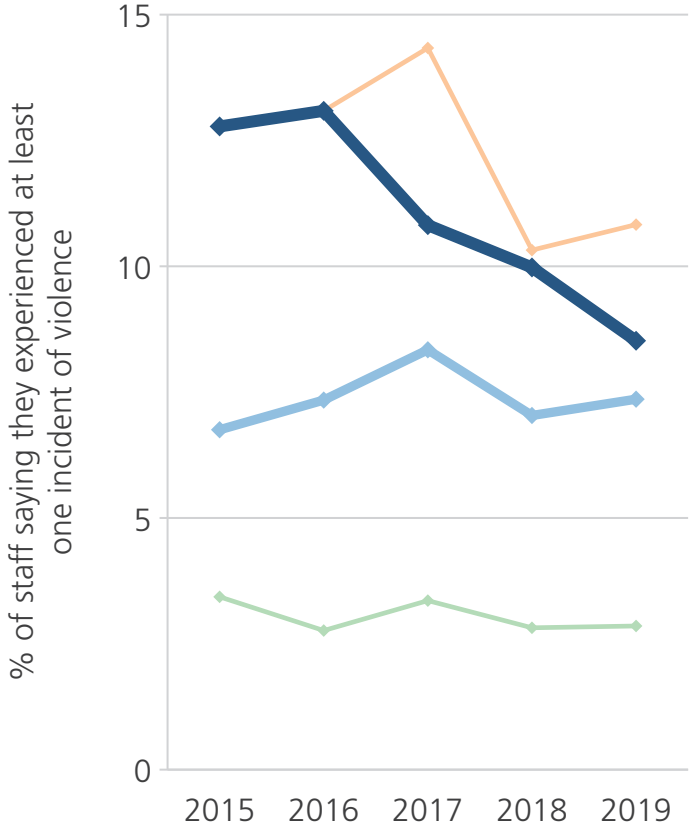
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from other colleagues?



	2015	2016	2017	2018	2019
Worst	18.4%	17.5%	18.8%	27.8%	22.5%
Your org	16.5%	14.4%	14.7%	14.6%	16.8%
Average	15.5%	14.4%	13.4%	15.1%	14.3%
Best	7.7%	11.1%	11.0%	10.3%	11.4%

Q12a

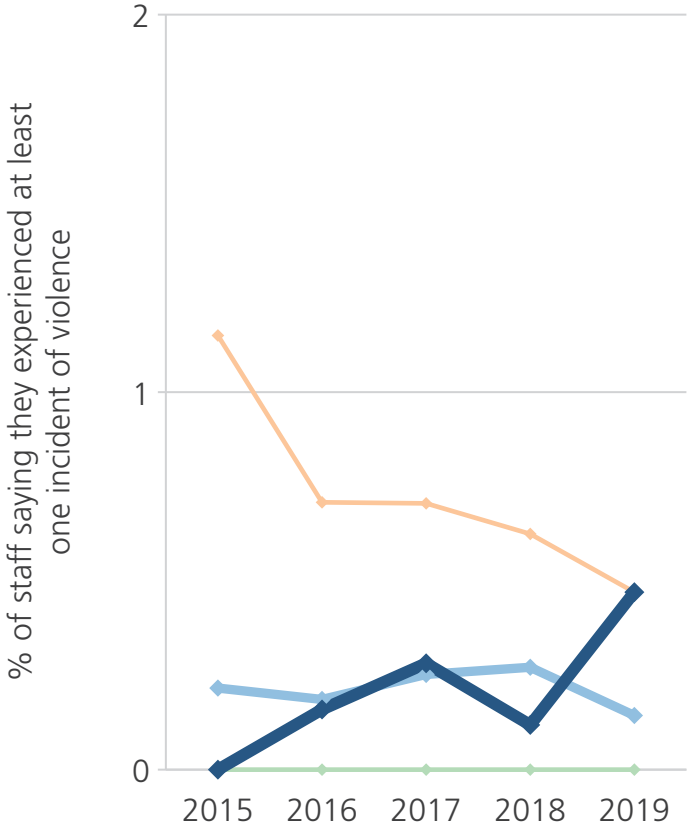
In the last 12 months how many times have you personally experienced physical violence at work from patients / service users, their relatives or other members of the public?



	2015	2016	2017	2018	2019
Worst	12.8%	13.1%	14.3%	10.3%	10.8%
Your org	12.8%	13.1%	10.8%	10.0%	8.5%
Average	6.8%	7.3%	8.3%	7.0%	7.4%
Best	3.4%	2.8%	3.4%	2.8%	2.9%

Q12b

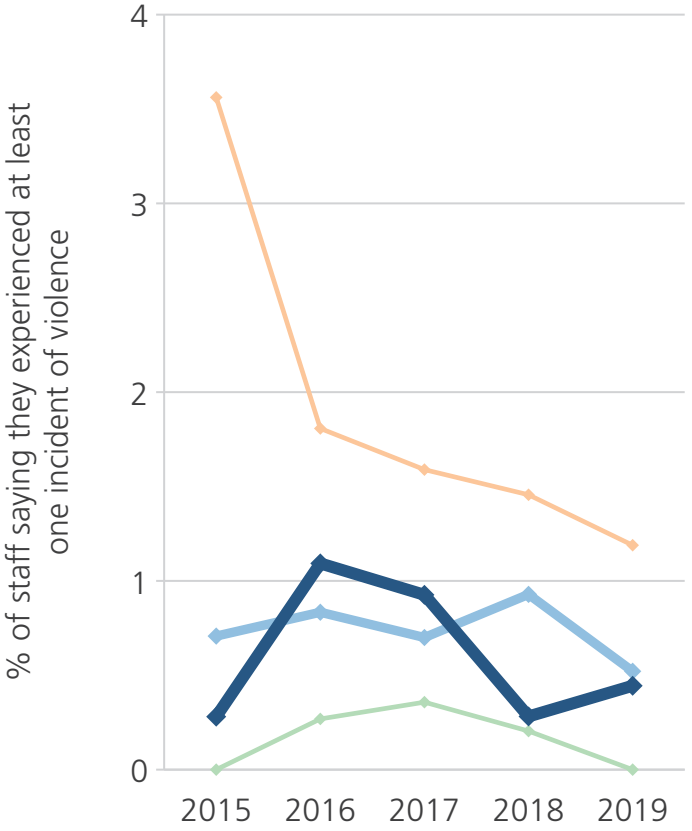
In the last 12 months how many times have you personally experienced physical violence at work from managers?



	2015	2016	2017	2018	2019
Worst	1.2%	0.7%	0.7%	0.6%	0.5%
Your org	0.0%	0.2%	0.3%	0.1%	0.5%
Average	0.2%	0.2%	0.3%	0.3%	0.1%
Best	0.0%	0.0%	0.0%	0.0%	0.0%

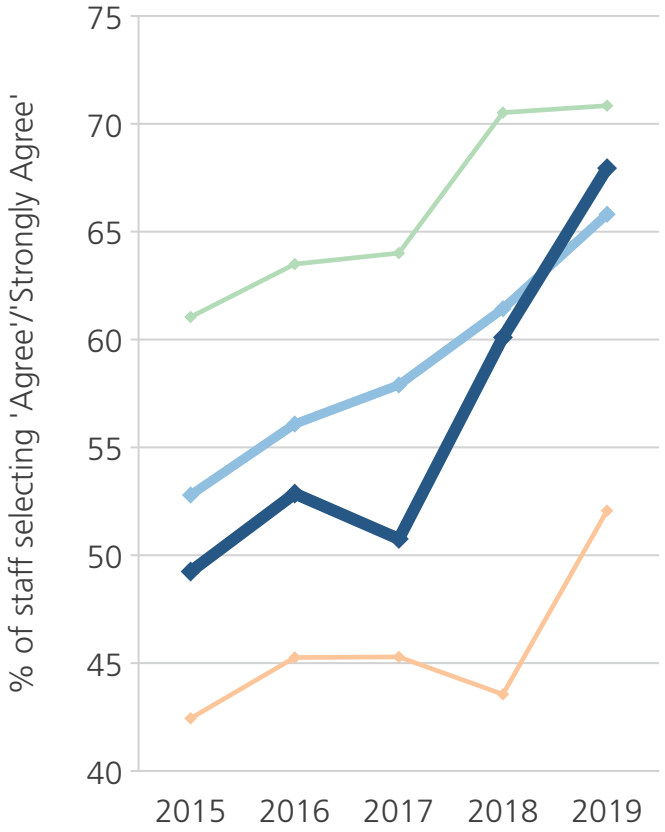
Q12c

In the last 12 months how many times have you personally experienced physical violence at work from other colleagues?



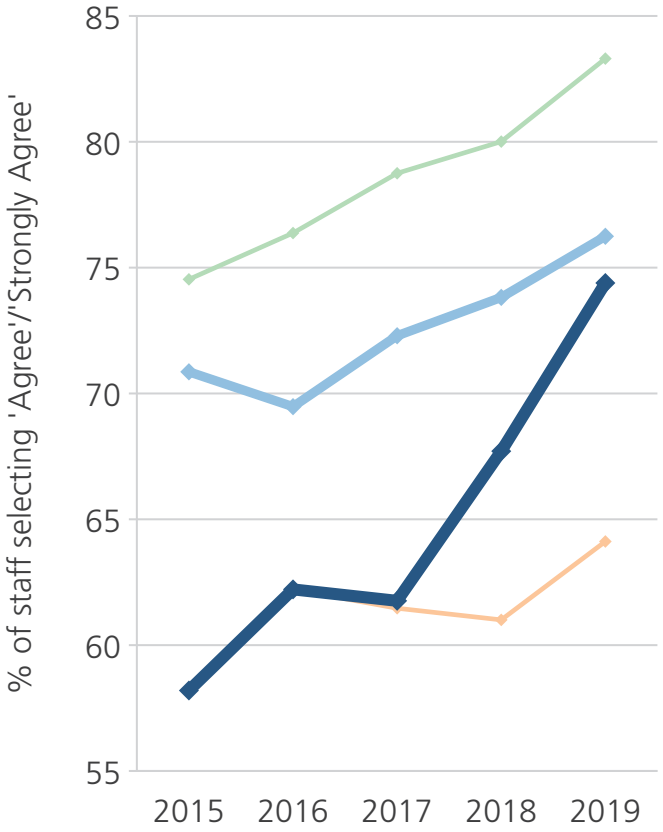
	2015	2016	2017	2018	2019
Worst	3.6%	1.8%	1.6%	1.5%	1.2%
Your org	0.3%	1.1%	0.9%	0.3%	0.4%
Average	0.7%	0.8%	0.7%	0.9%	0.5%
Best	0.0%	0.3%	0.4%	0.2%	0.0%

Q17a
My organisation treats staff who are involved in an error, near miss or incident fairly



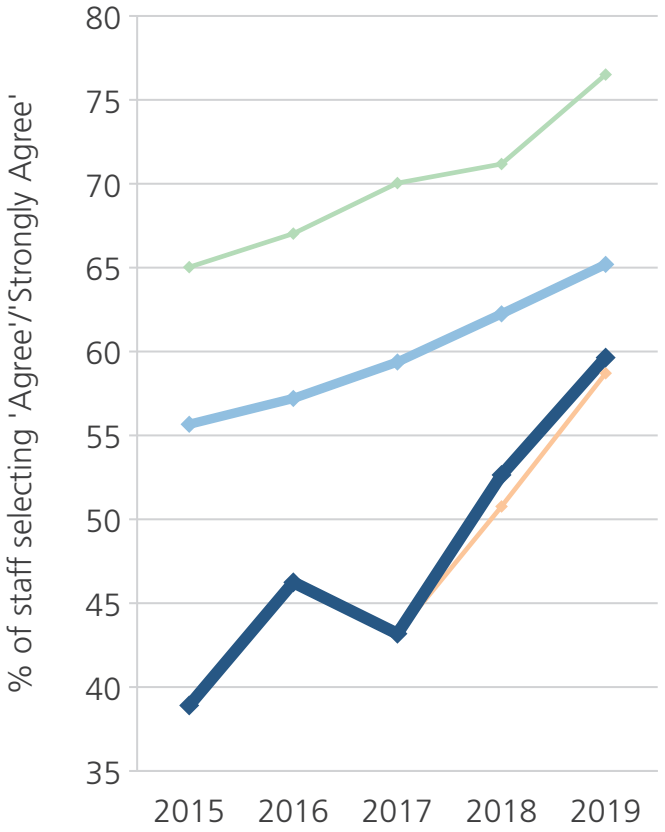
	2015	2016	2017	2018	2019
Best	61.0%	63.5%	64.0%	70.5%	70.8%
Your org	49.2%	52.9%	50.8%	60.1%	67.9%
Average	52.8%	56.1%	57.9%	61.4%	65.8%
Worst	42.4%	45.3%	45.3%	43.6%	52.1%

Q17c
When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again



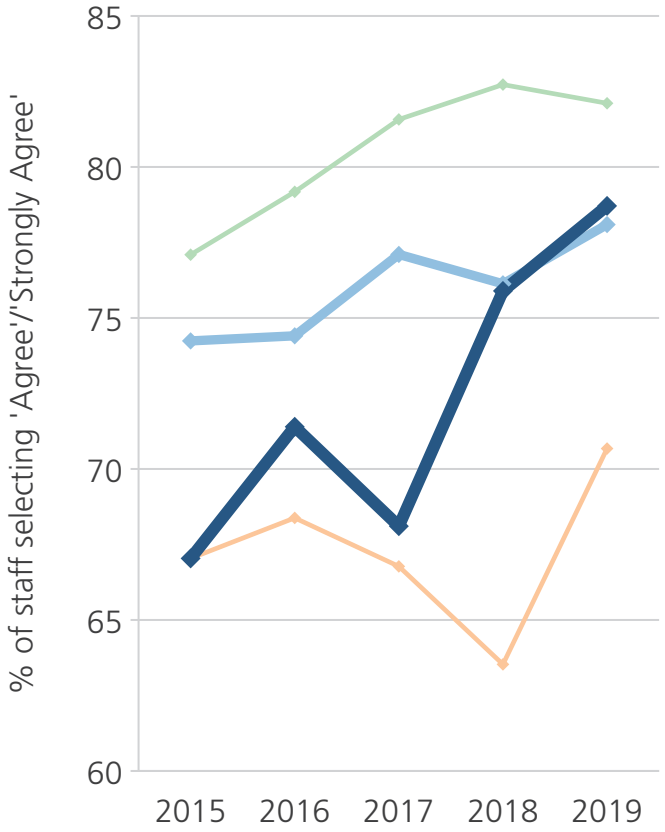
	2015	2016	2017	2018	2019
Best	74.5%	76.4%	78.7%	80.0%	83.3%
Your org	58.2%	62.2%	61.8%	67.7%	74.4%
Average	70.9%	69.5%	72.3%	73.8%	76.2%
Worst	58.2%	62.2%	61.5%	61.0%	64.1%

Q17d
We are given feedback about changes made in response to reported errors, near misses and incidents



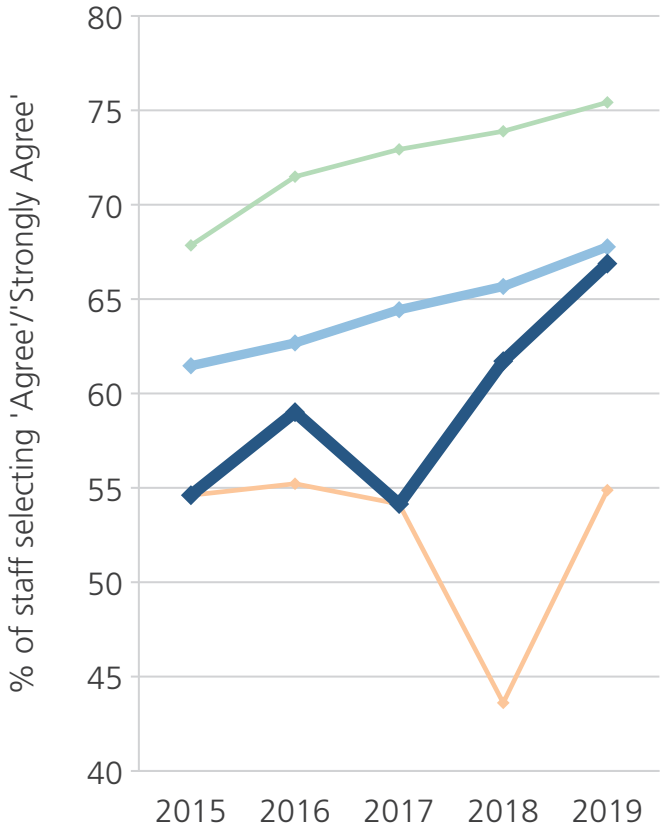
	2015	2016	2017	2018	2019
Best	65.0%	67.0%	70.0%	71.2%	76.5%
Your org	38.9%	46.2%	43.2%	52.6%	59.6%
Average	55.7%	57.2%	59.4%	62.2%	65.2%
Worst	38.9%	46.2%	43.2%	50.8%	58.7%

Q18b
I would feel secure raising concerns about unsafe clinical practice



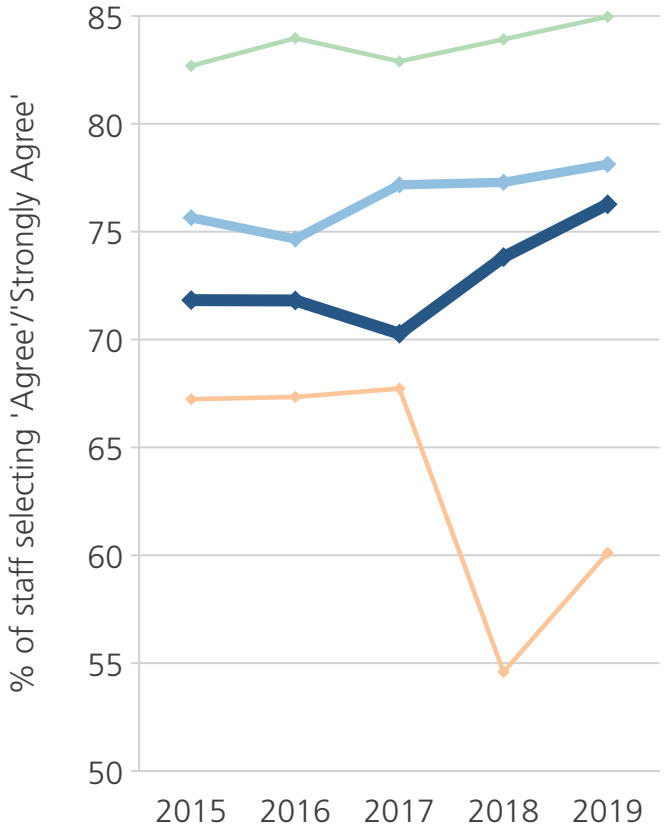
	2015	2016	2017	2018	2019
Best	77.1%	79.2%	81.6%	82.7%	82.1%
Your org	67.0%	71.4%	68.1%	75.9%	78.7%
Average	74.2%	74.4%	77.1%	76.1%	78.1%
Worst	67.0%	68.4%	66.8%	63.5%	70.7%

Q18c
I am confident that my organisation would address my concern



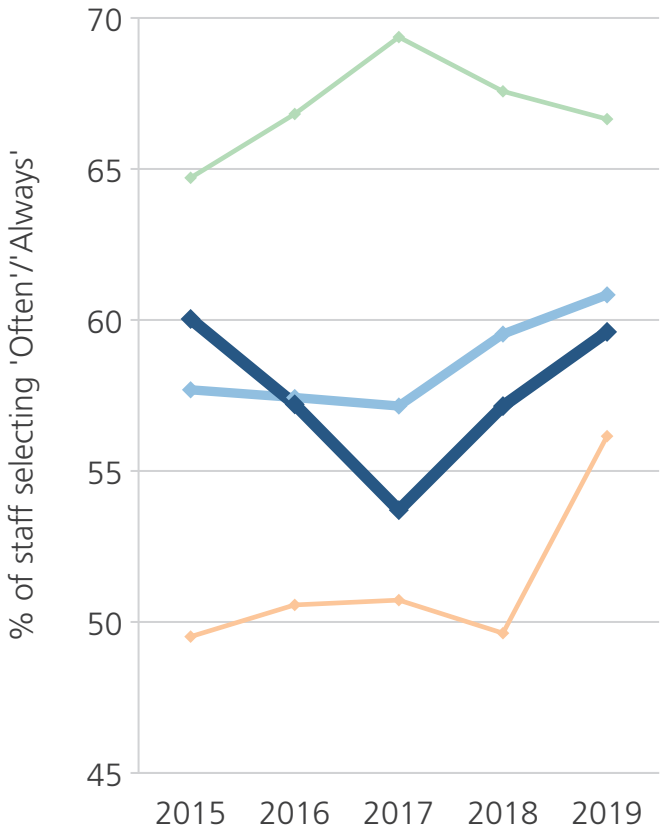
	2015	2016	2017	2018	2019
Best	67.8%	71.5%	72.9%	73.9%	75.4%
Your org	54.6%	59.0%	54.1%	61.7%	66.9%
Average	61.5%	62.7%	64.4%	65.7%	67.8%
Worst	54.6%	55.2%	54.1%	43.6%	54.9%

Q21b
My organisation acts on concerns raised by patients / service users



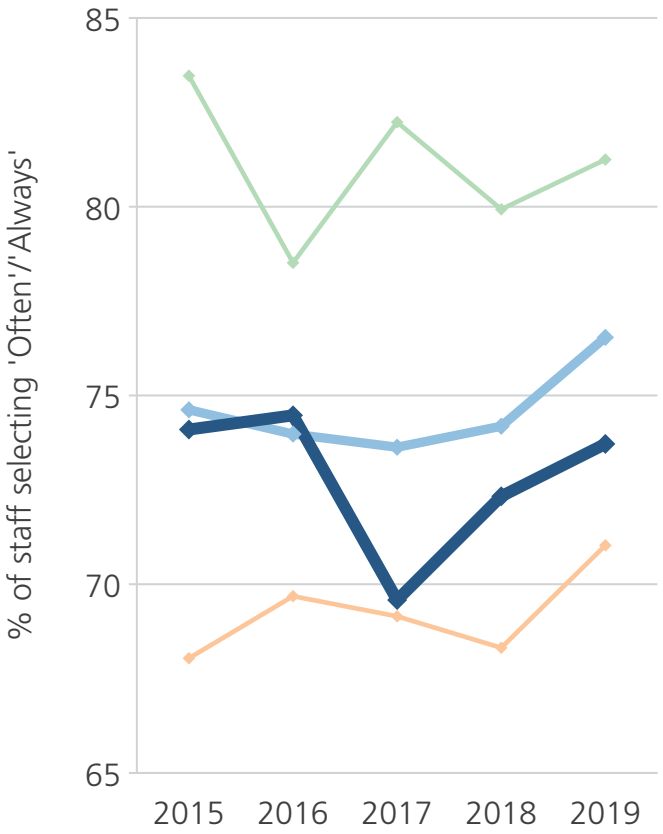
	2015	2016	2017	2018	2019
Best	82.7%	84.0%	82.9%	83.9%	85.0%
Your org	71.8%	71.8%	70.3%	73.8%	76.3%
Average	75.6%	74.7%	77.2%	77.3%	78.1%
Worst	67.2%	67.3%	67.7%	54.6%	60.1%

Q2a
I look forward to going to work



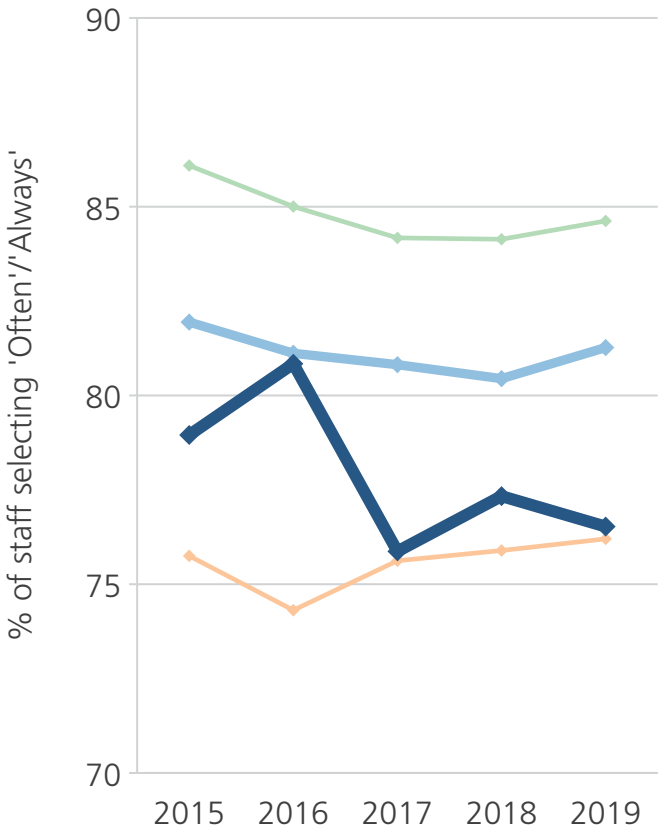
	2015	2016	2017	2018	2019
Best	64.7%	66.8%	69.4%	67.6%	66.7%
Your org	60.0%	57.2%	53.7%	57.1%	59.6%
Average	57.7%	57.4%	57.2%	59.5%	60.8%
Worst	49.5%	50.6%	50.7%	49.6%	56.2%

Q2b
I am enthusiastic about my job



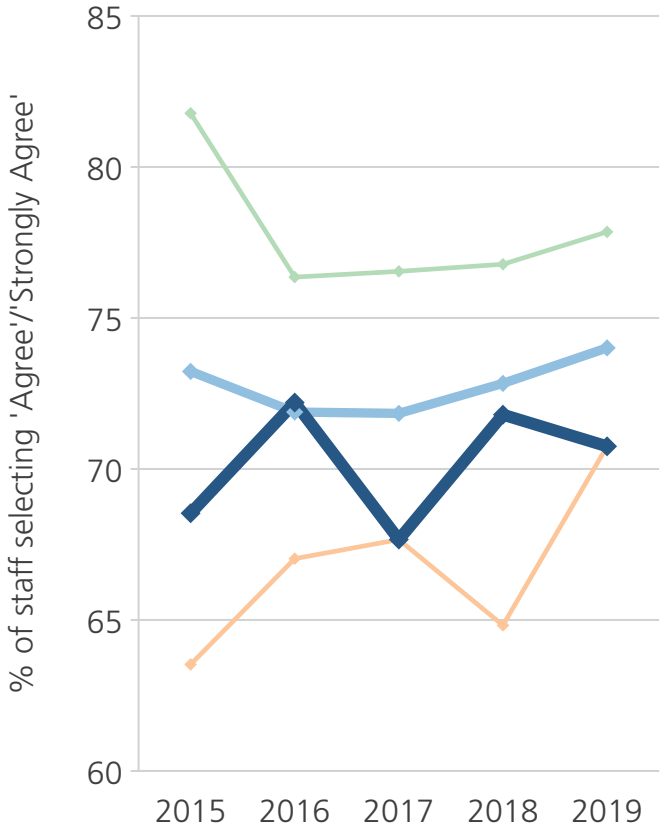
	2015	2016	2017	2018	2019
Best	83.5%	78.5%	82.2%	79.9%	81.2%
Your org	74.1%	74.5%	69.6%	72.3%	73.7%
Average	74.6%	74.0%	73.6%	74.2%	76.5%
Worst	68.0%	69.7%	69.1%	68.3%	71.0%

Q2c
Time passes quickly when I am working



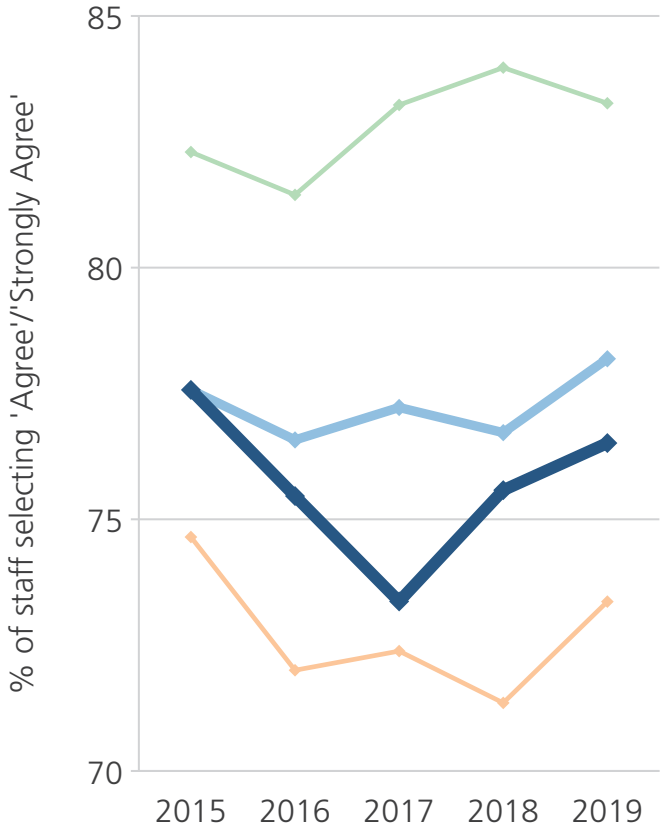
	2015	2016	2017	2018	2019
Best	86.1%	85.0%	84.2%	84.1%	84.6%
Your org	79.0%	80.8%	75.9%	77.3%	76.5%
Average	81.9%	81.1%	80.8%	80.4%	81.3%
Worst	75.8%	74.3%	75.6%	75.9%	76.2%

Q4a
There are frequent opportunities for me to show initiative in my role



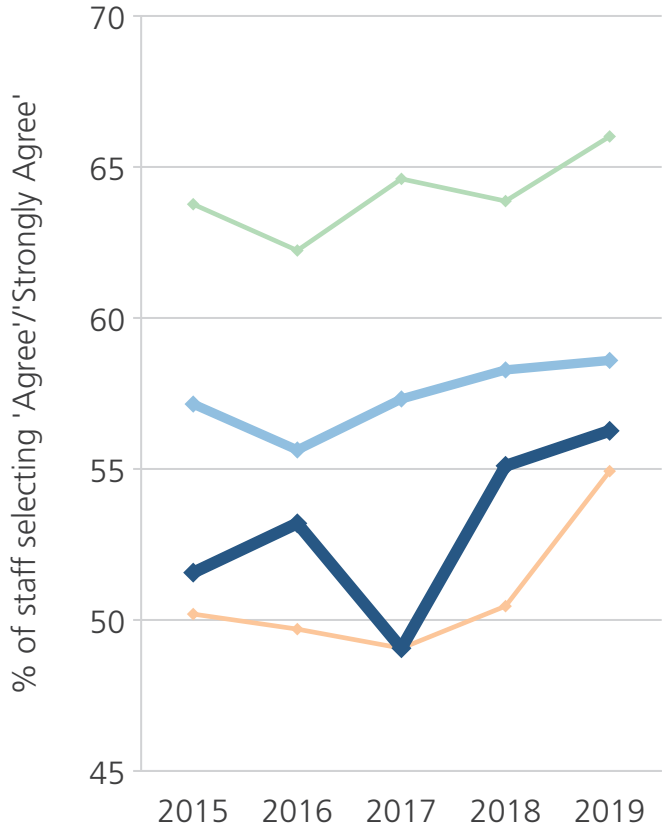
	2015	2016	2017	2018	2019
Best	81.8%	76.4%	76.5%	76.8%	77.9%
Your org	68.5%	72.2%	67.7%	71.8%	70.7%
Average	73.2%	71.9%	71.8%	72.8%	74.0%
Worst	63.5%	67.0%	67.7%	64.8%	70.7%

Q4b
I am able to make suggestions to improve the work of my team / department



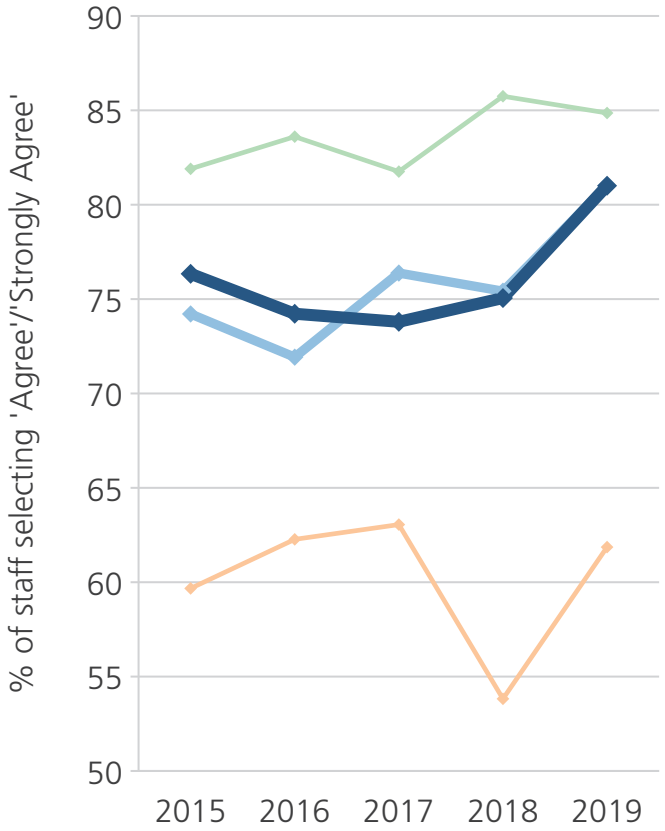
	2015	2016	2017	2018	2019
Best	82.3%	81.4%	83.2%	84.0%	83.3%
Your org	77.6%	75.5%	73.4%	75.6%	76.5%
Average	77.6%	76.6%	77.2%	76.7%	78.2%
Worst	74.6%	72.0%	72.4%	71.4%	73.4%

Q4d
I am able to make improvements happen in my area of work



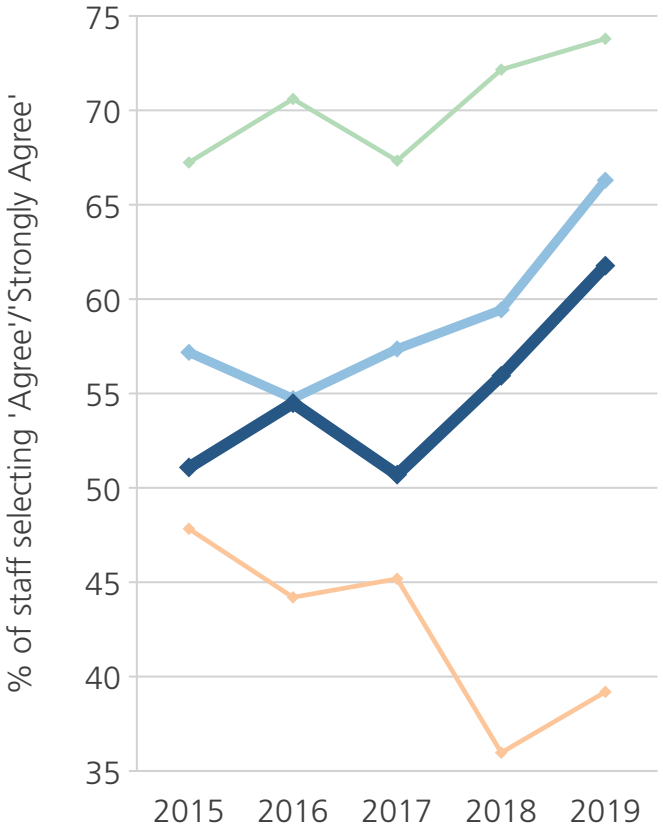
	2015	2016	2017	2018	2019
Best	63.8%	62.2%	64.6%	63.9%	66.0%
Your org	51.6%	53.2%	49.1%	55.1%	56.3%
Average	57.1%	55.6%	57.3%	58.3%	58.6%
Worst	50.2%	49.7%	49.1%	50.5%	54.9%

Q21a
Care of patients / service users is my organisation's top priority



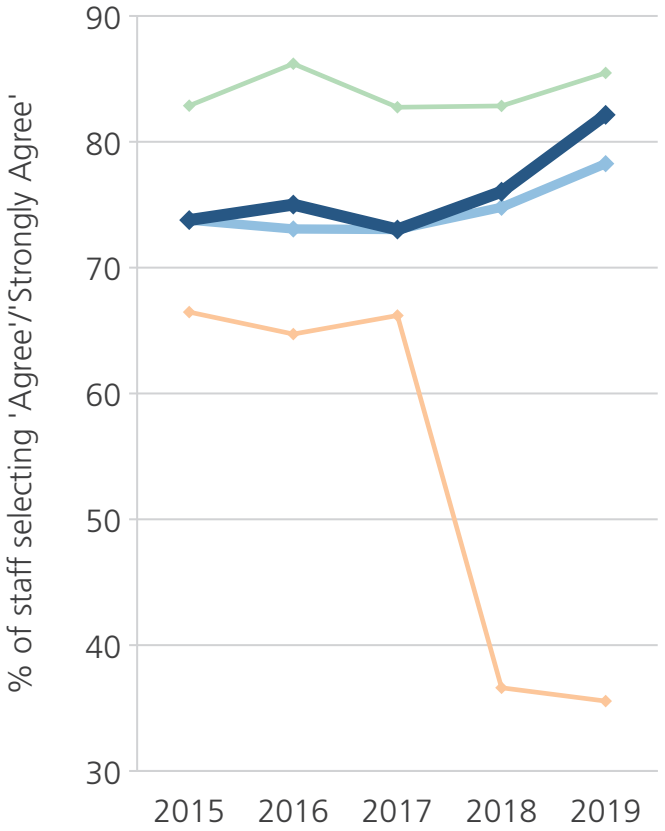
	2015	2016	2017	2018	2019
Best	81.9%	83.6%	81.8%	85.7%	84.9%
Your org	76.3%	74.2%	73.8%	75.1%	81.0%
Average	74.2%	71.9%	76.4%	75.4%	81.0%
Worst	59.7%	62.3%	63.1%	53.8%	61.9%

Q21c
I would recommend my organisation as a place to work



	2015	2016	2017	2018	2019
Best	67.2%	70.6%	67.3%	72.2%	73.8%
Your org	51.1%	54.5%	50.7%	55.9%	61.8%
Average	57.2%	54.7%	57.4%	59.4%	66.3%
Worst	47.8%	44.2%	45.2%	36.0%	39.2%

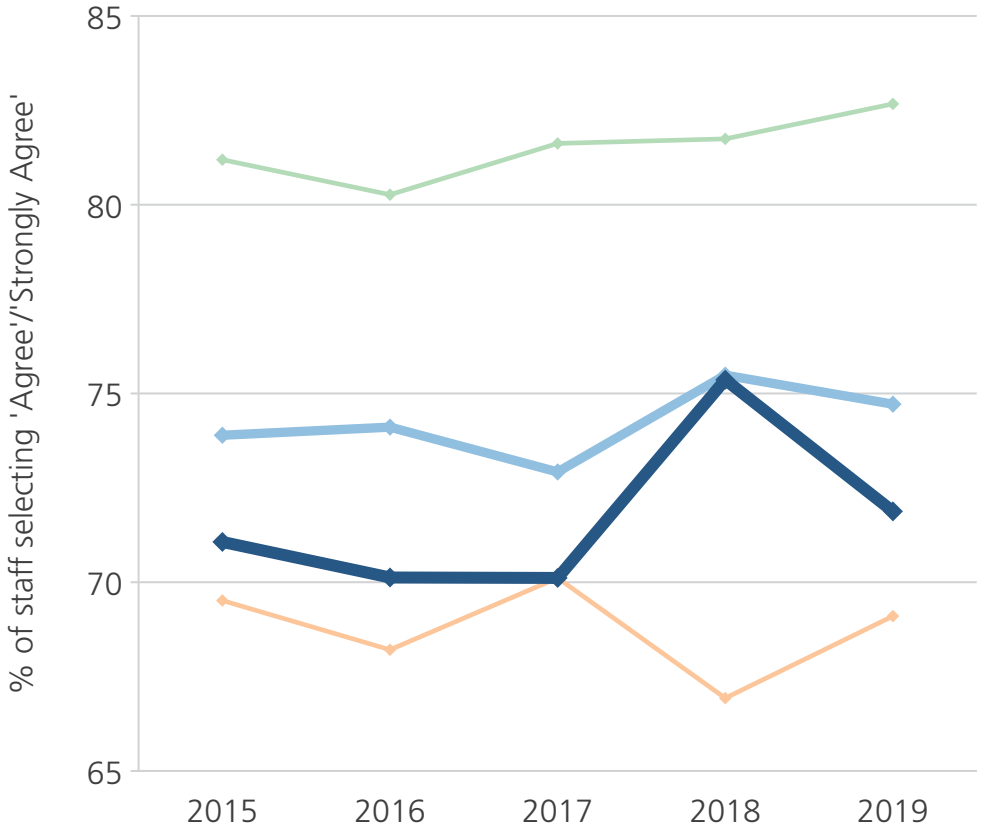
Q21d
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation



	2015	2016	2017	2018	2019
Best	82.9%	86.2%	82.7%	82.9%	85.5%
Your org	73.8%	75.0%	73.0%	76.0%	82.1%
Average	73.8%	73.1%	73.0%	74.8%	78.3%
Worst	66.5%	64.7%	66.2%	36.6%	35.6%

Q4h

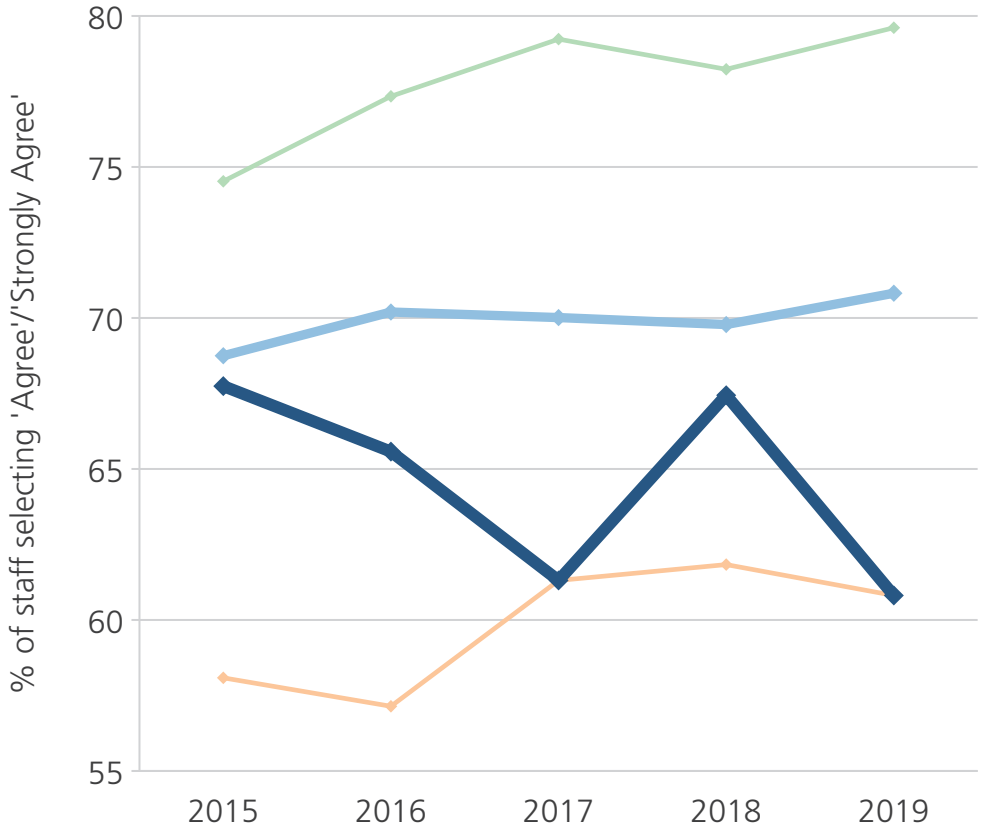
The team I work in has a set of shared objectives



	2015	2016	2017	2018	2019
Best	81.2%	80.3%	81.6%	81.7%	82.7%
Your org	71.1%	70.1%	70.1%	75.4%	71.9%
Average	73.9%	74.1%	72.9%	75.5%	74.7%
Worst	69.5%	68.2%	70.1%	66.9%	69.1%

Q4i

The team I work in often meets to discuss the team's effectiveness



	2015	2016	2017	2018	2019
Best	74.5%	77.3%	79.2%	78.2%	79.6%
Your org	67.7%	65.6%	61.3%	67.4%	60.8%
Average	68.7%	70.2%	70.0%	69.8%	70.8%
Worst	58.1%	57.1%	61.3%	61.8%	60.8%

Survey Coordination Centre

NHS England

Workforce Equality Standards

Gloucestershire Care Services NHS Trust

2019 NHS Staff Survey Results

Workforce Equality Standards

This section contains data required for the NHS Staff Survey indicators used in the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES). Data presented in this section are unweighted.

Full details of how the data are calculated are included in the Technical Document, available to download from our results website.

Workforce Race Equality Standard (WRES)

- This contains data for each organisation required for the NHS Staff Survey indicators used in the Workforce Race Equality Standard (WRES). It includes the 2017, 2018 and 2019 trust/CCG and benchmarking group median results for q13a, q13b&c combined, q14, and q15b split by ethnicity (by white / BME staff).

Workforce Disability Equality Standard (WDES)

- This contains data for each organisation required for the NHS Staff Survey indicators used in the Workforce Disability Equality Standard (WDES). It includes the 2018 and 2019 trust/CCG and benchmarking group median results for q5f, q11e, q13, and q14 split by disabled staff compared to non-disabled staff. It also shows results for q28b (for disabled staff only), and the staff engagement score for disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.

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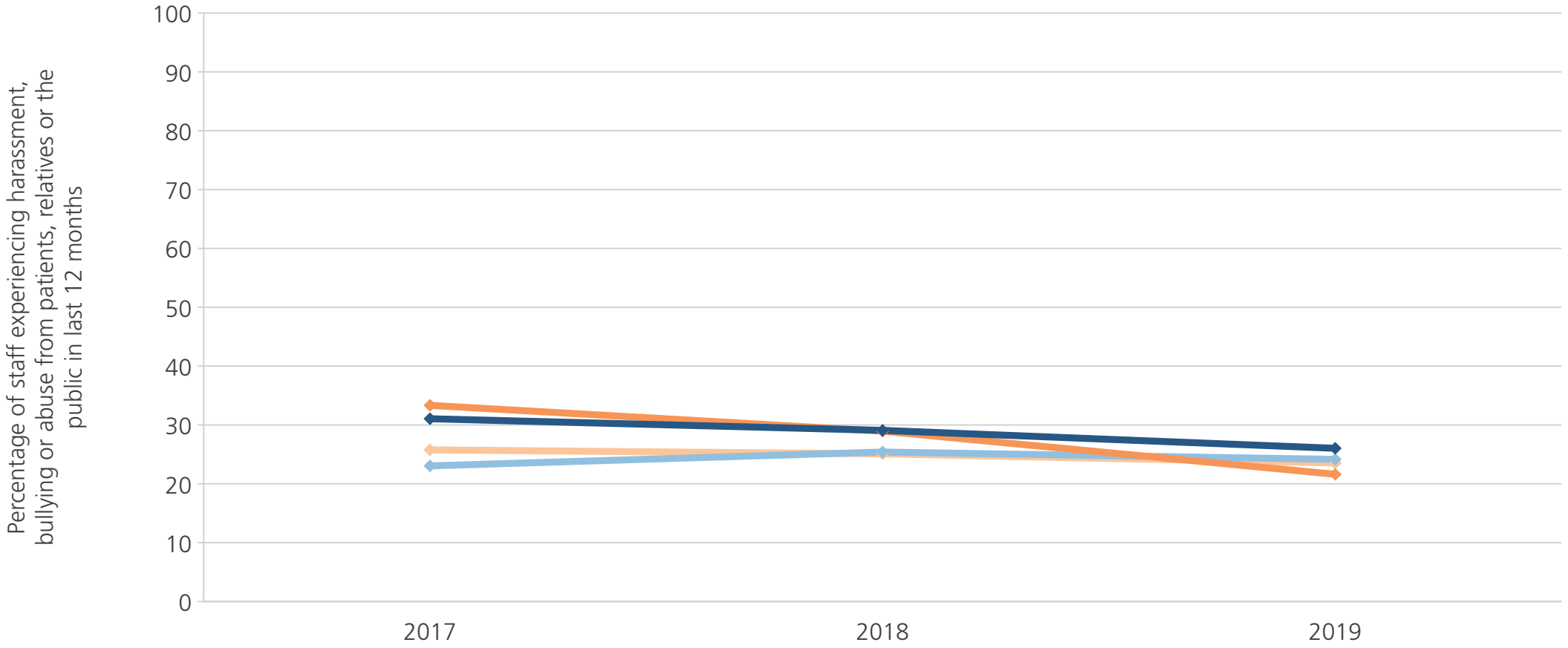
NHS England

Workforce Race Equality Standard (WRES)

Gloucestershire Care Services NHS Trust

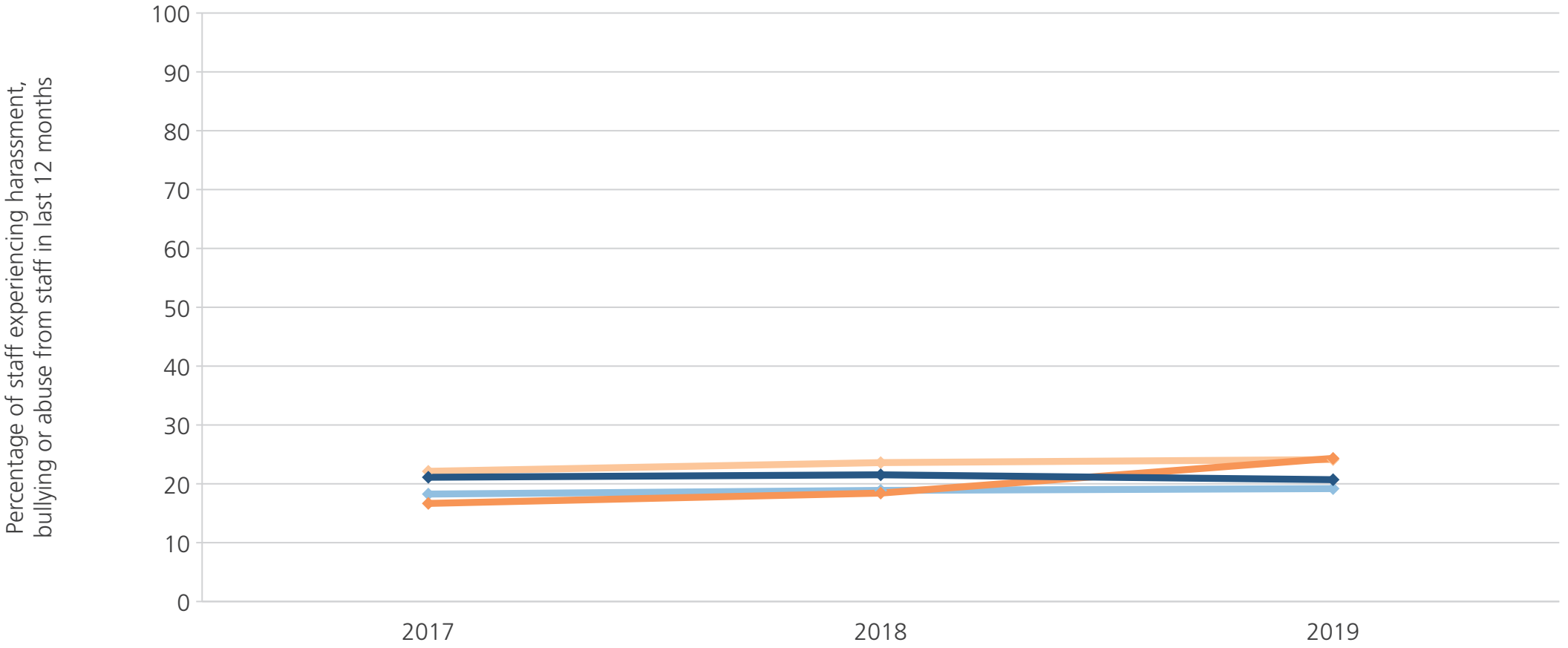
2019 NHS Staff Survey Results



	2017	2018	2019
White: Your org	31.1%	29.1%	26.0%
BME: Your org	33.3%	28.9%	21.6%
White: Average	23.0%	25.4%	24.2%
BME: Average	25.8%	25.1%	23.5%

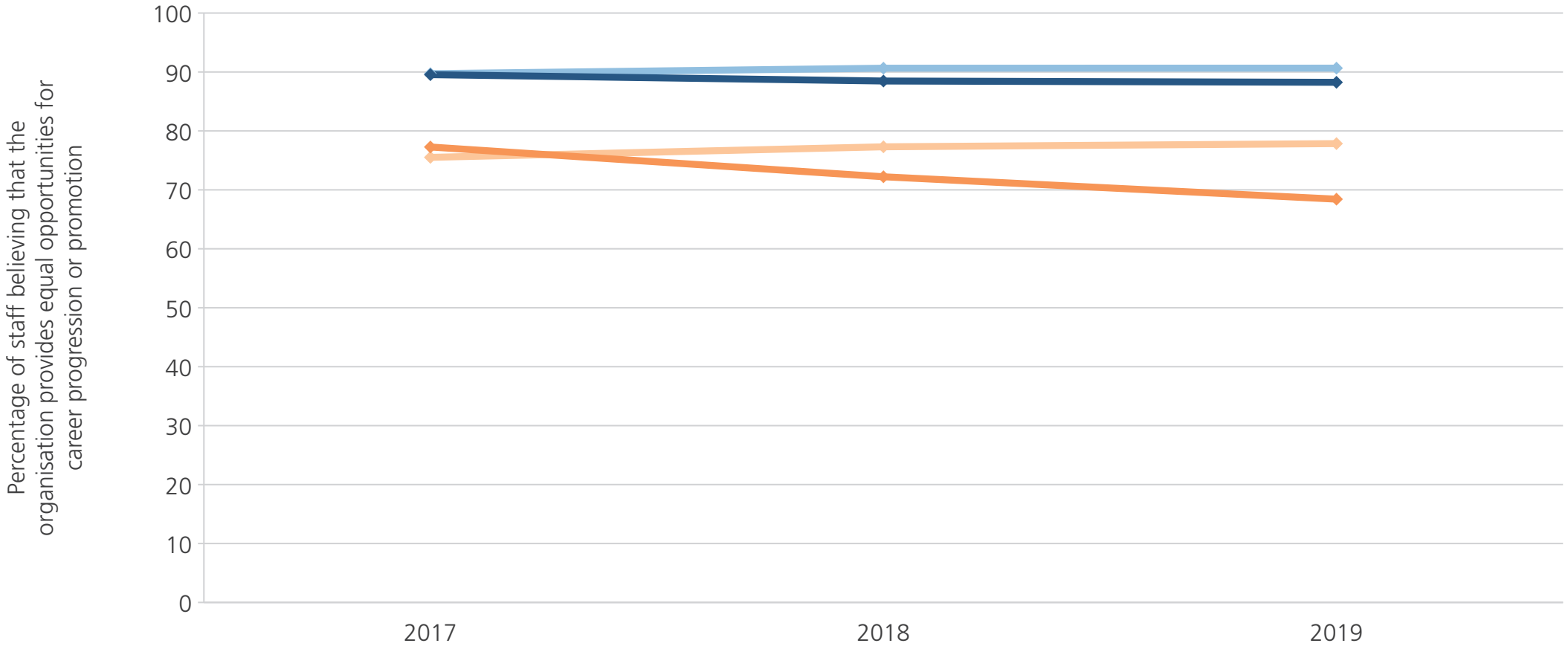
White: Responses	1,040	925	822
BME: Responses	36	38	37

Average calculated as the median for the benchmark group



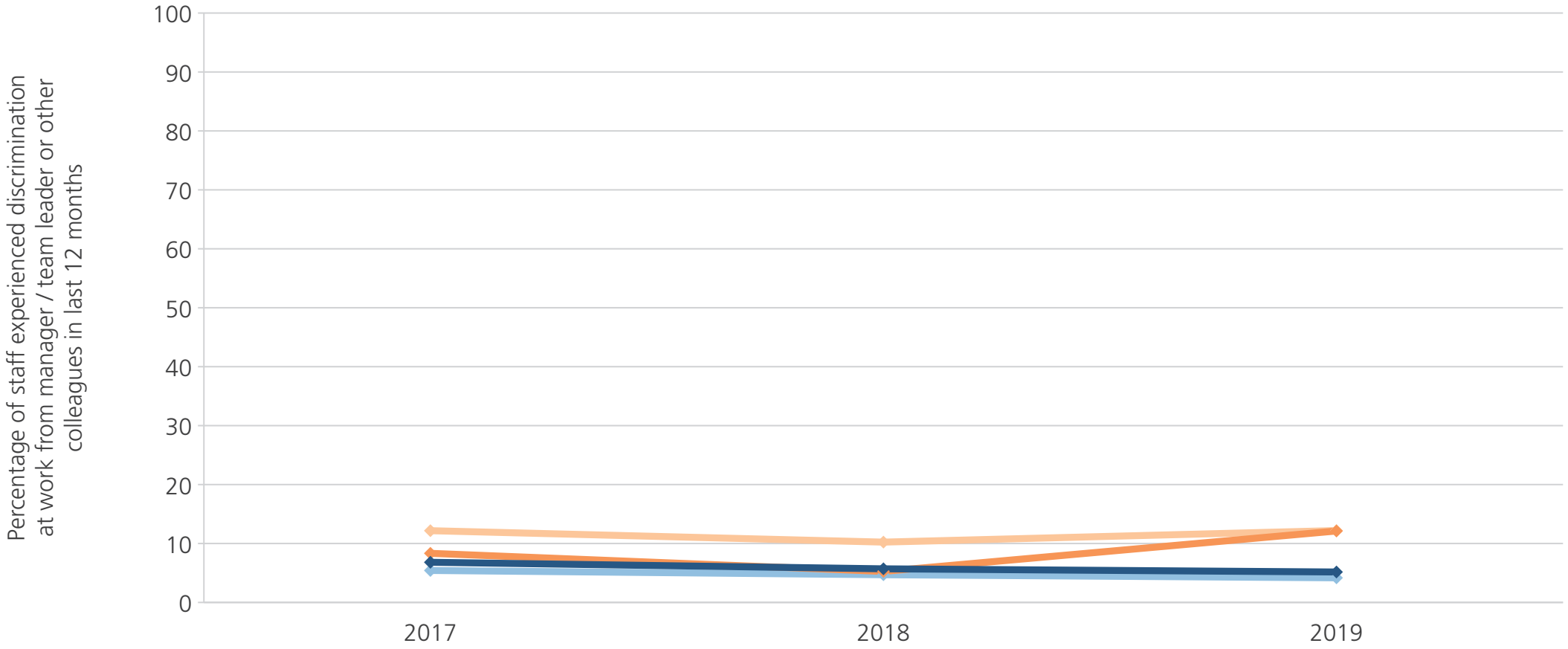
	2017	2018	2019
White: Your org	21.1%	21.5%	20.7%
BME: Your org	16.7%	18.4%	24.3%
White: Average	18.3%	18.9%	19.2%
BME: Average	22.1%	23.6%	24.1%
White: Responses	1,042	929	826
BME: Responses	36	38	37

Average calculated as the median for the benchmark group



	2017	2018	2019
White: Your org	89.5%	88.5%	88.2%
BME: Your org	77.3%	72.2%	68.4%
White: Average	89.7%	90.6%	90.7%
BME: Average	75.5%	77.3%	77.8%
White: Responses	708	581	536
BME: Responses	22	18	19

Average calculated as the median for the benchmark group



	2017	2018	2019
White: Your org	6.8%	5.7%	5.2%
BME: Your org	8.3%	5.3%	12.1%
White: Average	5.4%	4.7%	4.2%
BME: Average	12.2%	10.2%	12.2%
White: Responses	1,042	929	813
BME: Responses	36	38	33

Average calculated as the median for the benchmark group

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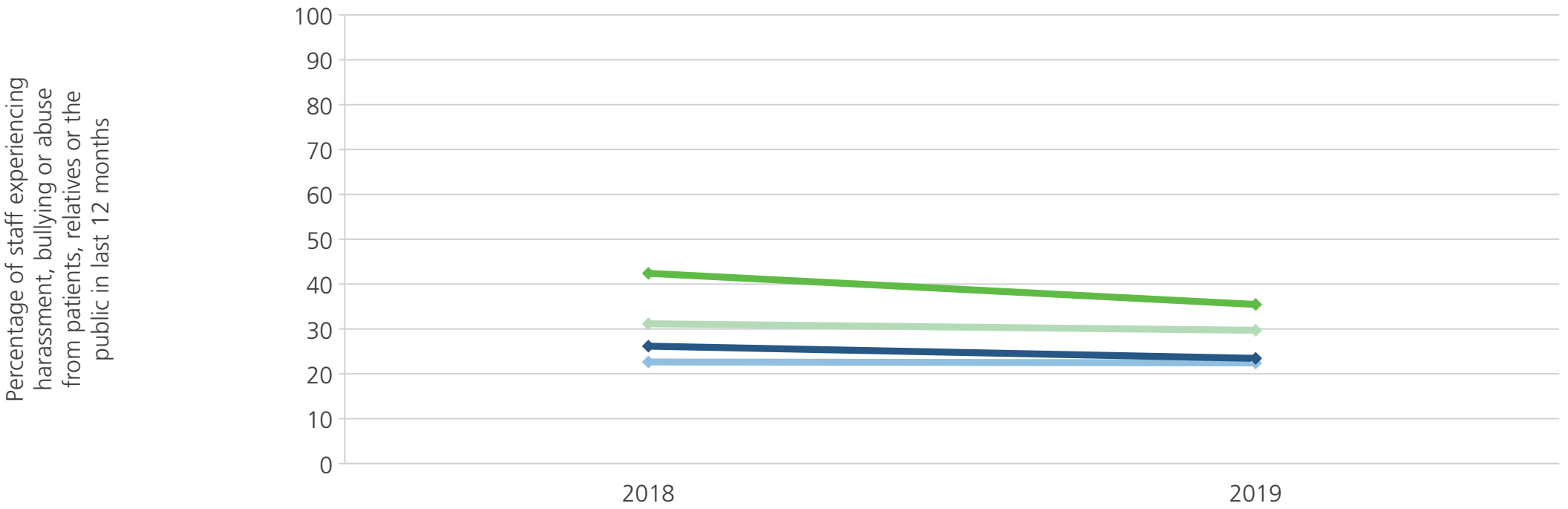
NHS England

Workforce Disability Equality Standard (WDES)

Gloucestershire Care Services NHS Trust

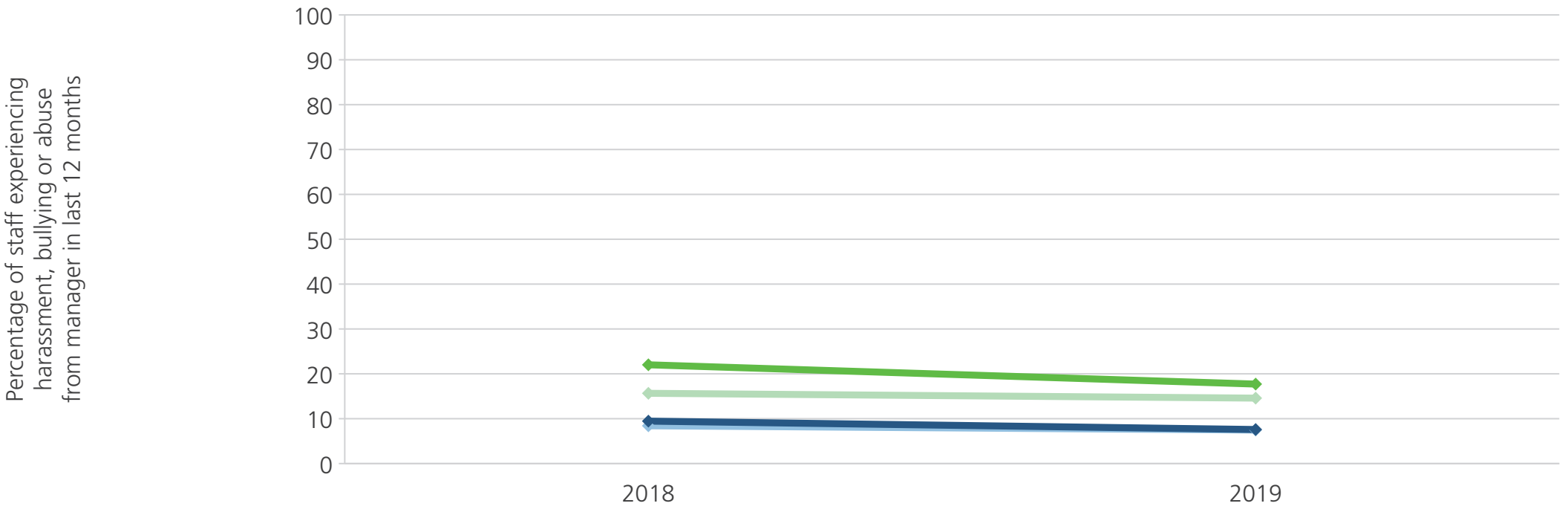
2019 NHS Staff Survey Results



Disabled staff: Your org	42.4%	35.5%
Non-disabled staff: Your org	26.2%	23.4%
Disabled staff: Average	31.2%	29.7%
Non-disabled staff: Average	22.6%	22.4%

Disabled staff: Responses	158	172
Non-disabled staff: Responses	791	691

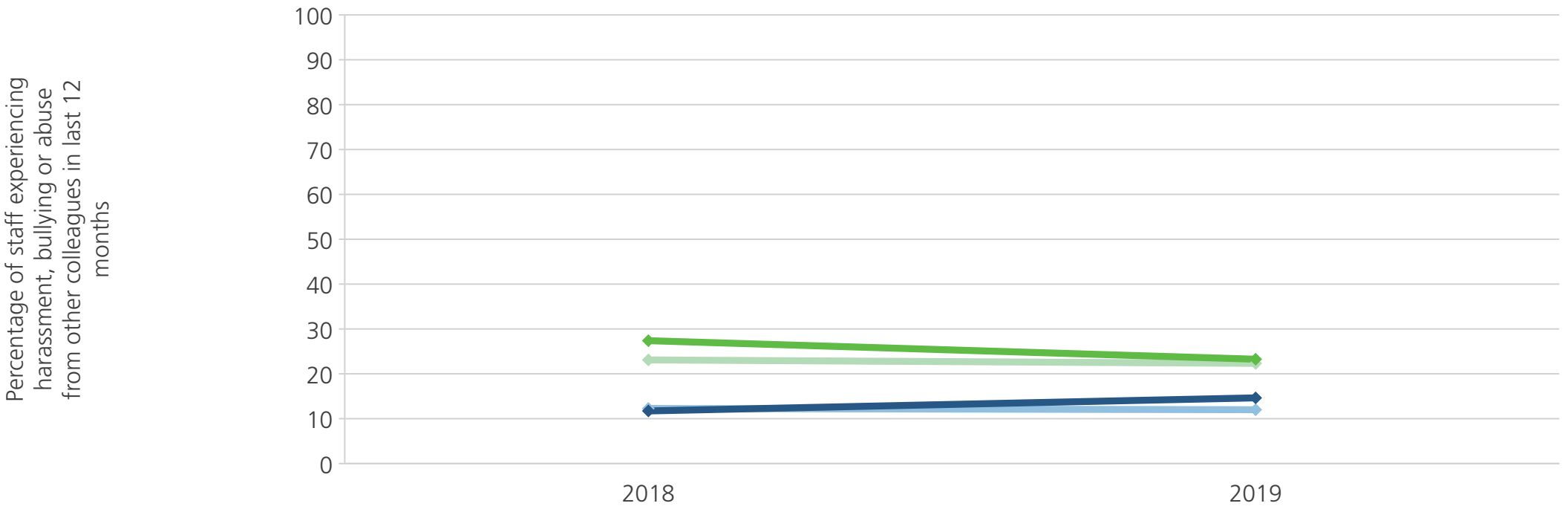
Average calculated as the median for the benchmark group



	2018	2019
Disabled staff: Your org	22.0%	17.7%
Non-disabled staff: Your org	9.5%	7.6%
Disabled staff: Average	15.7%	14.6%
Non-disabled staff: Average	8.4%	7.5%

Disabled staff: Responses	159	175
Non-disabled staff: Responses	793	685

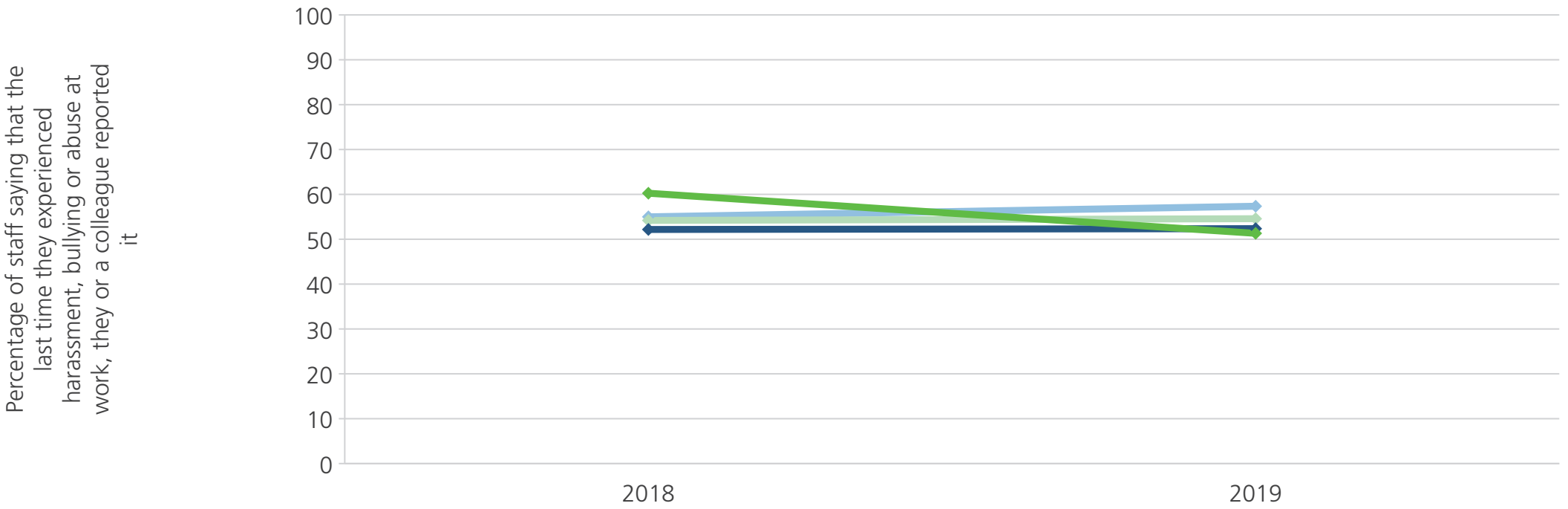
Average calculated as the median for the benchmark group



	2018	2019
Disabled staff: Your org	27.4%	23.3%
Non-disabled staff: Your org	11.7%	14.6%
Disabled staff: Average	23.1%	22.3%
Non-disabled staff: Average	12.3%	12.0%

Disabled staff: Responses	157	172
Non-disabled staff: Responses	793	683

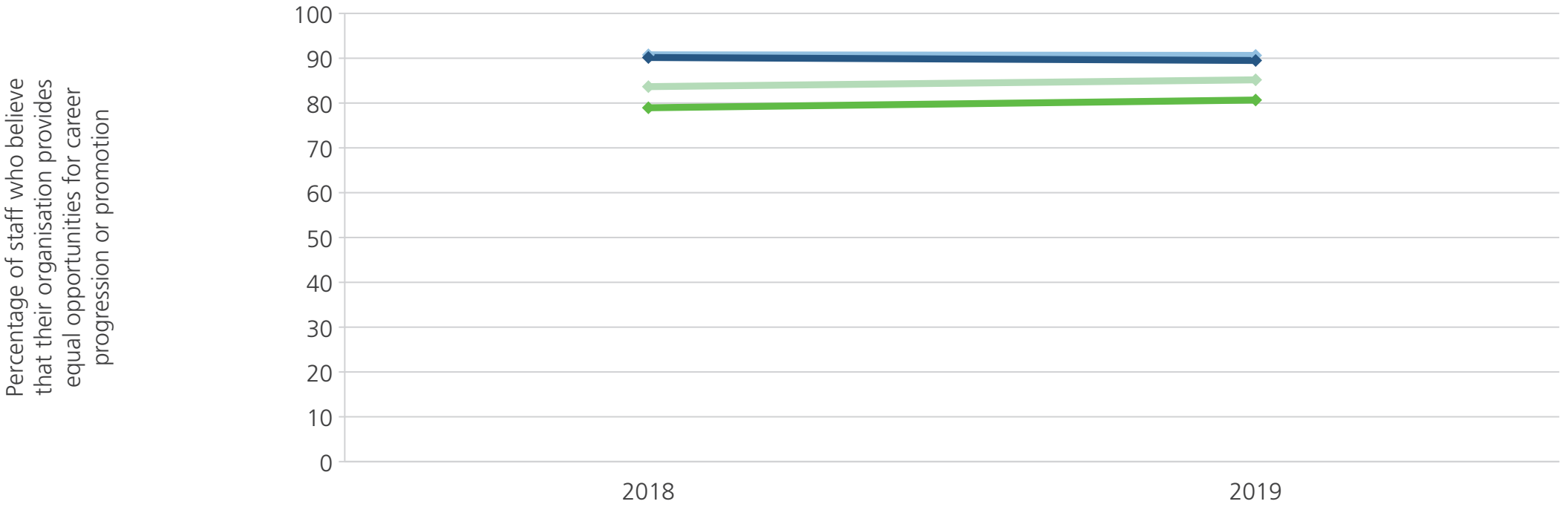
Average calculated as the median for the benchmark group



Disabled staff: Your org	60.3%	51.3%
Non-disabled staff: Your org	52.2%	52.4%
Disabled staff: Average	54.2%	54.6%
Non-disabled staff: Average	55.0%	57.4%

Disabled staff: Responses	78	76
Non-disabled staff: Responses	253	212

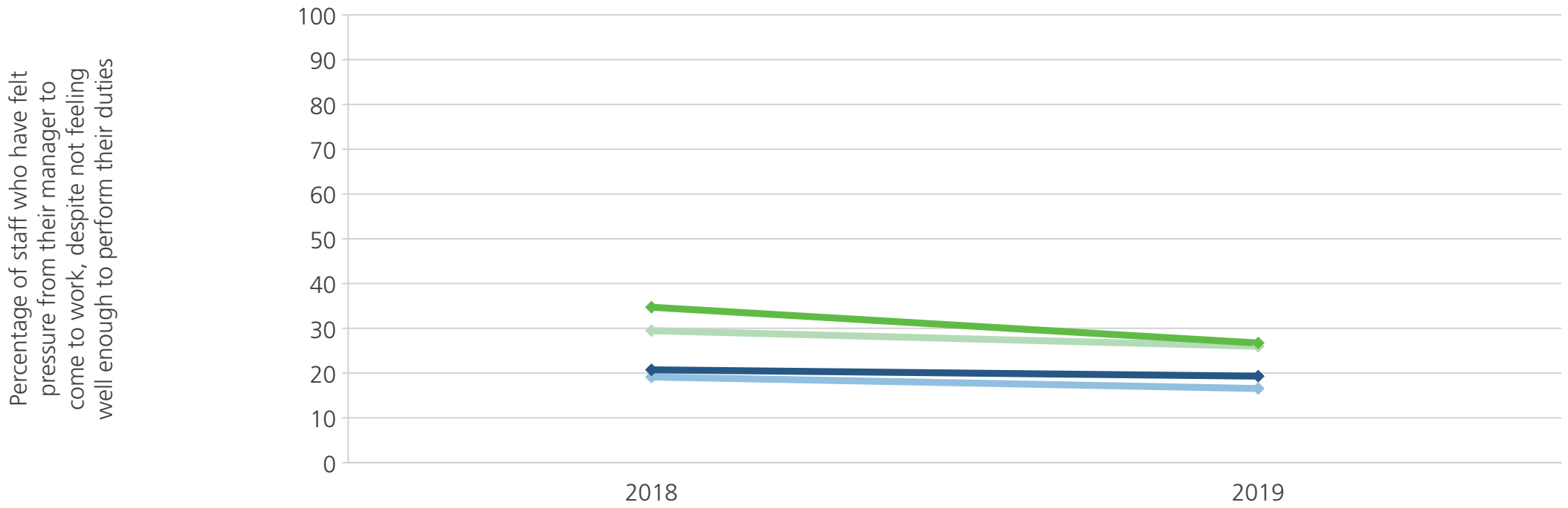
Average calculated as the median for the benchmark group



	2018	2019
Disabled staff: Your org	78.9%	80.7%
Non-disabled staff: Your org	90.2%	89.5%
Disabled staff: Average	83.7%	85.2%
Non-disabled staff: Average	90.8%	90.6%

Disabled staff: Responses	95	119
Non-disabled staff: Responses	498	438

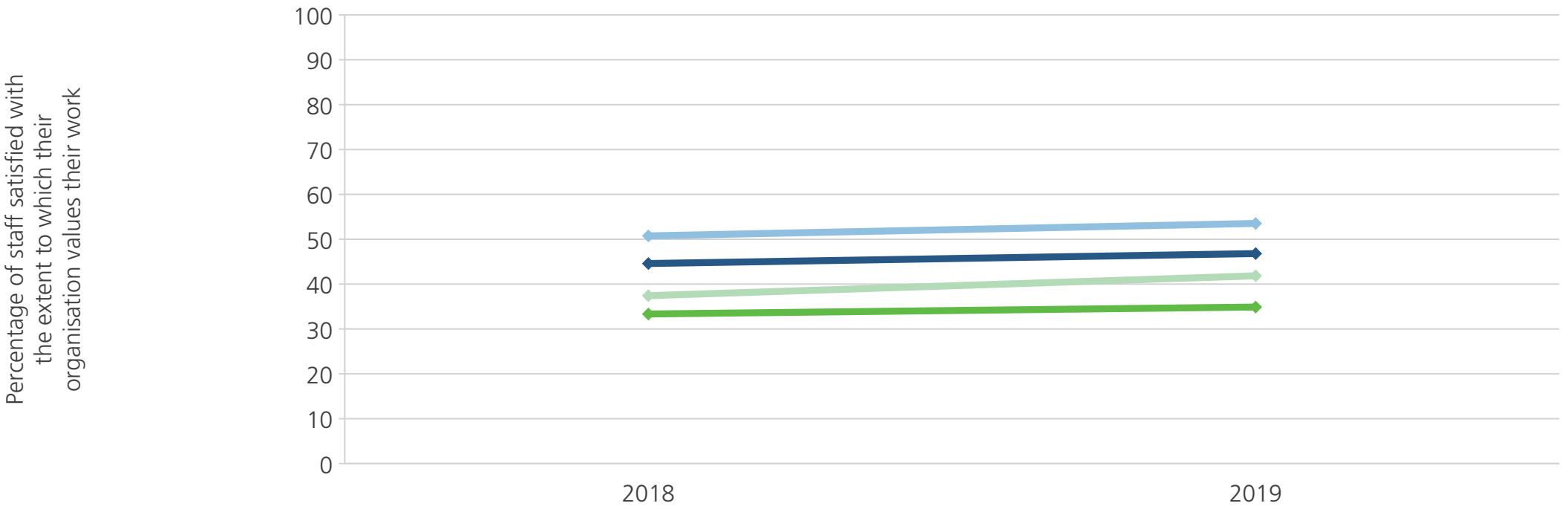
Average calculated as the median for the benchmark group



Disabled staff: Your org	34.7%	26.7%
Non-disabled staff: Your org	20.7%	19.3%
Disabled staff: Average	29.5%	26.0%
Non-disabled staff: Average	19.1%	16.6%

Disabled staff: Responses	121	131
Non-disabled staff: Responses	410	352

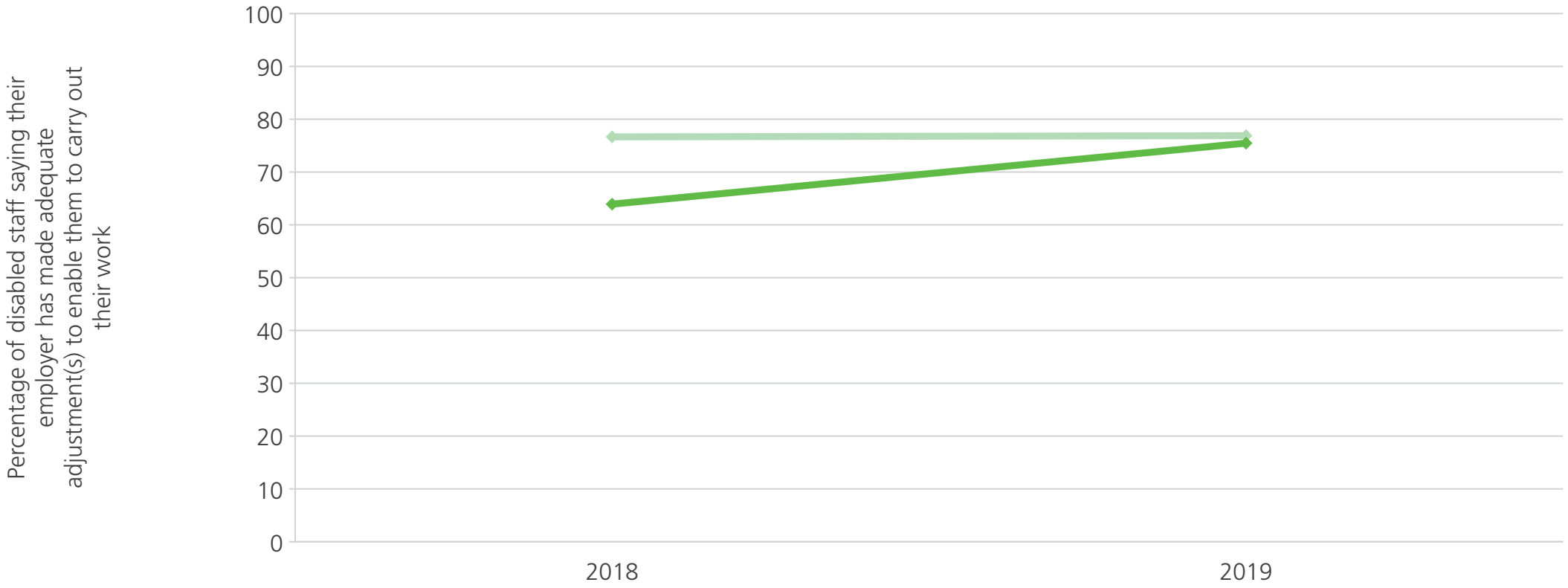
Average calculated as the median for the benchmark group



Disabled staff: Your org	33.3%	34.9%
Non-disabled staff: Your org	44.6%	46.8%
Disabled staff: Average	37.4%	41.8%
Non-disabled staff: Average	50.7%	53.5%

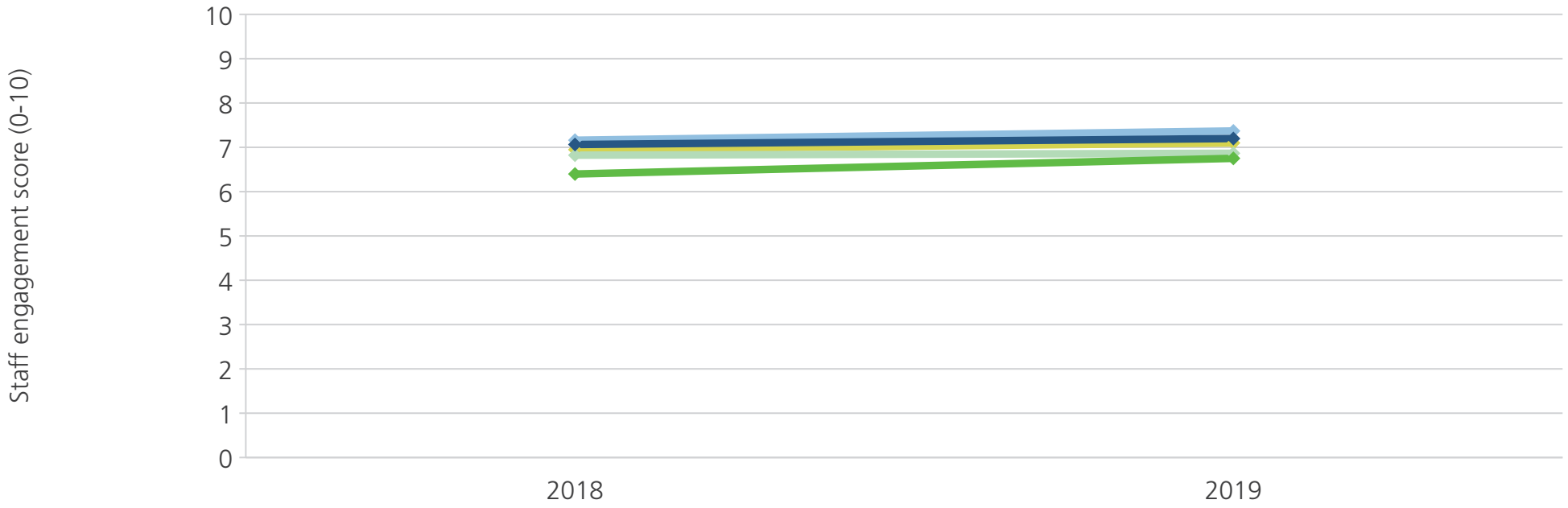
Disabled staff: Responses	159	172
Non-disabled staff: Responses	794	688

Average calculated as the median for the benchmark group



Disabled staff: Your org	63.9%	75.5%
Disabled staff: Average	76.7%	76.9%
Disabled staff: Responses	97	106

Average calculated as the median for the benchmark group



Organisation average	6.9	7.1
Disabled staff: Your org	6.4	6.8
Non-disabled staff: Your org	7.1	7.2
Disabled staff: Average	6.8	6.9
Non-disabled staff: Average	7.2	7.4

Organisation Responses	1,002	886
Disabled staff: Responses	159	175
Non-disabled staff: Responses	797	694

Average calculated as the median for the benchmark group

Survey Coordination Centre

NHS England

Appendices

Gloucestershire Care Services NHS Trust

2019 NHS Staff Survey Results

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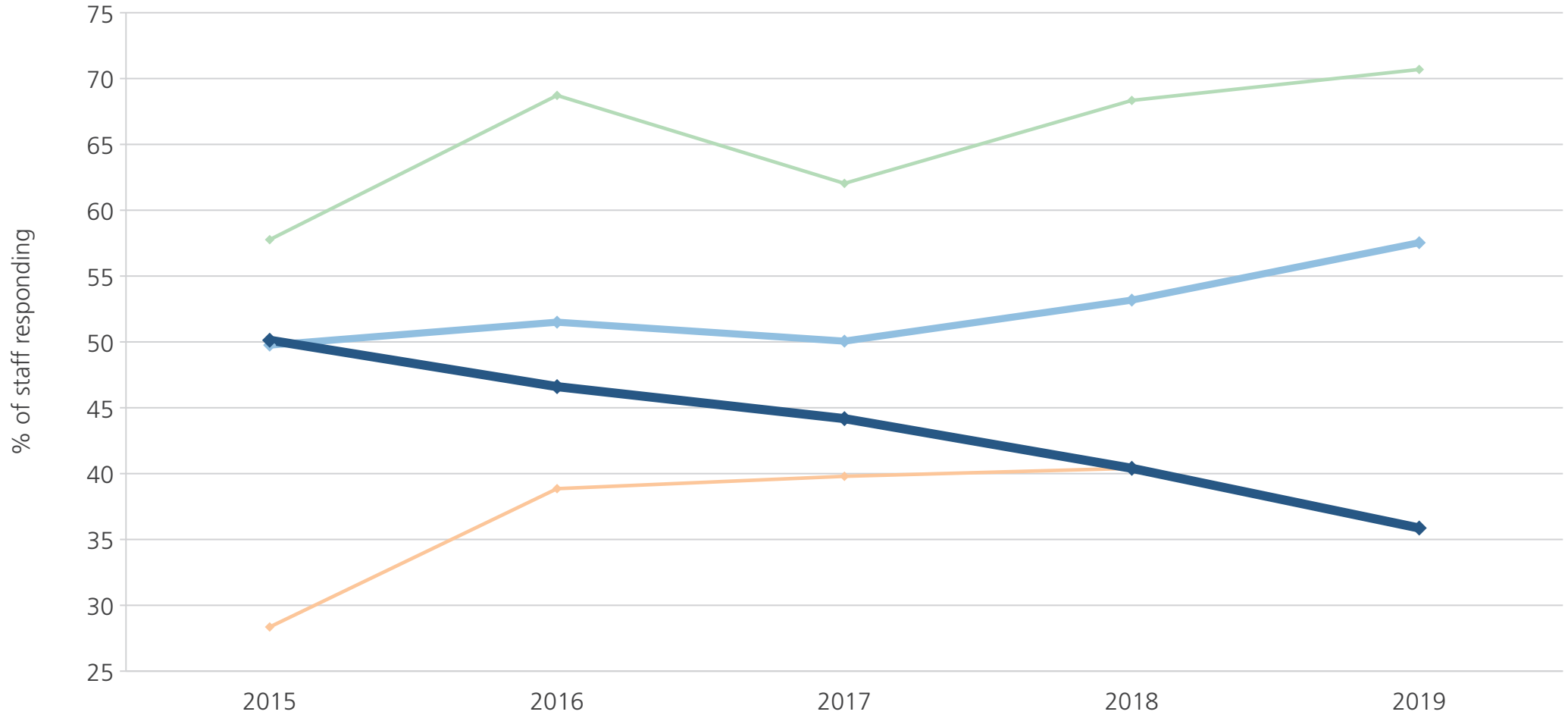
Appendix A: Response rate

Gloucestershire Care Services NHS Trust

2019 NHS Staff Survey Results



	2015	2016	2017	2018	2019
Best	57.8%	68.7%	62.0%	68.3%	70.7%
Your org	50.1%	46.6%	44.2%	40.4%	35.9%
Median	49.8%	51.5%	50.1%	53.2%	57.5%
Worst	28.4%	38.9%	39.8%	40.4%	35.9%

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Appendix B: Significance testing - 2018 v 2019 theme results

Gloucestershire Care Services NHS Trust

2019 NHS Staff Survey Results

The table below presents the results of significance testing conducted on this year's theme scores and those from last year*. It details the organisation's theme scores for both years and the number of responses each of these are based on.

The final column contains the outcome of the significance testing: ↑ indicates that the 2019 score is significantly higher than last year's, whereas ↓ indicates that the 2019 score is significantly lower. If there is no statistically significant difference, you will see 'Not significant'. When there is no comparable data from the past survey year, you will see 'N/A'.

Theme	2018 score	2018 respondents	2019 score	2019 respondents	Statistically significant change?
Equality, diversity & inclusion	**9.3**	991	**9.3**	868	Not significant
Health & wellbeing	**5.9**	991	**6.0**	881	Not significant
Immediate managers	**6.9**	993	**7.2**	882	↑
Morale	**6.0**	975	**6.2**	878	Not significant
Quality of appraisals	**5.3**	877	**5.5**	780	Not significant
Quality of care	**7.2**	860	**7.4**	745	↑
Safe environment - Bullying & harassment	**8.1**	986	**8.3**	878	Not significant
Safe environment - Violence	**9.7**	990	**9.7**	875	Not significant
Safety culture	**6.7**	986	**7.0**	876	↑
Staff engagement	**6.9**	1002	**7.1**	886	Not significant
Team working	**6.8**	990	**6.6**	865	Not significant

* Statistical significance is tested using a two-tailed t-test with a 95% level of confidence.

Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 15/0320

REPORT TO:	Board of Directors, Gloucestershire Health and Care NHS Foundation Trust
PRESENTED BY:	Neil Savage, Director of HR and Organisational Development
AUTHORS:	Sue Heafield, Associate Director, Workforce Systems and Planning Andrew Mills, Workforce Systems Manager
SUBJECT:	**GENDER PAY GAP ANALYSIS COMBINED REPORT 2019 ²gether NHS Foundation Trust and Gloucestershire Care Services NHS Trust**

This report is provided for:

Decision ☑ Endorsement ☑ Assurance ☐ Information ☑

The purpose of this report is to

Inform the Trust Board on the gender pay gap across the former ²gether NHS Foundation Trust and former Gloucestershire Care Services NHS Trust.

Executive summary

Current UK Gender Pay Gap legislation requires NHS Trusts to publish annually a series of details and calculations that highlight the gender pay gap across the workforce. The information must be published on the Trust website and Gov.UK by 30 March 2020. The information for the March 2020 publication is based on data drawn from 31 March 2019 and therefore this report refers to the former ²gether NHS Foundation Trust and Gloucestershire Care Services NHS Trust independently.

²gether NHS Foundation Trust and Gloucestershire Care Services NHS Trust merged on 1st October 2019 to become Gloucestershire Health and Care NHS Foundation Trust and therefore this is the last time that Gender Pay Gap information will be published separately.

Organisations with 250 or more employees, public and private sector, must publish gender pay gap information on their website and on the Government website. Employers that fail to report on time or report inaccurate data will be in breach of the regulations and risk facing legal action from the Equality and Human Rights Commission.

2019 HMRC figures suggest that being a woman in Gloucestershire reduces pay income by 26%, meaning that being a woman in the county means that their earnings will be nearly £9,000 less per annum than men. This picture reflects a similar pattern more widely across the South West, with women having an average pre-tax income of £25,000 compared to £33,987 per annum for men. The picture is similar at a national level.

This report contains the statutorily required calculations, presenting the gender pay gap within ²gether NHS Foundation Trust (²g) and Gloucestershire Care Services NHS Trust (GCS) against the six indicators. These are the result of a snapshot of the Trusts' workforce on the required date of 31st March 2019 as required and are summarised below:

- **Mean average gender pay gap**. Females earn less than males in the former ²g by 22% and the former GCS 12%
- **Median average gender pay gap**. Females earn less than males for former ²g by 14% and in the former GCS workforce there is no gap
- **Mean average bonus gender pay gap**. Females are paid less than males in the former ²g by 7% and in the former GCS by 71%
- **Median average bonus gender pay gap**. Females are paid more than males for the former ²g by 35%, however this figures is reversed in the former GCS Trust where females are paid 83% less than males. The latter figure is impacted by the small number of staff that fall into this category (2 females and 1 male).
- The proportion of males and females (when divided into four groups) ordered from lowest to highest pay shows there are a higher proportion of females in all quartiles and the gap closes with progression toward the upper quartile.

Previous legacy Trusts confirmed a similar statement of commitment as the one outlined below, and the Board is asked to endorse this amended statement:

"The Board of Gloucestershire Health and Care NHS Foundation Trust confirm its commitment to ongoing monitoring and analysis of its Gender Pay Gap data and to developing the appropriate actions which will reduce and eradicate this gap over time."

Recommendations and decisions required

The Board of Directors is asked to:

- **Note** the current report and agree to ongoing scrutiny of current data via the Trust's Workforce Management Group, reporting annually to the Resources Committee
- **Agree** to publish this report on the Trust website with a link to the government website
- **Agree** the statement **(above in bold**) that will be published on the Trust website and via the government website.

Corporate Considerations	
Quality implications	The Trust strives to provide equality for all colleagues, leading to increased levels of colleague satisfaction and ultimately improved patient care.
Resource implications:	By failing to recognise and address issues of equality, colleague turnover could increase and also increase the amount of casework by responding to claims of detrimental treatment.
Equalities implications:	The Equalities Act 2010 sets out the duties of the Trust and the Equality and Human Rights Commission give clear guidance which the Trust should endeavour to meet. This report is intended to progress the agenda to meet these duties and guidance and to ensure compliance.

Risks associated with meeting the Trust's values

Failure to provide equality of opportunity may result in claims of discrimination and damage to the reputation to the Trust as a fair employer.

Where has this issue been discussed before?

Gender Pay Gap Reporting has been in existence since 2018 and has been reported within each Trust. For former ²gether NHS Foundation Trust this was through the Appointment and Terms of Service Committee and for former Gloucestershire Care Services NHS Trust through the Resources Committee (GCS) and to the Trust Boards in addition to being published on the Trust's Websites

Explanation of acronyms used:	GCS – Gloucestershire Care Services 2G – 2gether NHS Foundation Trust ESR – Electronic Staff Record
Report authorised by: Neil Savage	**Title:** Director of HR & OD

GENDER PAY GAP REPORT 2019 - ²gether NHS Foundation Trust and Gloucestershire Care Services NHS Trust

1.0 INTRODUCTION

1.1 **What is gender pay gap reporting?**
Legislation requires employers with more than 250 employees to publish annually a range of statutory calculations showing the size of the pay gap between their female and male employees. There are two sets of regulations, one mainly for the private and voluntary sectors, which became effective from 5th April 2017. The second, mainly for public sector organisations, took effect from March 2017 and was required to be reported by the end of March 2018.

1.2 The subsequent rounds of reporting are required to be published on both the Trust's and the Government's websites by 30 March each year. The data is based on a snapshot of the workforce on 31 March the previous year. This report it is based on a snapshot of data drawn from the Trust's Electronic Staff Records System (ESR) from 31 March 2019.

1.3 These results must be accompanied by a written statement of confirmation from the Chief Executive or another appropriate person. Any actions should also be published outlining how the organisation plans to reduce the gender pay gap.

1.4 It should be noted that gender pay reporting is different to equal pay. This is important and a point that is often confused and misunderstood when considering the gender pay gap.

1.5 **Equal pay** deals with the difference in pay between men and women doing the same or similar jobs or jobs of equal value. It is unlawful to pay people unequally because of their gender and has been since the adoption of the UK Equal Pay Act, 1970 which prohibited any less favourable treatment between men and women in terms of pay and conditions of employment.

1.6 **The gender pay gap** shows the difference in the **average (or mean) pay** between all men and all women in the workforce. If the workforce has a high gender pay gap, this may indicate a number of issues to deal with, and the individual calculation may help to identify what these issues are.

1.7 The NHS Agenda for Change terms and conditions of service contain the national pay and conditions of service for NHS colleagues other than very senior managers and medical staff.

1.8 The majority of the former ²gether NHS Foundation Trust and Gloucestershire Care Services NHS colleagues work under the national NHS terms and conditions known as "Agenda for Change". These arrangements were introduced in 2004 with the express intention of removing and avoiding pay inequalities. Agenda for Change covers more than 1 million people and harmonises their pay scales and career progression arrangements across

traditionally separate pay groups. Colleagues are expected to move up the pay bands irrespective of gender. The Agenda for Change Job Evaluation process enables jobs to be matched to national job profiles and allows Trusts to evaluate jobs locally to determine in which Agenda for Change pay band post should sit.

1.9 Medical and Dental colleagues have different sets of Terms and Conditions, depending upon their seniority. However, these too are based on the principles of equal opportunity and are set across a number of pay scales for basic pay, which have varying thresholds within them. Directors are usually appointed on Hay or similar equal opportunity job evaluation methods and are regularly benchmarked using national surveys, for example from NHS Providers.

2.0 Gender Pay Gap Indicators

2.1 Employers must publish the results of six calculations showing their:

1) Average gender pay gap as a mean average
2) Average gender pay gap as a median average
3) Average bonus gender pay gap as a mean average
4) Average bonus gender pay gap as a median average
5) Proportion of males receiving a bonus payment and proportion of females receiving a bonus payment
6) Proportion of males and females when divided into four groups ordered from lowest to highest pay.

2.2 It should be noted that Consultant Medical colleagues are the only employees to receive bonus payments within the Trust in the form of either national or local Clinical Excellence Awards. Foundation Trust Directors and Senior Managers do not receive any or performance related pay, with the exception of non-FT directors potentially receiving bonus pay (as in the case of ex-GCS directors).

3.0 2gether NHS Foundation Trust

3.1 Gender Pay Gap Analysis (31st March 3019 snapshot)

Pay band	Female	% make up	Male	% make up
Band 1	42	70%	18	30%
Band 2	89	87%	13	13%
Band 3	350	79%	94	21%
Band 4	183	89%	23	11%
Band 5	267	77%	82	23%
Band 6	383	79%	100	21%
Band 7	181	77%	53	23%
Band 8a	56	67%	27	33%
Band 8b	42	78%	12	22%
Band 8c	11	61%	7	39%

Band 8d	6	55%	5	45%
Band 9	0	0%	2	100%
Board Member	1	14%	6	86%
Medical	54	51%	52	49%
Student	14	74%	5	26%
Grand Total	**1679**	**77%**	**499**	**23%**

Table 1 – 2gether NHS Foundation Trust headcount as at 31 March 2019 (exc. Staff Bank

TThe percentages in table 1 above are mostly identical to the last 2 years' data, although there has been a slight increase in headcount year on year.

3.2 **Table 2 – 2gether NHS Foundation Trust Staff Bank headcount as at 31 March 2019**

Payband	Female	% make up	Male	% make up
Band 1	4	67%	2	33%
Band 2	26	84%	5	16%
Band 3	156	78%	43	22%
Band 4	31	94%	2	6%
Band 5	47	78%	13	22%
Band 6	49	79%	13	21%
Band 7	14	82%	3	18%
Band 8a	1	50%	1	50%
Band 8b	3	75%	1	25%
Medical	3	43%	4	57%
Student	11	92%	1	8%
Grand Total	**345**	**80%**	**88**	**20%**

The percentages in table 2 remain similar to the previous two years. Last year's percentages were 81% and 19% respectively.

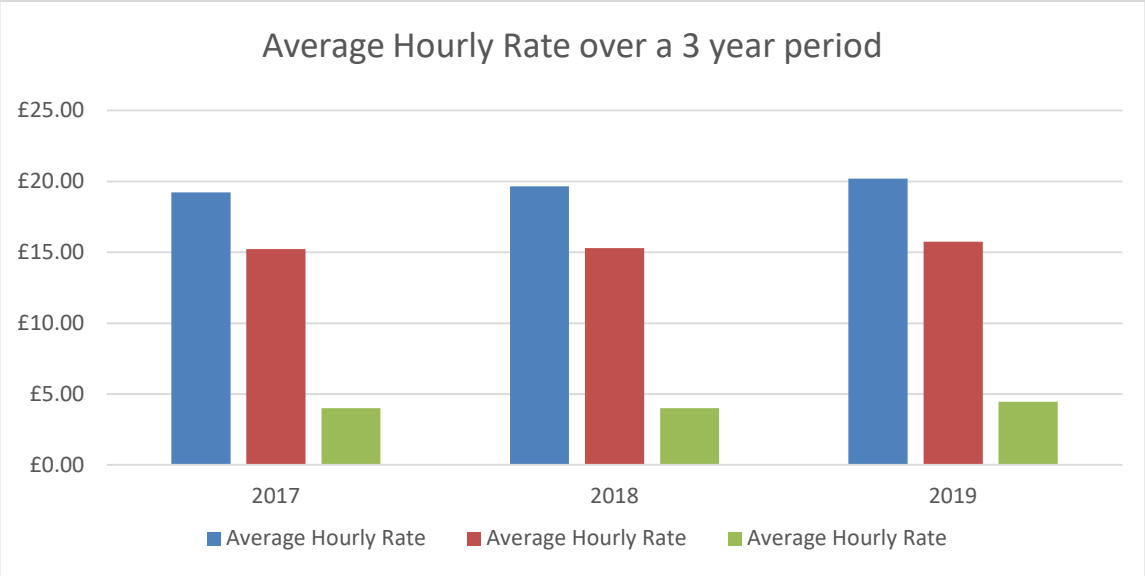
3.3 **Table 3a – Average and Median Hourly Rates – all eligible staff and pay schemes**

Gender	Avg. Hourly Rate	Median Hourly Rate
Male	£20.21 (£19.65)	£16.45 (£16.21)
Female	£15.76 (£15.29)	£14.34 (£13.59)
Difference	£4.45 (£4.01)	£2.11 (£2.61)
Pay Gap %	22% (22.16%)	14.74% (16.13%)

(Last year's figures in brackets)

The figures in table 3a above show a statistically insignificant widening of the gender pay gap when reviewing the average hourly rate, however there is a 1.39% difference between the median hourly rate.

3.4 **Table 3b – Change in average hourly rate**

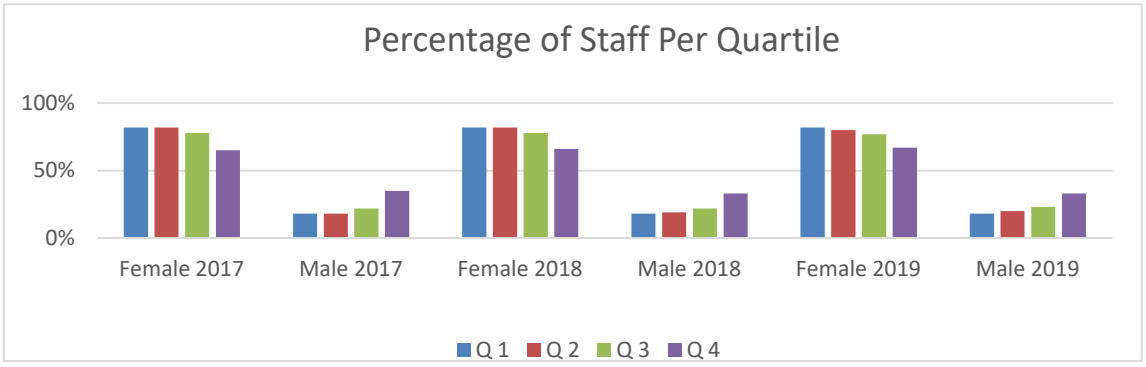


3.5 **Table 4a – Number of employees – Q1 = Low, Q4 = High**

Quartile	Female	Male	Female %	Male %
1	520 (457)	115 (100)	82 (82)	18 (18)
2	511 (452)	125 (106)	80 (82)	20 (19)
3	492 (434)	144 (123)	77 (78)	23 (22)
4	426 (370)	210 (188)	67 (66)	33 (33)

(Last year's figures in brackets)

3.6 **Table 4a** above shows a static workforce in relation to gender breakdown, and this is shown pictorially in the bar chart (4b) below.

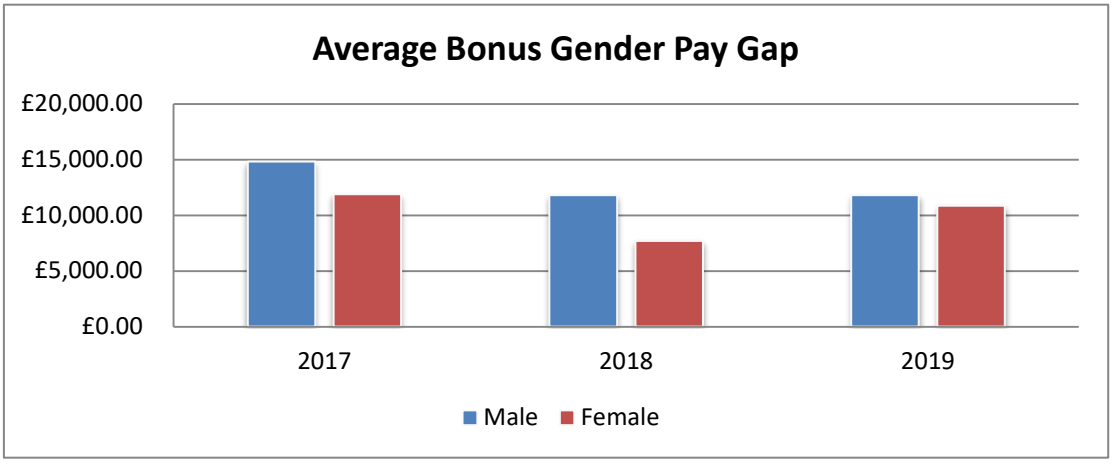


3.7 **Table 5a – Average Bonus* Gender Pay Gap**

Gender	Avg. Pay	Median Pay
Male	£11800.08 (£11,808)	£8922.335 (£7810.23)
Female	£10857.60 (£7704.98)	£12063.96 (£7786.35)
Difference	£942.475 (£4103.57)	-3141.63 (£23.88)
Pay Gap %	7.99	-35.21

The figures in table 5a above illustrate a reduction in the gender pay gap for bonus pay. This is particularly evident when median pay is reviewed. This is shown also in the chart (5b) below.

3.8 **Chart 5b – Gender Pay Gap for Average Bonus* Pay**



3.9 **Table 6** – Proportion of males and females receiving a bonus* against the overall totals

Total Medical Staff	Total	Gender		% of total		Number of staff receiving a bonus		% of staff receiving a bonus	
		Male	Female	Male	Female	Male	Female	Male	Female
2017	95	49	46	52%	48%	21	6	43%	13%
2018	107	54	53	50%	50%	24	7	44%	13%
2019	104	51	53	49%	51%	25	5	49%	9%

*Clinical Excellence Awards – apply to medical staff only

Figures in the table above illustrated that there has been an increase in the number of male consultants receiving a Clinical Excellence Award and a reduction in the number of females receiving an award.

4.0 Gloucestershire Care Services NHS Foundation Trust

4.1 **Gender Pay Gap Analysis (snapshot 31 March 2019)**

At the time the snapshot was taken the Trust had 2798 assignments, of which 2502 (89%) were female, and 296 (11%) were male. The ratio of male to female colleagues that the Trust has is lower than many NHS organisations, largely due to the lower (comparative) number of medical and dental staff employed by the Trust. Typical NHS ratios would show a ratio of 21% male to 79% female colleagues.

4.2 **Table 1 – GCS headcount as at 31 March 2019**

Payband	Female	% make up	Male	% make up
Band 1	95	94%	6	6%
Band 2	377	86%	62	14%
Band 3	371	91%	38	9%
Band 4	165	95%	8	5%
Band 5	579	93%	44	7%
Band 6	536	90%	58	10%
Band 7	256	88%	35	12%
Band 8a	55	83%	11	17%
Band 8b	14	78%	4	22%
Band 8c	5	45%	6	55%
Band 8d	4	80%	1	20%
Band 9	0	0%	2	100%
Other	45	68%	21	32%
Grand total	**2502**	**89%**	**296**	**11%**

These percentages remain relatively similar to last year's data which was 91% and 9% respectively but there is a slight increase in male colleagues.

4.3 **Table 2 – Average and Median Hourly Rates** – all eligible staff and pay schemes

Gender	Avg. Hourly Rate	Median Hourly Rate
Male	£17.07 (£16.50)	£14.34 (£14.01)
Female	£14.98 (£14.60)	£14.34 (£14.15)
Difference	£2.09 (£1.90)	£-0.00 (£-0.14)
Pay Gap %	12.25% (11.52%)	-0.00% (-1.01%)

(Last year's figures in brackets)

The above figures show a widening of the gender pay gap as measured by average and median hourly rate.

4.4 **Table 3 – Number of employees by quartile – Q1=Low, Q4=High**

Quartile	Female	Male	Female %	Male %

1	597 (607)	75 (67)	88.84 (90.06%)	11.16 (9.94%)
2	582 (602)	62 (73)	90.37 (89.19%)	9.63 (10.81%)
3	648 (630)	56 (45)	92.05 (93.33%)	7.95 (6.67%)
4	585 (589)	89 (86)	86.80 (87.26%)	13.20 (12.74%)

At the time the snapshot was taken the percentage of female colleagues was 89% and the percentage of male colleagues was 11%. As shown in the table above this percentage split is mostly mirrored across quartiles 1, 2 and 4. There is a reduction in the percentage of male colleagues in the upper middle quartile, however the upper quartile demonstrates there is an increase in the percentage of male colleagues in the roles that attract the higher hourly rates of pay.

4.5 **Table 4 - Increases and decreases by quartile of females and males colleagues within GCS between as 2017 and 2019**

Quartile	Female 2019	Female 2018	Female 2017	Female Difference from 2017	Male 2019	Male 2018	Male 2017	Male Difference from 2017	Female %	Male %
1	597	607	619	-22	75	67	60	15.00	88.89	11.11
2	582	602	611	-29	62	73	69	-7.00	90.40	9.60
3	648	630	638	10	56	45	42	14.00	91.78	8.22
4	585	589	600	-15	89	86	80	9.00	86.98	13.02
Totals	2412	2428	2468	-56	282	271	251	31.00	89.51%	10.49%

4.6 **Table 5 - The mean bonus gender pay gap for the Trust reveals that females are paid less than male colleagues**

Gender	Avg. Pay	Median Pay
Male	£15,080.04	£15,080.04
Female	£5876.00	£2938.00
Difference	£9204.04	£12142.04
Pay Gap %	71.96%	83.69%

However, there are very small numbers of staff involved in this metric (medics and directors). For this reporting period, one male colleague in the Trust received a recurring Clinical Excellence Award (awarded to Consultant Medical Staff under national and local schemes). There were also performance related pay bonuses awarded to two female colleagues this year. These two females are Directors receiving the VSM PRP bonus.

4.7 **Table 6 - Proportion of Males and Females Receiving a Bonus Payment**

Gender	Employees Paid Bonus	Total Relevant Employees	%
Female	2.00	2702	0.00
Male	1.00	309	0.32

Of the total workforce, 0%of females (rounded down) received bonuses compared to 0.32% of males (see above for explanation).

5.0 CONCLUSIONS AND RECOMMENDATIONS

5.1 2gether NHS Foundation Trust

5.2 The headline figure based on all eligible Trust employees and pay schemes indicates that women are paid 22% less on average than men. This is consistent with results from the 2018 analysis and an increase when compared to the data drawn in 2017 which was the first year of reporting. Table 3 shows that whilst both men and women are receiving a higher hourly average rate of pay, the male average hourly rate has increased by 56p, whilst the average hourly rate for women has increase by 47p. Table 3b highlights the difference over the last 3 years of reporting graphically.

5.3 The gap for median (middle point) earnings is closer standing at 14.74% less for women. This figure was 16.13% less for women in the previous year.

5.4 The data shows that 77% of the Trust's substantive workforce were women, and ideally an analysis would show this is broadly reflected in each of the Agenda for Change pay bands, Medical and Dental pay and Executive Board level pay. However, as with previous years the split between male and females evens out towards the more senior end of the pay bands which indicates that there are less opportunities for women in more senior roles or that jobs for this group are less attractive. Even allowing for the availability of promotional opportunities, the pay gap will only close gradually due to incremental progression and the time it takes to rise through the pay bands. The new Agenda for Change Pay Award and related pay structure which was agreed in 2018 is expected to help with closing the gap to a certain extent as it removes some of the incremental points in each pay band meaning that employees will reach the maximum pay within the band sooner. Changes in working patterns and choices about career breaks will also factor into this.

5.5 Gender pay gap reporting has to include all earnings including bonus payments. The only payments that fall into this category are Clinical Excellence Awards (CEA) and these can only be applied to and awarded to Medical Consultants. Although there was an even divide in the numbers of male and female consultants, considerably more men than women apply for t these payments, thereby being a significant contributing factor to the Trust's overall average pay gap. This pattern is repeated across the NHS, particularly in Acute, Acute Specialist Mental Health and Learning Disability

Trusts in view of the low number of medics in the latter. However both male and female colleagues were in receipt of lower CEAs during the reporting period and the median bonus pay gap has now reversed.

5.6 The gender pay gap is also significant at Executive Director level with an average hourly rate which is 33% lower for females than males. Six of the post holders were men and one a woman. It is important to note that this snapshot was taken on the 31 March 2019 and there were a number of joint posts made for the Shadow Board in readiness for the merger of Gloucestershire Health and Care NHS Trust and ²gether NHS Foundation Trust which at the time was due to take place on 1 October 2019.

5.7 It should be noted that of the 12 organisations that had uploaded their Gender Pay Gap reporting information on or before 11 March 2020. 5 Trusts had reported the same pay gap between men and women as the previous year, 5 had improved, however the improvement was not significantly different and 2 were worse than the previous year. The CIPD reports that one of the major issue lies in the low overall participation of women, and improvement will involve long-term change. In other areas, the gap is down to limits on progression and under-representation in senior roles.

5.8 The Trust has regularly stated its full commitment to equality of opportunity across the whole organisation and should recognise from the most recent data that there remains much work to be done to close the gender pay gap. Progress is unlikely to be achieve quickly or exclusively by internal organisational actions, requiring a wider societal shift in attitudes and behaviours. However, there are clear actions the Trust can take to make a positive difference.

5.9 The Trust can narrow the gap by taking some short and medium term actions. As an example, given the success in increasing the BAME representation at Board level for both Executive and Non-Executive Director since 2017, a similar approach should be adopted to highlight that for senior vacancies, while we welcome all applicants, we are currently under-represented by women. We can also apply the similar “all other things being equal” approach taken to the recent Non-Executive Director appointments, to senior appointments, allowing positive action to be taken. Positive action is lawful under the Equality Act. An action plan is required to work toward closing the gap, accepting that there is no single ‘quick fix’.

5.10 **Gloucestershire Care Services NHS Trust**

The data shown above and to be published on the Trust website is based on a snapshot of data from 31 March 2019.

There is a gender pay gap of 12% for which a number of explanations can be offered with the majority of them having historical roots. Indications suggest that this figure is lower than the majority of Trusts and certainly much better than those figures published by a number of flagship private companies.

6.0 Recommendations

6.1 Going forwards, our new Trust's values and emerging strategy are rooted in fairness and equity and our goal must be to understand and work towards eradicating any unfairness, perceived or real.

6.2 All parts of our workforce, irrespective of gender, race or creed are vital to our sustainability and our recruitment and promotion practices are rooted in these principles.

6.3 However, in order to further tackle the gender pay gap differences, additional actions are recommended as being taken forward as follows:-

1) The continued roll out of the agreed "Valuing Difference Leadership strategy" and its associated implementation plan which the Board approved in 2019. A key aspect of this is the commissioning and delivery of our new entrance, middle and senior management leadership development programme which is currently out to tender. A new equality and diversity training offer is being scoped by the OD function in addition to the inclusion of Equality, Diversity and Gender Pay Gap considerations in the leadership development programmes.

2) Through the new Flexible Working Policy which was implemented in October 2019, continuing to consider and proactively promote more possibilities of flexible and non-standard working in the higher paid tier 4 level by using job sharing and part-time working.

3) By taking positive gender action. The Board is asked to endorse all adverts for the higher paid tier 4 roles to be flagged as welcoming applicants from all sections of our community but highlighting that we are currently under-represented by women in these roles and are particularly interested in female applicants

4) Development coaching and mentoring opportunities for underrepresented roles in particular for Tier 4, this includes the continued support of the recently created Trust coaching network and the developing ICS offer.

5) The continued sponsorship, support and facilitation of the Trust's Women's Leadership Network.

6) Regular refresher communications and management and HR support for paternity leave.

7) Continued colleague and applicant access to Little Oaks and Little Apples NHS Childcare Nurseries alongside our Childcare Vouchers offer though VIVUP.

8) A presentation and training session run by the Medical Director and the Director of HR and OD to encourage additional female applicants to the next Consultant Clinical Excellence Award round.

9) The agreement of the following statement (below) confirming our commitment to fairness and equity in pay for all staff;

'The Board of Gloucestershire Health and Care NHS Foundation Trust confirms its commitment to ongoing monitoring and analysis of its Gender Pay Gap data and to developing the appropriate actions which will reduce and eradicate this gap over time'

Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 16/0320

REPORT TO: Trust Board 25 March 2020

PRESENTED BY: John Trevains, Director of Nursing, Therapies & Quality

AUTHOR: Gordon Benson, Associate Director of Clinical Governance & Compliance

SUBJECT: **QUARTER 3 QUALITY REPORT**

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

This report is provided for:

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

The purpose of this report is to:

This paper provides an overview of the Quarter 3 Quality Report for the Trust which reflects activity concerning the quality priorities for both mental health and physical health services.

Appendix 1: Provides the Quality Report Performance Dashboard. Data covering Physical Health Services for the period April 2019- February 2020 & includes the previous Q3 data for Mental Health and Learning Disabilities.

Appendix 2: Provides the first iteration of the formal Quality Report (Quarter 3) set out according to the requirements of the quality accounts regulations. This provides a combine approach to the Quality Report for our merged organisation and provides the mental health and learning disability quality data.

Recommendations and decisions required

The Board is asked to note the contents of this report for information and assurance.

Executive summary

NHS England and NHS Improvement published the *Detailed requirements for quality reports 2019/20* in February 2020; the requirements of this document are mandated for NHS foundation trusts. All organisations prepare quality accounts but only NHS foundation trusts are required to produce quality reports. The Quarter 3 Quality Report

has, therefore, been formatted in accordance with the requirements of this guidance, and using the mandated language where indicated.

The report shows the progress made towards achieving targets, objectives and initiatives identified in the Annual Quality Report which ultimately must be published as part of the Trust's Annual report.

Commentary regarding performance against objectives is not detailed within the Executive Summary as this is reported via the monthly Quality Report Performance Dashboard. Where information is currently unavailable, not yet reportable, or in development, this is clearly identified in red; all such sections will be completed by the year end in readiness for being formally signed off at the Audit Committee in May 2020. Use of language and the accessibility of the document will be further reviewed during March & April 2020.

NHS foundation trusts are also required to obtain external assurance on their quality reports; this process of independent scrutiny improves the quality of data on which performance depends. This process is described in the *Detailed requirements for external assurance for quality reports 2019/20.* Our external auditor, KPMG, has commenced this process and will review the content of the quality report against the requirements set out in the *NHS foundation trust annual reporting manual 2019/20.* The process requires a content and format check as well as sample testing on two mandated performance indicators and one locally selected indicator, chosen by the Governors. External audit is required to provide a signed limited assurance report on whether there is evidence to suggest that the two mandated indicators have not been reasonably stated in all material aspects. This will be reported to both the Council of Governors and the Audit Committee.

NHS Trust's providing a mix of different services should follow the guidance for the category of services from which they receive the most income. For the Trust in 2019/20 this determines that the mandated indicators for testing will be from mental health services, the following indicators are, therefore, selected:

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

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

The Council of Governors, at their meeting on 19 March 2020 will select the local indicator for testing, this can be any of the local physical or mental health quality priorities reported in Part 3 of the Quality Report.

Risks associated with meeting the Trust's values
Failure of the Quality Report to meet the requirements of the *NHS foundation trust annual reporting manual 2019/20,* evaluated through the external audit process, could lead to our external audit issuing a modified opinion as part of the limited assurance report. This could present a significant reputational risk.

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
Equality Implications	None

Where has this issue been discussed before?
Quality Committee, 5 March 2020.

Appendices:	Appendix 1: Quality Report Performance Dashboard. Data covering the period April 2019-Febuary 2020. Appendix 2: Quality Report (Quarter 3) set out according to the requirements of the quality accounts regulations.

Report authorised by: John Trevains	**Title:** Director of Nursing, Therapies & Quality

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Gloucestershire Health and Care
NHS Foundation Trust

Quality Report – Summary Update

Data covering April 2019 to February 2020

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Physical Health Services
(formerly Gloucestershire Care Services NHS Trust)

Data covering April 2019 to February 2020

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Executive Summary

Gloucestershire Health and Care
NHS Foundation Trust

This report contains the Quality measures and Quality priority section from the previous Quality and Performance report. A separate report is produced covering the Performance metrics.

Are Our Services Caring?

- Friends and Family Test response rate increased in February to **12.8%** compared to **10.5%** in January.
- The proportion of patients indicating 'Likely' or 'Extremely Likely' to recommend our services decreased in February to **93.4**% compared to **94.8**% in January (Apr-2017 – Feb-2020 mean **93.52%**).

Are Our Services Safe?

- Safety Thermometer Harm free score decreased slightly in February to **93.2%** compared to **93.3%** in January, target 95%, and remains below the mean **93.72%** (Apr-2017 –Feb-2020). Work is in progress to remedy this, noting Safety Thermometer may be removed as a national indicator in 2020/21 national contract.
- Based on new harms only, the Trust achieved harm-free care of **97.7%** in February, compared to **96.6%** in January, target 98%, and below the mean **97.98% (**Apr-2017 – Feb-2020). The national benchmark is currently 96.8%. We are seeking to understand the issues around the low prevalence scores of harm free care as they do not match our incident data for harms. Some of this is due to the low census returns and work is in progress to attempt to automate the safety thermometer records collection process. We are doing a further lookback audit to examine data and correct erroneous scoring where and we expect scores to improve. It is also noted that Safety Thermometer is currently being reviewed as a national indicator in the 2020/21 national contract.
- We had no post-48 hour Clostridium Difficle infections in February.
- We had one MRSA infection in February on Coln ward, Cirencester Community Hospital which is currently being investigated.

Quality Priorities

Quality Priorities for 2019/20 included in this report are based on a mixture of metrics and audits. Where audits or actions are to be reported on a quarterly basis a RAG rating will be applied and updated during the quarter to provide an update of progress towards completion of audits or actions. In light of current system pressures a number of planned Q4 audit activity may be delayed.

- Our acquired pressure ulcer quality metrics and mental capacity act continue to make progress and are on trajectory
- Deteriorating patient monitoring has made a significant positive improvement in Qtr. 3
- We are seeing mixed results with the quality of reporting of medication incidents and our medicines management team are working to resolve this. Q4 data will be available in April 2020
- MUST scores and End of Life Template require further attention regarding data quality and completion of tool and this work is in progress
- Wound assessments: small sample sizes are leading to results that are not significant. Issues with data completeness are resulting in difficulties determining analysis of this quality priority. A plan to address this in an additional audit is in scheduled following end of Q4.

Quality Dashboard

- The Trust compiles a quality dashboard covering the Community Hospital Inpatient and Minor Injury and Illness Units, updated on a monthly basis and displayed within each of the units. This is featured on page 14 of this report. In terms of underperformance we are seeing reduced variance between sites which is an encouraging picture. Work is in progress to reduce this variance

Quality Dashboard

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CQC DOMAIN - ARE SERVICES CARING?

		Reporting Level	Threshold	2018/19 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2019/20 YTD	RAG	Exception Report?	DQ Rating	Benchmarking Report Jan Figure
1	Friends and Family Test Response Rate	N - T	15%	14.5%	17.7%	19.4%	16.7%	15.1%	11.5%	15.9%	11.0%	9.7%	10.1%	10.5%	12.8%		13.7%		No - within SPC limits	G	
2	% of respondents indicating 'extremely likely' or 'likely' to recommend service	N - R L - I	95%	92.7%	93.4%	92.7%	92.7%	92.7%	94.1%	92.6%	92.6%	96.0%	96.3%	94.8%	93.4%		93.8%		No - within SPC limits	G	95.9%
3	Number of Compliments	L - R	1,317	1,317	124	104	180	178	132	134	146	151	170	102	132		1,553			G	
4	Number of Complaints	N - R	42	42	6	5	6	2	5	3	3	6	2	4	0		42			G	
5	Number of Concerns	L - R	485	485	40	32	23	40	34	35	33	20	22	21	33		333			G	

CQC DOMAIN - ARE SERVICES SAFE?

		Reporting Level	Threshold	2018/19 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2019/20 YTD	RAG	Exception Report?	DQ Rating	Benchmarking Report Jan Figure
6	Number of Never Events	N - R		0	0	0	0	0	1	0	0	0	0	0	0		1			G	
7	Number of Serious Incidents Requiring Investigation (SIRI)	N - R		11	0	2	3	0	0	0	0	2	4	3	0		14			G	
8	Number of Serious Incidents Requiring Investigation (SIRI) where Medication errors caused serious harm	N - R		0	0	0	0	0	0	0	0	0	0	0	0		0			G	
9	Total number of incidents reported	L - R		4,443	398	410	342	424	371	344	378	383	410	405	348		4,213			G	
10	% incidents resulting in low or no harm	L - R		96.4%	97.2%	95.1%	94.4%	95.5%	95.7%	93.9%	93.9%	94.8%	92.9%	94.1%	96.0%		94.9%			G	
11	% incidents resulting in moderate harm, severe harm or death	L - R		3.6%	2.8%	4.9%	5.6%	4.5%	4.3%	6.1%	6.1%	5.2%	7.1%	5.9%	4.0%		5.1%			G	
12	% falls incidents resulting in moderate, severe harm or death	L - R		1.8%	3.1%	3.1%	2.9%	0.0%	4.9%	0.0%	1.6%	0.0%	1.5%	5.7%	3.5%		2.4%			G	
13	% medication errors resulting in moderate, severe harm or death	L - R		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		0.0%			G	
14	Number of post 48 hour Clostridium Difficile Infections	N - R L - C	1*	15	0	0	1	1	1	5	1	1	0	0	0		10	G		G	
15	Number of MRSA bacteraemias	N - R L - C	0	0	0	0	0	0	0	0	0	0	0	0	1		1	R		G	
16	Number of MSSA Infections	L - R	0	0	0	0	0	0	0	0	0	0	0	0	0		0			G	
17	Number of E.Coli Bloodstream Infections	L - R	0	2	0	0	0	0	0	0	0	0	0	0	0		0			G	
18	Safer Staffing Fill Rate - Community Hospitals	N - R		100.2%	102.0%	100.7%	101.3%	99.7%	100.8%	99.7%	102.5%	101.3%	99.7%	100.3%	100.5%		100.8%			G	
19	VTE Risk Assessment - % of inpatients with assessment completed	N - T	95%	96.9%	99.5%	98.9%	97.0%	95.5%	96.1%	95.9%	96.5%	99.4%	96.1%	97.6%	100.0%		97.5%	G		G	
20	Safety Thermometer - % Harm Free	N - R L - C	95%	93.7%	94.3%	92.6%	93.4%	94.4%	93.5%	92.9%	93.7%	91.9%	92.5%	93.3%	93.2%		93.2%	R	Pg. 13	A	
21	Safety Thermometer - % Harm Free (New Harms only)	L - I	98%	98.1%	98.3%	98.1%	98.4%	98.4%	98.5%	97.8%	96.9%	96.9%	98.1%	96.6%	97.7%		97.8%	R		A	96.8%
22	Total number of Acquired pressure ulcers	L - R		728	79	63	56	64	60	59	65	60	70	85	65		726			G	
23	Total number of grades 1 & 2 Acquired pressure ulcers	L - R		671	74	59	60	59	56	54	64	54	67	78	60		685			G	
24	Number of grade 3 Acquired pressure ulcers	L - R		52	5	4	3	4	4	4	1	2	2	7	5		41			G	
25	Number of grade 4 Acquired pressure ulcers	L - R		5	0	0	0	1	0	1	0	4	1	0	0		7			G	

*In-month threshold (i.e. February)

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

RAG Key: R – Red, A – Amber, G - Green

Quality Priority | Are Service Safe?

1. Medication Incidents

Outcome: Improve learning from "no-harm" and "low-harm" medication incidents to enhance patient safety

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This priority will enable (1) identification and theming of factors contributing/causing low and no harm medication incidents and (2) recommendations to address identified themes

Improve the learning from "no-harm" and "low-harm" incidents		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Actions		Establish a baseline of quality of reporting of harm reported medication incidents using quality audits - Completed, see below.			Quality Improvement working group will establish a training needs analysis on baseline data and agree actions required to improve quality of reporting			Implementation of actions agreed from Qtr. 2			A repeat audit of harm reported medication incidents will be performed to determine if the aims of the outcome have been achieved		
Low/no harm incidents have been investigated and closed by end of each quarter	Target				45%			60%			75%		
	No-harm medication incidents	Baseline: 32%			25%			54%			Audit available April 2020		
	Low-harm medication incidents	Baseline: 29%			57%			29%					
Low/no harm incidents should state the medication involved	Target				91%			95%			100%		
	No-harm medication incidents	Baseline: 87%			85%			95%			Audit available April 2020		
	Target				80%			90%			100%		
	Low-harm medication incidents	Baseline: 71%			57%			100%			Audit available April 2020		
Low/no harm incidents should state the indication for the medication involved	Target				33%			66%			100%		
	No-harm medication incidents	Baseline: 0%			30%			35%			Audit available April 2020		
	Low-harm medication incidents	Baseline: 0%			0%			0%					

Additional information:

Performance
There were 16 medication incidents with Community Physical Health Services responsibility reported in February.
- 15 resulted in no harm, 1 resulted in low harm

SPC charts show the number of medication incidents, no harm medication incidents and low harm medication incidents to be within control limits (normal variation).

Actions
- Continue to encourage timely investigation of incidents and improved medication detail in reports.
- Medication safety group met for the first time. Actions from the meeting include producing a medication error management policy for GHC and agreeing an RCA template that is fit for purpose to review medication incidents and near misses.

2. Mental Capacity Act

Outcome: Improve the usage of mental capacity assessments in our hospital and community settings to ensure that individuals who lack the ability to make decisions are the focus of any decisions made, or actions taken on their behalf

Mental capacity Act and DoLS operational practice
Reference – 559
Rating – 12

The philosophy of the Mental Capacity Act 2005 (MCA) is to ensure that individuals who lack the capacity to make specific decisions are the focus of any decisions, or actions taken, on their behalf. It is a legal requirement to carry out an assessment when a person's capacity is in doubt. MCA needs to become a "business as usual" exercise, to ensure that the Trust is compliant with legislation and to achieve optimum benefits to our patients and families. Metrics will focus on the completion of the MCA2 and Deprivation of Liberty Safeguards (DoLS) assessments for significant decisions.

MCA Metrics		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Has an MCA2 been completed for restrained or restricted patients in our community hospitals? (Baseline from March 2019 audit 11%. Measured from dip test audit mid quarter)	Target	15%			30%			60%			90%		
	Actual	33%			65%			92%			Audit available end March 2020		
Has a deprivation of Liberty Safeguards application been made for all patients who do not have capacity to consent to being restricted or restrained? (Baseline 22% from March 2019 audit)	Target	25%			40%			60%			90%		
	Actual	33%			55%			85%			Audit available end March 2020		

Actions:

- For the Qtr. 3 audit MCA 2s completed needs to be qualified, as 46% of those completed had been saved as final version, while 46% were recorded on SystmOne but were saved for future editing. This continues to be an issue, and the SNSA will feed this back to staff to encourage them to save as final version.
- The quality of the MCA 2 forms completed is variable, but it is encouraging that so far we have surpassed our target number, which indicates staff are confident and skilled in completing them.
- For Qtr. 4, 10 DoLs have been notified as completed which appears low for the quarter to date. Investigation ongoing with Community Hospitals and DoLS team at GCC.

3. "Better Conversations" and Personalised Care

Outcome: Develop a programme of personalised care planning to enable patients to manage their long term conditions more effectively

Personalised care is a priority in the Long Term Plan, with a stated objective that it should become "business as usual across the health and care system". In the ICS workforce strategy the vision is to see this facilitated by a health coaching approach, called "Better Conversations". It is noted that both the GCS and 2Gether NHS FT contracts for 2019-20 include a commitment to work with the GCCG to develop "5 core measurable statements for the ICS personalised care programme that define outcomes for patients and success". This programme will directly feed in to this growing body of work.

NHSE have committed to "*consider, develop and test the most appropriate personalised care activity metrics*" including the development of a new Long Term Conditions Patient Recorded Outcomes Measure (PROM).

The Patient Activation Measure (PAM) will be a key tool in these early stages. Patient "activation" describes the knowledge, skills and confidence a person has in managing their own health and care. The concept of patient activation links to all the principles of person-centred care, and enables the delivery of personalised care that supports people to recognise and develop their own strengths and abilities. Services included will be MacMillan Next Steps, Self Management, Diabetes Education, and part of the ICTs (Complex Care at Home and Berkeley Vale ICT where health coaching training has taken place).

Actions completed:

- No update since last report

Better Conversations and Personalised Care Measures	Qtr. 1	Qtr.2	Qtr. 3	Qtr. 4
Number of care planning conversations taking place for the identified cohorts	Set by individual teams and based on relevance to patient cohort(s)	This is happening, however more work is required to report from SystmOne	SystmOne reports 7,148 patients with a care plan. Caution is required as definitions are not standard, and some eligible plans are not recorded on SystmOne.	Available end March 2020
Number of patients completing a Patient Activation Measure (PAM) questionnaire	Baseline: 1,500 per annum; target + 30%	Numbers are stable rather than rising but this is attributable to specific difficulties within 2 services and these are now resolved/resolving. Expect to recover lost ground	Trajectory now back on track. First 3 Quarters of 2018/19 = 552 people had PAM score; same period 2019/20 = 926 people had a PAM score	Available end March 2020
Number of patients completing a second PAM	Baseline: 500 per annum; target + 30%	This is increasing in line with target	264 compared to 420 at same point last year (Qtr. 3)	Available end March 2020
The use of PAM data to tailor interventions to further the personalisation agenda	Narrative reporting - commenced June 2019 in Complex Care at Home, MacMillan Next Steps	Progressing well. Embedded in 2 services and embryonic in others	Progressing well. Embedded in 2 services and embryonic in others	Available end March 2020
Delivery of a quarterly qualitative report detailing ongoing developmental activities and examples of good practice, patient stories and shared learning	Linked to quarterly PAM data; most teams dependent upon CCG feed and Qtr. 1 data; delivery expected during Qtr.2	Some case studies produced and shared with system partners as well as internally. Increasing anecdotal evidence of successes but failed thus far to produce "formal" report	Case Study report submitted to Clinical Quality Review Group (14 November 2019).	Available end March 2020

Quality Priority | Are Service Safe?

4. Catheter Management

Outcome: Quality Improvement programme to improve management of catheters in community settings

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Long term catheters whilst beneficial for some patients are also associated with morbidity. Infections (including sepsis) and other complexities which include anxiety over unpredictability of catheter problems (e.g. sudden blockage), difficulties managing away from home (e.g., taking equipment on holiday), sense of physical restraint, limited clothing choices, interruptions to sleep due to discomfort or pulling, and self-identity issues.

It has been identified that some patients appear to have clinically unnecessary urinary catheters in situ; the above risks and problems can therefore impact on the safety, morbidity and quality of life of these cohorts of patients.

Catheter Management metrics	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4
	Target	95% of baseline	90% of baseline	85% of baseline
Reduce the amount of community nursing contacts to patients between planned routine catheter changes to manage catheter associated problems.	Set targets for use in Qtrs. 2 to 4 Baseline: 3,900 Contacts per quarter (1,300 per month)	5% reduction	9.5% reduction from baseline (average = 1185/month)	Available end April 2020
Reduce the number of (clinically unnecessary) urinary catheters inserted in the community setting.	Establish baseline and set targets for use in Qtrs. 2 to 4 Delay due to determining percentage of patients whose first catheter insertions were not on GCS Nurse caseloads, or may have a positive TWOC* outcome.	Delayed data capture continuing through October, report available November	Data suggests this is up to 15% of catheters in situ at any one time, but clinical appraisal is challenging as the majority of catheters are initiated in GHFT not community – so unable to review records. (76% in Oct 19 were initiated outside of community setting)	Audit available Autumn 2020 following changes to SystmOne

Actions completed:

* TWOC – Trial Without Catheter to determine if clinically indicated.

- An audit of new catheter requests during Qtr. 3 in the ICTs demonstrated:
  - 85% of all (33) new catheter requests received into ICTs in October were found to be clinically relevant and appropriate
  - Of the remaining 15% of people referred in October (5 people) their reasons for catheterisation were: 1 x End of life care – catheter was not inserted / 1 x reduce mobility – was catheterised in GHFT / 1 x post-operative, but not urology surgery – again decision to catheterise was taken outside of GHC / 1 x incontinence + dementia and cancer of the prostate (this may have been inappropriate but insufficient clinical information available to appraise) / 1 x undefined need patient (insufficient assessment information available to appraise)
  - 77% of requests were for male patients with clinical need, of those the majority will go on to have surgical intervention as such they would all be clinically appropriate catheterisations.
- We have now reviewed the draft of the countywide catheter passport and comments returned to lead in GHFT – asserting this needs to be a countywide document under the One Gloucestershire umbrella not branded to GHFT.
- A practice improvement poster is nearly completed by One Gloucestershire based on GHC work undertaken. This will be disseminated to all clinical areas, care homes and care agencies across the county.
- PDSA work is underway for small scale improvement in service areas as follows:
  - Evening & Overnight nursing – production of a standard equipment in the home list and to standardise equipment.
  - Complex Care @ Home – catheter education required for all colleagues as not all nurses in team.
  - Community Hospitals - knowledge on trouble shooting guidance e.g. CAUTI and Trial Without Catheter/retention trouble shooting, focus on untrained education (nothing currently available for HCA's).
  - ICTs – Bowel routine recording on clinical SystmOne template.
- A countywide continence formulary is in the final stages of development between the Continence Specialist Lead, the CCG and the Head of Community Nursing. This will standardise equipment in use, identify best value for money and reduction in unwarranted variation which will help improve practice. This is now appraised by the Trust and agreed. Delays in this moving forward are not of GHCs causing.
- Education offers for bladder and bowel assessment and care are now on ESR.

5. Wound Care

Outcome: Increase the quality of wound assessments and management countywide in order to reduce clinical variation and improve wound healing rates

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This priority builds on the 2017-2019 CQUIN which was put in place nationally following UK studies that identified inconsistencies in the assessment and management of wounds and the opportunities to improve both efficiency of working and patient outcomes.
There are two principle reasons why wound assessment has been targeted:

1. A need to improve the quality and consistency of care delivered.
2. A need to reduce the cost burden of wounds. Clinical practice and wound outcomes should ultimately improve.

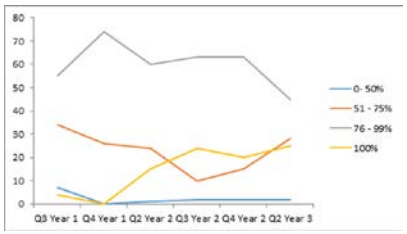
The Trust has been working to improve wound care as per the 2017-19 CQUIN, performance from Qtr. 4 of year 2 of the CQUIN is used below as a baseline for the Quality Improvement.

Wound Care Metrics		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
To increase the number of patients who receive a fully compliant assessment (to the "leading change adding value" clinical assessment domains of the 2017-19 wound assessment CQUIN) on admission to Community Nursing caseloads, Complex Leg wound services, Podiatry Service or Inpatient Settings from baseline.	Target	**30%**						**40%**			**60%** By the end of year 1 of the QI project. Metrics to be reviewed again if project goes into year 2		
	Actual	25.0%						25.0%			Audit potentially paused to Autumn 2020		
To increase the number of patients who have received a full wound assessment according to the "leading change adding value" Clinical Assessment domains of the 2017-19 wound assessment CQUIN AND whose wounds have healed within 4 weeks.	Target	**60%**						**65%**			**70%**		
	Actual	22.0%						33.0%			Audit potentially paused to Autumn 2020		

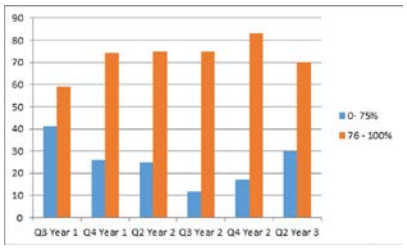
Improvement aims:

- To increase the number of patients who receive a fully compliant assessment *(to the leading change adding value clinical assessment domains of the 2017-19 wound assessment CQUIN)* on admission to community nursing caseloads, Complex Leg wound services, podiatry services or inpatient settings from baseline.

This has increased to 25% so movement is positive. See right for shift.

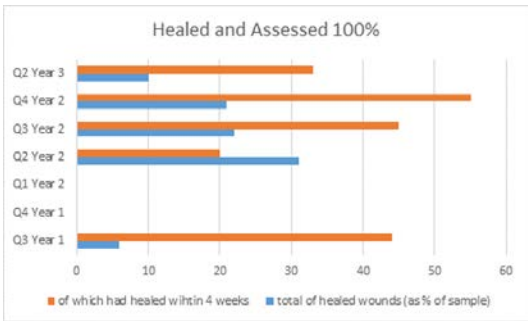


Breakdown of the 75% or above completed compliance:



- To increase the number of patients who have received a full wound assessment according to the leading change adding value clinical assessment domains of the 2017-19 wound assessment CQUIN AND whose wounds have healed within 4 weeks.

This measure is not delivering required progress– 33% at latest audit. The chart below shows the latest quarter (Qtr. 2, year 3) has the lowest percentage of healed within 4 weeks since Qtr. 2, year 2. However, the sample size is not as high as we need for the result to be significant. There are issues with data completeness resulting in the smallest sample size in 4 audits and 3rd lowest result.



6. Pressure Ulcers

Outcome: Build on our success of reducing pressure ulcers by working with the NHSI Stop the Pressure Collaborative framework. This will focus on specific community programmes to reduce pressure ulcers

The prevention of pressure ulcers remains one of our top priorities with regards to patient safety. Despite great strides in the past 2 years our aim will be to continue to monitor the number and incidence of pressure ulcers and to continue to drive our reduction plans forward. Metrics for measuring performance therefore are:

1. Pressure ulcers will continue to reduce across our patient facing services where our span of influence can have an impact.
2. Quality improvement methodology continues to target areas of high incidence and as a response to incident reports to understand the issues, current focus on Cotswolds, Cheltenham and Forest hospitals to showcase improvement. The PDSA cycle will report quarterly on these areas and will include a qualitative report.

Plans also include working collaboratively with GHFT and / or care homes where specific incidences or themes demonstrate the potential for system wide learning. Qualitative reporting will also include case studies where pressure ulcers have been managed and healed, following the patient journey and taking in to account other factors such as nutrition and hydration.

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Pressure Ulcers		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Acquired Pressure Ulcers will continue to reduce across patient facing services where our span of influence can have an impact	Target (Number of avoidable acquired pressure ulcers over total pressure ulcers)	**8%** (2018-19 Q4 baseline 8.9%)			**7%**			**6%**			**5%**		
	Actual	8.6%			6.6%			5.9%			Audit available end March 2020		
	Number of acquired and avoidable pressure ulcers	37			24			24					
	Total number of pressure ulcers in audit	430			365			409					

Preventing Pressure Ulcers update:

- The quarterly metrics taken from Datix reports continue to evidence that clinicians are reporting and recognising skin integrity damage at earlier stages in patient's care journey. This is reflected in increased category 1 & 2 Pressure Ulcers and reduced occurrence of avoidable categories 3 & 4. This suggests that the posture and risk management approach to education is improving patient safety.
- Monthly deep dive review into all reported category 3 & 4 ulcers commenced in November.
- Deep dive into the pressure ulcers for Qtr. 3 that are recorded as developed or worsened under our care and categorised as unavoidable will be reviewed for themes and reported to the Quality committee in February/March
- Community Hospitals have completed their quality improvement PDSA cycle across the Forest Community Hospitals and this has rolled out to Tewkesbury and Cirencester hospitals.
- North Cotswolds professional leads in Physiotherapy, Occupational Therapy and Community Nursing have completed 2 workshops focused on risk assessment and posture for AHP's. This approach is a result of the #stopthepressure PDSA results which highlighted training to reduce avoidable harm should focus on holistic assessment and posture management. Additionally this AHP approach is underway in Cheltenham with cross locality support from North Cotswolds

Risks
(Pressure Ulcers)
Reference – 562 - Rating – 12

Compliance with published standards from NHS Improvement (July 2018) and National Reporting and Learning System (NRLS) (March 2019) have been achieved. Definitions of acquired and inherited have been updated on the Datix incident reporting system. This has completed the outstanding actions from the gap analysis report for the Quality and Performance Committee (July 2018): Pressure ulcer developed or worsened during care by this organisation (previously: *acquired*). Pressure ulcer present before admission to this organisation (previously: *inherited*).

Benchmarking: In the 'Rate of New Grade 2, 3 and 4 Pressure Ulcers acquired whilst under care of the provider in a Comm. Hospital setting per 1,000 patient bed days' the Trust submitted a figure of 1.36 in January. The benchmarking figure is 1.12 for Community Hospital settings. In the 'Rate of New Grade 2, 3 and 4 Pressure Ulcers acquired whilst under care of the provider in a Community setting per 1,000 patients (on caseload)' the Trust submitted a figure of 0.42 in January. The benchmarking figure is 1.73 for a Community setting.

Gloucestershire Health and Care NHS Foundation Trust

7. Nutrition and Hydration

Outcome: Increase the use of nutrition and hydration assessments in all appropriate settings in order for patient's to be optimally nourished and hydrated

The quality improvement group is adopting a Quality Improvement methodology and the metrics include:

- Patients will have a baseline MUST on admission to wards or clinical caseloads (the maximum time frame is 72 hours for in-patient settings or 2 visits for Integrated Community Teams - ICTs).
- An audit approach to measure performance will be used until more reliable reporting can be assured from SystmOne.
- Qualitative, quarterly reporting will also be included as part of the Quality Improvement approach (using a PDSA methodology). This will focus on reviewing samples of patients where MUST scores have triggered the need for interventions to establish whether patients are being managed appropriately and to a high quality. This will include all aspects of the patient's care such as food charts, supplements, referrals to dieticians and impacts on other aspects of care such as the prevention or healing of pressure ulcers.

Nutrition and Hydration metrics 2019/20 (performance from audit data)						
Service area	Baseline		Q1	Q2	Q3	Q4
ICTs	December 2018 audit 66%	Target	65%	70%	75%	95%
		Actual	66.0%	65.0%	60.0%	Audit end March 2020
Community Hospitals	March 2019 audit 80%	Target	80%	85%	90%	95%
		Actual	91.4%	76.0%	84.0%	Audit end March 2020

Actions completed:

- Good improvement note for Community Hospitals. Revised audit collection tool working well.
- ICT show reduction in performance, however the ICT record keeping (which includes MUST) has shown a increase of 7% up to 72%. Plan to review how the snap shot MUST audit for ICT is collected for Qtr. 4 will be reviewed.
- Currently reviewing MUST audit process for Physical and Mental Health.

8. End of Life Care

Our aim will be to embed as "business as usual" with dedicated leadership.

End of Life Care improvements will continue to be reported during 2019/20.

- Percentage of patients on an End of Life template has not increased. Efforts are focussing on our Community teams as Community Hospitals consistently use the template in most cases.

End of life Care	Baseline	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Q4
Percentage of Community Hospital inpatients with End of Life care recorded on SystmOne EoL template	81.0%	81.8%	100.0%	90.9%	83.3%	82.4%	86.7%	75.0%	77.8%	75.0%	Audit available early April 2020
Percentage of all Trust patients who have End of Life care recorded on SystmOne EoL template	48.6%	52.1%	56.6%	55.2%	57.3%	59.2%	60.0%	55.1%	57.6%	48.3%	
Number of patients who have End of Life care recorded on SystmOne EoL template	n/a	76	82	74	82	77	69	75	76	71	
Number of patients who died in the month	n/a	146	145	134	143	130	115	136	132	147	Available early April 2020

Actions completed:

- The exemption criteria has now been applied and although the completion rate for the Community Hospitals has improved, The criteria applied is: any unexpected deaths, or deaths within 24 hours of referral/admission, and patients referred to the Physiotherapy and Occupational Therapy services (with the exception of the Palliative Care Occupational Therapists).
- No significant improvement was seen in community nursing with the exemptions applied. A deep dive of all the patient records without EoL template for October has shown that there are a number of deaths that should be excluded from the numbers. Unfortunately due to the way that the information is recorded we are unable to exclude these during the reporting processes. For October, out 66 patient record 18 patients died in the acute hospital, 4 in a hospice, 5 died unexpectedly at (no EoL indication in record) a and 13 died in nursing/care home (no EoL indication seen in record). For Qtr. 4 we will carry out a further patient record audit as we are unable to exclude the exemptions through reporting.
- Further deep dive of patients from ICT planned for Qtr. 4.
- ReSPECT launch countywide on 10th October 2019. Document is being used widely across Gloucestershire. Event being held in April to target Nursing/Care homes and GP to complete ReSPECT forms.
- National Audit of Care at End of Life (NACEL) result will be published mid-February. Registration for 2020 NACEL audit now open and collection across MH & PH inpatients will start April 2020.

9. The Deteriorating Patient

Outcome: Continue to train and support front line colleagues to recognise and manage deteriorating patients to ensure that they are managed quickly and effectively

The metrics are:

- All patients admitted onto Trust caseloads (Community and Inpatients) will have their NEWS recorded as a baseline. This will be measured with a snapshot audit which also extracts information about deterioration, recognition of sepsis and appropriate escalation.
- The qualitative data from the snapshot) audits will establish whether rapidly deteriorating patients have been identified and escalated appropriately within the service where their care is being managed (according to the Trust policy action cards).

For some patients this will include looking to assess whether there were any challenges evident to colleagues identifying early enough that the patient was deteriorating and at risk of sepsis and to identify key issues that may be used to develop further measures for improvement. For example, this may be clinical practice such as the frequency of observations once a NEWS has raised above a certain threshold for a patient – or around ensuring the NEWS scale 2 is used is for patients who have COPD with a clinically diagnosed oxygen (O_2) deficit and therefore need prescribed oxygen (O_2) at an lower rate (88-92).

NEWS Recording Targets 2019/20 (performance from audit data)						
Service area	**Baseline**		**Q1**	**Q2**	**Q3**	**Q4**
Community Hospital In-patients	March 2019 audit 89%	Target	89%	91%	93%	95%
		Actual	92%	98%	98%	Audit end March 2020
ICTs	March 2019 audit 33%	Target	33%	40%	50%	60%
		Actual	54%	31%	70%	Audit end March 2020

Actions completed:

- Results for Qtr. 3 snapshot audit results from NEWS in the ICT's show an encouraging improvement.
- Community Hospitals removed from risk register due to their percentage compliance with NEWS assessments.
- A review of each locality's results to be shared with operational colleagues and a focus on areas that need support will commence in February/March.

10. Falls Prevention and Management

Our aim will be to embed as "business as usual" with dedicated leadership.

Gloucestershire Health and Care NHS Foundation Trust

The Trust will be participating in a national CQUIN associated with falls and especially with regards to:

- Lying and standing blood pressures
- Rationale for documenting prescribed hypnotic or anxiolytic medications
- Mobility Assessments

Falls Prevention and Management	Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	YTD RAG
Quarterly national CQUIN. Percentage of patients meeting **all three** actions shown individually below:	80%		28.4%			43.8%			49.9%		Audit available early April 20			R
CQUIN element 1: Lying and Standing Blood Pressure recorded on SystmOne at least once	80%	55.6%	51.3%	53.3%	60.8%	60.3%	67.3%	69.9%	63.9%	75.5%	Audit available early April 20			R
CQUIN element 2: No hypnotics, antipsychotics or anxiolytics prescribed **or** rationale for prescribing documented	80%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	Audit available early April 20			G
CQUIN element 2: Mobility assessment completed within 24 hours **or** walking aid provided within 24 hours	80%	41.5%	38.8%	50.3%	72.3%	60.3%	61.9%	67.1%	61.7%	61.2%	Audit available early April 20			R
Mobility assessment completed at any time during inpatient spell	No Target	67.7%	74.5%	85.0%	94.6%	87.2%	85.7%	91.6%	87.5%	85.2%	80.0%	86.9%		
% of those assessed where a walking aid was not required	No Target	88.2%	83.7%	87.2%	85.4%	87.0%	88.1%	80.3%	82.5%	70.1%	73.3%	80.5%		
Post fall SWARM completed	80%	N/A	78.5%	79.4%	91.0%	90.5%	93.0%	91.8%	88.3%	85.9%	77.0%	84.2%		G

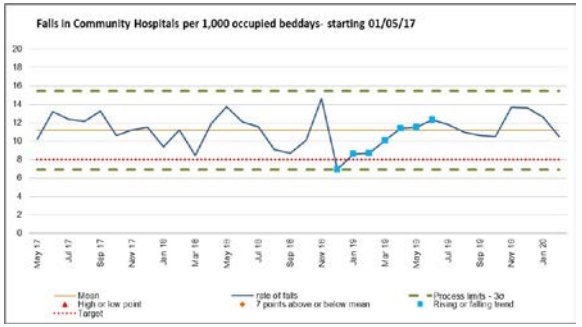
Actions required:

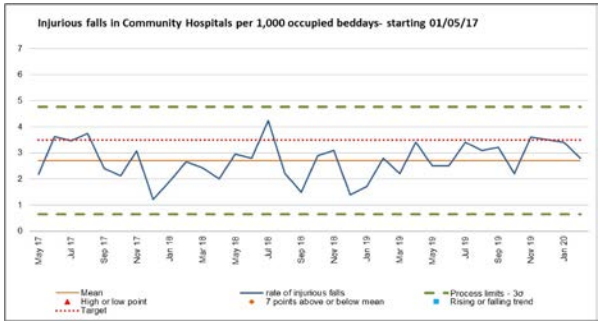
The national CQUIN identifies three key actions that should be completed as part of a comprehensive multidisciplinary falls intervention and result in fewer falls, bringing length of stay improvements and reduced treatment costs. The three key actions which must **all** be completed are:

- Lying and standing blood pressure recorded.
- No hypnotics or anxiolytics prescribed, or rationale documented.
- Mobility assessment completed or walking aid provided within 24 hours.

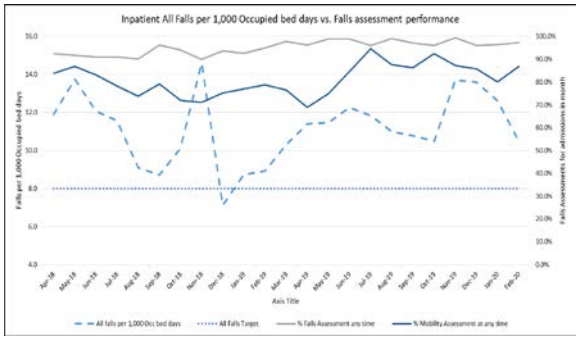
Actions completed:

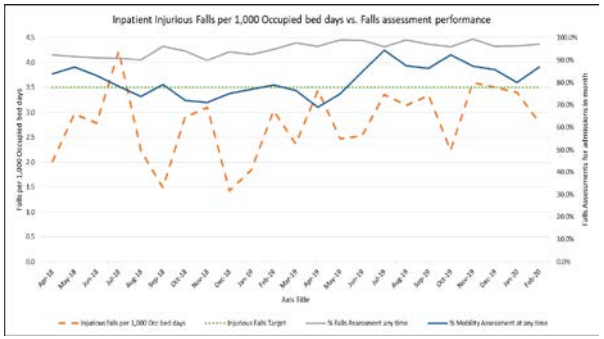
- Agreement from CCG that an audit can be undertaken in Qtr. 4 to demonstrate compliance with the requirements of the CQUIN.
- Audit tool developed and piloted on two wards. Results being analysed.
- Audit of all inpatients across all wards in March completed. Currently being analysed with a report expected by the end of March.





The SPC charts show all falls and injurious falls to be within control limit.
The internal target of 8 falls per 1,000 occupied bed days is above the mean in November 2019 to January 2020 following a low in October 2019 The target was only achieved in December 2018 suggesting this may need to be reviewed.
74.3% of all falls reported in the year to date are **without harm.**





The charts above show how performance in completing Falls and Mobility assessments during admission compare over time with rates of all falls and injurious falls.

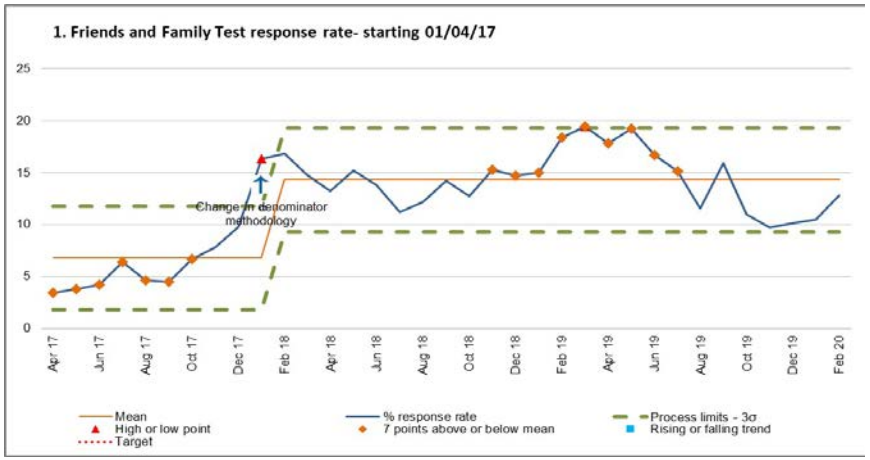
Quality | Are Services Caring?

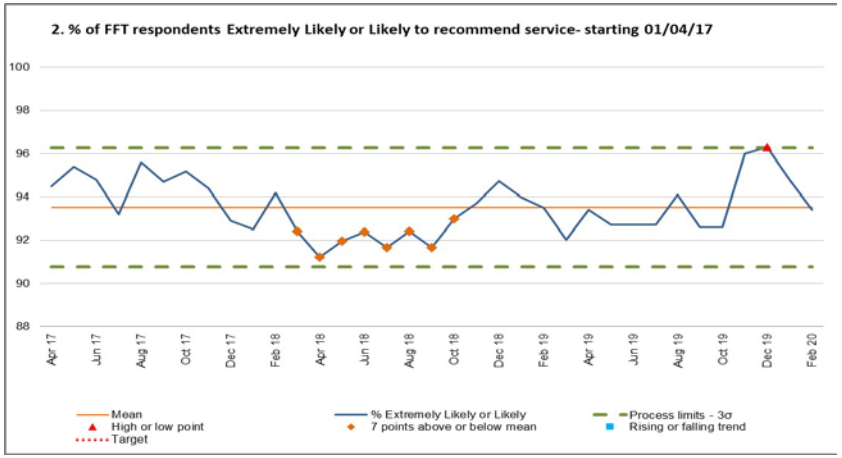
Patient Experience

Gloucestershire Health and Care
NHS Foundation Trust

CQC DOMAIN - ARE SERVICES CARING?

		Reporting Level	Threshold	2018/19 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2019/20 YTD	RAG	Exception Report?	DQ Rating	Benchmarking Report Jan Figure
1	Friends and Family Test Response Rate	N - T	15%	14.5%	17.7%	19.4%	16.7%	15.1%	11.5%	15.9%	11.0%	9.7%	10.1%	10.5%	12.8%		13.7%		No - within SPC limits	G	
2	% of respondents indicating 'extremely likely' or 'likely' to recommend service	N - R L - I	95%	92.7%	93.4%	92.7%	92.7%	92.7%	94.1%	92.6%	92.6%	96.0%	96.3%	94.8%	93.4%		93.8%		No - within SPC limits	G	95.9%
3	Number of Compliments	L - R	1,317	1,317	124	104	180	178	132	134	146	151	170	102	132		1,553			G	
4	Number of Complaints	N - R	42	42	6	5	6	2	5	3	3	6	2	4	0		42			G	
5	Number of Concerns	L - R	485	485	40	32	23	40	34	35	33	20	22	21	33		333			G	





Additional information related to performance	What actions have been taken to improve performance?
Friends and Family Test (FFT) response rate SPC chart shows a increase in response rate since November 2019. The percentage of FFT respondents recommending our services has increased since October 2019.	• February saw an increase in the response rate from recent months as the problem with sending sms and emails has been partly resolved. Emails are still not being sent but sms are sent whenever possible. March 2020 is the last month of the current FFT process; a new Trustwide GHC process will commence on 1st April 2020. • February satisfaction rate has decreased from January (94.8%) at 93.4%, and is slightly below the year to date figure of 93.8%.

Note: there is no formal benchmark for the level of 'extremely likely'/'likely' response to the Friends and Family Test, but the average from NHS Benchmarking Network for January is 95.9%.

SPC charts for Concerns, Complaints and Compliments show the following:
Concerns – Number of Concerns within normal variation.
Complaints – Number of Complaints within normal variation.
Compliments – Number of Compliments within normal variation based on the recalculated mean.

Exception Report | Are Services Safe?

Safety Thermometer

Gloucestershire Health and Care
NHS Foundation Trust

CQC DOMAIN - ARE SERVICES SAFE?

RAG Key: R – Red, A – Amber, G - Green

		Reporting Level	Threshold	2018/19 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2019/20 YTD	RAG	Exception Report?	DQ Rating	Benchmarking Report Jan Figure
20	Safety Thermometer - % Harm Free	N - R L - C	95%	93.7%	94.3%	92.6%	93.4%	94.4%	93.5%	92.9%	93.7%	91.9%	92.5%	93.3%	93.2%		93.2%	R	Pg. 13	A	
21	Safety Thermometer - % Harm Free (New Harms only)	L - I	98%	98.1%	98.3%	98.1%	98.4%	98.4%	98.5%	97.8%	96.9%	96.9%	98.1%	96.6%	97.7%		97.8%	R		A	96.8%

Additional information related to performance

- The overall sample number has decreased from 584 in January to 488 in February. This has resulted in an inaccurate denominator and is skewing still below our internal target of 98% the scores downwards.
- Harm free care (new harms only) is; **97.7%** in February compared to **96.6%** in January .

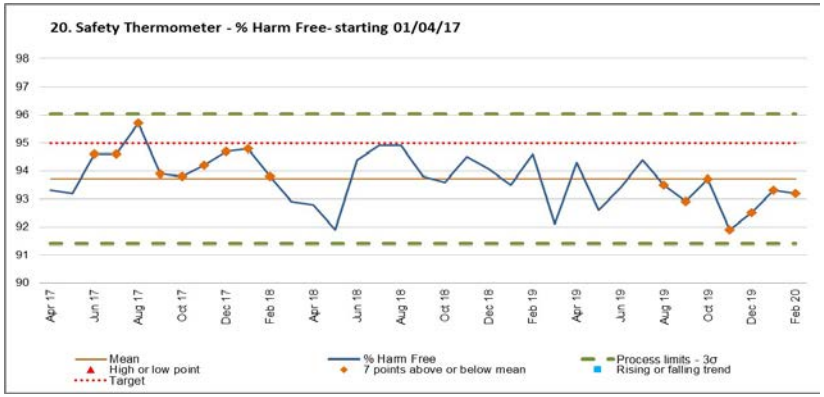
What actions have been taken to improve performance?

A new work stream was due to start to determine if it was possible to automate the safety thermometer process due to the amount of time it takes front line staff to conduct the census each month (over 200 hours a month for community teams). This has been put on hold as key staff who were to be involved in this project are now involved in the Covid-19 response.

Safety thermometer has currently been put on hold while the Trust responds to the current national Covid-19 situation. Harms are recorded as incident data through the Datix system and there are no current plans to cease incident data reporting at this time, therefore all the harms captured on safety thermometer are still captured through the Trust's incident governance processes and therefore not missed and acted upon as necessary.

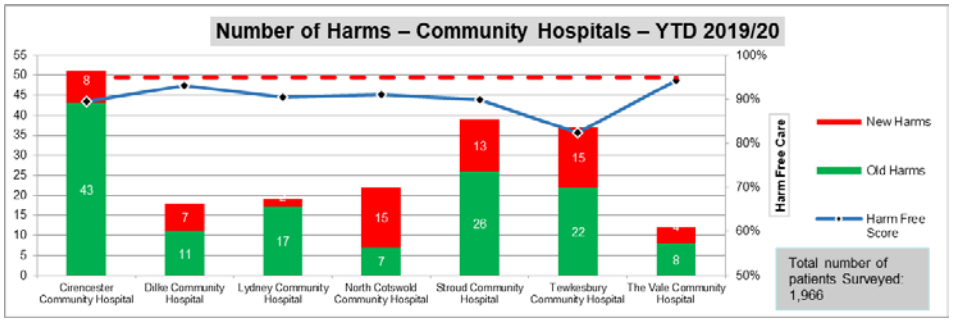
Risks
Pressure Ulcers
Reference – 562, Rating – 12

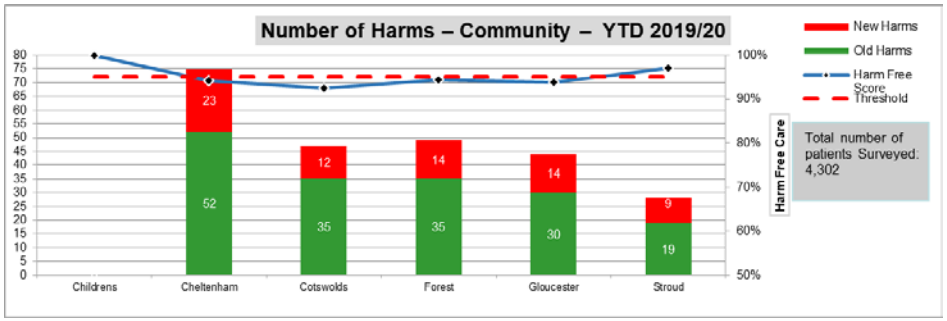
- **Benchmarking:** In the 'Safety Thermometer – Percentage of 'Harm Free Care (New Harms Only)' measure, the Trust submitted a figure of 96.6% in January. The benchmark is 96.8% for January.



Safety Thermometer Harm Free Care within normal variation. However target consistently missed.

SPC Charts have been reviewed for other harms: VTE harms fluctuate above and below the mean – but remain within control limits and are very low numbers. UTI / Catheter harms show a steady reduction over the period. Falls resulting in harm fluctuate above and below the mean – but remain within control limits and are very low numbers.





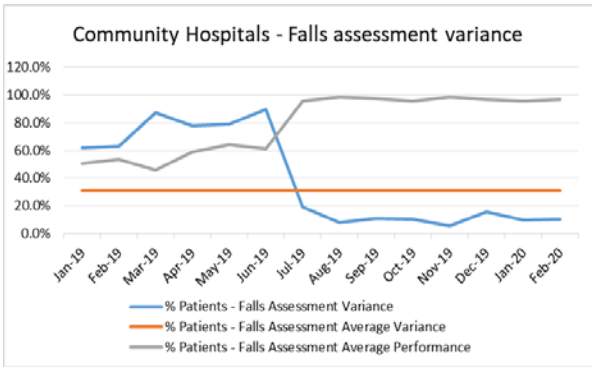
Quality | Are Services Caring?

Quality Dashboards

NHS
Gloucestershire Health and Care
NHS Foundation Trust

Feb-20	Safe	Safe	Safe	Effective	Effective	Effective	Well Led	Well Led	Well Led	Caring	Caring	Caring
CoHos	% Patients - Blood Clot (VTE) Assessment	Pressure Ulcers Developed (Acquired)	% Patients - Falls Assessment	% Unplanned Re-admissions (CoHo 30 Days)	Number of Infections	% Days lost to Delayed Discharges	% Safe Staffing fill rate	% Staff up to date PDR	% Hand Hygiene Compliance	Compliments	Complaints	% in FFT say treated with Dignity & Respect
Trust Average	100.0%	1	97.2%	4.0%	0.0	6.1%						
Cirencester - Coln Ward	100.0%	0	96.2%	3.8%	1	9.8%	98.0%	79.1%	100.0%	2	0	87.0%
Cirencester - Windrush Ward	100.0%	0	100.0%	0.0%	0	12.1%	100.8%	64.3%	100.0%	1	0	100.0%
Dilke - Forest Ward	100.0%	1	100.0%	4.3%	0	0.7%	99.7%	100.0%	100.0%	2	0	100.0%
Lydney	100.0%	2	93.3%	0.0%	0	0.0%	95.7%	84.1%	100.0%	1	0	100.0%
North Cots - Cotswold View Ward	100.0%	0	100.0%	5.6%	0	1.4%	95.8%	81.6%	100.0%	5	0	100.0%
Stroud - Cashes Green Ward	100.0%	2	93.3%	6.3%	0	8.7%	97.3%	83.9%	100.0%	3	0	100.0%
Stroud - Jubilee Ward	100.0%	2	100.0%	7.1%	0	14.2%	97.8%	86.2%	100.0%	3	0	100.0%
Tewkesbury - Abbey View Ward	100.0%	0	90.0%	0.0%	0	8.6%	98.2%	46.0%	100.0%	0	0	50.0%
Vale	100.0%	0	100.0%	11.1%	0	0.0%	120.0%	97.5%	90.0%	1	0	82.0%
MIIUs	% Staff Trained in Resuscitation (Target: 92%)	Average Time to Initial Assessment (Target: 15 min)	% of shifts filled by agency staff	% Patients seen within 4 hours	% Unplanned Reattendances	% Referred on to A&E or GP (Target: 4.4%)	% Who say in the FFT they would recommend our services	% Staff up to date PDR	% Hand Hygiene Compliance	Compliments	Complaints	% in FFT say treated with Dignity & Respect
Trust Average			1.7%	99.5%	1.6%							
Cirencester MIIU	100.0%	10	0.7%	99.5%	2.2%	4.4%	92.3%	72.7%	100.0%	0	0	98.0%
Dilke MIIU	100.0%	9	4.0%	99.7%	1.0%	10.9%	100.0%	60.0%	95.0%	0	0	100.0%
Lydney MIIU	100.0%	9	4.0%	99.8%	0.2%	5.8%	100.0%	75.0%	100.0%	0	0	100.0%
NCH MIIU	100.0%	8	0.0%	100.0%	2.7%	4.2%	100.0%	90.9%	100.0%	2	0	100.0%
Stroud MIIU	100.0%	10	0.0%	98.6%	1.1%	4.0%	71.4%	84.2%	N/A	1	0	96.0%
Tewkesbury MIIU	100.0%	9	1.2%	100.0%	3.3%	6.8%	100.0%	75.0%	100.0%	0	0	98.0%
Vale MIIU	100.0%	9	0.8%	100.0%	1.3%	3.4%	100.0%	100.0%	100.0%	0	0	100.0%

The Trust compiles a quality dashboard covering the Community Hospital Inpatient and Minor Injury and Illness Units, updated on a monthly basis (February 2020 data above). The figures are copied onto posters displayed within each of the units. The dashboard includes measures from the Safe, Effective, Well Led and Caring domains.

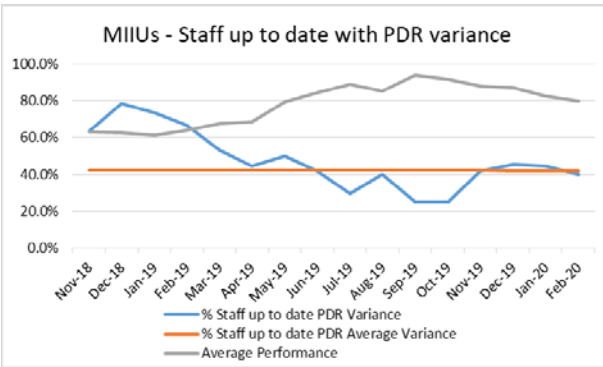


Analysis of the monthly data shows the variance in measures between the different sites over time.

Variance (blue line in the charts) is the monthly difference between the minimum and maximum for a measure across the sites. The red line is the average of this variance over time. Average performance of the measure across the sites is in grey.

The left hand chart shows how the variance, between wards, of patients having falls assessments has decreased considerably over time while the overall percentage of assessments has increased. Indicating the improvement is across all sites.

The chart on on the right shows that while the variance of staff PDR being up to date has decreased over time, there is still a significant difference in performance between sites.



Physical Health Performance Dashboard

NHS
Gloucestershire Health and Care
NHS Foundation Trust

		Reporting Level	Threshold	2018/19 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2019/20 YTD	RAG	Exception Report?	DQ Rating	Benchmarking Report Jan Figure
CQC DOMAIN - ARE SERVICES EFFECTIVE?																					
Community Hospitals																					
26	Re-admission within 30 days of discharge following a non-elective admission**	N - R		8.2%	9.5%	11.6%	6.9%	9.8%	10.5%	11.4%	8.7%	5.3%	5.5%	10.5%	4.0%		8.6%			G	
27	Inpatients - Average Length of Stay	L - R		27.7	30.5	29.9	27.9	30.6	28.6	26.5	29.1	28.8	30.3	34.4	36.6		30.3			G	29.3
28	Bed Occupancy - Community Hospitals	L - C	92%	93.6%	94.1%	93.4%	95.0%	93.4%	94.6%	92.2%	95.9%	95.6%	96.2%	97.2%	96.8%		94.9%	A		A	93.0%
29	% of direct admissions to community hospitals	L - R		19.3%	18.9%	12.6%	10.4%	16.1%	7.7%	20.5%	17.4%	11.2%	7.1%	8.7%	8.7%		12.7%			G	
30	Delayed Transfers of Care (average number of patients each month)	L - R		2	2	2	3	3	2	2	2	4	5	6	8		4			A	
31	Bed days lost due to delayed discharge as percentage of total beddays	L - R	<3.5%	1.4%	1.5%	1.7%	2.8%	2.1%	2.6%	2.3%	3.6%	3.6%	4.4%	3.1%	6.1%		3.1%	G		A	8.9%
Childrens Services - Immunisations				2018/19 Academic Year	Academic Year 2019/20					Academic Year 2019/20											
31a	HPV Immunisation coverage for girls aged 12/13 years old (2nd Immunisation)	N - T	80%*	86.5%						Programme commences January 2020				82.8%	85.0%		85.0%	G		G	
31b	HPV Immunisation coverage for girls aged 12/13 years old (1st Immunisation)	N - T	60%*	89.5%						Programme commences January 2020				13.0%	44.1%		44.1%	R		G	
Childrens Services - National Childhod Measurement Programme				2018/19 Academic Year	Academic Year 2019/20					Academic Year 2019/20											
31c	Percentage of children in Reception Year with height and weight recorded	N - T	45%*	97.7%								14.9%	26.4%	42.6%	56.7%		56.7%	G		G	
31d	Percentage of children in Year 6 with height and weight recorded	N - T	45%*	97.2%								22.6%	35.8%	46.9%	59.5%		59.5%	G		G	
CQC DOMAIN - ARE SERVICES RESPONSIVE?																					
Minor Injury and Illness Units																					
32	MIIU % seen and discharged within 4 Hours	N - T	95%	99.0%	99.1%	98.9%	99.5%	98.8%	99.3%	99.2%	99.0%	99.6%	99.5%	99.5%	99.5%		99.3%	G		G	
33	MIIU Number of breaches of 4 hour target	L - R		828	59	75	30	95	50	56	59	21	32	32	27		536			G	
34	Total time spent in MIIU less than 4 hours (95th percentile)	L - I	<4hrs	02:58	03:07	03:01	02:46	03:06	02:49	03:00	02:41	02:47	02:45	02:43	02:49		02:52	G		G	
35	MIIU - Time to treatment in department (median)	L - I	<60 m	00:34	00:34	00:35	00:31	00:36	00:24	00:32	00:31	00:30	00:29	00:23	00:30		00:31	G		G	
36	MIIU - Unplanned re-attendance rate within 7 days	L - C	<5%	0.9%	0.4%	1.5%	1.5%	1.3%	1.1%	1.4%	1.5%	1.1%	1.5%	1.5%	1.6%		1.3%	G		G	
37	MIIU - % of patients who left department without being seen	L - C	<5%	3.9%	1.1%	0.8%	0.8%	1.1%	0.7%	1.0%	0.6%	0.5%	0.7%	0.5%	0.8%		0.8%	G		A	
38	Time to initial assessment for patients arriving by ambulance (95th percentile)	N - T	<15 m	00:20	00:14	00:12	00:13	00:14	00:13	00:12	00:11	00:12	00:12	00:16	00:22		00:13	G		A	
39	Trolley waits in the MIU must not be longer than 12 hours	N - T	< 12 hrs	0	0	0	0	0	0	0	0	0	0	0	0		0	G		G	
Referral to Treatment																					
40	Adult Speech and Language Therapy - % treated within 8 Weeks	L - C	#	55.8%	69.4%	56.3%	53.6%	63.8%	69.7%	78.1%	81.3%	98.1%	83.5%	71.5%	77.9%		73.6%			A	
41	Podiatry - % treated within 8 Weeks	L - C	95%	97.2%	88.8%	81.2%	76.5%	82.1%	75.2%	68.1%	59.8%	71.5%	67.1%	55.6%	70.1%		72.2%	R		A	
42	MSKAPS Service - % treated within 8 Weeks	L - C	95%	96.5%	92.4%	87.7%	96.4%	95.1%	90.7%	90.5%	90.3%	94.3%	94.1%	90.9%	96.4%		92.9%	A		A	
43	MSK Physiotherapy - % treated within 8 Weeks	L - C	95%	89.7%	80.4%	69.1%	65.6%	64.1%	68.1%	71.2%	75.9%	74.6%	79.5%	76.8%	85.6%		73.7%	R		G	
44	ICT Physiotherapy - % treated within 8 Weeks	L - C	95%	82.8%	81.0%	81.9%	79.8%	80.7%	83.1%	72.8%	76.2%	82.8%	86.5%	75.2%	73.9%		79.5%	R		A	
45	ICT Occupational Therapy Services - % treated within 8 Weeks	L - C	95%	75.5%	82.6%	83.7%	81.4%	84.6%	85.2%	85.6%	81.9%	88.4%	84.3%	80.8%	78.7%		83.4%	R		A	
46	Diabetes Nursing - % treated within 8 Weeks	L - C	95%	93.5%	100.0%	97.2%	97.0%	95.8%	97.6%	96.2%	90.3%	100.0%	95.7%	91.2%	100.0%		96.4%	G		A	
47	Bone Health Service - % treated within 8 Weeks	L - C	95%	99.1%	99.4%	99.4%	100.0%	99.5%	100.0%	100.0%	99.4%	99.4%	100.0%	99.4%	100.0%		99.6%	G		A	
48	Contraception Service and Sexual Health- % treated within 8 Weeks	L - C	95%	99.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%			G	
49	HIV Service - % treated within 8 Weeks	L - C	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	G		G	
50	Psychosexual Service - % treated within 8 Weeks	L - C	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%			G	
51	Sexual Health - % of terminations carried out within 9 weeks and 6 days of gestation	L - C	70%	77.6%	78.4%	86.3%	89.0%	87.9%	81.4%	82.1%	81.8%	86.9%	80.6%	80.9%	89.6%		83.8%	G		R	
52	Paediatric Speech and Language Therapy - % treated within 8 Weeks	L - C	95%	97.5%	90.9%	90.9%	67.3%	86.9%	97.1%	97.0%	98.8%	95.2%	97.9%	87.7%	81.6%		89.9%	R		G	
53	Paediatric Physiotherapy - % treated within 8 Weeks	L - C	95%	91.9%	87.2%	86.5%	90.4%	89.0%	85.8%	72.6%	76.6%	86.4%	92.1%	78.1%	85.5%		83.9%	R		G	
54	Paediatric Occupational Therapy - % treated within 8 Weeks	L - C	95%	95.7%	97.9%	91.5%	91.7%	94.2%	97.1%	95.4%	95.9%	97.9%	97.3%	97.3%	94.6%		95.6%	G		A	

*Cumulative threshold (i.e. February) # Adult Speech and Language Therapy RAG rating and target temporarily removed following discussion with Commissioners.

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

RAG Key: R – Red, A – Amber, G - Green

Physical Health Performance Dashboard

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		Reporting Level	Threshold	2018/19 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2019/20 YTD	RAG	Exception Report?	DQ Rating	Benchmarking Report Jan Figure
CQC DOMAIN - ARE SERVICES RESPONSIVE?																					
55	MSKAPS Service - % of referrals referred on to secondary care	L - C	<30%	15.9%	21.1%	20.5%	24.3%	24.5%	20.2%	21.7%	15.0%	17.7%	15.6%	15.1%	3.8%		18.3%	G		A	
56	MSKAPS Service - Patients referred to secondary care within 2 days of decision to refer onwards	L - C	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	G		A	
58	Stroke ESD - Proportion of new patients assessed within 2 days of notification	L - C	95%	84.3%	100.0%	97.1%	100.0%	89.7%	90.3%	91.3%	94.4%	100.0%	100.0%	100.0%	100.0%		96.5%	G		A	
59	Stroke ESD - Proportion of patients discharged within 6 weeks	L - C	95%	97.0%	97.1%	84.6%	100.0%	93.8%	94.4%	93.8%	100.0%	88.9%	100.0%	94.4%	100.0%		95.0%	G		A	
60	Social Care ICT - % of Referrals resolved at Referral Centres and closed	L - C		49.2%	47.6%	52.3%	51.1%	48.8%	48.5%	48.3%	47.2%	48.8%	51.9%	43.2%	36.1%		47.6%			A	
63	Single Point of Clinical Access (SPCA) Calls Offered (received)	L - R		39,348	2,975	3,045	3,048	3,033	3,007	2,934	3,319	3,234	3,089	3,045	2,699		33,428			G	
64	SPCA % of calls abandoned	L - C	<5%	1.4%	0.9%	0.5%	0.9%	0.7%	1.1%	0.8%	1.8%	1.7%	1.7%	1.5%	1.2%		1.2%	G		G	
65	95% of priority 1 & 2 calls answered within 60 seconds after introductory message finishing	L - C	95%	97.2%	97.9%	98.5%	98.0%	98.1%	97.1%	98.0%	95.4%	95.6%	95.9%	97.0%	96.6%		97.1%	G		G	
66	Rapid Response - Number of referrals	L - C	*3,384	3,905	346	318	333	356	329	335	300	326	345	342	306		3,636	G		A	
67	Wheelchair Service. Adults: New referrals assessed within 8 weeks	L - C	90%	26.9%	4.5%	23.1%	7.1%	40.9%	35.7%	68.8%	22.4%	15.4%	37.0%	26.7%	37.5%		29.4%			R	
68	Wheelchair Service. Adults: Priority Referrals seen within 5 working days	L - C	95%	20.0%	100.0%	0.0%	No priority Assessments	No priority Assessments	0.0%	100.0%	0.0%	7.1%	0.0%	22.2%	0.0%		13.0%			R	
69	Wheelchair Service. Under 18s: New referrals assessed within 8 weeks	L - C	90%	35.3%	50.0%	50.0%	50.0%	33.3%	0.0%	33.0%	44.4%	50.0%	100.0%	20.0%	70.0%		58.1%			R	
70	Wheelchair Service. Under 18s: Priority Referrals seen within 5 working days	L - C	95%	75.0%	No priority Assessments	No priority Assessments	No priority Assessments	No priority Assessments	No priority Assessments	No priority Assessments	No priority Assessments	0.0%	No priority Assessments	50.0%	No priority Assessments		25.0%			R	
71	Wheelchair Service: Under 18s: Equipment delivered within 18 weeks of referral	L - C	92%	31.8%	No Deliveries	100.0%	100.0%	0.0%	0.0%	50.0%	100.0%	33.3%	50.0%	66.6%	50.0%		63.2%			R	
72	Percentage of patients waiting less than 6 weeks from referral for a diagnostic test	N - T	>99%	100.0%	100.0%	100.0%	100.0%	100.0%	95.9%	85.9%	98.8%	100.0%	94.0%	100.0%	100.0%		97.1%	R		G	
Cancelled operations																					
73	No urgent operation should be cancelled for a second time	N - T	0	0	0	0	0	0	0	0	0	0	0	0	0		0	G		G	
74	Number of patients who have had operations cancelled for non-clinical reasons that have not been offered another binding date within 28 days	N - T	0	0	0	0	0	0	0	0	0	0	0	0	0		0	G		G	

*Year to date threshold

Wheelchair Service RAG rating removed following discussion with Commissioners.

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

RAG Key: R – Red, A – Amber, G - Green

Physical Health Performance Dashboard

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NHS Foundation Trust

CQC DOMAIN - ARE SERVICES WELL LED?

		Reporting Level	Threshold	2018/19 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2019/20 YTD	RAG	Exception Report?	DQ Rating	Benchmarking Report Jan Figure
75	Staff Friends and Family Test - Percentage of staff who would recommend the Trust as a place of work	N - R L - T	61%	58.5%			52.0%			58.0%			60.7%				55.0%	R		G	
76	Staff Friends and Family Test - Percentage of staff who would recommend the Trust as a place to receive treatment	N - R L - T	67%	84.6%			83.0%			88.0%			80.4%				85.5%	G		G	
77	Mandatory Training	L - I	90%	85.90%	85.8%	86.62%	86.71%	86.40%	91.08%	90.02%	90.38%	90.12%	90.40%	91.19%	90.75%		89.04%	A		A	87.1%
78	% of Staff with completed Personal Development Reviews (Appraisal)	L - I	90%	77.1%	76.42%	77.72%	79.42%	82.22%	82.57%	80.35%	80.63%	80.14%	79.20%	82.33%	81.70%		80.25%	R		A	87.6%
78a	% of Staff with completed Personal Development Reviews (Appraisal) Active Assignments Only	L - I	90%	81.4%	81.24%	82.54%	85.35%	87.38%	86.72%	84.91%	85.84%	85.79%	84.82%	82.36%	82.43%		84.49%	R		A	
79	Sickness absence average % rolling rate - 12 months	L - I	<4%	4.8%	4.90%	4.87%	4.82%	4.80%	4.76%	4.77%	4.78%	4.76%	4.74%	4.92%	4.73%		4.80%	A		A	5.2%
80	SUS+ (Secondary Uses Service) Data Quality Validity - Available in arrears	N-R	96.3%	99.1%	71.00%	74.30%	76.50%	76.60%	76.60%	78.90%	89.60%	₸					77.6%	R		R	

Additional KPIs

		Reporting Level	Threshold	2018/19 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2019/20 YTD	RAG	Exception Report?	DQ Rating	Benchmarking Report Jan Figure
81	Mixed Sex accommodation breaches			0	0	0	0	0	0	0	0	0	0	0	0		0			G	
82	Proportion of eligible children who receive vision screens at or around school entry.		45%*	98.2%								12.2%	22.3%	37.5%	51.0%		51.0%	G		A	
83	Number of AnteNatal visits carried out		N/A	1107	89	82	74	99	93	66	63	59	66	94	47		832			G	
84	Percentage of live births that receive a face to face NBV (New Birth Visit) within 7- 14 days by a Health Visitor		95%	88.6%	92.30%	91.40%	89.8%	92.00%	89.8%	91.10%	90.50%	93.60%	90.60%	91.60%	92.20%		91.3%	A		A	
85	Percentage of children who received a 6-8 weeks review.		95%	93.37%	96.5%	95.5%	94.20%	96.3%	95.1%	93.20%	94.50%	94.50%	94.70%	92.50%	93.80%		94.6%	A		A	
86	Percentage of children who received a 9-12 month review by the time they turned 12 months.		95%	83.4%	83.8%	83.0%	79.9%	85.8%	84.1%	88.4%	83.8%	86.6%	86.2%	83.80%	80.40%		84.2%	A^		A	
87	Percentage of children who received a 12 month review by the time they turned 15 months.		95%	86.2%	89.4%	89.5%	91.50%	91.00%	90.70%	90.10%	90.60%	89.9%	92.40%	89.60%	90.50%		89.9%	A^		A	
88	Percentage of children who received a 2-2.5 year review by 2.5 years.		95%	80.2%	86.1%	84.3%	83.2%	81.6%	85.8%	85.9%	79.6%	82.0%	84.4%	82.80%	82.00%		83.4%	A^		A	
89	Percentage of children who received a 2-2.5 year review using ASQ 3.		95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	G		A	
90	Percentage of infants for whom breastfeeding status is recorded at 6-8wk check.		95%	99.2%	98.8%	97.7%	98.8%	99.2%	98.3%	96.5%	98.3%	98.4%	97.7%	98.3%	99.3%		98.3%	G		A	
91	Percentage of infants being totally or partially breastfed at 6-8wks(breastfeeding prevalence).		58%	54.5%	53.5%	56.2%	54.6%	52.9%	52.6%	55.9%	57.7%	58.5%	56.1%	53.5%	57.7%		55.4%			A	
92	% of mothers who are still breastfeeding at 8 weeks who were breastfeeding at 2 weeks.		80%	81.4%	79.50%	82.6%	81.9%	80.5%	79.80%	81.0%	83.7%	79.90%	81.5%	79.40%	83.7%		81.2%	G		A	
93	Chlamydia Screening of Gloucestershire residents aged 15-24 via the Chlamydia Screening Service (minimum positivity rate)		N/A	3108	2044	2432	2314	2009	1908	1908	2094	1621	1266	1959	2213		1979			A	
94	Number of Positive Screens - GCS and Joint responsibility		N/A	2031	113	120	127	119	113	113	124	96	75	116	131		1247			A	
95	Average Number of Community Hospital Beds Open		N/A	194.3	195.8	196.0	194.7	195.7	195.4	194.8	195.5	195.5	192.6	194.5	192.8		194.9			G	
96	Average Number of Community Hospital Beds Closed		N/A	0.6	0.2	0.0	1.3	0.3	0.6	1.4	1.4	0.5	3.1	1.5	3.2		1.2			G	

*Cumulative threshold (i.e. February)

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RAG Key: R – Red, A – Amber, G - Green

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Mental Health & Learning Disability Services (formerly 2gether NHS Foundation Trust)

Data covering April to December 2019 –Q3 Position

Note- Mental Health & Learning Disability quality data is historically reported quarterly. This will be brought into a monthly reporting cycle for the 2020/21 Quality Schedule

Executive Summary

Gloucestershire Health and Care NHS Foundation Trust

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

Are Our Services Effective?
In 2019/20 we remain 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.

Do We listen And Act on Patient & Carer Feedback?

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

- Were you involved as much as you wanted to be in agreeing the care you will receive? > 84%
- Have you been given information about who to contact outside of office hours if you have a crisis? > 71%
- Have you had help and advice about taking part in activities that are important to you? > 64%
- Have you had help and advice to find support for physical health needs if you have needed it? > 73%

Are Our Services Safe?
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 5 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;
- To ensure that 100% of service users within Berkeley House have a bespoke restrictive intervention care plan tailored to their individual needs;
- Embed the learning from our reported serious incidents:

Targets Not Being Met

1. **Target 1.1 Improving the physical health care for people with schizophrenia and other serious mental illnesses;** Compliance within the inpatient service is at **78%** against a target of **90%.**

- The Audit & Assurance Team will establish an electronic audit which should provide ward/team managers compliance data on a weekly basis and actively promote intervention if required.

- A re launch of the Health & Lifestyle form is planned for February 2020 which will involve ward/team training and posters to be displayed around the Trust. This is to coincide with some minor changes made to the form to increase awareness around national screening programmes, but will also act as a reminder to staff to complete the form fully.

Risks

1. Target 1.2 Ensuring that people are discharged from hospital with personalised care plans. 48hr follow up is currently showing as 72% ,this appears low compared to historical trends and will need validating by the Information Team where we expect the score to improve .

2. Targets 2.1 & 2.4 (Survey questions) were none compliant respectively in Q2 & Q3 although cumulatively compliance is achieved. This appears to be a consequence of significantly reduced response rates, including a zero return from Herefordshire Services in Q3. There is ongoing work to promote the survey during Q4 ahead of the new FFT and harmonised physical and mental health patient and Carer survey being launched in April 2020.

Quality Priority | Effective?

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

Gloucestershire Health and Care NHS Foundation Trust

Within Quarter 3, the Gloucestershire Health and Care NHS Foundation Trust has committed to offer a full cardio metabolic check to all inpatients and all SMI/CPA service users in the community. Our target for compliance remains at;

75% of community patients will receive the health check and will have any associated interventions offered if required.
90% of inpatients will receive the health check and will have any associated interventions offered if required.

An audit continues to establish if the six parameters of the Lester tool are completed, along with the recording of any interventions offered. The Quarter 3 audit shows:

76% of community patients have had these checks and interventions in place.
78% of inpatients have had these checks and interventions in place

We are not currently meeting the inpatient target

Actions completed:

Successful physical health clinics continue to run at Pullman Place and 27a St Owen Street, providing service users in the community access to physical health checks in an environment with staff who are familiar to them. Such is the success of the physical health clinics, a Physical Health nurse has been employed for one day a week to take a lead on developing the clinics further within Pullman Place.

The Trust has purchased nine ECG machines for the community hubs. These will provide the opportunity for routine ECG screening for possible cardiac anomalies for patients who are at an increased cardio metabolic risk, largely due to medication side effects and lifestyle factors. Training for staff to take ECG's has been provided by the Physical Health Facilitator, and refresher training for medics to interpret ECG's will be held internally by the Trust own Medical team.

Alongside this health screening work, Gloucestershire Health and Care NHS Foundation Trust continues to increase access to physical health treatment for service users. The Quality Improvement initiative 'Well Woman Wednesdays' at Wotton Lawn Hospital, where ladies are offered a full range of advice and success to cervical screening in house, has now been expanded to the community Hub. This has enabled service users to access this vital screening in an environment they are familiar with.

The recent Trust merger has offered further opportunities for staff to access community physical health services such as Tissue Viability, Community Diabetes Teams and District Nursing teams. This will enhance the services and opportunities available for service users and improve the knowledge of physical health for our mental health staff.

Actions Planned

- The Audit & Assurance Team will establish an electronic audit which should provide ward/team managers compliance data on a weekly basis and thereby promote timely interventions.
- A re launch of the Health & Lifestyle form is planned for February 2020 which will involve ward/team training and posters to be displayed around the Trust. This is to coincide with some minor changes made to the form to increase awareness around national screening programmes, but will also act as a reminder to staff to complete the form fully.

Quality Priority | Effective?

Target 1.2 To improve personalised discharge care planning in:
a) Adult inpatient wards and
b) Older people's wards.

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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. We have continued with this 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 HEF been completed (LD only
4.Has the Pre-Discharge Planning Form been completed?
5.Have the inpatient care plans been closed within 7 days of discharge?
6.Has the patient been discharged from the bed?
7.Has the Nursing Discharge Summary Letter to Client/GP been sent within 24 hours of discharge?
8.Has the 48 hour follow up been completed?

Outcome:

Overall compliance for the Mental Health Inpatient Units across Gloucestershire and Herefordshire for Q3 was **79%**, compared to **75%** in Q2. This shows an increase of **4%** compliance across the Trust.

Overall compliance for Gloucestershire only for Q3 was **76%** compared to **72%** in Q2; this means that there has been a **4%** increase in compliance.
Overall compliance for Herefordshire only for Q3 was **82%** compared to **78%** in Q2; this means that there has been a **4%** increase in compliance.

During Q3 of 2019-20, there were 80 discharges from Herefordshire, and 158 from Gloucestershire. The total number of discharges from all Mental Health Inpatient Units across the Trust was 238.
We are currently meeting the target

	Criterion	Current compliance (Q3 2019-20)	Direction of travel and previous compliance
1	Has a Risk Summary been completed?	99%	⇔ 100%
2	Has the Clustering Assessment and Allocation been completed?	96%	⇧ 92%
3	Has HEF been completed (LD only)?	100%	⇔ 100%
4	Has the Pre-Discharge Planning Form been completed?	28%	⇧ 23%
5	Have the inpatient care plans been closed within 7 days of discharge?	45%	⇧ 26%
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?	88%	⇩ 93%
8	Has the 48 hour follow up been completed if the Community Team are not doing it?	73%	⇩ 92%

Quality Priority | Effective?

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.

Gloucestershire Health and Care NHS Foundation Trust

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

Outcome

During Q3

- In Gloucestershire 3 young people transitioned from CYPS to adult mental health services, all had a joint CPA meeting.
- In Herefordshire 1 young person transitioned from CYPS to adult mental health services, all had a joint CPA meeting.

We are currently meeting the target

Gloucestershire Services	Qtr. 1	Qtr.2	Qtr. 3	Qtr. 4
Joint CPA Review	100%	100%	100%	Available end March 2020

HerefordshireServices	Qtr. 1	Qtr.2	Qtr. 3	Qtr. 4
Joint CPA Review	100%	100%	100%	Available end March 2020

Quality Priority | User Experience

NHS
Gloucestershire Health and Care
NHS Foundation Trust

Target 2. The local mental health survey (User Experience Quality Indicator) has an overall goal of improving patient and Carer experience with 4 associated targets:

2.1 Were you involved as much as you wanted to be in agreeing the care you will receive? > 84%
2.2 Have you been given information about who to contact outside of office hours if you have a crisis? > 71%
2.3 Have you had help and advice about taking part in activities that are important to you? > 64%
2.4 Have you had help and advice to find support for physical health needs if you have needed it? > 73%

Outcome :

Results show the combined totals for both Gloucestershire and Herefordshire mental health services

Analysis

Response rates have significantly reduced quarter on quarter for each county, which in turn impacts negatively upon levels of compliance.

Text messaging as a means of communicating and collecting survey responses ended in January 2019 when the contract with Healthcare Communications ended, although feedback/responses continued to be received for several subsequent months.

Significantly lower responses rates mean that singular + or – responses to questions bias the overall outcome dramatically.

Responses have dropped each consecutive quarter as follows:

- Herefordshire range **124** responses Q1 to **0 (Zero)** in Q3

- Gloucestershire range **97** responses Q2 to **10** in Q3

PALS visits to the Stonebow Unit in Hereford reduced from 3-2 in Q3 (a consequence of merger activity and relocation of the Service Experience Team to Edward Jenner Court.

As a balancing measure, the results of the 2019 CQC community mental health survey provides significant assurance of the Trust's delivery of high quality adult community mental health services.

We are currently meeting this target.

Actions Planned

- There is now a dedicated Survey Team in place to coordinate and promote patient and carer feedback .
- SNAP survey software will be the platform for managing the process going forward (GCS used SNAP very successfully) and core questions applicable in both mental health and physical health services have been agreed for use from April 2020.). This software solution enables us to design our surveys and distribute these in a number of ways including paper, online, mobile (tablets, mobile phones and kiosks). An action plan is in place.

Quality Survey Question	Qtr. 1	Qtr.2	Qtr. 3	Qtr. 4	Cumulative Outcome
Were you involved as much as you wanted to be in agreeing the care you will receive? **> 84%**	90%	79%	88%	Available end March 2020	86%
Have you been given information about who to contact outside of office hours if you have a crisis? **> 71%**	86%	74%	90%	Available end March 2020	83%
Have you had help and advice about taking part in activities that are important to you? **> 64%**	81%	74%	71%	Available end March 2020	79%
Have you had help and advice to find support for physical health needs if you have needed it? **> 73%**	82%	89%	71%	Available end March 2020	83%

Quality Priority | Safe?

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.

Gloucestershire Health and Care NHS Foundation Trust

We aim to minimise the risk of suicide amongst those with mental disorders through systematic implementation of sound risk management principles.

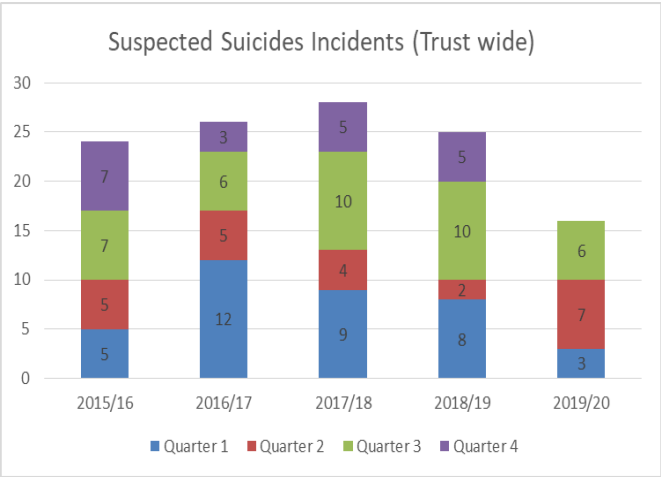
What we also know is that we are seeing more and more service users on our caseload year on year, so we measured this important target differently this year by reporting as a rate per 1000 service users on the Trust caseload.

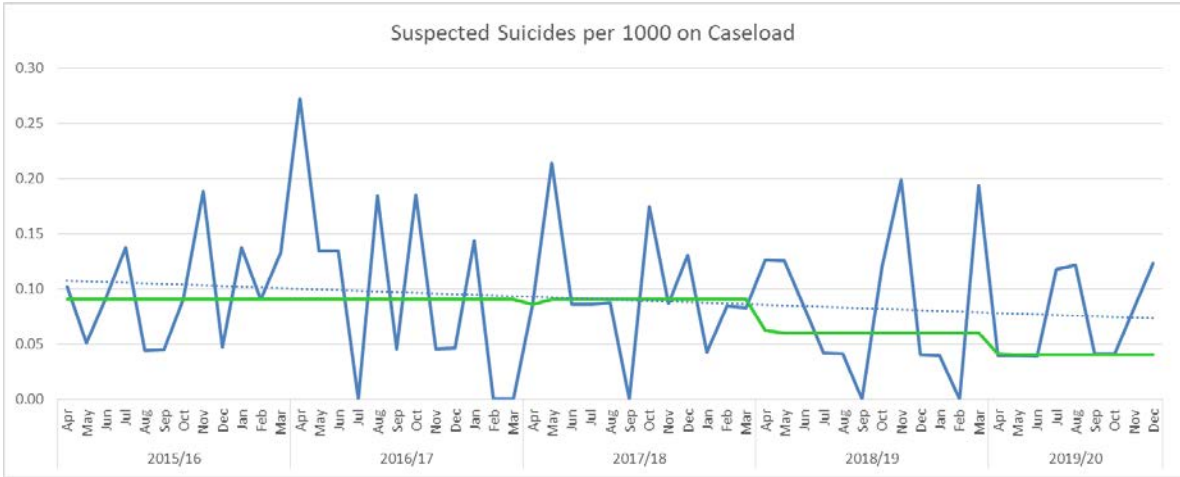
Outcome

The number of reported suspected suicides increased during 2016/17 to **26** suspected suicides and in 2017/18 further increased to **28**. We were pleased to report that by the end of 2018/19 the number had reduced and that we reported **25** suspected suicides. At the end of Quarter 3 2019/20, **16** suspected suicides have been reported , the lowest number for 5 years.

In terms of the rate per 1000 patients on the caseload, during 2015/16, 2016/17 and 2017/18 the median value was **0.09.** By the end of 2018/19 the median value reduced to **0.06** and at the end of Quarter 3 2019/20 this has reduced further to **0.04**.

We are currently meeting 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 detained service users who are AWOL come to serious harm or death, so we are measuring the level of harm that people come to when absent.

Outcome

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. In 2017/18 we reported **170** occurrences of AWOL (142 in Gloucestershire and 28 in Herefordshire) . **190** occurrences were reported during 2018/19 (144 in Gloucestershire and 46 in Herefordshire), none of these led to serious harm or death.

At the end of Q3 2019/20, **160** occurrences have been report with none of these events leading to serious harm or death

We are currently meeting this target.

	Absconded from a ward	Did not return from leave	Absconded from an escort	Total
Gloucestershire	71	46	13	**130**
Herefordshire	27	1	2	**30**
Total	**98**	**47**	**15**	**160**

Target 3.3 To increase the use of supine restraint as an alternative to prone restraint (on all adult wards & PICU)

The use of prone restraint (face down) is sometimes necessary to manage and contain escalating violent behaviour, however it is also a response that has potential to cause serious harm to an individual. As a Trust we want to minimise the use of this wherever possible through therapeutic engagement and occupation in the inpatient environment; alongside effective de-escalation techniques and alternatives to prone restraint.

Outcome

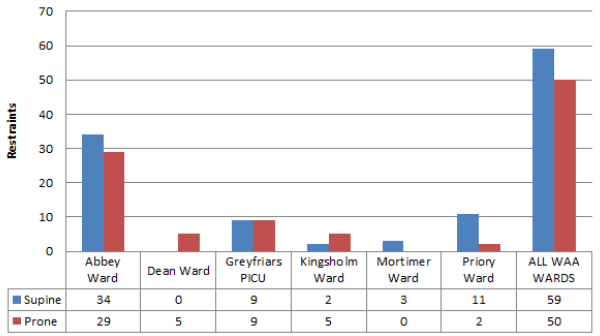
The Trust has a sub group focused on reducing physical restraint, in line with national guidance, reporting into our Quality Assurance Group. From reviewing our restraint data in detail over the past 3 years, we have seen a reduction in prone restraint and a positive increase in the use of supine restraint as an appropriate and safer alternative to prone restraint. This is due to active promotion of techniques used and additional training in the use of alternate injection sites.

Review of Q3 data shows that when restrictive techniques were required to safely manage a rapid escalating situation, **88.9%** of these resulted in the use of supine restraint, compared to **11.1%** requiring prone.

The pie chart below shows the spread of all physical interventions used on our adult wards and the PICU during Quarter 3 and it is reassuring to note that, wherever possible, the least restrictive practices e.g. seated or precautionary holds are used. Supine or prone restraint are only used when a person's safety becomes compromised.

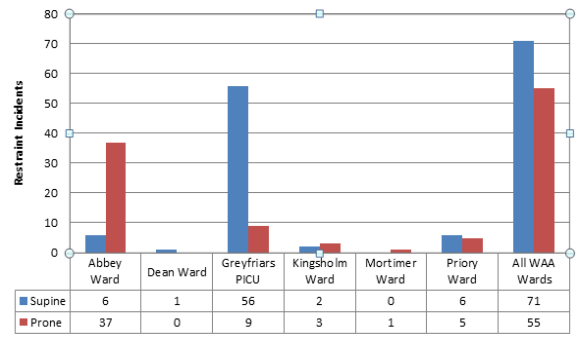
We are currently meeting this target.

Prone vs Supine restraints by inpatient ward (Inpatient Working Age Adults) - 2019/20 Q1



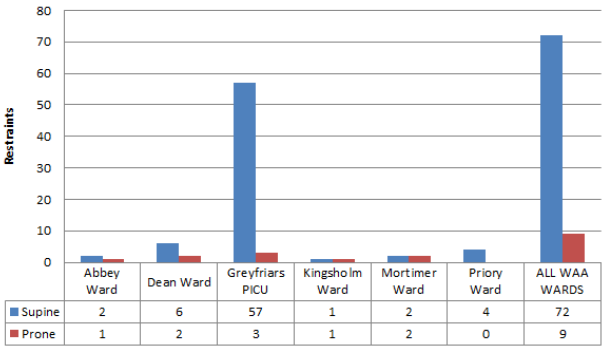
	Abbey Ward	Dean Ward	Greyfriars PICU	Kingsholm Ward	Mortimer Ward	Priory Ward	ALL WAA WARDS
Supine	34	0	9	2	3	11	59
Prone	29	5	9	5	0	2	50

Q2 2019/20 - Prone vs Supine restraints by inpatient ward (Inpatient Working Age Adults)



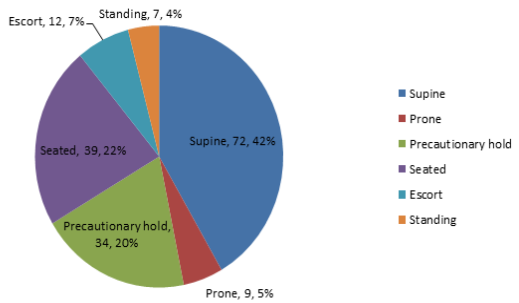
	Abbey Ward	Dean Ward	Greyfriars PICU	Kingsholm Ward	Mortimer Ward	Priory Ward	All WAA Wards
Supine	6	1	56	2	0	6	71
Prone	37	0	9	3	1	5	55

Q3 2019/20 - Prone vs Supine restraints by inpatient ward (Inpatient Working Age Adults)



	Abbey Ward	Dean Ward	Greyfriars PICU	Kingsholm Ward	Mortimer Ward	Priory Ward	ALL WAA WARDS
Supine	2	6	57	1	2	4	72
Prone	1	2	3	1	2	0	9

Q3 2019/20 Physical Intervention incidents by 'type of position used' (most restrictive) (Working Age Adults)



Gloucestershire Health and Care NHS Foundation Trust

Target 3.4 To ensure that 100% of service users within Berkeley House have a bespoke restrictive intervention care plan tailored to their individual needs.

The aim is for all patients to have a bespoke Positive Behaviour Management (PBM) assessment and care plan, written in conjunction with the Behaviour Support & Training Team, the PBM trainer within the staffing establishment at Berkeley House and the wider Multidisciplinary team. These plans must include sensory interventions formulated by an occupational therapist. The PBM assessment (Individual Patient Physical Intervention Technique Checklist) clearly identifies techniques to be implemented for each individual as and when proportional to the risk to self and others.

Outcome

Berkeley House currently has 7 patients all of whom have specific care plans for Positive Behaviour Management (PBM) interventions; these care plans are on RiO and a copy of an accessible care plan is available for the patient.

They also have Positive Behavioural Support (PBS) plans which contain detailed information regarding primary, secondary and tertiary strategies for each person. Within these plans are functional assessments of behaviours that individuals may display. These include what a good day looks like and individualised strategies to manage behaviours when a patient begins to show signs of distress.
Primary prevention strategies aim to enhance the service users' quality of life and meet their unique needs thereby reducing the likelihood of behavioural disturbances.
Secondary prevention strategies focus on the recognition of early warning signs of impending behavioural disturbance and how to respond in order to encourage the patient to be calm.
Tertiary strategies guide the responses required to manage behavioural disturbance and acknowledge that the use of proportionate restrictive interventions may be required to minimise harm

We are currently meeting this target.

Target 3.5 To further develop a quality improvement led approach to robustly embed lessons learned following serious incidents.

The Trust Serious Incident Review Process was reviewed during Quarter 4 2018/19 by Price Waterhouse Coopers (PWC) internal audit team. PWC assessed the effectiveness of the change in the Trust's Serious Incidents Requiring Investigation (reporting mechanisms, examined the processes in place for implementing relevant SIRI action plans and how lessons learned identified are shared across the Trust. The audit provided positive assurance regarding the quality of investigations and identified that there was a robust and effective mechanism to share lessons learned across the Trust, however there was scope to enhance the implementation in practice, embed the learning and the assurance mechanisms to determine effectiveness.

Actions Ongoing & Planned.

- Work is ongoing via the Nursing, Therapies & Quality Team regarding improving embedding lessons learned from serious incidents and this will be monitored and evaluated by the Quality Committee. A new approach for embedding learning has been designed and is now being rolled out
- Web based platforms for the dissemination of the learning from SIRIs are being explored, which would include confirmation that the recipient had both read the detail and taken any relevant action. The Trust Learning and Development Team are working to adapt the Trusts current on line platform to provide an in house solution for this.
- A review of the Duty of Candour process was commissioned by the Director of Nursing, Therapies & Quality and undertaken during Q3. Recommendations have been made and implemented to improve this important process.
- The newly merged Clinical Governance & Compliance Team held a series of team workshops throughout November and December 2019 to review the legacy Incident Management (including SIRIs), Duty of Candour and Complaints processes from both GCS & 2G and begin harmonizing these in readiness to establish robust policy and practice to implement from April 2020. A further workshop has been held in January to consolidate the work on incident management and learning assurance processes.

We anticipate meeting this target by April 2020.

with you, for you

Gloucestershire Health and Care
NHS Foundation Trust

APPENDIX 2

AGENDA ITEM: 16/0320

Quality Report 2019/20

(Q3 update – please note this is a working document that is fully completed at end of Q4 for submission – areas awaiting final agreed updates are in red text)

CONTENTS

Part 1: Statement on Quality from the Chief Executive

Introduction

To be completed at year end.

Part 2.1: Looking ahead to 2020/21

Quality Priorities for Improvement 2020/21

This section of the report looks ahead to our priorities for quality improvement in 2020/21. 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 Gloucestershire Healthwatch, we have identified **8** goals and **11** associated targets for 2020/21. These targets will be measured and monitored through reporting to the Trust's Quality 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:

- NHSE Long Term Plan 2019;
- NHSE: NHS Mental Health Implementation Plan 2019/20 - 2023/24;
- Care Quality Commission (via CQC Comprehensive Inspections and Mental Health Act inpsections at our sites)
- NHS Outcomes Framework Indicators February 2020;
- NHS England: Commissioning for Quality & Innovation (CQUIN) Guidance for 2020-2021.
- NHS Improvement. Oversight Framework for 2019/20;
- National Institute for Health & Care Excellence publications including their quality standards;
- Preventing suicide in England: Forth annual report on the cross-government outcomes strategy to save lives. Department of Health 2019;
- National Confidential Inquiry into Suicide and Safety in Mental Health: Annual Report 2019;
- Gloucestershire Sustainability Transformation Plan (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
To improve the physical health care for adults (aged18 and over) who are malnourished or at risk of malnutrition in hospital including identifying people at risk of malnutrition and providing nutrition support.	1.1 To achieve a target 70% of hospital inpatients having a nutritional screening that meets NICE Quality Standard QS24 with evidence of actions against identified risks. (CQUIN CCG3)	To support NHS England's commitment to the prevention of ill health we aim to continue to make improvements relating to the physical health for those people in contact with our services. This is a new indicator with no comparable data This is primarily a Community CQUIN however we will endeavour to implement it across all inpatient sites
To ensure that End of Life care is provided with excellence and compassion	1.2 To deliver the ICS 'RESPECT' programme	
Improve transition processes for child and young people who move into adult.	1.3 To ensure that there are appropriate plans in place for all children and young people that transistion into adult services.	We wish to continue to support this as a key quality priority during 2020/21 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 patients in key areas. This will be measured though defined survey questions for both people in the community and inpatients, and spanning both physical health and mental health services.	2.1 Overall, how was your experience with our service and the quality of care you received? **Target :** To achieve a response 'Very good' or 'Good'' for more than **90%** of the people surveyed.	To continously improve on both our Friends and Family Test and CQC Community Mental Health Survey scores as part of our ambition to deliver outstanding care.
	2.2 Did you feel you were treated with respect and dignity? **Target :** To achieve a response 'Yes, definitely' for more than **90%** of the people surveyed.	
	2.3 Did you feel the service was delivered safely and protected your welfare? **Target :** To achieve a response 'Yes, definitely' for more than **90%** of the people surveyed.	
	2.4 Were you involved as much as you wanted to be in decisions about your care and treatment? **Target :** To achieve a response 'Yes, definitely' for more than **90%** of the people surveyed.	

Safety

Goal	Target	Drivers
Minimise the risk of suicide of people who use our services.	3.1 To 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. And For all our mental health inpatient services to have zero suicides.	Gloucestershire Suicide Prevention Strategy and Action Plan. Preventing suicide in England: Third annual report on the cross-government outcomes strategy to save lives. National Confidential Inquiry into Suicide & Safety in Mental Health. To deliver the NHSE/I Zero Suicide Plan for inpatient mental health services We have historical data available for year on year comparison.
Promote the delivery of safe physical health care for all people with a learning disability when they need admission to an acute hospital	3.2 For all people on the caseload of the Community Learning Disability Teams to have a hospital/personal passport ready for use on admission.	
Embedding Learning from Serious incidents	3.3 Focus on further development of quality improvement led approach to robustly embedding lessons learned following incidents.	We wish to develop, improve, and cascade learning from across the organisation in order to increase patient safety and minimise risk of harm. This is a continuation of last year's target.
To improve physical health care for hospital inpatients (aged 18 and over) by the improved assessment and documentation of pressure ulcer risks.	3.4 To achieve a target of 60% of hospital inpatients (aged 18 and over) having a pressure ulcer risk assessment that meets NICE guidance with evidence of actions against all identified risks. (CQUIN CCG12)	In order to support NHS England's commitment to the improvement of patient safety we are committed to improving the safety of patients within our care . This is a new indicator with no comparative data. This is primarily a Community CQUIN however we will endeavour to implement it across all inpatient sites

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

Review of Services

To be completed at year end.

Participation in Clinical Audits and National Confidential Enquiries

To be completed at year end.

Participation in Clinical Research

To be completed at year end.

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

A proportion of Gloucestershire Health and Care NHS Foundation Trust's income in 2019/20 was conditional on achieving quality improvement and innovation goals agreed between Gloucestershire Health and Care 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 2019/20 and for the following 12 month period are available electronically at **tbc**

2019/20 CQUIN Goals

Gloucestershire Mental Health Services

Gloucestershire Goal Name	Description	Goal weighting	Expected value	Quality Domain
CCG 2: Staff Flu Vaccinations.	Improving the uptake of flu vaccinations for front line staff	.25	£199000	Safety
CCG4: 72 hour follow up Post Discharge : Routine Submission to MHSDS	72 hour follow up is a key part of the work to support the Suicide Prevention Agenda. The NCE into Suicide and Safety in Mental Health found that the highest number of deaths occurred on day 3 post discharge.	.25	£199000	Safety
CCG 5 :Mental Health Data Quality: MHSDS (a)Data Quality Maturity Index (b) Mental Health Data Quality Interventions:	Accurate data is a key enabler for improvement in MH services The MHSDS DQMI score is an overall assessment of data quality for each provider, based on a list of key MHSDS data items. The MHSDS DQMI score is defined as the mean of all the data item scores for percentage valid & complete multiplied by a coverage score for the MHSDS. Achieving 70% of referrals where the second attended contact takes place between Q3-4 with at least one intervention (SNOMED CT procedure code) recorded using between the referral start date and the end of the reporting period.	.25	£199000	Safety

CCG 6: Use of Anxiety Disorder Specific Measures in IAPT: Routine submission to IAPT Data Set.	Achieving 65% of referrals with a specific anxiety disorder problem descriptor finishing a course of treatment having paired scores recorded on the specified Anxiety Disorder Specific Measure	.5	£398000	Safety

Low Secure Services

Low Secure Goal Name	Description	Goal weighting	Expected value	Quality Domain
Maintenance of healthy weight	Substantial consequential health benefits and cost savings.	1.25	£24592	Effectiveness

Herefordshire Mental Health Services

Herefordshire Goal Name	Description	Goal weighting	Expected value	Quality Domain
CCG 2: Staff Flu Vaccinations.	Improving the uptake of flu vaccinations for front line staff	0.25	£52800	Safety
CCG4: 72 hour follow up Post Discharge : Routine Submission to MHSDS	72 hour follow up is a key part of the work to support the Suicide Prevention Agenda. The NCE into Suicide and Safety in Mental Health found that the highest number of deaths occurred on day 3 post discharge.	0.25	£52800	Safety
CCG 5 :Mental Health Data Quality: MHSDS (a)Data Quality Maturity Index (b) Mental Health Data Quality Interventions:	Accurate data is a key enabler for improvement in MH services The MHSDS DQMI score is an overall assessment of data quality for each provider, based on a list of key MHSDS data items. The MHSDS DQMI score is defined as the mean of all the data item scores for percentage valid & complete multiplied by a coverage score for the MHSDS. Achieving 70% of referrals where the second attended contact takes place between Q3-4 with at least one intervention (SNOMED CT procedure code) recorded using between the referral start date and the end of the reporting period.	0.25	£52800	Safety
CCG 6: Use of Anxiety Disorder Specific Measures in IAPT: Routine submission to IAPT Data Set.	Achieving 65% of referrals with a specific anxiety disorder problem descriptor finishing a course of treatment having paired scores recorded on the specified Anxiety Disorder Specific Measure	0.25	£52800	Safety
5.Preventing ill health by risky behaviours – Alcohol and Tobacco	To offer advice and interventions aimed at reducing risky behaviour in admitted patients	0.25	£52800	Safety

Liaison Diversion

Low Secure Goal Name	Description	Goal weighting	Expected value	Quality Domain
Maintenance of healthy weight	Substantial consequential health benefits and cost savings.	1.25	£24592	Effectiveness

Gloucestershire Physical Health Services

Gloucestershire Goal Name	Description	Goal weighting	Expected value	Quality Domain
CCG 2: Staff Flu Vaccinations.	Improving the uptake of flu vaccinations for front line staff	.41	£353643	Safety
CCG 7: Three high impact actions to prevent Hospital Falls.	Using key actions as part of a comprehensive multidisciplinary falls intervention will result in fewer falls bringing length of stay improvements and reduced treatment costs.	.41	£353643	Safety
CCG9: Six Month Reviews for Stroke Survivors .	Improved stroke rehabilitation is a key pillar of the stroke improvement landscape. The six month assessments have been highlighted as the most fundamental [art of that work.	.41	£353643	Safety

For mental health services the total potential value of the income conditional on reaching the targets within the CQUINs during 2019/20 is £1,294,257.00 of which xxxx (to be completed at year end) was achieved.

In 2018/19, the total potential value of the income conditional on reaching the targets within the CQUINs was £2,440,000.00 of which £2,440,000.00 was achieved

For community physical health services the total potential value of the income conditional on reaching the targets within the CQUINs during 2019/20 is £xxxxx of which xxxx (to be completed at year end) was achieved.

In 2018/19, the total potential value of the income conditional on reaching the targets within the CQUINs was £xxxxxxx of which £xxxxxx was achieved

2020/21 CQUIN Goals

To be completed at year end.

Statements from the Care Quality Commission

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

Gloucestershire Health and Care NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is "Good" and covers 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.
- Personal Care
- Surgical Procedures
- Family Planning Services
- Termination of Pregnancies

Gloucestershire Health and Care NHS Foundation Trust has no conditions on its registration.

The CQC has not taken enforcement action against Gloucestershire Health and Care NHS Foundation Trust during 2019/20.

Gloucestershire Health and Care NHS Foundation has not participated in any special reviews or investigations by the CQC during the reporting period.

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

Quality of Data

To be completed at year end.

Information Governance

To be completed at year end.

Clinical Coding

To be completed at year end.

Learning from Deaths

Mental Health Services

During 2019-2020 Q1-Q3, 507 Gloucester Health and Care NHS Foundation Trust (the Trust) patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

188 in the first quarter;
173 in the second quarter;
146 in the third quarter.

34 case record reviews and 14 investigations have been carried out in relation to the 507 deaths of the deaths included in the 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:
28 in the first quarter;
14 in the second quarter;
5 in the third quarter.

0 representing 0.0% of the patient deaths during the reporting period are judged more likely than not to have been due to problems in the care provided to the patient.
In relation to each quarter, this consisted of:
0 representing 0.0% for the first quarter;
0 representing 0.0% for the second quarter;
0 representing 0.0% for the third quarter.

These numbers have been estimated using Structured Judgement Review (SJR). For deaths of mental health patients, the RCPsych Mortality Review Tool 2019 is employed. For deaths of LD patients, a similar Trust-developed SJR tool is utilised which pre-dates the RCPsych tool, which has been maintained to allow consistent approach with the Learning Disabilities Premature Mortality Review (LeDeR) programme. All case record reviews are discussed at a Mortality Review Group meeting chaired by Clinical Directors. For any deaths meeting Serious Incident or Clinical Incident criteria, a Comprehensive Investigation is carried out.

The Trust has identified:

- In some cases, escalation plans for informal inpatients taking leave had not been clearly discussed and agreed with the patient or clearly recorded on RiO, (the Trust's electronic records system).
- Communication with patients' GPs was not always as up to date as expected in terms of informing with regards to disengaged patients, patients who had been discharged from community teams and patients who had been accepted onto a community team caseload, including being allocated a care coordinator.
- During a case of an unexpected death of a formal mental health inpatient, CPR was not instigated as quickly as per Trust policy.
- In some cases, the recording of Risk on RiO was not consistent with Trust policy.
- In one case, following discharge of a patient from an independent, out of area, acute mental health inpatient unit, there was an absence of an appropriately agreed discharge plan, which impacted on the range and timelines of a follow-up service in order to support the patient and reduce the risk of them ending their life.
- In some cases, the Trust found a delay in prescribing End of Life medication during out of hours, due to junior doctors on call not being familiar with patients or not feeling confident to prescribe.
- Following review of mental health inpatient deaths, the Trust found that in some cases Cause of Death had not been recorded on RiO
- Following review of several End of Life mental health inpatients suffering with dementia, it would seem there is some anecdotal evidence to suggest that dementia patients require higher doses of End of Life medications than currently stated in the BNF and consequently often advice from Palliative Care needs to be sought in order to make patients comfortable.

In response to the above learning points, the Trust has:

- Put measures in place to ensure that, with regard to informal mental health patients, prior to leave being taken, staff must agree with the patient and document on a case by case basis, what the expected return to the ward time is, and in the event of a patient being late, at what time contact with them/their family will be attempted and escalation process initiated.
- Put measures in place to ensure that GPs are informed if their patient disengages from a community team and Trust community colleagues have been reminded to inform GPs if their patient is accepted onto a community team caseload, if their patient is allocated a

care coordinator and if their patient is discharged from the team, to include re-referral routes where services are not offered following discharge.

- With regards to resuscitation, The Trust has:
    i. instigated an urgent review of the Observations Policy to consider the need to provide additional direction with regards to physical wellbeing and mental health observations;
    ii. instigated an urgent review of resuscitation training to clarify that causation should be used in identifying Signs of Life Extinct
    iii. sought urgent assurance from Medacs agency that all staff employed by them will be aware of the need for commencing CPR in accordance with standard resuscitation guidance.
- Colleagues have been reminded that Risk Assessments should be updated following patient contact with A&E and that reported risk of use of a firearm must be clearly documented in the RiO Risk Assessment and Management Plan.
- The Trust is considering re-establishing a preferred provider relationship for mental health inpatient and acute care services.
- The Trust has put measures in place to ensure that, where indicated, End of Life medication will be written up by responsible consultant beforehand with a clear plan outlined on RiO, so that only approval to begin End of Life medication is sought from a junior medic on call.
- The Trust has put measures in place to ensure that death certifications issued by the Trust should be uploaded to RiO.
- The Trust is looking into the possibility of an audit of doses of End of Life medications in conjunction with Palliative Care. The Trust is further investigating whether medication doses for End of Life patients suffering from dementia could be addressed using a standard operating procedure (SOP) and whether scripts could be checked against the SOP by the junior doctor (if applicable) and the nurse in charge.

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

As a Trust we are committed to the National Quality Boards (2017) Learning from Deaths guidance. The Trust ensures that it seeks to actively learn and implement changes in practice identified from reviews of death. The Trust is a an active supporter of the Learning Disabilities Premature Mortality Review programme (LeDeR) in Gloucestershire and Herefordshire

All our staff are required to notify, using the Datix system, the deaths of all Trust patients. This comprises anyone open to a Trust caseload at the time of their death and who dies within 30 days of receiving care from the Trust. Deaths recorded on Datix are collated for discussion at the Mortality Review Group meetings chaired by the lead Clinical Directors. All deaths of patients with a learning disability will be also reported through the appropriate LeDeR process, and deaths of people under the age of 18 will be reported through the current child death reporting methodology.

Learning From Death continues to provide vital guidance. As a Trust, we are fully committed to recognising the need to improve services following learning from events both nationally and locally such as Gosport, Mid Staffordshire and LeDeR programme, alongside our own local serious incidents investigation process.

From 1st January 2017 152 LeDeR referrals had been received in Gloucestershire, 101 have had an initial review completed (66% review completed) and 49 are open (15 remain unable to be allocated due to reviewer capacity).

Status of LeDeR reviews in Gloucestershire to 7th February 2020

	CLOSED	OPEN	Grand Total	% completed
2017	44	2	48	**92%**
2018	43	6	49	**88%**
2019	14	32	46	**30%**
2020		9	9	**0%**
Grand Total	**101**	**49**	**152**	**66%**

The Trust awaits the end of the 2019-20 Q4 reporting period for the 2019-20 LeDeR annual report containing learning themes. Learning themes identified by the end of the 2018-19 reporting period:

- Communications and support to access primary care Learning Disability Annual Health Checks
- Reasonable adjustments made to access to mainstream healthy lifestyles preventative services e.g. smoking cessation, weight management and eating well
- Suitable reasonable adjustments being put in place in mainstream health services is inconsistent particularly around meeting communication needs.
- Utilisation and documentation of the Mental Capacity Act by mainstream health services is inconsistent
- Treatment escalation practices particularly in relation to end of life protocols for those individuals who are considered to be frail.

19 case record reviews and 6 investigations completed after 31st March 2019 related to deaths which took place before the start of the reporting period.

0 representing 0.0% 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 SJR. For deaths of mental health patients, the RCPsych Mortality Review Tool 2019 is employed. For deaths of LD patients a similar Trust-developed SJR tool is utilised which pre-dates the RCPsych tool, which has been maintained to allow consistent approach with the LeDeR programme. All case record reviews are discussed at a mortality review meeting chaired by Clinical Directors. For any deaths meeting Serious Incident or Clinical Incident criteria, a Comprehensive Investigation is carried out.

0 representing 0.0% of the patient deaths during 2018-2019 are judged to be more likely than not to have been due to problems in the care provided to the patient.

Physical Health Services

During 2019-2020 Q1-Q3, 136 Gloucester Health and Care NHS Foundation Trust (the Trust) patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:
34 in the first quarter;
61 in the second quarter;
41 in the third quarter.

11 case record reviews and 0 investigations have been carried out in relation to the 136 deaths.

In 0 cases 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:
2 in the first quarter;

5 in the second quarter;
4 in the third quarter.

0 representing 0.0% of the patient deaths during the reporting period are judged more likely than not to have been due to problems in the care provided to the patient.
In relation to each quarter, this consisted of:
0 representing 0.0% for the first quarter;
0 representing 0.0% for the second quarter;
0 representing 0.0% for the third quarter.

These numbers have been estimated using a Structured Judgement Review (SJR) tool developed by the Trust to robustly assess the standard of care provided to patients that die during an inpatient stay at a community hospital. Cases are discussed at a Mortality Review meetings attended by the Trust's Deputy Medical Director / Clinical Director and the County Medical Examiner.

The Trust has identified:

- a common theme across all community hospitals whereby a significant proportion of patients admitted from the acute trust for rehabilitation have since been identified as being for end of life care soon after their admission, this is a reflection of age and frailty rather than undiagnosed illness;
- that in some cases, patients' causes of death could discussed with the County Medical Examiner before being formally certified.

In response to the above learning points, the Trust has:

- set up the Joint Patient Safety Group with GHNHSFT, which has quarterly meetings, where issues around admissions and transfers between Trusts can be taken for discussion. The Trust also continues to invite SWAST to Physical Health Mortality Review meetings;
- reminded medical staff at the appropriate community hospitals that cause of death can be discussed with the Medical Examiner.

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

As a Trust we are committed to the National Quality Boards (2017) Learning from Deaths guidance. The Trust ensures that it seeks to actively learn and implement changes in practice identified from reviews of death. The Trust is a an active supporter of the Learning Disabilities Premature Mortality Review programme (LeDeR) in Gloucestershire.

All our staff are required to notify, currently using the MIDAS system, the deaths of all patients who die whilst receiving inpatient care. Deaths recorded on MIDAS are collated for discussion at Physical Health Mortality Review Group meetings chaired by the Head of Clinical Governance and Compliance. All deaths of patients with a learning disability will be also reported through the appropriate LeDeR process, and deaths of people under the age of 18 will be reported through the current child death reporting methodology.

In order to align systems and processes as one merged organisation, and to facilitate learning and data collection, from 1st April 2020, deaths of inpatients will be reported using Datix.

Part 2.3: Mandated Core Indicators 2019/20

This data relates to mental health services, both within the new, merged organisation and previously 2gether NHS Foundation Trust. No mandated core indicators for community health services have been indentified.

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 2 2018-19	Quarter 3 2018-19	Quarter 4 2018-19	Quarter 1 2019-20	Quarter 2 2019-20
Gloucestershire Health & Care NHS Foundation	98.4%	97.7%	99.1%	100%	100%
National Average	95.7%	95.5%	95.5%	95.1%	94.5%
Lowest Trust	88.3%	81.6%	83.5%	86.1%	77.9%
Highest Trust	100.%	100%	100%	100%	100%

Gloucestershire Health & Care 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 and continues to support the patient safety aspects of our follow up contacts.

Gloucestershire Health & Care 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 2 2018-19	Quarter 3 2018-19	Quarter 4 2018-19	Quarter 1 2019-20	Quarter 2 2019-20
Gloucestershire Health & Care NHS Foundation	99.4%	98.9%	99.3%	100%	100%
National Average	98.4%	97.8%	98.1%	98.2%	98.2%
Lowest Trust	81.4%	78.8%	88.2%	84.0%	91.2%
Highest Trust	100.00%	100%	100%	100%	100%

Gloucestershire Health & Care 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.

Gloucestershire Health & Care 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.

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 2018-19	Quarter 4 2018-19	Quarter 1 2019-20	Quarter 2 2019-20	Quarter 3 2019-20
Gloucestershire Health & Care NHS Foundation 0-15	0%	0%	0%	0%	0%
Gloucestershire Health & Care NHS Foundation 16 +	7.8%	5.6%	4.0%	5.8%	6.9%

Gloucestershire Health & Care 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.

Gloucestershire Health & Care 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 responded positively to " if a friend or relative needed treatment I would be happy with the standard of care provided by the Organisation"

	NHS Staff Survey 2016	NHS Staff Survey 2017	NHS Staff Survey 2018	NHS Staff Survey 2019
Gloucestershire Health & Care NHS Foundation	72.6%	74.2%	74.5%	Not yet reportable
National Average Score	58.9%	61.2%	61.3%	
Worst Trust Score	44.1%	41.6%	38.2%	
Best Trust Score	82.2%	86.5%	80.8%	

To be provided at year end: This data, when available, will report the results of the merged organisation, therefore reflecting the responses of staff previously employed by both ^{2}gether NHS Foundation Trust and Gloucestershire Care Services.

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 2016	NHS Community Mental Health Survey 2017	NHS Community Mental Health Survey 2018	NHS Community Mental Health Survey 2019
Gloucestershire Health & Care NHS Foundation	8.0	8.0	7.7	7.7
National Average Score	Not available	Not available	Not available	Not available
Lowest Score	6.9	6.4	5.9	6.0
Highest Score	8.1	8.1	7.7	7.7

Gloucestershire Health & Care NHS Foundation Trust considers that this data is as described for the following reasons:

- Only 2 Trusts were classed as 'better than expected' in 2019 and our Trust was one of them. We are the only Trust to have received this rating for the third consecutive year;
- The Trust obtained the highest Trust scores in England on 6 of the 28 (n=21%) evaluative questions and on 4 of the 11 domains.

Gloucestershire Health & Care NHS Foundation Trust has taken the following actions to improve this score and so the quality of its services, by:

- Giving people information about getting support from people with experience of the same mental health needs as them;
- Discussing the possible side-effects of medication with people;
- Asking people for their views on the quality of their care.

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

	1 April 2018 - 30 September 2018				1 October 2018 - 31 March 2019			
	Number	Rate*	Severe	Death	Number	Rate*	Severe	Death
Gloucestershire Health & Care NHS Foundation	2385	68.2	2	14	2872	79.64	6	15
National	169,041	-	548	25.21	187,449	-	556	1312
Lowest Trust	16	24.9	0	110	3	14.92	0	0
Highest Trust	9204	114.3	129	1286	9058	118.87	118	77

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

Gloucestershire Health & Care 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 increase in rate between the reporting periods relates to a small number of patients and admissions within our learning disability inpatient unit. Current unpublished data suggests that this rate is now reducing due to positive responses to treatment plans.

Gloucestershire Health & Care NHS Foundation Trust has taken the following action to improve this rate, and so the quality of its services, by:

- Continuing to hold 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 and we have added some further support hours.

- Developing a suite of reports and Dashboards to aid monitoring of incidents on wards to assist staff in identifying themes and trends plus hot spots.

Part 3: Looking Back: A Review of Quality during 2019/20

Introduction

The 2019/20 quality priorities were agreed in May 2019.

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 Mental Health Quality Measures for 2019/20

Effectiveness		2017 - 2018	2018 - 2019	Q3 2019-2020
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).	**Achieved**	**Achieved**	**Not 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.	**Not achieved**	**Not achieved**	**Achieved**
1.3	To ensure that joint Care Programme Approach reviews occur for **all** service users who make the transition from children's to adult services.	**Not achieved**	**Achieved**	**Achieved**
User Experience				
2.1	Were you involved as much as you wanted to be in agreeing the care you will receive? **> 84%**	**Not achieved**	**Achieved**	**Achieved**
2.2	Have you been given information about who to contact outside of office hours if you have a crisis? **> 71%**	**Achieved**	**Achieved**	**Achieved**
2.3	Have you had help and advice about taking part in activities that are important to you? **> 64%**	**Achieved**	**Achieved**	**Achieved**
2.4	Have you had help and advice to find support to meet your physical health needs if you needed it? **> 73%**	**Achieved**	**Achieved**	**Not achieved**
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**	**Achieved**	**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**	**Achieved**	**Achieved**
3.3	To increase the use of supine restraint as an alternative to prone restraint	**Not Measured**	**Not achieved**	**Achieved**
3.4	To ensure that 100% of service users within Berkeley House have a bespoke restrictive intervention care plan tailored to their individual need.	**Not measured**	**Achieved**	**Achieved**
3.5	To further develop a quality improvement led approach to robustly embed lessons learned following serious incidents.	**Not measured**	**Not measured**	**On Target**

Quality Report 	This report looks at the quality of 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 did not meet the target.	
Discharge Care Plans 	More people had all parts of their discharge care plan completed at the end of the quarter than previously. There is improvement being made. We met the target.	
Care (CPA) Review 	All people moving from children's to adult services had a care review. We met the target.	
Care Plans 	88% of people said they felt involved in their care plan. This is more than the target (84%). We met the target.	
Crisis 	90% of people said they know who to contact if they have a crisis. This is more than the target (71%). We met the target.	
Activity 	71% of people said they had advice about taking part in activities. This is more than the target (64%). We met the target.	
Physical Health 	71% of people said they had advice about their physical health This is more than the target (73%). We met the target.	

Suicide 	There were fewer suicides compared to this time last year. We met the target	↑
AWOL 	In patients who were absent without leave did not come to serious harm or death. We met the target.	↑
Face down restraint 	We have reduced the number of face-down restraints this year but we are still doing more of these than face up restraints. We met the target.	↑
Physical Intervention Care Plans 	Everyone at Berkley House has one of these. We met the target.	↑
Learning from serious incidents 	We are working hard to learn from serious incidents so that fewer people will come to harm. We aim to have met this target by March 2019.	↔

Summary Report on Physical Health Quality Measures for 2019/20

Effectiveness		**Q3 2019- 2020**
1.4	Improve the usage of mental capacity assessments in our hospital and community settings to ensure that individuals who lack the ability to make decisions are the focus of any decisions made, or actions taken on their behalf	**Achieved**
1.5	Develop a programme of personalised care planning to enable patients to manage their long term conditions more effectively	**On Target**
1.6	To increase the use of nutrition and hydration assessments in all appropriate settings in order for patients to be optimally nourished and hydrated	**Not achieved**
1.7	To increase the quality of wound assessments and management countywide in order to reduce clinical variation and improve wound healing rates	**Not achieved**
1.8	To embed End of Life care as 'business as usual' with dedicated leadership	**Not achieved**
User Experience		
	The number of respondents who are 'extremely likely' or 'likely to recommend the service **> 95%**	**On Target**
Safety		
3.6	Improved learning from 'no-harm' and'low-harm' medication incidents to enhance patient safety	**Not achieved**
3.7	Implement a Quality Improvement Programme to improve the management of catheters in community settings	**On Target**
3.8	Continue to reduce pressure ulcers by working with the NHSI Stop the Pressure Collaborative framework	**Achieved**
3.9	Continue to train and support front line colleagues to recognise and manage deteriorating patients to ensure that they are managed quickly and effectively	**Achieved**
3.10	To embed falls prevention and management as 'business as usual' with dedicated leadership.	**On Target**

Easy Read Report on Mental Health Quality Measures fo 2019/20

To be developed by year end.

Effectiveness

Mental Health Services

In 2019/20 we remain 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

Within Quarter 3, the Gloucestershire Health and Care NHS Foundation Trust has committed to offer a full cardio metabolic check to all inpatients and all SMI/CPA service users in the community. Our target for compliance remains at; **75%** of community patients and **90%** of inpatients will receive the health check and will have any associated interventions offered if required.

A monthly audit continues to ensure all six parameters of the Lester tool are completed, along with the recording of any interventions offered. The Quarter 3 audit shows that **76%** of community patients and **78%** of inpatients have had these checks and interventions in place. We are, therefore, meeting the target for community patients but not our inpatients.

There are robust systems in place to ensure existing staff continue to receive refresher training about the importance of the physical health checks and that all new staff receive information on physical health checks on their induction to the Trust. The Health & Lifestyle form on the electronic patient record has been updated to include details of national screening, dental and contraception options available for service users. This will be relaunched in February 2020 and has meant extra training for staff so that they are aware of the further referral process and options available for service users. There is also a plan to implement and electronic audit which will provide both ward managers and community team managers with weekly compliance figures which should provide a focus to drive up compliance.

Successful physical health clinics continue to run at Pullman Place and 27a St Owen Street, providing service users in the community access to physical health checks in an environment with staff who are familiar to them. Such is the success of the physical health clinics, a Physical Health nurse has been employed for one day a week to take a lead on developing the clinics further within Pullman Place.

The Trust has purchased nine ECG machines for the community hubs. These will provide the opportunity for routine ECG screening for possible cardiac anomalies for patients who are at an increased cardio metabolic risk, largely due to medication side effects and lifestyle factors. Training for staff to take ECG's has been provided by the Physical Health Facilitator, and refresher training for medics to interpret ECG's will be held internally by the Trust own Medical team.

Alongside this health screening work, Gloucestershire Health and Care NHS Foundation Trust continues to increase access to physical health treatment for service users. The Quality Improvement initiative 'Well Woman Wednesdays' at Wotton Lawn Hospital, where ladies are offered a full range of advice and success to cervical screening in house, has now been expanded to the community Hub. This has enable service users to access this vital screening in an environment they are familiar with.

The recent Trust merger has offered further opportunities for staff to access community physical health services such as Tissue Viability, Community Diabetes Teams and District Nursing teams. This will only enhance the services and opportunities available for service users and improve the knowledge of physical health our staff.

We are currently not meeting this target.

Target 1.2 To improve personalised discharge care planning in:
a) Adult inpatient wards and
b) Older people's wards.

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?

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.

	Criterion	Current compliance (Q3 2019-20)	Direction of travel and previous compliance (Q2 2019-20)
1	Has a Risk Summary been completed?	99%	⇔100%
2	Has the Clustering Assessment and Allocation been completed?	96%	⇧ 92%
3	Has HEF been completed (LD only)?	100%	⇔ 100%
4	Has the Pre-Discharge Planning Form been completed?	28%	⇧ 23%
5	Have the inpatient care plans been closed within 7 days of discharge?	45%	⇧ 26%
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?	88%	⇩ 93%
8	Has the 48 hour follow up been completed if the Community Team are not doing it?	73%*	⇩ 92%

The 48 hour follow up data set is currently being reviewed as it is believed that compliance is higher.

Overall compliance for the Trust (Gloucestershire and Herefordshire) for Quarter 3 was **79%** compared to **75%** in Quarter 2; This shows an increase of 4% compliance across the Trust.

Overall compliance for Gloucestershire only for Q3 was 76% compared to 72% in Q2; this means that there has been a 4% increase in compliance. Overall compliance for Herefordshire only for Q3 was 82% compared to 78% in Q2; this means that there has been a 4% increase in compliance.

During Q3 of 2019-20, there were 80 discharges from Herefordshire, and 158 from Gloucestershire. The total number of discharges from all Mental Health Inpatient Units across the Trust was 238.

Quarter 3 results from the audits against these standards are seen below. Cumulative compliance for the year is also provided as this will be the result at year end and measured against the 2018/19 cumulative result to provide the direction of travel.

Gloucestershire Services

		Compliance				
Criterion	**Year End (2018/19)**	**Quarter 1 (2019/20)**	**Quarter 2 (2019/20)**	**Quarter 3 (2019/20)**	**Cumulative (2019/20)**	**Direction of Travel**
Overall Average Compliance	**69%**	**76%**	**72%**	**76%**	**75%**	⇧
Chestnut Ward	84%	85%	69%	**78%**	77%	⇩
Mulberry Ward	70%	74%	72%	**72%**	73%	⇧
Willow Ward	69%	70%	67%	**70%**	69%	⇔
Abbey Ward	70%	75%	84%	**78%**	79%	⇧
Dean Ward	71%	82%	85%	**87%**	85%	⇧
Greyfriars PICU	58%	70%	71%	**70%**	70%	⇧
Kingsholm Ward	72%	70%	70%	**71%**	70%	⇩
Priory Ward	76%	87%	78%	**76%**	80%	⇧
Montpellier Unit	61%	62%	50%	**67%**	60%	⇩
Honeybourne	64%	78%	61%	**94%**	78%	⇩
Laurel House	71%	79%	83%	**75%**	79%	⇧
Berkeley House	63%	N/A	N/A	**75%**	75%	⇧

Herefordshire Services

Criterion	**Year End (2018/19)**	**Quarter 1 (2019/20)**	**Quarter 2 (2019/20)**	**Quarter 3 (2019/20)**	**Cumulative (2019/20)**	**Direction of Travel**
Overall Average Compliance	**71%**	**74%**	**78%**	**82%**	**78%**	⇧
Cantilupe Ward	78%	78%	71%	89%	80%	⇧
Jenny Lind Ward	70%	73%	76%	71%	74%	⇧
Mortimer Ward	66%	75%	82%	86%	81%	⇧
Oak House	65%	71%	83%	N/A	77%	⇧

We are currently meeting this target.

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 2018-19 transitions are also included below so that historical comparative information is available.

2018-19 Results

Gloucestershire Services

Criterion	Compliance Quarter 1 (2018/19)	Compliance Quarter 2 (2018/19)	Compliance Quarter 3 (2018/19)	Compliance Quarter 4 (2018/19)
Joint CPA Review	100%	100%	100%	100%

Herefordshire Services

Criterion	Compliance Quarter 1 (2018/19)	Compliance Quarter 2 (2018/19)	Compliance Quarter 3 (2018/19)	Compliance Quarter 4 (2018/19)
Joint CPA Review	100%	Not applicable	100%	100%

2019-20 Results

Gloucestershire Services

Criterion	Compliance Quarter 1 (2019/20)	Compliance Quarter 2 (2019/20)	Compliance Quarter 3 (2019/20)	Compliance Quarter 4 (2019/20)
Joint CPA Review	100%	Not applicable	100%	

Herefordshire Services

Criterion	Compliance Quarter 1 (2019/20)	Compliance Quarter 2 (2019/20)	Compliance Quarter 3 (2019/20)	Compliance Quarter 4 (2019/20)
Joint CPA Review	100%	100%	100%	

We are pleased to report that during Quarters 1-3 inclusice 2019/20 all young people who transitioned into adult services had a joint CPA review. This is consistent with last year's performance.

To improve our practice and documentation in relation to this target, a number of measures were developed and implemented during 2018-19 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 then 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 into 2019/20.

We are currently meeting this target.

Physical Health Services

In 2019/20 we set ourselves 5 targets against the goals of:

- Improving the usage of mental capacity assessments in our hospital and community settings to ensure that individuals who lack the ability to make specific decisions are the focus of any decisions made, or actions taken, on their behalf;
- Develop a programme of personalised care planning to enable patients to manage their long term conditions more effectively;
- To increase the use of nutrician and hydration assessments in all appropriate settings in order for patients to be optimally nourished and hydrated;
- To increase the quality of wound assessments and management countywide in order to reduce clinical variation and improve wound healing rates;
- To embed End of Life care as 'business as usual' with dedicated leadership.

1.4 Improving the usage of mental capacity assessments in our hospital and community settings to ensure that individuals who lack the ability to make specific decisions are the focus of any decisions made, or actions taken, on their behalf.

The philosophy of the Mental Capacity Act 2005 (MCA) is to ensure that individuals who lack the capacity to make specific decisions are the focus of any decisions, or actions taken, on their behalf. It is a legal requirement to carry out an assessment when a person's capacity is in doubt. Understanding the MCA needs to become a "business as usual" exercise, to ensure that the Trust is compliant with legislation and to achieve optimum benefits to our patients and families. This year, our metrics will focus on the completion of the Mental Capacity Act 2 (principle of encouraging and supporting people to make decisions themselves, and even if they lack capacity, to be included in the process of making decisions) and Deprivation of Liberty Safeguards (DoLS) assessments for significant decisions.

Results

Metric		Quarter 1	Quarter 2	Quarter 3	Quarter 4
Has an MCA2 been completed for restrained or restricted patients in our community hospitals? (Baseline from March 2019 audit 11%. Measured from dip test audit mid quarter)	Target	15%	30%	60%	90%
	Actual	33%	65%	92%	
Has a deprivation of Liberty Safeguards application been made for all patients who do not have capacity to consent to being restricted or restrained? (Baseline 22% from March 2019 audit)	Target	25%	40%	60%	90%
	Actual	33%	55%	85%	

A review of the audit findings at the end of Quarter 3 shows that 46% of completed MCA2 forms have been saved as the final versions, and the remaining 46% were record but saved for future editing. There is a plan in place to encourage staff to save all these as final versions.

The quality of these forms is variable but it is encouraging that so far we have surpassed our target number, which indicates staff are confident and skilled in completing them.

We are currently meeting this target.

1.5 Develop a programme of personalised care planning to enable patients to manage their long term conditions more effectively

Personalised care is a priority in the Long Term Plan, with a stated objective that it should become "business as usual across the health and care system". In the Intergrated Care System (ICS) workforce strategy the vision is to see this facilitated by a health coaching approach, called "Better Conversations". It is noted that both the physical health and mental health services contracts for 2019-20 include a commitment to work with the Clinical Commissioning Groups to develop "5 core measurable statements for the ICS personalised care programme that define outcomes for patients and success". This programme will directly feed in to this growing body of work.

The Patient Activation Measure (PAM) will be a key tool in these early stages. Patient "activation" describes the knowledge, skills and confidence a person has in managing their own health and care. The concept of patient activation links to all the principles of person-centred care, and enables the delivery of personalised care that supports people to recognise and develop their own strengths and abilities. Services included will be MacMillan Next Steps, Self Management, Diabetes Education, and part of the ICTs (Complex Care at Home and Berkeley Vale ICT where health coaching training has taken place).

Results

Better Conversations and Personalised Care Measure	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Number of care planning conversations taking place for the identified cohorts	Set by individual teams and based on relevance to patient cohort(s)	This is happening, however more work is required to report from SystmOne	SystmOne reports 7,148 patients with a care plan. Caution is required as definitions are not standard, and some eligible plans are not recorded on SystmOne.	
Number of patients completing a Patient Activation Measure (PAM) questionnaire	Baseline: 1,500 per annum; target + 30%	Numbers are stable rather than rising but this is attributable to specific difficulties within 2 services and these are now resolved/resolving. Expect to recover lost ground	Trajectory now back on track. First 3 Quarters of 2018/19 = 552 people had PAM score; same period 2019/20 = 926 people had a PAM score	
Number of patients completing a second PAM	Baseline: 500 per annum; target + 30%	This is increasing in line with target	264 compared to 420 at same point last year (Qtr. 3)	
The use of PAM data to tailor interventions to further the personalisation agenda	Narrative reporting - commenced June 2019 in Complex Care at Home, MacMillan Next Steps	Progressing well. Embedded in 2 services and embryonic in others	Progressing well. Embedded in 2 services and embryonic in others	
Delivery of a quarterly qualitative report detailing ongoing developmental activities and examples of good practice, patient stories and shared learning	Linked to quarterly PAM data; most teams dependent upon CCG feed and Qtr. 1 data; delivery expected during Qtr.2	Some case studies produced and shared with system partners as well as internally. Increasing anecdotal evidence of successes but failed thus far to produce "formal" report	Case Study report submitted to Clinical Quality Review Group (14 November 2019).	

Some staff have been able to attend an NHSE/I workshop of evaluating personalised care, and 3 staff have received PAM Trainer traning in how to use PAM, and are currently rolling this out within Integrated Community Teams.

We are on target to meet this by year end.

1.6 To increase the use of nutrician and hydration assessments in all appropriate settings in order for patients to be optimally nourished and hydrated.

The Trust is using Quality Improvement methodology to increase the numbers of assessments being offered to patients. The metrics this include the following:

- Patients will have a baseline Malnutrician Universal Screening Tool (MUST) on admission to wards or clinical caseloads (the maximum time frame is 72 hours for in-patient settings or 2 visits for Integrated Community Teams - ICTs).

- An audit approach to measure performance will be used until more reliable reporting can be assured from SystmOne.

- Qualitative, quarterly reporting will also be included as part of the Quality Improvement approach (using Plan Do Study Act PDSA cycles). This will focus on reviewing samples of patients where MUST scores have triggered the need for interventions to establish whether patients are being managed appropriately and to a high quality. Included are all aspects of the patient's care such as food charts, supplements, referrals to dieticians and impacts on other aspects of care such as the prevention or healing of pressure ulcers.

Service Area	Baseline		Quarter 1	Quarter 2	Quarter 3	Quarter 4
ICTs	66%	Target	65%	70%	75%	95%
		Actual	66%	65%	60%	
Community Hospitals	80%	Target	80%	85%	90%	95%
		Actual	91.4%	76%	84%	

An electronic audit tool was developed and subsequently tested at Cirencester Hospital where it was found to be user friendly and time efficient. All Community Hospital Matrons have also tested the tool by undertaking a snapshot data capture for each patient. The tool will be further reviewed during Quarter 4 and the Quality Improvement Team will assist with data entry in Januaty 2020.

We are not yet meeting this target.

1.7 To increase the quality of wound assessments and management countywide in order to reduce clinical variation and improve wound healing rates.

This priority builds on the 2017-2019 CQUIN which was put in place nationally following UK studies that identified inconsistencies in the assessment and management of wounds and the opportunities to improve both efficiency of working and patient outcomes.

There are two principle reasons why wound assessment has been targeted:

1. A need to improve the quality and consistency of care delivered.
2. A need to reduce the cost burden of wounds. Clinical practice and wound outcomes should ultimately improve.

The Trust has been working to improve wound care as per the 2017-19 CQUIN, performance from Qtr. 4 of year 2 of the CQUIN is used below as a baseline for the Quality Improvement.

Wound Care Metrics		Quarters 1 & 2	Quarter 3	Quarter 4
To increase the number of patients who receive a fully compliant assessment (to the "leading change adding value" clinical assessment domains of the 2017-19 wound assessment CQUIN) on admission to Community Nursing caseloads, Complex Leg wound services, Podiatry Service or Inpatient Settings from baseline.	Target	30%	40%	60%
	Actual	25%	25%	
To increase the number of patients who have received a full wound assessment according to the "leading change adding value" Clinical Assessment domains of the 2017-19 wound assessment CQUIN AND whose wounds have healed within 4 weeks.	Target	60%	65%	70%
	Actual	22%	33%	

A revised education offer for all aspects of wound assessment is under development – this includes all areas where wound assessment will be discussed and will be:

- Revised Tissue Viability education offers go live in January.

- We have trialled a new SystmOne wide wound assessment and treatment template for all services – next step is to appraise this to coding and data extract needs (reference costs).
- Working with the CCG on countywide clinical pathways and resources for all areas to aid clinical decision making, this is developing with multiple clinical pathways in development.
- Revised exceptions reporting form issued (on intranet for countywide use).
- Bespoke Tissue Viability education has been offered into Gloucester City ICT to support novice practitioners in wound assessment, this was identified in a number of reported incidents as required learning.
- Compliance to the revised wound formulary (issued April 19) is relatively good, with the exception of barrier cream use, work underway to reduce this and move patients to formulary advised products.
- A picture clinical decision making tool related to the new formulary has been issued service wide and well received.
  We are not yet meeting this target.

1.8 To embed End of Life care as 'business as usual' with dedicated leadership

The Trust aims to ensure that all End of Life care will be delivered with excellence and compassion. This year, the focus has been to report the numbers of all patients on End of Life care within a bespoke template our clinical system, SystmOne. We want to ensure that this template is used consistently.

Results

End of Life Care	Base line	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
% of Community Hospital inpatients	81	81.8	100	90.9	83.3	82.4	86.7	75	77.8	75			
% of all Trust patients	48.	52.1	56.6	55.2	57.3	59.2	60	55.1	57.6	48.3			
Number of patients	n/a	76	82	74	82	77	69	75	76	71			
No. of deaths	n/a	146	145	134	143	130	115	136	132	147			

- An exemption criteria has now been applied and although the completion rate for the Community Hospitals has improved, The criteria applied is: any unexpected deaths, or deaths within 24 hours of referral/admission, and patients referred to the Physiotherapy and Occupational Therapy services (with the exception of the Palliative Care Occupational Therapists).

- No significant improvement was seen in community nursing with the exemptions applied. A deep dive of all the patient records without EoL template for October has show that there are a number of deaths that should be excluded from the numbers. Unfortunately due to the way that the information is recorded we are unable to exclude these during the reporting processes. For October, out of 66 patient records 18 patients died in the acute hospital, 4 in a hospice, 5 died unexpectedly (no EoL indication in record) and 13 died in nursing/care home (no EoL indication seen in record)

- ReSPECT launch countywide on 10th October 2019. Document is being used widely across Gloucestershire. Event being held in April to target Nursing/Care homes and GP to complete ReSPECT forms

- National Audit of Care at End of Life (NACEL): completed the collection of data and the audit is now closed. Poor return response rate, only one completed questionnaire received. This is significantly less than the response rate to local bereavement survey.

We are not yet meeting this target

User Experience

Mental Health Services

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 our local 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 3 2019/20 – October to December 2019) results:

Target 2.1 Were you involved as much as you wanted to be in agreeing the care you will receive? < 84%

Question	County	Number of responses	Target Met?
Were you involved as much as you wanted to be in agreeing the care you receive?	Gloucestershire	8 (7 positive)	88% TARGET 84%
	Herefordshire	0 (0 positive)	
	Total	8 (7 positive)	

This target has been met.

Target 2.2 Have you been given information about who to contact outside of office hours if you have a crisis? > 71%

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	10 (9 positive)	90% TARGET 71%
	Herefordshire	0 (0 positive)	
	Total	10 (9 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? > 64%

Question	County	Number of responses	Target Met?
Have you had help and advice about taking part in activities that are important to you?	Gloucestershire	7 (5 positive)	71% TARGET 64%
	Herefordshire	0 (0 positive)	
	Total	7 (5 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? > 73%

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	7 (5 positive)	71% TARGET 73%
	Herefordshire	0 (0 positive)	
	Total	7 (5 positive)	

This target has not been met this quarter.

Cumulative Results 2019-20

Target 2.1 Were you involved as much as you wanted to be in agreeing the care you will receive? < 84%

Question	County	Number of responses	Target Met?
Were you involved as much as you wanted to be in agreeing the care you receive?	Gloucestershire	167 (143 positive)	86% TARGET 84%
	Herefordshire	123 (110 positive)	
	Total	290 (253 positive)	

This target has been met.

Target 2.2 Have you been given information about who to contact outside of office hours if you have a crisis? > 71%

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	184 (149 positive)	83% TARGET 71%
	Herefordshire	132 (114 positive)	
	Total	316 (263 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? > 64%

Question	County	Number of responses	Target Met?
Have you had help and advice about taking part in activities that are important to you?	Gloucestershire	162 (124 positive)	79% TARGET 64%
	Herefordshire	125 (103 positive)	
	Total	287 (227 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? > 73%

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	161 (134 positive)	83% TARGET 73%
	Herefordshire	119 (99 positive)	
	Total	280 (233 positive)	

This target has been met.

Feedback from the Quality Survey along with the National Community Mental Health survey results helped us to identify the need to increase the involvement of people in the development of their care plans. This is the focus of our work to implement an Always Event as part of the NHS England campaign.

We were non-compliant with Target 2.4 in Q3, although cumulative compliance is achieved for year end to date. This appears to be a consequence of significantly reduced response rates following a change in contracts for the provision of text responses as a means of communicating and colleceting survey responses. There was a zero return from Herefordshire Services in Q3 following diminishing returns in Q1 and Q2. Recovery actions are in place to seek to improve this for Q4 and there is ongoing work to promote the survey during Q4 ahead of the new FFT and a

new harmonised physical and mental health patient and carer survey being launched in April 2020.

From 1st October 2019 the Patient Experience Department has had a dedicated survey lead and work stream to focus on seeking feedback via differing survey methods with the aim of increasing response rates and obtaining more opinion and meaningful data about the services that we provide.

Friends and Family Test (FFT)

FFT responses and scores for Quarter 3, 2019/20

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?*"

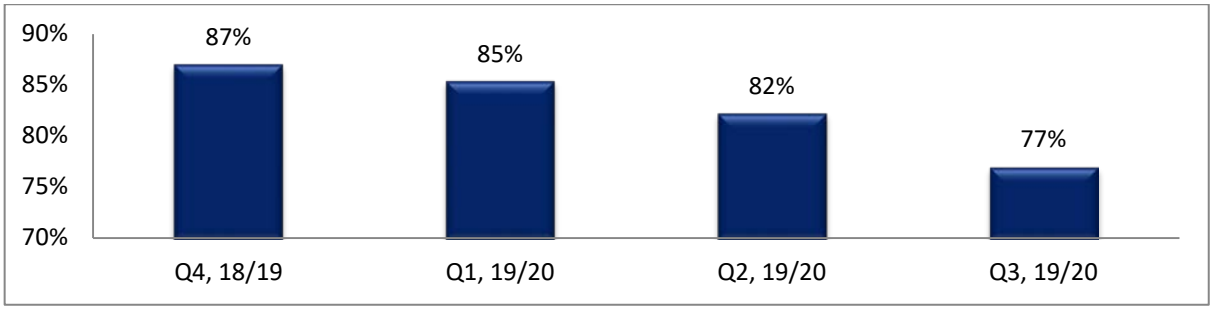
Our Trust played a key role in the development of an Easy Read version of the FFT. Roll out of this version ensures that everybody is supported to provide feedback.

The table below details the number of combined total responses received by the Trust each month in Quarter 1. 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 2019	40 (30 positive)	75%
November 2019	73 (57 positive)	78%
December 2019	Not yet submitted	-%
Total	40 (30 positive) **(last quarter = 169)**	**77%** **(last quarter = 82%)**

The FFT score for our Trust has remained about the same this quarter; this continues to be encouraging news following disappointing decreases seen in previous quarters last year. The Patient & Carer Experience Team continue to monitor FFT scores and undertake further analysis of scores to identify any areas that are influencing lower ratings.

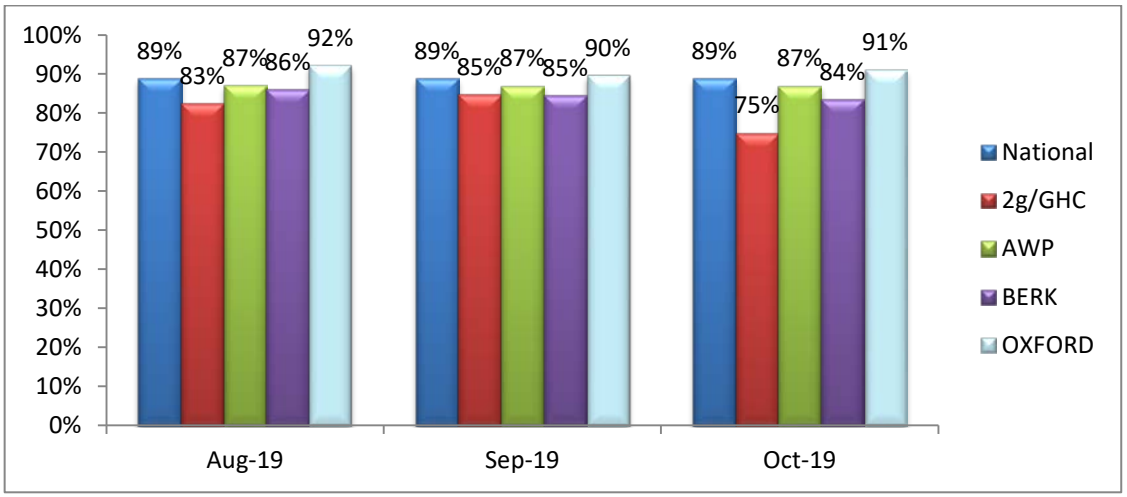
FFT Scores for ^{2}gether NHS Foundation Trust/Gloucestershire Health & Care NHS Foundation Trust for the past year. The following graph shows the FFT Scores for the past rolling year, including this quarter. The Trust generally receives mostly positive feedback.



Please note that the Q3 figures do not include December 2019 as this data is not yet available.

Friends and Family Test Scores – comparison between ^{2}gether NHS Foundation Trust/Gloucestershire Health & Care NHS Foundation Trust and other Mental Health Trusts across England

The chart below shows the FFT scores for August, September, and October 2019 (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 although we have achieved lower scores than other Trusts in our region in recent quarters. This is a reversal from previous years and does not triangulate with our positive National Survey scores

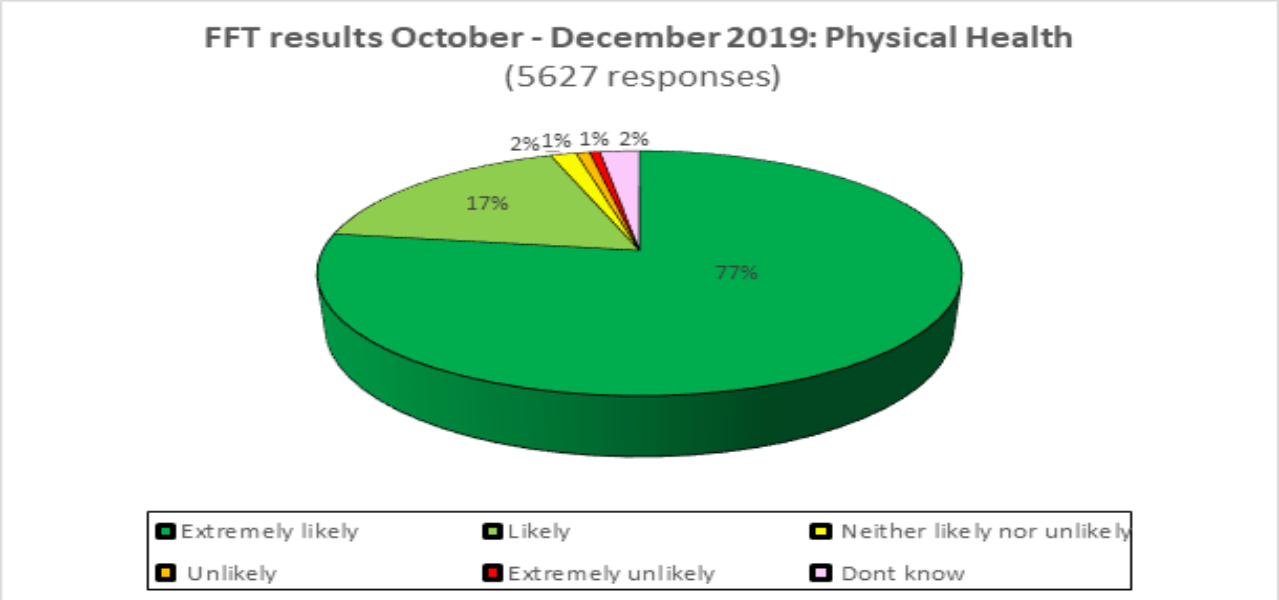


2g – 2gether NHS Foundation Trust // AWP – Avon and Wiltshire Mental Health Partnership NHS Trust
BERK – Berkshire Healthcare NHS Foundation Trust // OXFORD – Oxford Health NHS Foundation Trust

Physical Health Services

No local user experience targets were set within this domain, however FFT information for Quarter 3 demonstrates a high response rate and high levels of patient satisfaction.

Of the 5,627 responses received, 94% (5,289) of the respondents said they were extremely likely or likely to recommend the service, as illustrated below:



The word cloud below shows an overview of feedback from patient across all physical health services (this is not currently available for mental health services):

Complaints

To be completed at year end

Safety

Mental Health Services

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 5 goals with 5 associated targets 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;
- Ensure all people who are inpatient at Berkeley House have a bespoke restrictive intervention care plan;
- Embed the learning from our reported serious incidents:

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 and in 2017/18 the number of reported suspected suicides increased to **28.** We are pleased to report that by the end of 2018/19 the number had reduced and that we reported **25** suspected suicides. At the end of Quarter 3 2019/20 **14** suspected suicides have been reported during the year as seen in Figure 1.

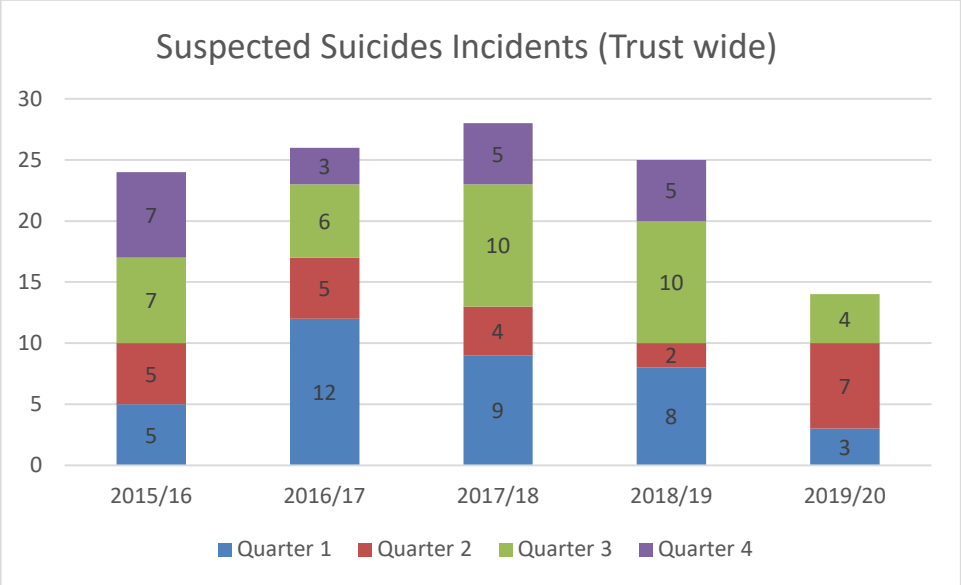


Figure 1

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 2 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 2015/16, 2016/17 and 2017/18 the median

value was 0.09. By the end of 2018/19 the median value reduced to 0.06 and at the end of Quarter 3 2019/20 this has reduced further to 0.04.

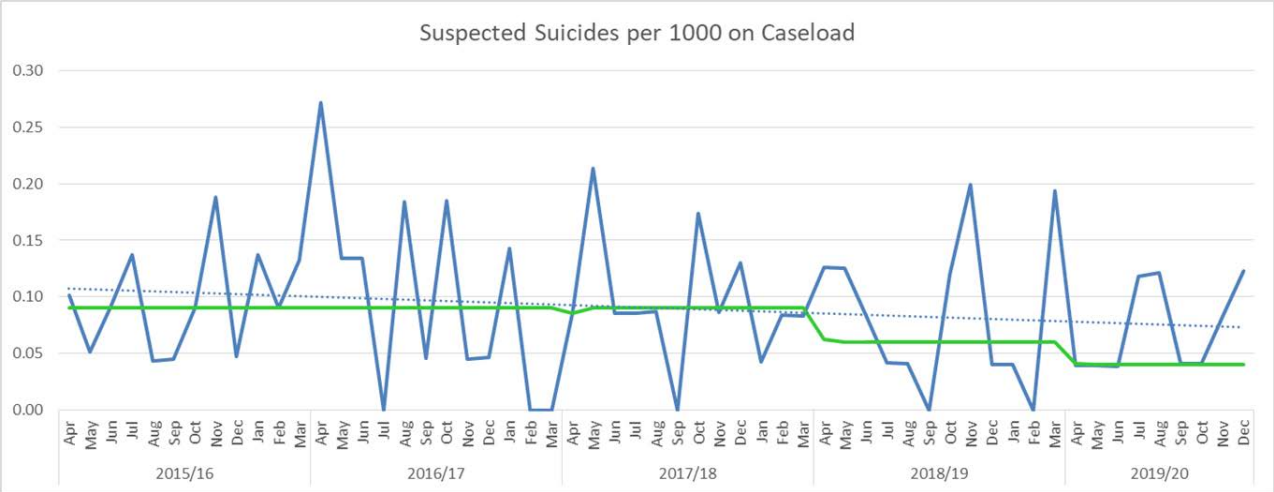


Figure 2

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 and may have had some role in reducing the suicide numbers seen this year.

In 2019/20 we are working with partners in our ICS and Public health to further improve suicide reduction approaches such as the “Zero Inpatient Suicide initiative”

We are currently meeting 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 detained 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 **2017/18** we reported **170** occurrences of AWOL (142 in Gloucestershire and 28 in Herefordshire detailed in the table below). 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. **190** occurrences were reported during **2017/18.**

At the end of **2017/18** the following occurrences of AWOL were 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.

At the end of **2018/19** the following occurrences of AWOL were reported.

	Absconded from a ward	Did not return from leave	Absconded from an escort	Total
Gloucestershire	62	66	16	**144**
Herefordshire	46	0	0	**46**
Total	**108**	**66**	**16**	**190**

None of these incidents led to serious harm or death.

At the ends of Quarter 3 2019/20 the following cumulative occurances were reported.

	Absconded from a ward	Did not return from leave	Absconded from an escort	Total
Gloucestershire	71	46	13	**130**
Herefordshire	27	1	2	**30**
Total	**98**	**47**	**15**	**160**

None of these incidents led to serious harm or death.

We are currently meeting this target

Target 3.3 To increase the use of supine restraint as an alternative to prone restraint (on all adult wards & PICU)

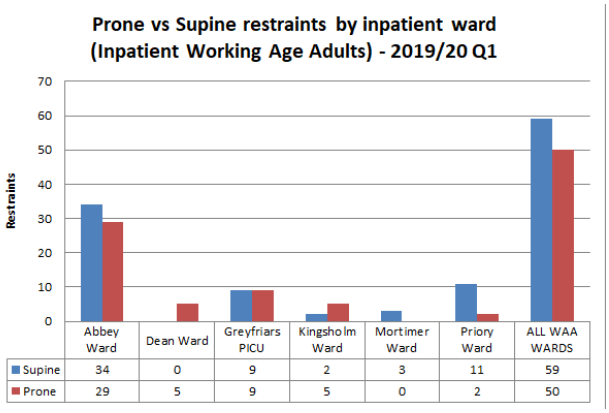
The use of prone restraint (face down) is sometimes necessary to manage and contain escalating violent behaviour, however it is also a response that has potential to cause harm to an individual. As a Trust we want to minimise the use of this wherever possible through therapeutic engagement and occupation in the inpatient environment; alongside effective de-escalation techniques and alternatives to prone restraint.

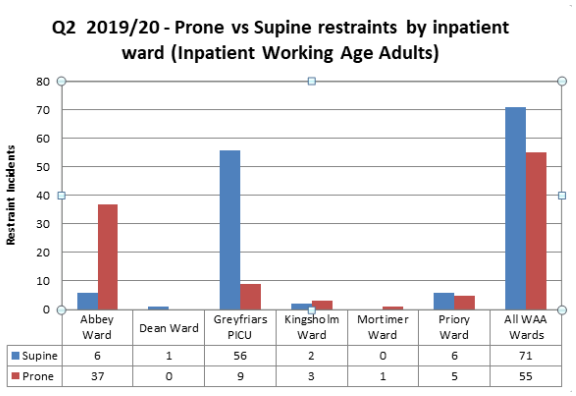
The Trust has a sub group focused on reducing physical restraint, in line with national guidance, reporting into our Trust Quality Committee. From reviewing our restraint data in detail over the past 3 years, we have seen a reduction in physical restraint and a positive increase in the use of supine restraint as an appropriate and safer alternative to prone restraint. This is due to active promotion of techniques used.

In 2018/19 our quality aim was to see a continued increase in the use of supine restraint as an alternative to prone restraint. During the year there were 124 prone restraints and 121 supine restraints, a difference of 3 more prone restraints. We, therefore, missed our 2018/19 quality improvement target for prone restraints to be lower than supine restraints, however, clinical staff

made good progress in this area and our analysis of the challenge has indicated where clinical exceptions have led to the use of prone restraint over supine.

In 2019/20 we will continue doing further work to address this including additional work on training staff in alternative injection sites, the development of new approaches to alternatives to prone restraint and, of course, on-going work to reduce all forms of restraint in inpatient services.





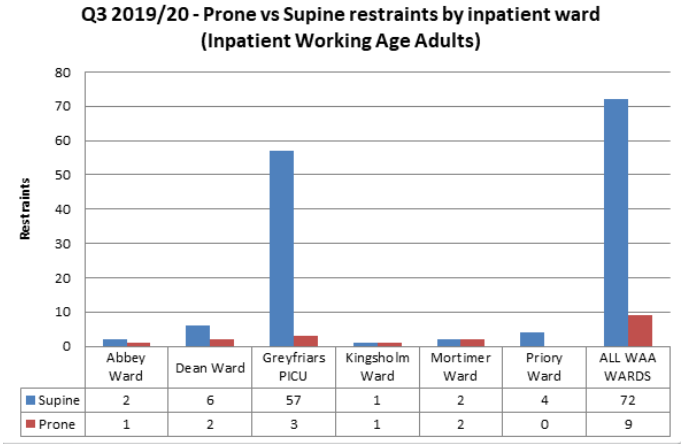


Figure 3

Figure 3 above shows a ward by ward comparision of the use of these techniques during Quarters 1 -3 . The higher use of prone restraint on Abbey Ward during Q2 was predominantly due to one patient who has specifically requested to be restrained (when such intervention is required) in the prone position.

Figure 4 below shows the spread of all physical inteventions used on our adult wards and the PICU during each quarter and it is reassuring to note that, wherever possible, the least restrictive practices e.g seated or precautonary holds are used. Supine or prone restraint are only used when a person's safety becomes compromised. Use of prone restraint has reduced significantly during Q3.

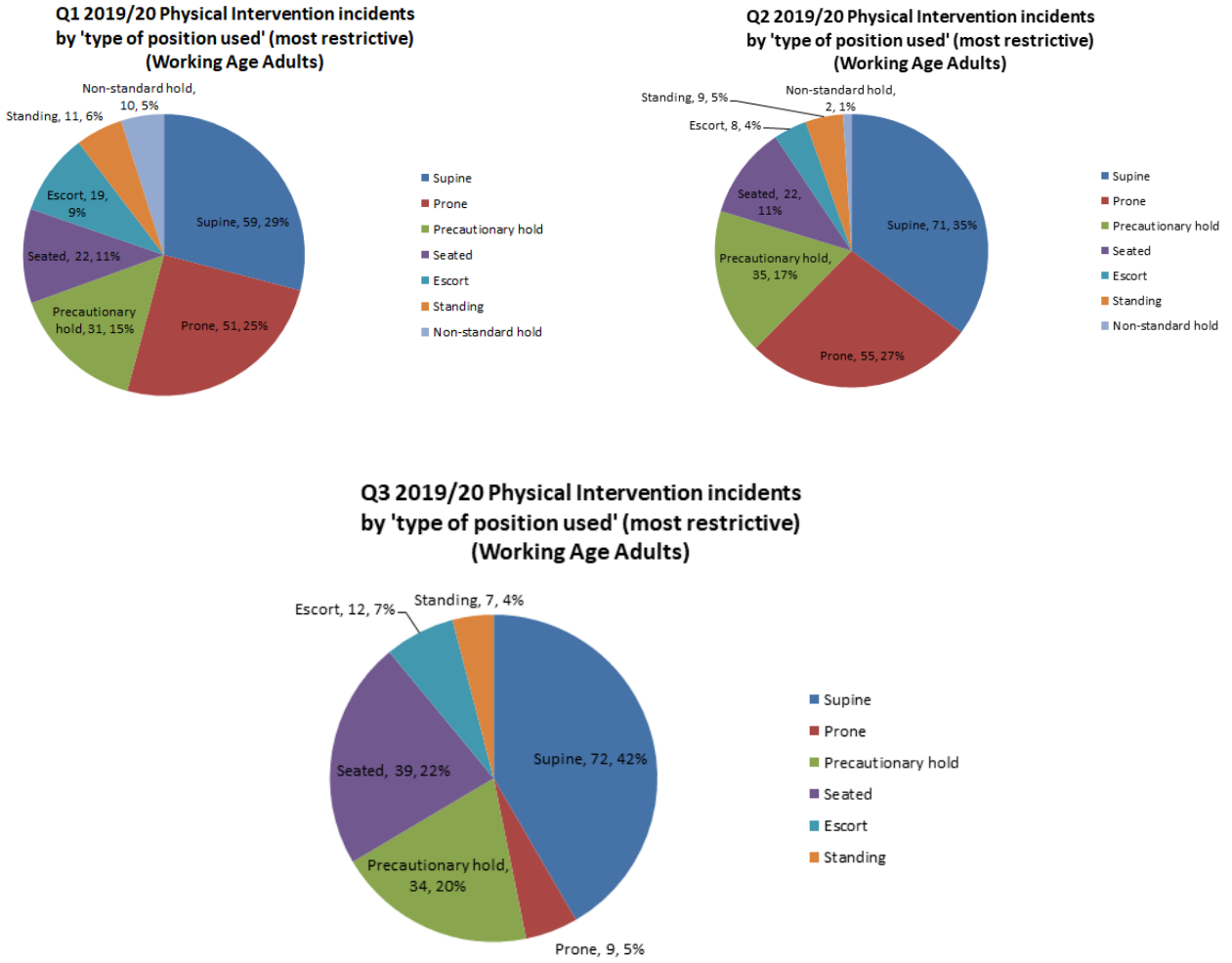


Figure 4

We are currently meeting this target.

Target 3.4 To ensure that 100% of service users within Berkeley House have a bespoke restrictive intervention care plan tailored to their individual need.

Berkeley House currently has 7 patients all of whom have specific care plans for Positive Behaviour Management (PBM) interventions; these care plans are on RiO and a copy of an accessible care plan is available for the patient.

They also have Positive Behavioural Support (PBS) plans which contain detailed information regarding primary, secondary and tertiary strategies for each person. Within these plans are functional assessments of behaviours that individuals may display. These include what a good day looks like and individualised strategies to manage behaviours when a patient begins to show signs of distress.

Primary prevention strategies aim to enhance the service users' quality of life and meet their unique needs thereby reducing the likelihood of behavioural disturbances.

Secondary prevention strategies focus on the recognition of early warning signs of impending behavioural disturbance and how to respond in order to encourage the patient to be calm.

Tertiary strategies guide the responses required to manage behavioural disturbance and acknowledge that the use of proportionate restrictive interventions may be required to minimise harm.

Alongside these strategies patients have activity care plans providing information on preferred activities, likes and dislikes and implementation of these activities for each individual. All patients also have a Health Action Plan and health and wellbeing care plan that gives information on health issues thus minimising possible influences pain may have an individual's behaviour.

All these plans are written following assessment and advice obtained from PBM trainers about any patient specific interventions (1 staff member at Berkeley House is also a PBM trainer). Also included in these plans are sensory interventions formulated by an occupational therapist which are implemented at associated primary and secondary phases appropriate for each individual.

All patients have a bespoke PBM assessment and care plan, this is written in conjunction with the Behaviour Support & Training Team, the PBM trainer we have within the staffing establishment at Berkeley House and the wider Multidisciplinary team. These plans include sensory interventions formulated by an occupational therapist. The PBM assessment (Individual Patient Physical Intervention Technique Checklist) clearly identifies techniques to be implemented for each individual as and when proportional to the risk to self and others.

Patients are physically monitored following all physical interventions to ensure that any concerns of physical harm or distress are acted upon within a timely manner. Where appropriate debriefs would be offered to patients post incident.

There are staff debriefs after any incidents of intervention, during which they are able to reassess and evaluate interactions and change care plans accordingly to better meet patient needs. Incidents are logged and discussed at MDT each week and interventions reviewed.

We are currently meeting this target.

Target 3.5 To further develop a quality improvement led approach to robustly embed lessons learned following serious incidents.

The Trust Serious Incident Review Process was reviewed during Quarter 4 2018/19 by Price Waterhouse Coopers (PWC) internal audit team. PWC assessed the effectiveness of the change in the Trust's Serious Incidents Requiring Investigation (reporting mechanisms, examined the processes in place for implementing relevant SIRI action plans and how lessons learned identified are shared across the Trust.

PWC Conclusion

Overall, the SIRI process has seen significant improvements in terms of timely submissions of SI reports, whilst also maintaining the quality. Investigations are undertaken by the central investigation team with the support of a relevant team manager, which has improved the quality, as the reports are now prepared by dedicated experts. There have been improvements in the process including overall turnaround time in producing reports, consistency in the quality of the reports, and the utilisation of a family liaison officer to support the families impacted, there is further scope to strengthen key areas that impact on the SIRI process and ensure the foundation and outcome of the investigations process is sustainable.

PWC raised 4 recommendations for Trust action

1. There is a robust and effective mechanism to share lessons learned across the Trust, however there is a scope to enhance the implementation in practice, embed the learning and the assurance mechanisms to determine effectiveness.

2. The incident policy document is not up to date and wholly reflective of the current process around engaging with local CCGs and related reporting mechanisms, elements were identified which would benefit from further clarity and detail matched to current activities and reporting mechanism.

3. The terms of reference for the SI action plan subcommittee has not been updated since April 2016 when the sub committee was formed there are opportunities to update the TOR and ensure it is reflective of current activities, roles and responsibilities.

4. Recommendations and actions arising from the serious incident reports should be measurable and realistic to ensure full implementation across the Trust a Sample tested found this not to be consistently the case

Action Taken to address

These recommendations have all been actioned and reported to the Trust Audit Committee. The Nursing, Therapies and Quality Team is continuing to explore and develop a sustainable system and process for embedding learning from incidents, complaints and claims. Below is a summary of the key aspects which will underpin the final approach.

Assessment	Key Lines of Enquiry	Evidence
1. Are recommendations and actions owned and complete?	• Was the action described appropriately? • Were the right staff involved in developing the action? • Do staff understand what the improvement outcome will look like in practice? • Are there any gaps in the completed action?	• Action plans • Minutes and reports • Polices and procedures • Communication and cascade
2. Are the actions complete and embedded?	• Is there a clear mechanism for ongoing monitoring? • Is there appropriate governance surrounding the action implementation and improvement cycle? • Has there been sufficient engagement, awareness and dissemination in all services and with key partners?	• Performance data • Care plan assessments • Service visits/peer review • Feedback from staff • Feedback from stakeholders
3. Have the actions had the right impact?	• Is the monitoring mechanism giving a complete picture • Are there any unintended consequences arising from implementation of the actions? • Do audit results demonstrate improvement?	• Improved outcomes • Change in practice • Internal/external audit evidence
4. Has the improvements been sustained?	• Has the action implementation positively changed culture? • Has the Board been provided with assurance? • Have the improvements informed strategic plans? • Have the improvements prompted ongoing and improving KPI achievements?	• Continuous quality improvement • Cultural shift indicators e.g. staff survey • Early alerts to events and instant action • Board oversight

We anticipate meeting this target by year end 2019/20.

Physical Health Services

In 2019/20 we set ourselves 5 targets against the goals of:

- Improved learning from 'no-harm' and'low-harm' medication incidents to enhance patient safety;
- Implement a Quality Improvement Programme to improve the management of catheters in community settings;
- Continue to reduce pressure ulcers by working with the NHSI Stop the Pressure Collaborative framework;
- Continue to train and support front line colleagues to recognise and manage deteriorating patients to ensure that they are managed quickly and effectively;
- To embed falls prevention and management as 'business as usual' with dedicated leadership.

Target 3.6 Improved learning from 'no-harm' and'low-harm' medication incidents to enhance patient safety

This priority has been designed to enable the identification and themes of factors contributing to, or causing no and low 'harm medication incidents, and make recommendations to address any identified themes.

Improved learning		Quarter 1	Quarter 2	Quarter 3	Quarter 4
Actions		Establish a baseline of quality of reporting of harm reported medication incidents using quality audits - Completed, see below.	Quality Improvement working group will establish a training needs analysis on baseline data and agree actions required to improve quality of reporting	Implementation of actions agreed from Qtr. 2	A repeat audit of harm reported medication incidents will be performed to determine if the aims of the outcome have been achieved
Low/no harm incidents have been investigated and closed by end of each quarter	Target		45%	60%	75%
	No-harm incidents	Baseline 32%	25%	54%	
	Low-harm incidents	Baseline 29%	57%	29%	
Low/no harm incidents should state the medication involved	Target		91%	95%	100%
	No-harm incidents	Baseline 87%	85%	95%	
	Target		80%	90%	100%
	Low-harm incidents	Baseline 71%	57%	100%	
Low/no harm incidents should state the indication for the medication involved	Target		33%	66%	100%
	No-harm incidents	Baseline 0%	30%	35%	
	Low-harm incidents	Baseline 0%	0%	0%	

There were 30 medication incidents with Community Physical Health Services responsibility reported in December.

- 2 resulted in low harm
- 28 resulted in no harm

A review of this information has shown that the numbers of reported incidents are within normal variation.

Actions

- Work is progressing with the Education and Learning team to develop medicines training (new starter and 3 yearly) refresher to be hosted on an electronic platform.

- The terms of reference for the new Medication Safety Group are being developed. This group will be focus on the Quality Priority and report to the Medicines Optimisation Group.

We are not yet meeting this target.

Target 3.7 Implement a Quality Improvement Programme to improve the management of catheters in community settings

Long term catheters whilst beneficial for some patients are also associated with morbidity. Infections (including sepsis) and other complexities which include anxiety over unpredictability of catheter problems (e.g. sudden blockage), difficulties managing away from home (e.g., taking equipment on holiday), sense of physical restraint, limited clothing choices, interruptions to sleep due to discomfort or pulling, and self-identity issues.

It has been identified that some patients appear to have clinically unnecessary urinary catheters in situ; the above risks and problems can therefore impact on the safety, morbidity and quality of life of these cohorts of patients.

Catheter Management metrics	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Reduce the amount of community nursing contacts to patients between planned routine catheter changes to manage catheter associated problems.	Target	95% of Baseline	90% of Baseline	85% of Baseline
	Set targets for use in Qtrs. 2 to 4 Baseline: 3,900 Contacts per quarter (1,300 per month)	5% reduction	9.5% reduction from baseline (average = 1185/month)	Available end April 2020
Reduce the number of (clinically unnecessary) urinary catheters inserted in the community setting.	Establish baseline and set targets for use in Qtrs. 2 to 4 Delay due to determining percentage of patients whose first catheter insertions were not on GCS Nurse caseloads, or may have a positive TWOC* outcome	Delayed data capture continuing through October, report available November	Data suggests this is up to 15% of catheters in situ at any one time, but clinical appraisal is challenging as the majority of catheters are initiated in GHFT not community – so unable to review records. (76% in Oct 19 were initiated outside of community setting)	Audit available end April 2020

* TWOC – Trial Without Catheter to determine if clinically indicated.

Actions Completed

An audit of new catheter requests for October in the ICTs demonstrated:

- 85% of all (33) new catheter requests received into ICTs in October were found to be clinically relevant and appropriate

- Of the remaining 15% of people referred in October (5 people) their reasons for catheterisation were: 1 x End of life care – catheter was not inserted / 1 x reduce mobility – was catheterised in GHFT / 1 x post-operative, but not urology surgery – again decision to catheterise was taken outside of GHC / 1 x incontinence + dementia and cancer of the prostate (this may have been inappropriate but insufficient clinical information available to appraise) / 1 x undefined need patient (insufficient assessment information available to appraise)

- 77% of requests were for male patients with clinical need, of those the majority will go on to have surgical intervention as such they would all be clinically appropriate catheterisations.

We have reviewed the draft of the countywide catheter passport and comments have been returned to the lead in Gloucestershire Hospitals NHS Foundation Trust, asserting this needs to be a countywide document under the One Gloucestershire umbrella not.

A practice improvement poster is nearly completed by One Gloucestershire based on GHC work undertaken. This will be disseminated to all clinical areas, care homes and care agencies across the county.

PDSA work is underway for small scale improvement in service areas as follows:

- Evening & Overnight nursing – production of a standard equipment in the home list and to standardise equipment.

- Complex Care @ Home – catheter education required for all colleagues as not all nurses in team.

- Community Hospitals - knowledge on trouble shooting guidance e.g. CAUTI and Trial Without Catheter/retention trouble shooting, focus on untrained education (nothing currently available for HCA's).

- ICTs – Bowel routine recording on clinical SystmOne template.

A countywide continence formulary is in the final stages of development between the Continence Specialist Lead, the CCG and the Head of Community Nursing. This will standardise equipment in use, identify best value for money and reduction in unwarranted variation which will help improve practice. This is now appraised by the Trust and agreed. Delays in this moving forward are not of GHCs causing.

Education offers for bladder and bowel assessment and care are now on ESR.

We anticipate meeting this target by year end 2019/20.

Target 3.8 Continue to reduce pressure ulcers by working with the NHSI Stop the Pressure Collaborative framework.

The prevention of pressure ulcers remains one of our top priorities with regards to patient safety. Despite great strides in the past 2 years our aim will be to continue to monitor the number and incidence of pressure ulcers and to continue to drive our reduction plans forward. Metrics for measuring performance therefore are:

1. Pressure ulcers will continue to reduce across our patient facing services where our span of influence can have an impact.

2. Quality improvement methodology continues to target areas of high incidence and as a response to incident reports to understand the issues, current focus on Cotswolds, Cheltenham and Forest hospitals to showcase improvement. The PDSA cycle will report quarterly on these areas and will include a qualitative report.

Plans also include working collaboratively with Gloucestershire Hospitals NHS Foundation Trust and / or care homes where specific incidences or themes demonstrate the potential for system wide learning. Qualitative reporting will also include case studies where pressure ulcers have been managed and healed, following the patient journey and taking in to account other factors such as nutrition and hydration.

Pressure Ulcers		Quarter 1	Quarter 2	Quarter 3	Quarter 4
Acquired Pressure Ulcers will continue to reduce across patient facing services where our span of influence can have an impact	Target (Number of avoidable acquired pressure ulcers over total pressure ulcers)	**8%** (2018-19 Q4 baseline 8.9%)	**7%**	**6%**	**5%**
	Actual	8.6%	6.6%	5.9%	
	Number of acquired and avoidable pressure ulcers	37	24	24	
	Total number of pressure ulcers in audit	430	365	409	

The quarterly metrics taken from Datix reports continue to evidence that clinicians are reporting and recognising skin integrity damage at earlier stages in patient's care journey. This is reflected in increased category 1 & 2 Pressure Ulcers and reduced occurrence of avoidable categories 3 & 4. This suggests that the posture and risk management approach to education is improving patient safety.

Monthly deep dive review into all reported category 3 & 4 ulcers commenced in November.

Deep dive into the pressure ulcers for Qtr. 3 that are recorded as developed or worsened under our care and categorised as unavoidable will be reviewed for themes and reported to the Quality committee in February/March

Community Hospitals have completed their quality improvement PDSA cycle across the Forest Community Hospitals and this has rolled out to Tewkesbury and Cirencester hospitals.

North Cotswolds professional leads in Physiotherapy, Occupational Therapy and Community Nursing have completed 2 workshops focused on risk assessment and posture for AHP's. This approach is a result of the #stopthepressure PDSA results which highlighted training to reduce avoidable harm should focus on holistic assessment and posture management. Additionally this AHP approach is underway in Cheltenham with cross locality support from North Cotswolds

Compliance with published standards from NHS Improvement (July 2018) and National Reporting and Learning System (NRLS) (March 2019) have been achieved. Definitions of acquired and inherited have been updated on the Datix incident reporting system. This has completed the outstanding actions from the gap analysis report for the Quality and Performance Committee (July 2018): Pressure ulcer developed or worsened during care by this organisation (previously: *acquired*). Pressure ulcer present before admission to this organisation (previously: *inherited*).

Benchmarking: In the 'Rate of new grade 2,3,4 avoidable pressure ulcers acquired in a Community Hospital setting per 1,000 occupied bed days' the Trust submitted a figure of 0.89 in November. The benchmarking figure is 1.01 for Community Hospital settings.

We are meeting this target.

Target 3.9 Continue to train and support front line colleagues to recognise and manage deteriorating patients to ensure that they are managed quickly and effectively.

The metrics are:

- All patients admitted onto Trust caseloads (Community and Inpatients) will have their NEWS recorded as a baseline. This will be measured with a snapshot audit which also extracts information about deterioration, recognition of sepsis and appropriate escalation;

- The qualitative data from the snapshot) audits will establish whether rapidly deteriorating patients have been identified and escalated appropriately within the service where their care is being managed (according to the Trust policy action cards).

For some patients this will include looking to assess whether there were any challenges evident to colleagues identifying early enough that the patient was deteriorating and at risk of sepsis and to identify key issues that may be used to develop further measures for improvement. For example, this may be clinical practice such as the frequency of observations once a NEWS has raised above a certain threshold for a patient – or around ensuring the NEWS scale 2 is used is for patients who have COPD with a clinically diagnosed oxygen (O_2) deficit and therefore need prescribed oxygen (O_2) at an lower rate (88-92).

NEWS Recording Targets 2019/20 (performance from audit data)						
Service Area	**Baseline**		**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
Community Hospital In-patients	March 2019 audit 89%	Target	89%	91%	93%	95%
		Actual	92%	98%	98%	
ICTs	March 2019 audit 33%	Target	33%	40%	50%	60%
		Actual	54%	31%	70%	

Results for Qtr. 3 snapshot audit results from NEWS in the ICT's show an encouraging improvement.

Community Hospitals removed from the risk register due to their percentage compliance with NEWS assessments.

Quality Improvement work with Community Nurses took place on 3 December 2019 reviewing data and developed an informative process map and plan to address compliance. A follow up workshop is scheduled for January.

A review of each locality's results to be shared with operational colleagues and a focus on areas that need support will commence in February/March.

We are meeting this target.

3.10 To embed falls prevention and management as 'business as usual' with dedicated leadership

The Trust aims to prevent as many falls as possible and has participated in the national CQUIN associated with falls. This CQUIN identifies three key actions that should be completed as part of a comprehensive multidisciplinary falls intervention and result in fewer falls, bringing length of stay improvements and reduced treatment costs. The three key actions which must **all** be completed are:

- Lying and standing blood pressure recorded.
- No hypnotics or anxiolytics prescribed, or rationale documented.
- Mobility assessment completed or walking aid provided within 24 hours.

Results

Falls Prevention	Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
% of patients meeting all 3 criterion shown below	80%	28.4%			43.8%			49.9%					
Lying & standing blood pressure recorded at least once+	80%	55.6 %	51.3 %	53.3 %	60.8 %	60.3 %	67.3 %	69.9 %	63.9 %	75.5 %			
No hypnotics, antipsychotics or anxiolytics prescribed or rationale for prescribgin documented	80%	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %			
Mobility Assessments completed within 24 hours or walking aid provided within 24 hours-	80%	41.5 %	38.8 %	50.3 %	72.3 %	60.3 %	61.9 %	67.1 %	61.7 %	61.2 %			

Colleagues have been reminded to ensure lying and standing blood pressure is recorded on SystmOne at least once during their admission (observations are usually recorded on the paper NEWS chart). We have added a box to SystmOne to enable 'not appropriate' to be selected, e.g. if patient hoisted or unwell/end of life. Suggestion to check that this has been completed before discharging a patient.

There will be a focussed education programme throughout January to ensure colleagues are fully aware of all the components of and the rationale for the CQUIN – this will include a reminder that the initial mobility assessment must be completed within 6 hours of admission and that this can be completed by any registered professional – does not have to be a physiotherapist.

We anticitate meeting this target by year end

Serious Incidents reported during 2019/20

Mental Health Services

By the end of Quarter 3 2019/20, **25** serious incidents were reported by the Trust; the types of these incidents reported are seen below.

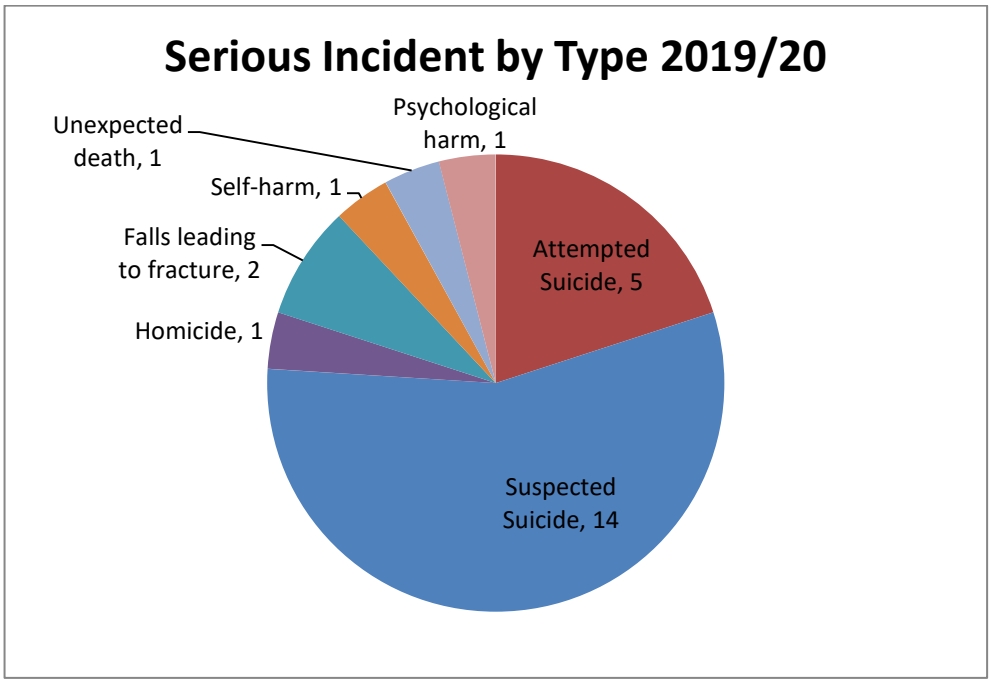


Figure 5

All serious incidents were investigated by a dedicated resource of clinicians, all of whom have been trained in root cause analysis techniques.

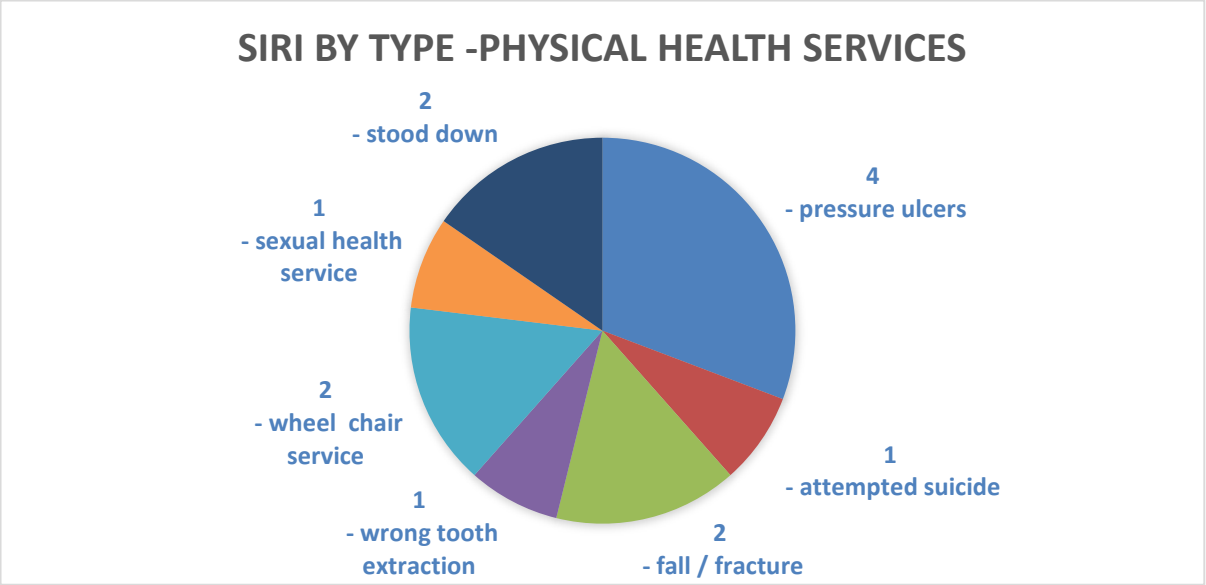
Wherever possible, we include service users and their families/carers to ensure that their views are central to the investigation, we then provide feedback to them on conclusion and copies of our investigation reports. During 2018/19 we continued to develop processes to provide improved support to people bereaved by suicide and in May 2018 18 staff were trained in Postvention techniques by the charity Suicide Bereavement UK. These trained staff now act voluntarily as Family Liaison Officers (FLOs) and are allocated to support families of service users on our caseload who have died by suspected suicide.

The Trust also 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” reported within the Trust. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

Physical Health Services

For the first 3 Quarters of 2019/20 the Trust reported **13 S**erious Incidents Requiring Investigation (SIRI); the types of these incidents reported are seen below.



All the SIRIs declared were investigated by a dedicated resource of clinicians, all have been trained in root cause analysis techniques.

There have been four pressure ulcers cases that met the criteria for a SIRI due to the wound deteriorating whilst the patient's were under the Trust's care.There was one incident of an attempted suicide within the Sexual Assault Referral Centre (SARC) and one incident of suboptimal assessment, diagnosis and aftercare from the Sexual Health Service. Two fall and fracture incidents (wrist and fingers) within 2 separate community hospital settings were escalated. There were two incidents of sub-optimal care being delivered to a deteriorating patient by the Wheelchair Service. One of these cases caused a pressure ulcer.

There were two incidents which were stood down within the agreed timeframe following comprehensive investigations. In both cases there was no evidence of harm caused to either patient as a result of the care provided by the Trust. One involved a delay in treatment and one a surgical procedure.

A child had an adult tooth extracted instead of a baby tooth (wrong tooth extraction). This incident was reported as a Never Event. 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.

Requires updating at year end to include physical health processes.

Freedom To Speak Up –

The Trust is committed to delivering high quality services and in conducting its business with honesty, openness, candour and integrity promoting a culture of openness in which all colleagues are encouraged to raise concerns without fear of suffering detriment.

The Trust has fully integrated the need for workers to speak up in line with the recommendations and in response to the independent 'Freedom to Speak Up' review 2015, led by Sir Robert Francis QC, and highlights the Trust's commitment to fostering a culture of safety and learning in which all colleagues feel safe and supported to raise a concern. These have been integrated into the Trusts 'Freedom to Speak Up policy' which describes the various routes that staff can employ in order to raise concerns. The following information outlines the current provision within the Trust in regard to how workers can raise concerns freely and without suffering detriment from doing so.

The Trust has also appointed and invested in, the Ambassador for Cultural Change, a unique role which incorporates the Freedom o Speak Up Guardian. She operates independently, impartially and objectively on all matters relating to concerns raised in the workplace, taking a highly visible leadership role in promoting the processes through which these concerns can be raised (including trust and confidence in the processes themselves). The wider role remit plays a key role in promoting a culture of transparency and service user safety.

There is an appointed **Freedom to Speak up Guardian** whose role is to help:

- protect patient safety and the quality of care
- improve the experience of workers
- promote learning and improvement

The Freedom to Speak up Guardian does this by ensuring that staff are supported in speaking up and that barriers to speaking up are addressed. They also help to ensure that a positive culture of speaking up is fostered and that any issues raised are used as opportunities for learning and improvement. To enhance the role and support further visibility and diversity throughout the Trust,

Freedom to Speak Up Advocates have also been appointed who assist workers to consider the available options to speak up and to identify appropriate routes to do so.

The Trusts 'Freedom to Speak Up Policy' clearly states that workers should feel safe to raise concerns. If they raise a genuine concern under this policy, they will not be at risk of losing their job or suffer any form of reprisal as a result. The Trust will not tolerate the harassment or victimisation of anyone raising a concern. Nor will they tolerate any attempt to bully a worker into not raising any such concern. Any such behaviour is a breach of our values as an organisation and, if upheld following investigation, could result in disciplinary action. Provided you are acting honestly, it does not matter if you are mistaken or if there is an innocent explanation for your concerns.

Other options available to staff within the Trust include:

Dignity at Work Officers – A Dignity at Work officer is a member of staff who undertakes this role in addition to their day to day job. They have been identified as someone who has the skills, understanding and empathy that makes them approachable to other staff. They are volunteers.
Their role is to provide support and guidance to anyone who feels that they are a victim of harassment or bullying in the workplace. They will provide unbiased and confidential independent advice as to the options available and try to help you gain an insight into what can be done about a situation..

Speak in Confidence – Speak In Confidence is a web-based system enabling staff to have an anonymous and confidential dialogue about issues that you may be concerned about, with a colleague of your choice (there is a list of those to choose from on the system which also includes the Trusts Freedom to Speak up Guardian to enable anonymous reporting to occur) Speak In Confidence has been introduced primarily to support staff who are subjected to inappropriate behaviour but who do not feel able to raise the issue through existing channels.

Additionally, the Trust is reviewing 'Speaking Up' support moving forwards to ensure that is clear to understand, supportive, confidential and offers a safe space.

To be further updated at year end.

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

The Trust has continued to build on the work previously reported under the umbrella of "Sign up to Safety". Sign up to Safety has evolved since its launch in 2014 and over time has narrowed its mission to focus on safety culture. The Patient Safety and Quality improvement initiatives are ongoing and some embedded as part of the way we do things here, demonstrating how a safety culture is in development. Monitoring is ongoing but reported every 6 months via the Trust Quality Committee. An example of this is the Trust's ongoing commitment to the South of England Mental Health Collaborative and the work developing around sharing the learning from deaths in mental health where an expert by experience is working in partnership with clinicians to understand ligature risks and ultimately learn together to improve safety.

Staffing in Adult and Older Adult Community Mental Health Services

New requirement: Providers of mental health services are asked to include a statement on their progress in bolstering staffing in their adult and older adult community mental health services, following additional investment from CCGs baseline funding (NHS Mental Health Implementation Plan 2019/20 -2023/24)

To be reported at year end

NHSI Indicators 2019/2020

The following table shows the NHSI mental health metrics that were monitored by the Trust during 2018/19.

		National Threshold	2017-2018 Actual	2018-2019 Actual	2019-2020 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	50%	**70%**	**72%**	**71%**
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%**	 **90%** **92%** **78%**	 **78%** tbc **76%**
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	50% 75% 95%	**50%** **67%** **85%**	**52%** **96%** **96%**	**50.5%** **99%** **99%**
4	Admissions to adult facilities of patients under 16 years old.		**1**	**0**	**0**

5 Inappropriate out-of area placements for adult mental health services

Month	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Ytd
Total Bed Days	126	140	106	132	109	245	258	199	240	1555
N. of out-of-area in period	6	8	5	8	6	11	13	11	10	78
Average Bed Days	**21**	**18**	**21**	**17**	**18**	**22**	**20**	**18**	**24**	**20**

Community Survey 2019

The Care Quality Commission (CQC) requires that all providers of NHS mental health services in England undertake an annual survey of patient feedback. For the 2019 survey, [2]gether NHS Foundation Trust was the named provider of these services, prior to the creation of Gloucestershire Health and Care NHS Foundation Trust. As has been the case for several years, the Trust commissioned Quality Health to undertake this work.

The 2019 survey of people who use community mental health services involved 56 providers in England, including combined mental health and social care trusts, Foundation Trusts and community healthcare social enterprises that provide NHS mental health services.The data collection was undertaken between February and June 2019 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 2018.

Full details of this survey questions and results can be found on the following website:
https://nhssurveys.org/wp-content/surveys/05-community-mental-health/05-benchmarks-reports/2019/2gether%20NHS%20Foundation%20Trust.pdf

The CQC results for the 2019 survey of people who use community mental health services were published on the 26th November 2019[1]. The Trust's overall results are summarised in Table 1 below. Only 2 Trusts were classed as 'better than expected' in 2019 and our Trust was one of them. We are the only Trust to have received this rating for the third consecutive year. The Trust obtained the **highest Trust scores in England** on 6 of the 28 (n=21%) evaluative questions and on 4 of the 11 domains.

Score (out of 10)	Domain of questions	How the score relates to other trusts
7.7	Health and social care workers	Better than others
8.8	Organising Care	Better than others
7.5	Planning care	Better than others
8.0	Reviewing care	Same as others
6.9	Crisis care	Same as others
7.4	Medicines	Same as others
	NHS Therapies	Better than others
5.5	Support and Wellbeing	Better than others
2.1	Feedback	Same as others
7.8	Overall view of care and services	Better than others
7.4	Overall experience	Better than others

Adult community mental health services provided by Gloucestershire Health and Care NHS Trust (GHC) scored well this year overall, being classed as 'better than expected' for the third consecutive year. However, there continue to be areas where further development and continued effort would enhance the experience of people in contact with our services. For example, the results in the feedback domain suggest that further work is required in this area.

The 2019 survey scores and information from a range of other service experience information (reported to Board quarterly) suggest that actions being taken to enhance service experience over recent years are having a positive impact and that learning from feedback is being embedded into practice.

Next Steps

These results represent a further improvement when compared to our results from last years' service user feedback in the same survey. The results are a testament to the expert and dedicated effort that colleagues are making to understand need, involve and respond well to people who use our services and their carers.

There is a need to sustain the effort made to develop practice in the areas identified in previous years.Where other organisations have scored well in particular areas we will collaborate and seek ideas to further develop local practice, particularly in relation to seeking feedback.

The following areas for further practice development have been identified:

- Giving people information about getting support from people with experience of the same mental health needs as them
- Discussing the possible side-effects of medication with people
- Asking people for their views on the quality of their care

[1] https://www.cqc.org.uk/provider/RTQ/survey/6

An action plan has been co-developed with senior operational and clinical leaders and will be monitored via the Locality Updates regularly brought to the Quality Assurance Group.

The 2019 results have been provided for all colleagues through a global email which celebrates our successes and thanks them for their dedication. The results will be cascaded to senior leaders for sharing with teams and for generating ideas for continued practice development. An infographic has been developed to share the results in a more accessible format.

Staff Survey 2019

To be completed when the national survey results are formally published.

PLACE Assessment 2019

To be completed when results are formally published.

Annex 1: Statements from our partners on the Quality Report

To be completed at year end.

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

To be completed at year end.

Annex 3: Glossary

BMI	Body Mass Index
CCG	Clinical Commissioning Group
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.
ECG	An electrocardiogram (ECG) is a test that is used to check the heart's rhythm and electrical activity.
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.
ICS	Integrated Care System. NHS Partnerships with local councils and others which take collective responsibility for managing resources, delivering NHS standards and improving the health of the population they serve.
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.
LeDer	Learning Disabilities Mortality Review. It is a national programme aimed at making improvements to the lives of people with learning disabilities
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
NHSI	NHSI 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.
PAM	Patient Activation Measure: This is a tool to measure a patient's skill, knowledge and confidence to manage their long term conditions.
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
ReSPECT	This is a plan created through a conversation between a patient and a healthcare professional which includes their personal priorities for care, particularly for those people who are likely to be nearing the end of their lives.
RiO	This is the name of the electronic system for recording service user care notes and related information within the Trust's mental health services.
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
SJR	Structured judgement reviews. A process to effectively review the care received by patients who have died
SystmOne	This is the name of the electronic system for recording service user care notes and related information within the Trust's physical health services.
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
Gloucestershire Health & Care NHS Foundation Trust
Edward Jenner Court
Pioneer Avenue
Gloucester Business Park
Brockworth
Gloucester
GL3 4AW

Telephone: 0300 421 8100 Email: GHCComms@ghc.nhs.uk

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 0300 421 8313;
- Completing our Online Feedback Form at www.ghc.nhs.uk
- Completing our Comment, Concern, Complaint, Compliment Leaflet, available from any of our Trust sites;
- Using one of the feedback screens at selected Trust sites
- Contacting the Patient & Carer Experience Team at experience@ghc.nhs.uk
- 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 0300 421 7146.

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 16/0320

REPORT TO: Trust Board 25 March 2020

PRESENTED BY: John Trevains, Director of Nursing, Therapies & Quality

AUTHOR: Gordon Benson, Associate Director of Clinical Governance & Compliance

SUBJECT: **PATIENT EXPERIENCE REPORT QUARTER 3 2019/20**

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

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

The purpose of this report is to

This paper provides an overview of people's reported experience of Gloucestershire Health and Care NHS Foundation Trust services between **1st October 2019 and 31st December 2019**. It provides examples of the learning that has been achieved through patient experience reporting, and an update on activity to enhance patient experience.

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

Recommendations and decisions required

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

Executive summary

1) Assurance
This Patient Experience Report provides a high level overview of feedback received from service users and carers in Quarter 3 2019/20. Learning from people's experiences is the key purpose of this paper, which provides assurance that patient experience information has been reviewed, scrutinised for themes, and considered for both service-specific and general learning across the organisation.

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

<u>Significant assurance</u> that the organisation has listened to, heard and understood service user and carer experience of GHC's services.
This assurance is offered from a triangulation of information gathered across all domains of feedback including complaints, concerns, comments and compliments. Survey information has been triangulated to understand patient experience.

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

<u>Assurance</u> that service users value the service being offered and would recommend it to others.
During Quarter 3 80% (n = 173) of people who completed the Friends and Family Test said that they would recommend GHC's mental health services. The sample size is too small to provide significant assurance in this regard, however, is a positive indication of how the service is valued. 94% (n= 5,289) said they would recommend our physical health services which does provide significant assurance that the service provided is valued.

(2) Recommended learning and improvement
The Trust continues to seek feedback about patient experience from multiple sources on a continuous basis.

This quarter concerns and complaint themes continue to focus on communication issues by our services with service users and/or their carers. Colleagues across the Trust are working hard to develop practice in this area.

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

- We must make sure that we talk to and listen to all those involved in a person's care;
- We must make sure that people understand our explanations and the information that we give them.

(3) Feedback from the Quality Committee
The following aspects were identified for inclusion in subsequent reports.

- Performance response times for both acknowledging complaints and for sending Final Response Letters;
- Provision of data/information on the ratio of complaints received per patient contact per service.

Risks associated with meeting the Trust's values
Survey response rates continue to be lower than hoped; this area is identified as having ***limited assurance*** within the Quarter 3 report. This risk is logged on the Trust Risk Register and a structured plan is in place led by PET to increase response numbers. From 1st October 2019 onwards the Patient & Carer Experience Team has a dedicated survey lead and work stream to focus on seeking feedback via differing survey methods with the aim of increasing response rates and obtaining more opinion and meaningful data about the services that we provide.

Corporate considerations	
Quality Implications	Patient and carer experience is a key component of the delivery of best quality of care. The report outlines what is known about experience of Trust services in Q3 2019/20 and makes key recommendations for actions to enhance quality.
Resource Implications	The Patient Experience Report offers assurance to the Trust that resources are being used to support best patient experience.
Equality Implications	The Patient Experience Report offers assurance that the Trust is attending to its responsibilities regarding equalities for service users and carers.

Where has this issue been discussed before?
Quality Assurance Group: 21 February 2020 Quality Committee: 5 March 2020

Appendices:	

Report authorised by: John Trevains	**Title:** Director of Nursing, Therapies & Quality

Patient and Carer Experience Report
1st October 2019 to 31st December 2019

Introduction and Purpose

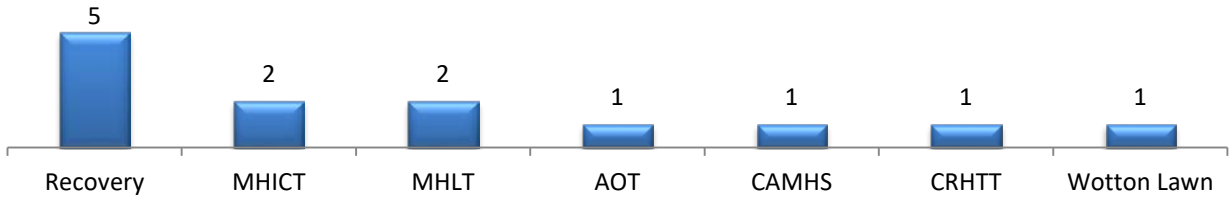
The purpose of this report is to inform the Committee of complaints, concerns and compliments received during Q3 2019-20 (October to December 2019). The report also provides an overview of the Friends and Family Test (FFT) responses during this period.

EXECUTIVE SUMMARY

Complaints 	**23** complaints were made this quarter (13 mental health / 10 physical health) We want people to tell us about any worries about their care. This way we can help to make things better.
Concerns 	**147** concerns were raised (72 Mental Health / 75 Physical Health)
Compliments 	**754** people told us they were pleased with our service (254 Mental Health / 500 Physical Health) We want teams to tell us about every compliment they get.
FFT 	**80%** of people said they would recommend our Mental Health Services to their family or friends **94%** of people said they would recommend our Physical Health services to their family or friends
Quality Survey 	Gloucestershire Mental Health Services (year to date): **184** people told us what they thought. Herefordshire Mental Health Services (year to date): **167** people told us what they thought. We want more people to tell us what they think.
We must listen 	**Mental Health example**: We must make sure that we talk to and listen to all those involved in a person's care. **Physical Health example**: We must make sure that people understand our explanations and the information that we give them.

During Q3 of 2019/20, GHC received 23 complaints about our services – 13 related to our Mental Health Services, and 10 to our Physical Health Services. The chart below presents numbers of complaints received according to Mental Health Service/team during this quarter:

Number of complaints relating to our mental health services, listed by team:



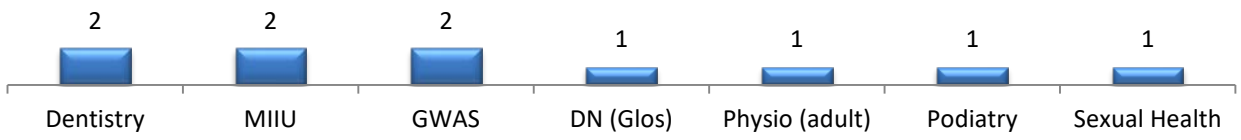
The table below gives a brief description of the 13 complaints received relating to mental health services during this quarter:

Team	Ref	Gender / age of patient	Description
Recovery	3280	Male / 24	Call in from independent advocate to say that patient was discharged after missing one appointment through sickness.
	3404	Male / 21	Concerns regarding misdiagnosis over several years.
	3427	Female / 62	Patient dissatisfied with the support she is receiving from Pullman Place.
	3293	Male / 38	Patient went for assessment and felt he left with no hope; would like to start a new medication *[patient sadly died – being reviewed as a serious incident].*
	3376	Female / 27	Mother of patient frustrated that team became involved in the patient's financial affairs and now the patient has taken control of a bank account that the mother feels she should not have access to.
MHICT (Therapy)	3361	Female / 48	Call received from patient who feels she has not been able to access psychology/psychiatric support.
	3442	Male / 46	Patient concerned that he has not been able to access Let's Talk, he gave information about his availability and preferred venue to attend, but this was not taken into consideration. When he did not attend appointment which he had said he could not attend, he was discharged within 24 hours.
MHLT	3343	Female / 56	Service user complained about a lack of support from the Mental Health Liaison Team and Crisis Resolution and Home Treatment Team, and that incorrect information was sent to her GP.
	3445	Male / 89	Family complained that a staff member was rude and dismissive towards them. The patient was also prescribed an anti-psychotic against the family's

Team	Ref	Gender / age of patient	Description
			wishes *[patient has since died].*
AOT	3310	Male / 35	Patient's mother feels that her son is getting insufficient care from the Assertive Outreach Team as he was living in unsanitary conditions. He was later detained under the Mental Health Act by police.
CAMHS	3386	Male / 13	Mother dissatisfied her son will not be re-assessed and would like an investigation into the referral process regarding an Autistic Spectrum Condition (ASC) assessment.
CRHTT	3407	Female / 31	Patient complained that a staff member linked to her family had been inappropriately accessing her health record.
Wotton Lawn	3367	Female / 23	Partner / carer not happy about the care his partner is receiving in Wotton Lawn, and "revolving door" of admission and discharge.

The chart below presents numbers of complaints received according to Physical Health service/team during this quarter:

Number of complaints relating to our physical health services, listed by team:



The table below gives a brief description of the 10 complaints received relating to physical health services during this quarter:

Team	Ref	Gender / age of patient	Description
Dentistry	11338	Male /	NHS 111 referred client in pain to our Dental Access Centre (DAC). Patient contacted the DAC twice but on both occasions he was denied treatment.
	11408	Female / 10	Child was accompanied to our dental service by an adult. Dental staff questioned the adult about why he was there with a child when he was not a blood relative. Adult reported being unnecessarily berated by the dentist for being there at all.
MIIU	11387	Female / 27	Client stated that a cast was improperly applied to her hand, causing pain. She has since been to the GHFT Fracture Clinic – at this appointment she reported the GHFT consultant implied that her hand had not been properly treated initially at

Team	Ref	Gender / age of patient	Description
			MIIU, and as a consequence surgery is now required.
	11162	Male / 21	Partner of patient complained about a missed scaphoid fracture suffered in July 2019. Patient had attended MIIU having injured his wrist which was diagnosed as a sprain; no x-ray was taken. Two months later an X-ray showed a fractured scaphoid.
Wheelchair Service	11152	Female / 16	Mother of patient reported her daughter has been issued a wheelchair that is too heavy to lift so it is hard to take her daughter out. She reported they had been promised a different wheelchair which would be more suitable but this has not happened.
	11546	Female / 22	Mother of patient reported her daughter's powered wheelchair was withdrawn by the Wheelchair Service as it was unsound. She has been promised a new motorised wheelchair, but that will not be ready for issue for six months. Mother feels this is compromising her daughter's physical and mental health since it is preventing her from her normal daily activities.
District Nursing	11550	Male / 77	Received via NHSE – complaint also involves concerns over care provided by GHFT and patient's GP. Patient has had urinary and catheter difficulties since July 2019. He feels the DN team (over some months) failed to attend promised appointments, keep him informed, communicate with his GP, apply his catheter correctly, provide consistent advice, and failed to diagnose (or refer him for diagnosis) an enlarged prostate.
Podiatry	11394	Male / 82	Family concerned over podiatry care received prior to admission to community hospital. Patient died within six hours of admission and the death certificate states a different time and cause of death from that which the family were initially informed.
Adult Physio	11386	Male / 49	Patient states he had been attending physiotherapy and was not given a correct diagnosis.
Sexual Health	11415	Female / 29	Patient attended Pregnancy Advisory Service whilst six weeks pregnant with twins, was informed the pregnancy was not viable and was offered a medical termination. Patient reported feeling pressured to make a decision on the day

Team	Ref	Gender / age of patient	Description
			(this complaint has now been declared as a SIRI).

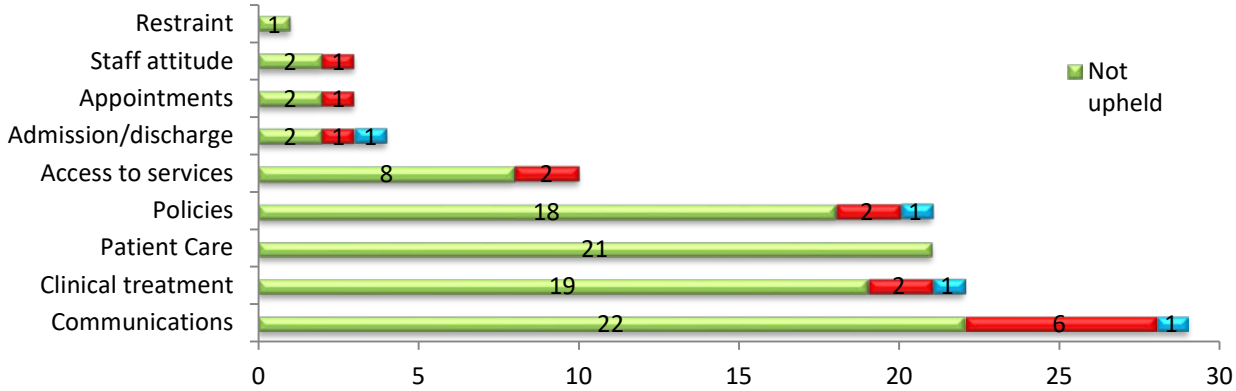
During quarter three of 2019/20, GHC closed 25 complaints about our services – 18 related to our mental health services, and 7 to our physical health services. The tables below summarises the overall outcomes of complaints according to service/team:

Mental health	Not upheld	Partly upheld	Withdrawn	Total
ASC	1	0	0	1
CAMHS	0	1	0	1
CCCT	0	1	0	1
CRHTT	1	0	1	2
GRIP	0	1	0	1
Wotton Lawn	2	1	1	4
MM2G	0	1	0	1
MHICT	0	1	0	1
Recovery	2	1	3	6
Total	**6**	**7**	**5**	**18**

Physical health	Not upheld	Partly upheld	Withdrawn	Total
Dentistry	1	0	0	1
DN (Glos)	0	1	0	1
DN (Stroud)	0	1	0	1
Podiatry	1	0	0	2
Sexual Health	0	1	0	1
GWAS	0	2	0	3
Total	**2**	**5**	**0**	**7**

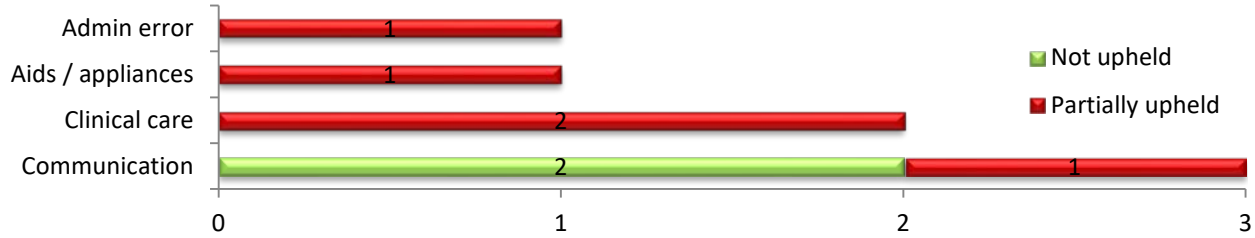
Individual issues in complaints relating to mental health services are recorded. Of the 114 issues raised in the 18 mental health complaints closed, 95 (83%) were not upheld, 4 (4%) were withdrawn, and 15 (13%) were upheld).

The chart below presents the themes/subjects raised in complaints about our Mental Health Services along with the outcome following investigation:



Complaints relating to physical health services are recorded in a different way – instead of individual issues, the overall outcome of the complaint is noted. Of the seven complaints closed this quarter, 2 (29%) were not upheld, and 5 (71%) were partially upheld.

The chart below presents the themes/subjects raised in complaints about our Physical Health Services along with the outcome following investigation:



Trust-wide points of learning from Patient and Carer Experience feedback Q3 closed complaints about mental health services are disseminated to localities via Practice Notes – assurance of actions to be sought from locality leads. From Q4 onward, this information will also be available for complaints relating to our Physical Health services.

Practice Note number	Organisational Learning
3115 (Mental Health)	• Colleagues should always make an appointment to see patients in an inpatient setting; this is to protect the patient and also the staff member. Wards can be very unsettled areas and patients can change in mental and behavioural state from minute to minute. • Colleagues visiting the ward should always report to the nursing office and be given a handover of any concerns, they should always report back to the nursing office following a meeting reporting any concerns. • Colleagues visiting the ward should always consider that another person may need to be present during meetings and if an appointment has been made this would allow for other people to be invited such as family, advocates nursing team. • Colleagues visiting the ward should be aware of each individual's specific mental and behavioural needs prior to seeing them so that

Practice Note number	Organisational Learning
	they can respond appropriately to meeting these. • When decisions have been made in meetings pertaining to a patient's care needs, changes should not be pursued unless there is clear rationale as to why this is happening and all relevant parties have been involved in such discussions.

The table below gives examples of complaints made by patients and their families, and how the Trust resolved them:

	You said	We did
Mental Health (Wotton Lawn) [3102]	The patient raised concerns about decisions made about their care in their absence, namely which team(s) would remain involved with them.	We apologised and agreed to share the patient's experience regarding the changes and decisions made about their care with the teams involved, so that staff better understand how the care delivered is received and the impact that people may experience.
Mental Health (CAMHS) [2997]	A father complained about a lack of communication in relation to his daughter's care, and reported that a letter suggested issues in the family home that did not exist.	Consider our choice of language in clinical letters, particularly in cases where there are safeguarding concerns.
Physical Health (Sexual Health) [10909]	A follow up letter from our sexual health clinic was sent to a patient's old address where it was opened and then returned to the service.	Apology offered along with an explanation that letters are usually handed to patients to take with them, but the letter was left behind. A member of staff took the patient's address from the wrong part of file. Discharge letters are now put inside the take home bag so they are not left.
Physical Health (GWAS) [11152]	A parent complained that a child's wheelchair was withdrawn and the family were informed they would need to hire one as needed. Calls were not returned.	We apologised and explained the rationale for the decision – the case was reviewed and it was agreed we would arrange an appointment with an external wheelchair company

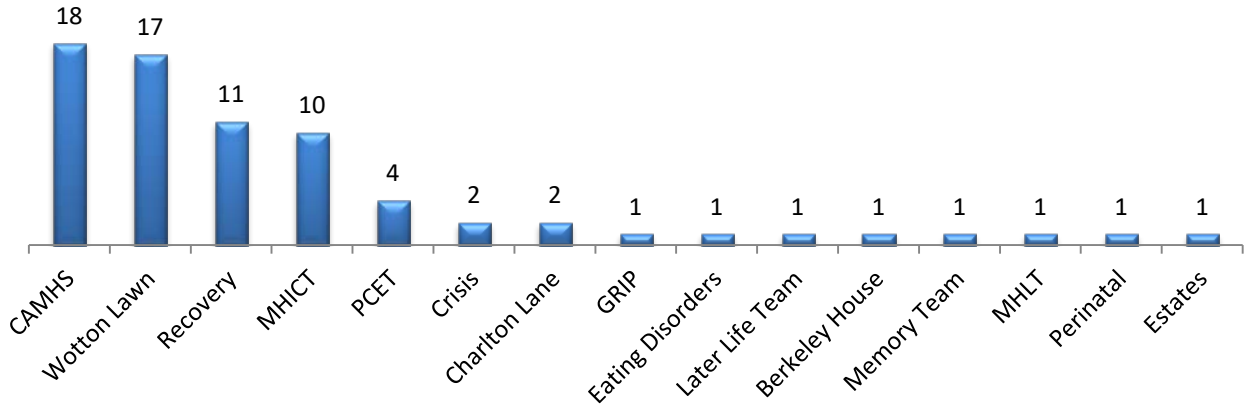
The table below lists any complaints that have been investigated and closed, and the complainant has then referred their complaint for external review by the Parliamentary and Health Service Ombudsman (PHSO). The following complaints were all relating to mental health services – there are currently no physical health complaints being reviewed by PHSO:

Reviewing organisation	Date of first contact from reviewing organisation	Date official investigation confirmed	Current status of referral
PHSO (1243)	04/09/2018	29/10/2018	Action plan ongoing – compensation paid
PHSO (415)	18/10/2018	24/01/2019	Investigation ongoing
PHSO (1359)	30/04/2019	08/10/2019	PHSO have asked us to investigate further elements of this case
PHSO (1567)	24/05/2019	Status unconfirmed	Awaiting further update from PHSO

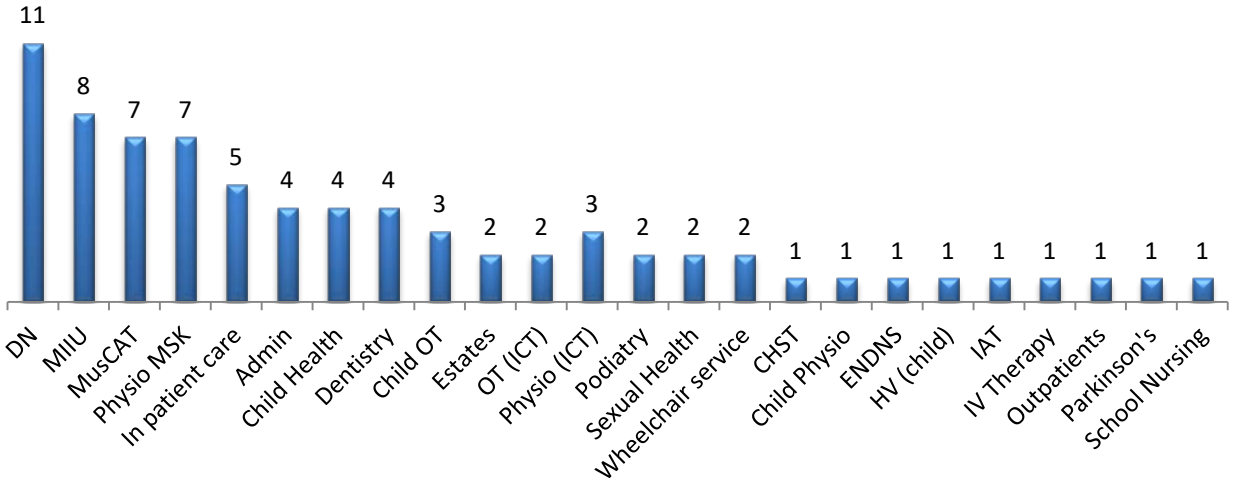
PHSO - Parliamentary and Health Service Ombudsman, LGO - Local Government Ombudsman

During quarter three of 2019/20, GHC received 147 concerns about our services – 72 (49%) related to our mental health services, and 75 (51%) to our physical health services:

Number of concerns relating to our Mental Health services, listed by team:



Number of concerns relating to our Physical Health Services, listed by team:

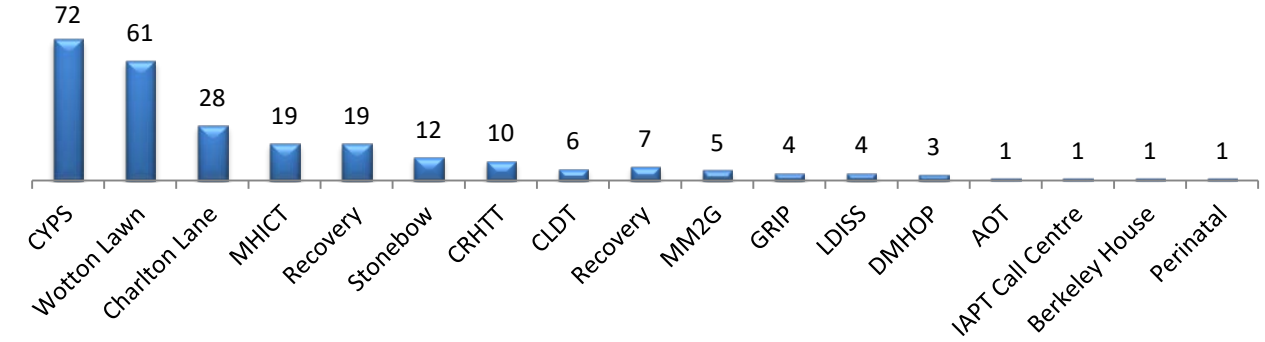


The table below gives examples of concerns raised by patients and their families, and how the Trust resolved them:

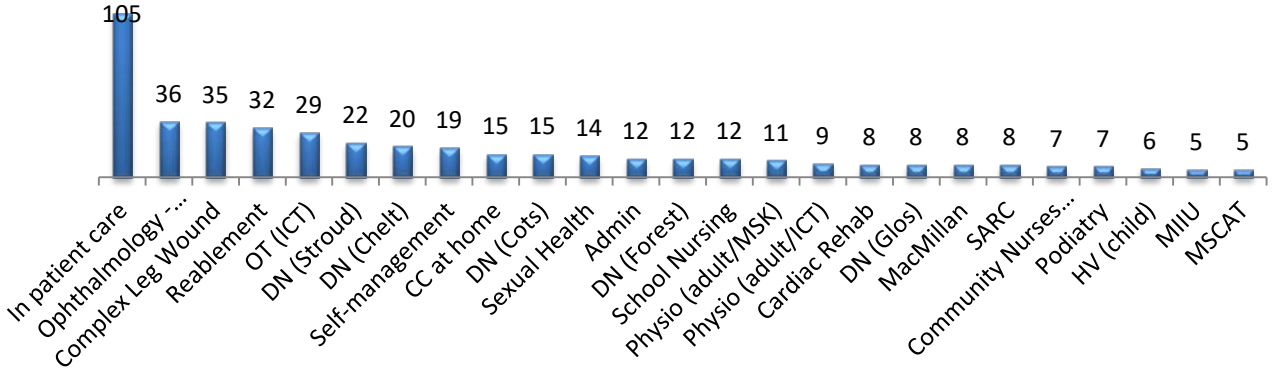
	You said	We did
Mental Health (Wotton Lawn) [3289]	Patient concerned that a doctor has not attended the last two MDT meeting and she is worried she won't be discharged.	Discussed with the Unit Manager who confirmed there has been a shortage of consultants which is being resolved. Another doctor came to the MDT and the plan is for the patient to be discharged this week - patient is very happy with the plan.
Mental Health (Let's Talk) [3245]	Service user is not happy with her therapist and would therefore like to change her therapist as she finds her over-zealous during her session.	Discussed with the Clinical Lead who has re-allocated the service user to another therapist.
Physical Health (HV) [11314]	Client says that she has recently been diagnosed by her GP with postpartum depression. She was expecting an HV to visit her at home, but no one turned up. This made her more distressed. She would like to talk to an HV.	Checked with the HV Team who believed she may have been allocated a phone consultation that day - not a home visit. The HV due to speak to her was away so another HV called her straightaway and arranged a home visit for her without delay
Physical Health (DN) [11312]	Client is the registered manager of a care home who says that two visiting DNs were unprofessional in that they were enquiring and then criticising the level of pay of the care home staff, compared to NHS levels of pay.	Apologised to the client and explained that this would be shared with the Senior Manager to discuss with the staff concerned.

During quarter three of 2019/20, GHC received 754 compliments about our services – 254 (34%) related to our Mental Health Services and 500 (66%) to our Physical Health Services:

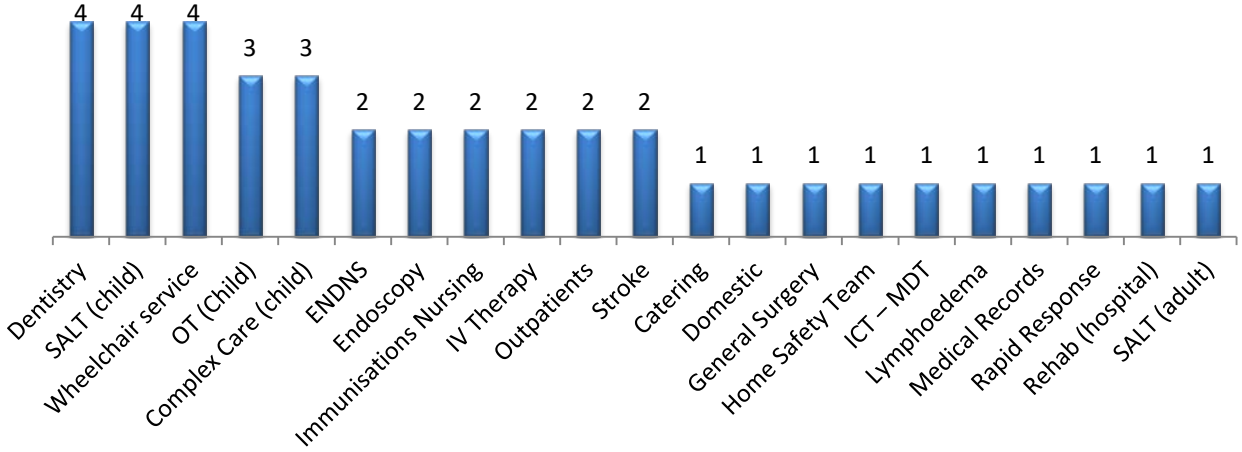
Mental Health compliments by team:



Physical Health compliments (five or more compliments) by team



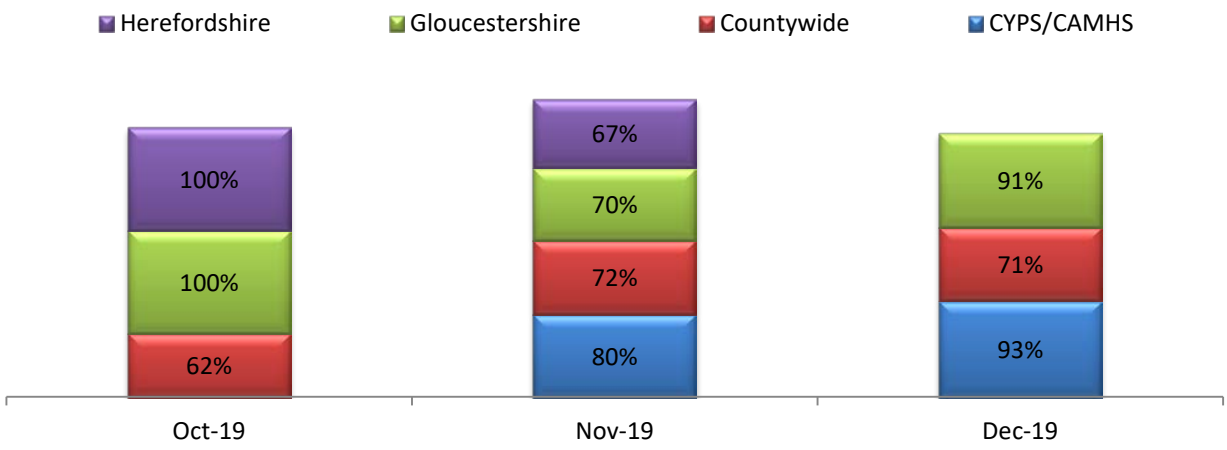
Physical Health compliments (up to four compliments) by team



In the Friends and Family Test (FFT) patients are asked "*How likely are you to recommend our service to your friends and family if they needed similar care or treatment?*" The FFT score is the percentage of people who stated that they would be 'extremely likely' or 'likely' to recommend our services. The FFT questionnaire is available in all Trust services.

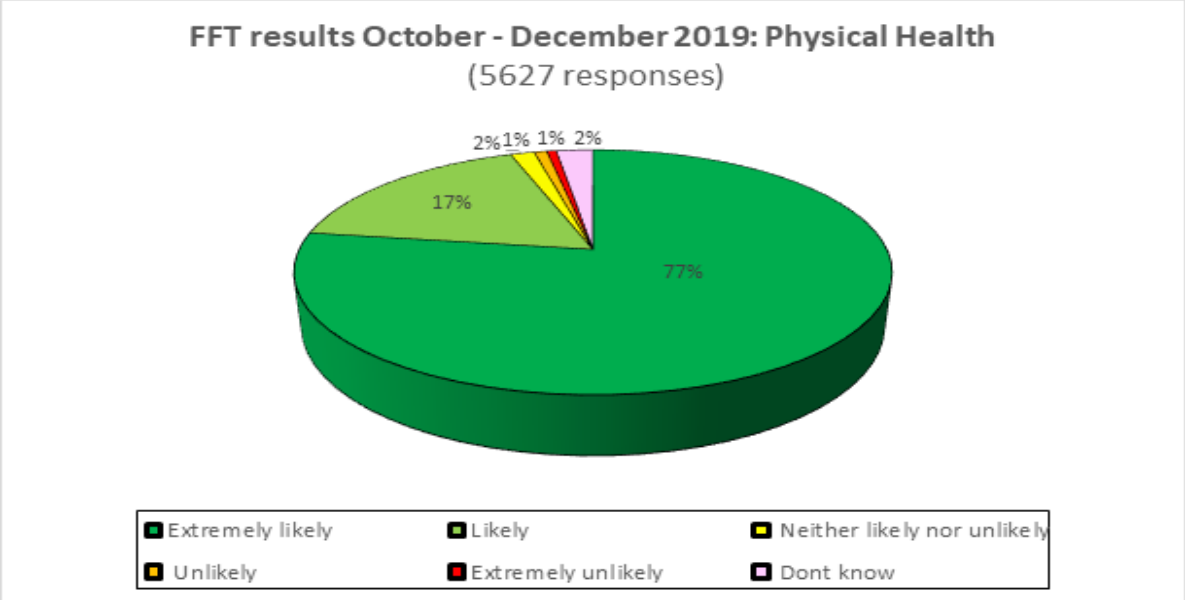
Mental Health Services

Of the 215 responses received, 80% (173) of the respondents said they were extremely likely or likely to recommend the service, as illustrated below:



Physical Health services

Of the 5,627 responses received, 94% (5,289) of the respondents said they were extremely likely or likely to recommend the service, as illustrated below:



The word cloud below shows an overview of feedback from patient across all physical health services (this is not currently available for mental health services):

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 17/0320

REPORT TO: Trust Board – 25 March 2020

PRESENTED BY: Dr Amjad Uppal, Medical Director

AUTHOR: Dr Nader Abbasi, Guardian of Safe Working Hours

SUBJECT: **GUARDIAN OF SAFE WORKING HOURS QUARTERLY REPORT – AUGUST TO OCTOBER 2019**

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

The purpose of this report is to
The Guardian of Safe Working report is required by the junior doctor's contract and is intended to provide the Board with an evidence based report on the working hours and practices of junior doctors within the trust, highlighting any areas of concern.

Recommendations and decisions required

The Board is asked to **note**:

- The report from the Guardian of Safe Working.
- The historical open reports will be closed following agreement between trainees, Guardian and Director of Medical Education

EXECUTIVE SUMMARY

- The exception reporting process is part of the new Juniors Doctors Contract to enable them to raise and resolve issues with their working hours and training.
- The Guardian's Quarterly report which summarises all exception reports, work schedule reviews and rota gaps, to provide assurance on compliance with safe working hours by both the employer and doctors in approved training programs, and will be considered by CQC, GMC, and NHS employers as key data during reviews.
- The purpose of the report is to give assurance to the Board that the doctors in training are safely rostered and their working hours are complaint with the TCS.

Risks associated with meeting the Trust's values

There are potential quality, safety, financial and reputational risks if the Trust does not comply with the requirements of the junior doctor's contract.

Corporate considerations	
Quality Implications	The Guardian of Safe Working Hours ensures the safe working practice of trainees
Resource Implications	Any quality implications are clearly referenced within the report
Equality Implications	Any quality implications are clearly referenced within the report

Where has this issue been discussed before?
Quality Committee – 5 March 2020

Report authorised by: Dr Amjad Uppal Medical Director	**Title:** 13 March 2020

1.0 Introduction

1.1 The safety of patients is of paramount importance for the NHS and staff fatigue is a hazard both to patients and the staff. The 2016 national contract for junior doctors encourages stronger safeguards to prevent doctors working excessive hours. It was agreed during negotiations with the BMA that a 'Guardian of Safe Working Hours' will be appointed in all NHS Trusts employing trainees (junior doctors) to ensure safe working practice.

1.2 The role of 'Guardian of Safe Working Hours' is independent of the Trust management structure, with the primary aim to represent and resolve issues related to working hours for the junior doctors employed by it. The Guardian will ensure that issues of compliance with safe working hours are addressed, as they arise, with the doctor and/or employer, as appropriate; and will provide assurance to the Trust Quality Committee and Board or equivalent body that doctors' working hours are safe.

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

1.4 The Trust has invested in relevant software to help monitor the 'Exception Reports' in line with national guidance and the system is relatively well established in the Trust now.

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

2.0 The Guardian of Safe Working Hours Report

2.1 Exception Reporting

The Trust uses 'Allocate' as the reporting software system, which appears to function reasonably well for this purpose.
Since beginning of August 2019 till end of October 2019, 3 exception reports (All from Gloucestershire and none from Hereford) have been generated and a break down has been provided in the full report.

2.2 All of 3 reports in this period have been related to hours and all have been addressed by educational supervisors

- 3/3 time in lieu agreed
- There was no need for work schedule reviews in this period.

2.3 The Guardian to close all the historical open exception reports. These are reports which mainly remained open due to the trainees leaving without addressing the issue. These were discussed between trainees, Guardian and DME and agreed to close. It is also important to note that in most of the cases an agreement had achieved between trainees and their supervisors but trainees failed to close them down before leaving the trust. These days we have a procedure in place to make sure that, trainees to outcome their reports before end of their placement.

2.4 Locum Booking and Vacancies

2.4.1 During this period nine on call shifts in Gloucester were covered by agency doctors and six in Hereford also covered by agency doctors.

2.4.2 In this time period we had 10 trainees not able to complete on calls as normal on Gloucester site and two on Hereford site.

2.5 Fines

At this stage no fines have as yet been applied.

3.0 Challenges

3.1 Completion of Exception Reports / Knowledge of the System: Although there has been improvement in the number of reports but response times remains a challenge. We had only one of our twelve reports in this quarter closed in a timely manner and the rest were addressed by delay. The Guardian has arranged meetings with trainees of all grades to discuss the issues and explore the challenges and ways to improve. We already had a meeting with our core trainees and addressed some of the issues and also arranged another meeting with our advance trainees. The Guardian also has arranged to present in weekly academic programme to update educational supervisors of the procedure and also explore their difficulties and challenges. The Guardian will continue to support junior doctors and supervisors in resolving these issues as soon as possible.

3.2 Software System: The Trust uses a nationally procured system for medical staff rotas called ‘Allocate Software System’; this system is now used for Exception reporting. All our junior doctors and educational supervisors are registered with the system. There are some issues with the system, which are nationwide and not limited to our Trust, and have been highlighted to the software company.

3.3 Junior doctor rota: Since changing rota in Gloucestershire to working ‘waking’ nights there has been a significant decline in number of exception reports. There has been significant improvement in number of reports raised by trainees working in Hereford following increase time allocated to on-call call out hours.

3.4 Workload: The new contract does have workload implications for the Guardian, administrator, DME, Educational and Clinical supervisors when a trainee submits an exception report.

3.5 Administrative support for the Guardian role: The Guardian is assisted by admin from medical staffing and they have been very supportive in introducing the new system and answering queries from users.

3.6 Junior Doctors Forum: Our Junior Doctors Forum predates the introduction of the new contract and has been further strengthened by the Guardian and the DME meeting quarterly. The attendance by junior doctors has been variable despite a proactive approach by the current junior doctors' rep to engage colleagues.

4.0 Exception Reports and Fines

There have been 3 exception reports during this period with all being addressed by the educational supervisor.

There has been no breach of contract to initiate any fines against the Trust yet.

5.0 CONCLUSION

5.1 All of our junior doctors now are on the new contract and committed to use the exception reporting system to ensure safe working practice. Information gleaned from the exception reports enables the DME to keep informed of the challenges and threats to the provision of quality Trainee placements at the Trust.

5.2 The Exception reporting process allows Trainees to give the Guardian notice of working unsafe hours. It is important that these issues are resolved in a timely manner.

5.3 The Guardian of Safe Working Quarterly Report provides assurance that Trust is positively engaged with its junior doctors via a number of routes and meetings. There was a surge of exception reports at the start of the implementation of the new contract but this has improved significantly with better understanding of the system through regular presentations at Induction and educating trainees and their supervisors.

5.4 There are some ongoing issues regarding engagement of both trainees and educational supervisors which are being addressed through regular training updates. We are developing a shorter guidebook for trainees to help with the compliance.

5.5 The Guardian to close the historical reports which have remained open due to trainees leaving the trust without addressing the reports although agreed an

outcome with their supervisors. This was agreed following discussion in junior doctors' forum and Medical Education Board meeting.

6.0 RECOMMENDATIONS

The Quality Committee is asked to **note** the assurance provided in the report.

Ongoing issues are being addressed through regular training updates and initial training at trainees' Induction which is mandatory.

The closure of historical reports.

with you, for you

Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 18/0320

REPORT TO: Trust Board – 25 March 2020

PRESENTED BY: Dr Amjad Uppal, Medical Director

AUTHOR: Zoë Lewis, Patient Safety Administrator

SUBJECT: **2019/20 QUARTER 3 LEARNING FROM DEATHS**

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

The purpose of this report is to

Inform the Board of the mortality review process and outcomes during 2019/20 quarter 3. It is a regulatory requirement for all NHS Trusts to identify, report, investigate and learn from deaths of patients in their care, as set out in the National Quality Board *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*, published March 2017.

Recommendations and decisions required

The Board is asked to **note** the contents of this mortality review report which covers Quarter 3 of 2019/20

Executive summary

The Board is asked to note that this is the first quarter of the merged organisation and as such, this is the first joint Learning From Deaths paper which includes data concerning both the deaths of mental health and physical health patients.

For the period 1 October 2019 to 31 December 2019, 119 mental health patient deaths and 44 physical health patient deaths were reported, a total of 163 patient deaths. At the time of reporting, 0 deaths representing 0.0% of the 163 patient deaths are judged to be more likely than not to have been due to problems in the care provided by the Trust. The Board is asked to note the learning presented here from mortality review of both physical and mental health patient deaths during 2019/20 Q3.

Risks associated with meeting the Trust's values
None

Corporate considerations	
Quality Implications	Required by National Guidance to support system learning
Resource Implications	Significant time commitment from clinical and administrative staff
Equality Implications	None

Where has this issue been discussed before?
Quality Assurance Group, 6 February 2020, agenda item 9.

Appendices:	None

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

Learning from Deaths 2019/20 Quarter 3

1.0 Introduction and Overview

The Board is asked to note that this is the first quarter of the merged organisation and as such, this is the first joint Learning from Deaths paper which includes data concerning both the deaths of mental health and physical health patients.

All data contained in this paper is correct as of 9 January 2019.

For physical health patients, inpatient only deaths are reported. For mental health patients (including LD), both inpatient and community deaths are reported.

1.1 Mental Health (including LD)

During 1 October–31 December 2019, **119** mental health patient deaths had been reported. This comprised the following number of deaths which occurred in each month of that reporting period:

- 44 in October
- 35 in November
- 40 in December.

1.2 Physical Health

During 1 October-31 December 2019, **44** physical health patient deaths had been reported. This comprised the following number of deaths which occurred in each month of that reporting period:

- 15 in October
- 12 in November
- 17 in December.

2.0 Mortality Review Process

2.1 Review of Mental Health and Learning Disability Patient Deaths

The Board is asked to note that since 1 October 2019, the former 2gether Trust's Mortality Review Committee (MoReC) is known as the Mental Health Mortality Review Group (MH MRG). MH MRG continues to use the RCPsych Structured Judgement Review (SJR) to conduct reviews. The Learning Disability Mortality Review Group (LD MRG) have decided to continue with the Care Record Review (CRR), previously developed in-house, to review LD patient deaths in order to facilitate continuity with the LeDeR process.

The Board is asked to note that the RCPsych SJR is split into 2 Sections. All mental health deaths are screened by the Patient Safety Administrator, and if certain criteria are met, the Patient Safety Administrator completes Section 1

of the SJR. If further criteria are met, including all expected mental health inpatient deaths at CLH, the review proceeds to Section 2 of the SJR, which is completed with discussion by MH MRG. MH MRG meets on a monthly basis.

All LD patient deaths are subject to CRR and discussion at the LD MRG. The completed CRR documents are forwarded to LeDeR to inform their review process. The LD MRG meets every other month.

If a death is considered to be a Serious Incident (SI) or a Clinical Incident (CI), the Mortality Review process described above is circumnavigated and a concise or comprehensive investigation is commenced. Any deaths reviewed by MH MRG or LD MRG may be escalated to SI or CI, as deemed appropriate.

At the time of writing this paper, for deaths occurring during 2019/20 Q3:

- 7 mortality reviews had been closed after completion of SJR Section 1
- 1 mortality review had been closed after completion of SJR Section 2 by MH MRG
- 1 mortality review had been closed following a SI investigation.

For the above figures, 0 deaths representing 0.0% of the 119 patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided by Gloucestershire Health and Care NHS Foundation Trust to the patient. In relation to each month, this consisted of:

- 0 representing 0% for October
- 0 representing 0.0% for November
- 0 representing 0% for December.

The above figures do not include current open SJRs, CRRs, CI Investigations and SI Investigations for deaths which occurred during 2019/20 Q3.

At time of writing this paper, 29 deaths, representing 23.5% of the 119 patient deaths occurring in 2019/20 Q3 were still open and undergoing mortality review. There were:

- 16 mortality reviews awaiting death information, which includes toxicology results
- 9 awaiting SJR Section 2 by MH MRG or CRR by LD MRG
- 3 open SI Investigations
- 1 open CI Investigation.

2.2 Review of Physical Health Patient Deaths

The Board is asked to note that since 1 October 2019, the former Gloucestershire Care Service's Mortality Review Group is known as the Physical Health Mortality Review Group (PH MRG).

Inpatient deaths are currently reported on MIDAS, however, from 1 April 2020, inpatient deaths will be reported on the new joint Datix system, which will facilitate internal reporting, as well as reporting to NLRS and NHSI.

During 1 October-31 December 2019, of the 44 physical health inpatient deaths, 1 was reported as unexpected and the other 43 were reported as expected. The one reported unexpected death occurred at the Vale Hospital and will be reviewed at the next PH MRG meeting at the Vale Hospital on 17 February 2020.

The PH MRG meets 10 times a year rotating in turn around the community hospitals. Thus, deaths occurring at a particular hospital may not be reviewed for some months by PH MRG. It is the ambition of the Head of Clinical Governance and Compliance to change the structure of the PH MRG meeting process to allow deaths to be reviewed in a timelier manner, which may lead to centralising the meetings and utilising video conferencing facilities if community hospital colleagues are unable to attend in person.

To negate the possible risk of unexpected inpatient deaths not being reviewed by PH MRG for some months post death, previously all unexpected deaths, together with 10% of expected deaths, were reviewed by the End of Life Pathways Lead to provide assurance. However, during summer 2019 there was a change in personnel, which led to delay of this work stream. This has further been compounded by the change of the End of Life Pathways Lead's job role post-merger to not incorporate this work-stream. Since this work has not been re-allocated, this assurance has not been provided for some months, but we will continue to seek clarification.

It is the responsibility of the ward teams and the End of Life Pathways Lead (as was; see previous paragraph) to bring deaths for review by PH MRG. At time of writing this paper, none of the physical health deaths reported in 2019/20 Q3 have, as yet been subject to discussion by PH MRG. PH MRG was unable to meet in November due to lack of availability of the Medical Examiner. PH MRG does not convene in December. PH MRG meetings are planned for January 2020 at the Dilke Hospital, February 2020 at the Vale Hospital, and March 2020 at Cirencester Hospital.

3.0 Learning

3.1 Learning following review by MH MRG

During 2019/20 Q3, following SJRs of patient deaths, together with patient deaths brought for discussion only, MH MRG has made the following

Recommendations:

- One death reviewed by MH MRG has been passed to physical health colleagues to review the physical health treatment received at CLH following a rapid deterioration and discharge to the acute trust where the patient sadly passed away a few days later. MH MRG raised concern that

  NEWS score recording seemed inconsistent for this patient and that there should be a protocol for stopping NEWS once it has been commenced. MH MRG awaits the outcome of the review by physical health colleagues.

- Following an expected death of an informal patient at CLH, who had recently been subject to Section 3 MHA, the MH MRG noted that this patient's behaviour on the ward had been difficult to manage, requiring 6x rapid tranquilisation (RT). The committee noted that after the first use of RT, Section 3 MHA should be considered, and also after each subsequent use of RT. Clinician's should ensure that the appropriate legal framework is in place. MH MRG is considering how best to disseminate this learning.

- Following the expected death of a patient on the End of Life (EoL) Shared Care Pathway at CLH, MH MRG noted that the BNF states doses for Glycopyrronium which do not match those of the prescription chart located on the Trust's intranet. The junior doctor discussed dosages with Palliative Care and was advised to prescribe above the maximum BNF dose. MH MRG has asked the EoL Pathways Lead and the Head of Medicines Management, via the EoL Quality Improvement Group, to consider and develop an SOP, if appropriate, and to consider whether the nurse in charge could check scripts with the junior doctor.

- The MH MRG notes that historically nurses at CLH have not used electric suction for management of secretions. However, there is now a new piece of equipment on the ward, for which the nurses have now been trained. Although training has been given, it has been highlighted to MH MRG that not all nurses are confident in using this equipment. MH MRG has passed this to Physiotherapy to follow up with additional training, as appropriate.

- Following an expected death of a patient on EoL Shared Care Pathway at the Stonebow Unit, who had unexplained pain (?silent lacunar infarction), the MH MRG noted the excellent practice in all areas, especially regarding building trust with the patient's family. The EoL Pathways Lead will share this case with the End of Life Quality Improvement Group in terms of notable practice.

3.2 Learning Following Review by LD MRG

Learning following LD MRG meeting 27/11/2019 is still being finalised. The minutes are awaited.

3.3 Learning Following Review by PH MRG

- Following a review of an expected death at Tewkesbury Hospital, PH MRG noted the ongoing reported issue of patients being transferred from the GHFT without complete admission paperwork. This has been passed to Patient Safety Manager, Clinical Incidents, for discussion at the One Gloucestershire Joint Patient Safety Meeting.

- Following a review of an expected death at Tewkesbury Hospital, PH MRG noted the good practice in terms of communication with the patient's family, despite a difficult family dynamic. The ME received a significant amount of positive feedback regarding the care the patient received at Tewkesbury Hospital during a telephone conversation with the family to talk through the death certificate. The Matron will update the ward staff with this feedback.

- Following the transfer of a patient from Cirencester Hospital to Tewkesbury Hospital, the PH MRG noted that the transfer team had noted rapid deterioration of the patient and it was clear to admitting team that the patient needed to be on EoL Shared Care Pathway. The PH MRG noted that this patient was not on EoL Shared Care Pathway when they left Cirencester Hospital and have asked the End of Life Pathways Lead to pick up with Cirencester Matron and Sister, to review notes, explore conversations with family around EoL and feedback.

AGENDA ITEM: 19/0320

REPORT TO: Trust Board – 25th March 2020

PRESENTED BY: John Trevains, Director of Nursing, Therapies & Quality

AUTHOR: John Trevains, Director of Nursing Therapies & Quality

SUBJECT: **6 MONTHLY SAFE STAFFING UPDATE**

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

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

The purpose of this report is to provide an update to the Trust Board on current safe staffing levels reporting within the Trust.

Recommendations

The Board is asked to:

- Note the current assurance against national guidance and locally agreed safe staffing levels.
- Note monthly reporting and compliance with fill rates

Executive summary

This 6 monthly update reports:

- National Reporting requirements, and the recent submitted data in the required format (Appendix 1 & Appendix 2)
- High Level Local Trust Exception Reporting – Mental Health & Learning Disability Services – Most recent 2 months of data
- Physical Health Services reporting – Most recent 2 months of data

National reporting with regards to fill rates continues to be uploaded monthly and reported to the Trust Quality Committee on a monthly basis. From April 2018 the Trust has been mandated to also include the Care House Per Patient Day (CHPPD) within the upload. The Trust continues to maintain safe overall compliance against planned versus actual fill rates – over 97% compliant for January and February 2020.

It is important to note qualified nursing availability in February in some areas has been challenging. This has been risk assessed and offset through additional staffing though ward management, AHP support and additional Health Care Assistant (HCA) numbers. However no exceptions were escalated to the Director of Nursing, Therapies and Quality and safety was maintained. Additional agency support for these areas has been requested and also a student nurse recruitment event carried out in January 2020 has been successful to assist in partly addressing vacancies.

Appendix 1 details the January 2020 figures that were presented at the March Quality Committee. Appendix 2 details the February 2020 figures recently compiled prior to Trust Board.

Please note that the narrative within this report relates to mental health and learning disability inpatient units for January 2020 and February 2020.The Community Hospital data is provided in this report, this data has historically been compiled and reported in a different format and we are working to homogenise reporting for the whole Trust for future editions of this report.

ASSURANCE

This report provides **ASSURANCE** on safe staffing and monthly reporting noting staffing level challenges.

Risks associated with meeting the Trust's values

If required staffing levels are not fully met there may be increased level of risk regarding delivery of safe and effective patient care.

Corporate considerations	
Quality Implications	Safe staffing is fundamental to ensuring high quality safe services are delivered. This guidance ensures that all relevant triangulation regarding safe services are highlighted and noted to the Trust Board.
Resource Implications	Increased use of agency to maintain staffing is a resource implication.
Equality Implications	No equality implications are identified

Where has this issue been discussed before?

Monthly report to Quality Committee

Appendices:	Appendix 1 – January 2020 Safe Staffing Appendix 2 – February 2020 Safe Staffing
Explanation of Acronyms used:	NQB – National Quality Board CHPPD – Care Hours Per Patient Day NHSI – NHS Improvement HCA – Health Care Assistant HEI – Higher Education Institution HEE – Health Education England

Report authorised by: John Trevains	**Title:** Director of Nursing, Therapies and Quality

6 MONTHLY SAFE STAFFING UPDATE

1.0 INTRODUCTION & CONTEXT

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

1.2 2gether NHS Foundation Trust Board received the last 6 monthly update in September 2019. The Gloucestershire Health and Care Quality Committee has received a monthly report detailing staffing levels across all mental health inpatient sites from October 2019. Recent developments have ensured the Trust Quality Committee now receives safe staffing updates for the physical health community hospitals. This was historically reported differently due to local arrangements with good compliance maintained

1.3 This 6 monthly update outlines:

- National Reporting requirements, and the recent submitted data in the required format (Appendix 1 & Appendix 2)
- High Level Local Trust Exception Reporting – Mental Health & Learning Disability Services – Most recent 2 months of data
- Physical Health Services reporting – Most recent 2 months of data

2.0 NATIONAL REPORTING REQUIREMENTS

2.1 The Trust has been required from 1st August 2019 to report the utilisation of registered and unregistered nursing associates within submitted safe staffing data returns. This has been implemented, noting that we report currently small number of nurse associates within HCA numbers.

2.2 The Trust has been required to report Care Hours per Patient Day (CHPPD) data from April 2018 which we upload alongside the safe staffing fill rates on a monthly basis.

2.3 The Trusts business intelligence team are working with the quality team to develop a quality dashboard that will be mapped to safe staffing reports across both mental and physical wards. The Director of Nursing, Therapies and Quality will provide a further update of progress at the Trust Board in September 2020.

2.4 The Trust continues to report satisfactory fill rates. Appendix 1 and 2 provides the national safe staffing reporting for January and February 2020. Since

September 2019, for mental health and learning disability services actual fill rates have been maintained at above 97% compliant against overall planned levels. Physical Health Services also report strong safe staffing levels. Work is being conducted by the quality team in collaboration with neighbouring mental health Trusts to review safe staffing numbers with oversight from the national NHS England lead for safe staffing.

3. TRUST EXCEPTION REPORTING – (Mental Health & Learning Disability Inpatient Services)

3.1 We collect and collate the reasons where core planned staffing levels have not been met through the internal exception codes. This local reporting is in addition to the national reporting and supports analysis of any issues which may arise regarding skill mix within the units and how the nurse in charge mitigates these risks.

3.2 Exception codes are defined as follows:

- **Exception Code 1** - Minimum staff numbers met – skill mix non- compliant but met needs of patients
- **Exception Code 2** - Minimum staff numbers not compliant but met needs of patients
- **Exception Code 3** - Minimum staff numbers met – skill mix non- compliant and did not meet needs of patients
- **Exception Code 4** - Minimum staff numbers not compliant and did not meet needs of patients
- **Exception Code 5** - Minimum staffing numbers and skill mix not met. Resulting in clinical incident / harm to patient or other

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

- Increase in staff on duty to provide one to one care for patients (increased observations)
- Decrease in staff, if the patient need does not require it e.g. patients on leave, or staff supporting other wards where the need and acuity are higher
- Unable to obtain staff

3.4 Planned staffing numbers are based on established commissioned activity and dependency levels; agreed by the Director of Nursing in collaboration with Commissioners. Immediate management of variance in staffing levels is determined by the nurse in charge and these may vary, for example; decisions may be made to replace a qualified nursing staff member with a health care assistant who knows the patients and the ward, rather than a bank or agency nurse who may not.

3.5 National Quality Board guidance states that the nurse in charge must use their professional judgement alongside the planned staffing requirements to meet the needs of the patients on the ward at any particular time. Safe staffing levels are monitored by ward managers, hospital matrons and operational management. Issues and concerns are escalated to the Director of Nursing.

3.6 January 2020 Summary

- No staffing issues were escalated to the Director of Nursing, Therapies and Quality or the Deputy Director of Nursing.
- Where staffing levels fell below the planned fill rates of 100% for qualified nurses this was usually offset by increasing staffing numbers of unqualified staff based on ward acuity, dependence and the professional judgement of the nurse in charge of the shift.
- **97.95%** of the hours exactly complied with the planned staffing levels.
- **1.72%** of the hours had a different skill mix than planned staffing, however overall staffing numbers were compliant and the needs of the patients were met.
- **0.32%** of the hours had a lower number of staff on duty than the planned levels; however this met the needs of the patients on the ward at the time.
- Dean ward reported a single Code 4 exception due to short notice staff sickness. No harms occurred.

Exception Summary Gloucestershire

	Code 1		Code 2		Code 3		Code 4		Code 5	
Ward Name	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions
Gloucestershire										
Dean	0	0	0	0	0	0	7.5	1	0	0
Abbey	212.5	28	40	5	0	0	0	0	0	0
Priory	262.5	35	0	0	0	0	0	0	0	0
Kingsholm	22.5	3	0	0	0	0	0	0	0	0
Montpellier	65	8	52.5	7	0	0	0	0	0	0
Greyfriars	277.5	33	0	0	0	0	0	0	0	0
Willow	30	4	82.5	11	0	0	0	0	0	0
Chestnut	57.5	8	0	0	0	0	0	0	0	0
Mulberry	37.5	5	0	0	0	0	0	0	0	0
Laurel	0	0	7.5	1	0	0	0	0	0	0
Honeybourne	0	0	0	0	0	0	0	0	0	0
Berkeley House	30	4	50	4	0	0	0	0	0	0
Total In Hours/Exceptions	995	128	233	28	0	0	7.5	1	0	0

Exception Summary Herefordshire

	Code 1		Code 2		Code 3		Code 4		Code 5	
Ward Name	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions
Herefordshire										
Mortimer										
Cantilupe	4	1								
Jenny Lind										
Oak House										
Total In Hours	4	1	0	0	0	0	0	0	0	0

3.7 February 2020 Summary

- No Individual staffing issues were escalated to the Director of Nursing, Therapies and Quality but concerns regarding forecasted availability in month were raised at Wotton Lawn Hospital and additional planning was required to support safe staffing. This was achieved through transfer of staff within the unit and additional regular agency utilisation.
- Where staffing levels fell below the planned fill rates of 100% for qualified nurses this was usually offset by increasing staffing numbers of unqualified staff based on ward acuity, dependence and the professional judgement of the nurse in charge of the shift.
- **97.25%** of the hours exactly complied with the planned staffing levels.
- **2.38%** of the hours had a different skill mix than planned staffing, however overall staffing numbers were compliant and the needs of the patients were met.
- **0.37%** of the hours had a lower number of staff on duty than the planned levels; however this met the needs of the patients on the ward at the time.
- No code 3 or above exceptions were reported. Berkeley House continues to decrease code 1 & 2 exceptions.

Exception Summary Gloucestershire

	Code 1		Code 2		Code 3		Code 4		Code 5	
Ward Name	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions
Gloucestershire										
Dean	7.5	1	0	0	0	0	0	0	0	0
Abbey	347.5	45	0	0	0	0	0	0	0	0
Priory	350	46	0	0	0	0	0	0	0	0
Kingsholm	7.5	1	0	0	0	0	0	0	0	0
Montpellier	112.5	14	67.5	9	0	0	0	0	0	0
Greyfriars	410	48	15	1	0	0	0	0	0	0
Willow	30	4	60	8	0	0	0	0	0	0
Chestnut	15	2	7.5	1	0	0	0	0	0	0
Mulberry	52.5	7	0	0	0	0	0	0	0	0
Laurel	0	0	22.5	1	0	0	0	0	0	0
Honeybourne	0	0	0	0	0	0	0	0	0	0
Berkeley House	0	0	30	4	0	0	0	0	0	0
Total In Hours/Exceptions	1333	168	203	24	0	0	0	0	0	0

Exception Summary Herefordshire

	Code 1		Code 2		Code 3		Code 4		Code 5	
Ward Name	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions
Herefordshire										
Mortimer	11.5	1	11.5	1						
Cantilupe	1	1								
Jenny Lind										
Oak House	23	2								
Total In Hours	35.5	4	11.5	1	0	0	0	0	0	0

3.8 COMMUNITY HOSPITALS SAFE STAFFING

Physical health community hospital data is provided below for January and February 2020. We are currently working to harmonise reporting for the whole Trust in future editions of this report as well as future reports to the Quality Committee.

JANUARY 2020

		Day				Night				APH	
HOSPITAL	WARD_NAME	Average fill rate - RNC	Average fill rate - HCA	Average fill rate - Reg Nurse Assoc	Average fill rate - Non Reg Nurse Assoc	Average fill rate - RNC	Average fill rate - HCA	Average fill rate - Reg Nurse Assoc	Average fill rate - Non Reg Nurse Assoc	Average fill rate - Registered Physio/OT/SALT	Average fill rate - Un-Registered Physio/OT
Cirencester Community Hospital	Coln	95.9%	94.0%	100.0%	-	98.4%	93.5%	-	-	97.4%	94.1%
Cirencester Community Hospital	Windrush	100.0%	99.2%	-	-	100.0%	101.6%	-		97.4%	94.1%
Dilke Community Hospital	Dilke	95.2%	103.2%	-	-	100.0%	98.9%	-	-	87.0%	92.4%
Lydney Community Hospital	Lydney	98.1%	98.4%	-	-	100.0%	104.8%	-	-	91.4%	94.9%
North Cotswold Community Hospital	North Cotswolds	99.2%	96.3%	-	-	100.0%	100.0%	-	-	68.9%	90.0%
Stroud Community Hospital	Cashes Green	98.1%	92.7%	89.5%	-	100.0%	98.4%	-	-	98.2%	95.6%
Stroud Community Hospital	Jubilee	98.4%	97.3%	-	-	98.4%	103.2%	-	-	98.2%	95.6%
Tewkesbury Community Hospital	Abbey View	99.2%	104.6%	-	-	100.0%	129.0%	-	-	92.5%	87.8%
The Vale Community Hospital	Vale	122.6%	111.8%	-	-	135.5%	130.6%	-	-	152.5%	-
Grand Total		100.3%	99.7%	93.6%	-	103.6%	105.6%	-	-	96.3%	92.0%

FEBRUARY 2020

		Day				Night				APH	
HOSPITAL	WARD_NAME	Average fill rate - **RNC**	Average fill rate - **HCA**	Average fill rate - **Reg Nurse Assoc**	Average fill rate - **Non Reg Nurse Assoc**	Average fill rate - **RNC**	Average fill rate - **HCA**	Average fill rate - **Reg Nurse Assoc**	Average fill rate - **Non Reg Nurse Assoc**	Average fill rate - **Registered** Physio/OT/SALT	Average fill rate - **Un-Registered** Physio/OT
Cirencester Community Hospital	Coln	98.00%	97.00%	103.20%	-	100.00%	98.90%	-	-	98.00%	94.20%
Cirencester Community Hospital	Windrush	100.00%	101.30%	-	-	100.00%	103.40%	-		98.00%	94.20%
Dilke Community Hospital	Dilke	99.00%	102.20%	-	-	100.00%	98.90%	-	-	96.70%	94.80%
Lydney Community Hospital	Lydney	95.90%	93.50%	-	-	98.30%	100.00%	-	-	95.80%	97.70%
North Cotswold Community Hospital	North Cotswolds	100.80%	98.10%	-	-	100.00%	100.00%	-	-	100.00%	26.90%
Stroud Community Hospital	Cashes Green	97.90%	95.60%	100.00%	-	100.00%	96.60%	-	-	95.90%	111.00%
Stroud Community Hospital	Jubilee	98.30%	95.40%	-	-	100.00%	100.00%	-	-	95.90%	111.00%
Tewkesbury Community Hospital	Abbey View	95.20%	101.00%	-	-	98.30%	105.20%	-	-	91.10%	99.60%
The Vale Community Hospital	Vale	122.40%	114.20%	-	-	144.80%	151.70%	-	-	100.00%	98.50%
Grand Total		**100.60%**	**99.80%**	**101.70%**	-	**104.60%**	**105.30%**	-	-	**96.10%**	**91.40%**

4.0 RECOMMENDATIONS

4.1 The Board is requested to:

- Note the current assurance against national guidance and locally agreed safe staffing levels.
- Note monthly reporting and compliance with fill rates.

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Appendix 1

NURSING STAFF FILL RATES	Day				Night				Day		Night		TOTAL STAFFING DAY/NIGHT		STAFF GROUP		CHPPD			
	Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - All staff DAY (%)	Average fill rate - All staff NIGHT (%)	Average fill rate - registered nurses/mid wives (%)	Average fill rate - care staff (%)	Midnight Occupancy	Registered nurses/ midwives	Care staff	Overall
Jan-2020	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours												
Gloucestershire																				
WL - Dean Ward	930	945	1395	1425	620	640	310	340	101.61%	102.15%	103.23%	109.68%	101.94%	105.38%	102.26%	103.52%	443	3.6	4.0	7.6
WL - Abbey Ward	1395	1193	930	1313	620	585	310	515	85.48%	141.13%	94.35%	166.13%	107.74%	118.28%	88.21%	147.38%	511	3.5	3.6	7.1
WL - Priory Ward	1395	1140	930	1305	620	640	310	370	81.72%	140.32%	103.23%	119.35%	105.16%	108.60%	88.34%	135.08%	550	3.2	3.0	6.3
WL - Kingsholm Ward	930	908	1395	1403	620	620	310	310	97.58%	100.54%	100.00%	100.00%	99.35%	100.00%	98.55%	100.44%	442	3.5	3.9	7.3
WL - Montpellier Unit	930	915	1395	1358	620	600	620	640	98.39%	97.31%	96.77%	103.23%	97.74%	100.00%	97.74%	99.13%	329	4.6	6.1	10.7
WL - Greyfriars PICU	1395	1163	1395	2048	620	640	620	1530	83.33%	146.77%	103.23%	246.77%	115.05%	175.00%	89.45%	177.54%	300	6.0	11.9	17.9
CL - Willow Ward	930	953	2325	2393	310	310	930	1140	102.42%	102.90%	100.00%	122.58%	102.76%	116.94%	101.81%	108.53%	479	2.6	7.4	10.0
CL - Chestnut Ward	930	953	1163	1158	310	310	620	780	102.42%	99.57%	100.00%	125.81%	100.84%	117.20%	101.81%	108.70%	418	3.0	4.6	7.7
CL - Mulberry Ward	930	893	1395	1733	310	310	620	670	95.97%	124.19%	100.00%	108.06%	112.90%	105.38%	96.98%	119.23%	494	2.4	4.9	7.3
WA - Laurel House	698	585	698	810	310	310	310	310	83.87%	116.13%	100.00%	100.00%	100.00%	100.00%	88.83%	111.17%	320	2.8	3.5	6.3
WA - Honeybourne	698	660	698	750	310	310	310	310	94.62%	107.53%	100.00%	100.00%	101.08%	100.00%	96.28%	105.21%	277	3.5	3.8	7.3
LD - Berkeley House	930	1200	4650	4733	310	320	2790	2730	129.03%	101.77%	103.23%	97.85%	106.32%	98.39%	122.58%	100.30%	217	7.0	34.4	41.4
Herefordshire																				
SB - Cantilupe Ward	713	836	1070	2142	356.5	426	1069.5	2302	117.18%	200.23%	119.35%	215.24%	167.01%	191.27%	117.91%	207.74%	368	3.4	12.1	15.5
SB - Jenny Lind Ward	713	713	357	555	356.5	357	356.5	724.5	100.00%	155.68%	100.00%	203.23%	118.56%	151.61%	100.00%	179.45%	242	4.4	5.3	9.7
SB - Mortimer Ward	1070	1070	713	1081	713	771	713	1058	100.00%	151.61%	108.06%	148.39%	120.65%	128.23%	103.23%	150.00%	615	3.0	3.5	6.5
WA - Oak House	713	713	357	391	356.5	357	356.5	368	100.00%	109.68%	100.00%	103.23%	103.23%	101.61%	100.00%	106.45%	230	4.7	3.3	8.0

Appendix 2

NURSING STAFF FILL RATES	Day				Night				Day		Night		TOTAL STAFFING DAY/NIGHT		STAFF GROUP		CHPPD			
	Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - All staff DAY (%)	Average fill rate - All staff NIGHT (%)	Average fill rate - registered nurses/mid wives (%)	Average fill rate - care staff (%)	Midnight Occupancy	Registered nurses/ midwives	Care staff	Overall
Feb-2020	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours												
Gloucestershire																				
WL- Dean Ward	870	863	1305	1523	580	580	290	480	99.14%	116.67%	100.00%	165.52%	109.66%	121.84%	99.48%	125.55%	404	3.6	5.0	8.5
WL- Abbey Ward	1305	968	870	1540	580	570	290	510	74.14%	177.01%	98.28%	175.86%	115.29%	124.14%	81.56%	176.72%	488	3.2	4.2	7.4
WL- Priory Ward	1305	998	870	1320	580	660	290	370	76.44%	151.72%	113.79%	127.59%	106.55%	118.39%	87.93%	145.69%	462	3.6	3.7	7.2
WL- Kingsholm Ward	870	878	1305	1380	580	580	290	290	100.86%	105.75%	100.00%	100.00%	103.79%	100.00%	100.52%	104.70%	398	3.7	4.2	7.9
WL- Montpellier Unit	870	765	1305	1350	580	550	580	610	87.93%	103.45%	94.83%	105.17%	97.24%	100.00%	90.69%	103.98%	251	5.2	7.8	13.0
WL- Greyfriars PICU	1305	930	1305	1725	580	560	580	820	71.26%	132.18%	96.55%	141.38%	101.72%	118.97%	79.05%	135.01%	284	5.2	9.0	14.2
CL - Willow Ward	870	840	2175	2183	290	290	870	970	96.55%	100.34%	100.00%	111.49%	99.26%	108.62%	97.41%	103.53%	421	2.7	7.5	10.2
CL - Chestnut Ward	870	855	1088	1125	290	870	580	870	98.28%	103.45%	300.00%	150.00%	101.15%	200.00%	148.71%	119.64%	369	4.7	5.4	10.1
CL - Mulberry Ward	870	825	1305	1673	290	290	580	660	94.83%	128.16%	100.00%	113.79%	114.83%	109.20%	96.12%	123.74%	504	2.2	4.6	6.8
WA - Laurel House	653	518	653	795	290	290	290	290	79.31%	121.84%	100.00%	100.00%	100.57%	100.00%	85.68%	115.12%	288	2.8	3.8	6.6
WA - Honeybourne	653	653	653	653	290	290	290	300	100.00%	100.00%	100.00%	103.45%	100.00%	101.72%	100.00%	101.06%	283	3.3	3.4	6.7
LD - Berkeley House	870	1253	4350	4463	290	290	2610	2850	143.97%	102.59%	100.00%	109.20%	109.48%	108.28%	132.97%	105.06%	203	7.6	36.0	43.6
Herefordshire																				
SB - Cantilupe Ward	667	699	1001	2107	333.5	345	1000.5	2081.5	104.72%	210.59%	103.45%	208.05%	168.25%	181.90%	104.30%	209.32%	331	3.2	12.7	15.8
SB - Jenny Lind Ward	667	667	334	443	333.5	334	333.5	471.5	100.00%	132.83%	100.00%	141.38%	110.94%	120.69%	100.00%	137.11%	219	4.6	4.2	8.7
SB - Mortimer Ward	1001	1058	667	1070	667	690	667	1035	105.75%	160.34%	103.45%	155.17%	127.59%	129.31%	104.83%	157.76%	525	3.3	4.0	7.3
WA - Oak House	667	645	334	391	333.5	334	333.5	333.5	96.63%	117.24%	100.00%	100.00%	103.50%	100.00%	97.75%	108.62%	219	4.5	3.3	7.8

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AGENDA ITEM: 20/0320

REPORT TO: Trust Board – 25 March 2020

PRESENTED BY: Jan Marriott – Non-Executive Director

AUTHOR: Jan Marriott – Non-Executive Director

SUBJECT: **NON-EXECUTIVE DIRECTOR AUDIT OF COMPLAINTS Q3**

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

The purpose of this report is to

Provide an additional source of assurance to the Board on the management of complaints within the trust and identify any additional learning points for implementation.

Recommendations and decisions required

The Board is asked to **note** the content of this report and the levels of assurance provided

Executive summary

A Non-Executive Director Audit of Complaints was conducted and considered the handling of four complaints that had been closed during Quarter 3 2019.

Risks associated with meeting the Trust's values

None identified.

Corporate considerations	
Quality Implications	As set out in the report
Resource Implications	None identified.
Equality Implications	Non identified.

Where has this issue been discussed before?
N/A

Report authorised by: Lavinia Rowsell	**Title:** Trust Secretary

1.0 Introduction

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

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

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

2.0 SUMMARY OF FINDINGS

2.1 **CASE 1**

2.2 **Summary of Complaint**

2.3 This complaint related to a meeting between a Senior Mental Health Social Worker and a patient at Wotton Lawn Hospital. The complaint was made by telephone by the patient's father.

2.4 The complainant explained that his daughter had been working with the Mental Health Case Management Service who were seeking support and funding for a placement for treatment at another hospital. He alleged that the Social Worker had met the patient without ensuring she was supported and had persuaded her not to go to the hospital but rather to have treatment in the community instead. Her father said she felt unable to disagree but later she took an overdose of cough medicine and was taken to Accident and Emergency Department. He wanted to know why the social worker had visited her unexpectedly when she had no support and appeared to reverse a treatment decision which had already been agreed. He also said that the social worker had shared with his daughter confidential information about another patient's treatment plan and wanted to know if it was acceptable to do so. The Patient and Carer Experience Team ensured the patient consented to the complaint being investigated and the sharing of information with her father. The complaint was made on 7th August and the final letter was sent on 19th November rather than 16th October in the first response letter. However the complainant was contacted and an apology made for the delay.

2.5 **Audit Findings**

2.6 The issues for investigation were agreed with the complainant before the investigation commenced and the investigator talked to the complainant to ensure that she had a thorough understanding from his perspective. In discussion with her father it was agreed it was not in his daughter's interest to be interviewed.

2.7 The complaint was investigated by a Ward Manager from a different Hospital. The investigation was thorough. The issues were clearly identified with evidence to support the conclusions. Where an issue or part of an issue was not upheld a clear rationale was given. The investigation report concluded with local learning which would be shared with the relevant Community Team Managers to action. It stated that the inpatient wards should report concerns where the learning was not being followed, to the appropriate Community Team Managers. It also highlighted organisational learning in relation to Mental Capacity Assessments in relation to patients making decisions about aspects of their care and suggested this should be audited. I was not sure who would ensure this would happen.

2.8 The CEO letter was signed on his behalf by the Director of Nursing, Therapies and Quality. The tone of the letter was empathic. It was apologetic and conveyed a personal apology from the social worker. It gave a very detailed account of what the investigator had ascertained. It demonstrated a real understanding of the issues raised. Where an issue was not upheld the explanation was given sensitively. Plain language was used with very little jargon. Learning for the individual concerned as well as the organisation was identified in the letter but in less depth than the lessons learned in the investigation report.

2.9 **Conclusion of the Auditor**

2.10 I would offer full assurance for the quality and comprehensiveness of the investigation and the CEO letter. I would offer full assurance in respect of the identification and sharing of the learning and suggested changes in practice. I was not completely clear how we ensured this happened and the follow-up mechanisms re completing the quality cycle. There was a delay in the conclusion of the investigation, but it was incredibly thorough.

2.11 **Case 2**

2.12 **Summary of complaint**

The complaint concerned an alleged breach of confidentiality by Hope House. The complainant was the patient, but she was supported by POhWER, the local advocacy provider, to make her complaint. Following a sensitive

procedure, a letter regarding her treatment was posted to the wrong address and the householder opened it. It was returned to Hope House and the lead nurse had apologised to the complainant. However, she said that as a result people in her local area were aware of the procedure she had undergone and that this had had an impact on her health. She no longer felt able to go out.

2.13 Her complaint letter asked why the letter was sent to the wrong address and what steps have been taken to ensure that this did not happen again.

2.14 In the previous Trust the investigator was provided with terms of reference which set out the issues for investigation. An initial response letter was sent out to the advocate as the point of contact as agreed with the person. This letter did not include the terms of reference but explained that the complaint would be formally investigated with a proposed response within five weeks.

2.15 **Audit Findings**

The complaint was investigated by the Interim Sexual Health Operations Manager. Terms of reference were agreed before the investigation commenced and form part of the investigation report. The investigation was thorough and well documented. There was a clear chronology of events and a sound analysis of the factors which contributed to the acknowledged error. The report concluded with a clear set of recommendations for changes and identified the person responsible for ensuring the recommendations were actioned and a timescale.

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2.16 The tone of the CEO letter was apologetic and sincere. The letter answered the questions raised by the patient in the original letter in a clear and succinct manner. There was no attempt to excuse the mistake but a good explanation of why it happened. It met the time frame as promised in the original response letter.

2.17 The letter sets out the changes that have been made to ensure it would not happen again

2.18 **Conclusion of the Auditor**

I would offer full assurance for the quality of the investigation, the response letter and timeliness. I would also offer full assurance for the identification of required changes with allocation of responsibility and speedy timeframes.

One could question whether the Manager of the service was an impartial investigator but in this case, there is absolutely no reason to believe she was not. I also wondered whether, given the impact on her mental health, whether we might have offered some additional support or advice on how she might access appropriate support.

2.19 **Case 3**

2.20 **Summary of complaint**

There were several issues raised by the complainant who was the patient. She was unhappy about her discharge from the Herefordshire Recovery Team

following the completion of the 10 week Activity through Recovery Programme which she said had been a shock for her as she felt this had not been explained and had been detrimental to her mental health.

2.21 Following her discharge, she had been referred to the Primary Care Mental Health Team but would only be seen every 6 weeks and she wanted to know why as she would prefer to be seen more often.

2.22 She had been to see her GP about her deteriorating mental health and he had completed an urgent referral to the Recovery Team. After several weeks with no response she contacted the service but said she was told they would not see her and to see her GP if her condition got worse. She wanted to know why they would not see her at least to undertake an assessment.

2.23 She said she had been told the Recovery Team had met to discuss the GP referral and they had decided she did not meet their criteria. She wanted to know how they could decide this without assessing her first.

2.24 **Audit findings**

2.25 The complainant had sent a detailed handwritten letter following a conversation with a Mr Norvill, former 2G Complaints Manager. I could not tell whether she had been asked to write rather than her verbal complaint being accepted and transcribed on her behalf. Asking people to write a formal complaint can be a barrier to people and put them off complaining.

2.26 Following receipt of her letter dated 26th July 2019, she received an initial response clarifying the issues she wanted to be investigated and was given the opportunity to alter them. She was given a name and number of a Service Experience Officer to contact and information about the local advocacy service. The letter began with an apology for her experience. She was told she should receive a response by 22nd October 2019 but that it might take longer and if so, they would write again to confirm the date. The response letter was sent on 18th November, but I could not find any other letter in the file.

2.27 The investigation was conducted by the Operations Manager, Primary Care Mental Health Team and Improving Access to Psychological Therapies. He interviewed members of the Recovery Team as well as meeting the complainant.

2.28 The investigation was thorough, and it appears that at his meeting with the complainant he was able to address some of her concerns in a more informal manner prior to her receiving the CEO response letter. The investigator did not uphold the first three issues and only partially upheld the fourth issue. However, he did make suggestions for improving patient experience particularly around referral processes and the development of objective criteria for assessing the eligibility for the Recovery Service. He also refers to the fact that discharge from services is often difficult for patients and the need to consider how best to do so. On several occasions the investigator refers to the

lack of resources, level of demand or level of service commissioned as restricting the level of service that can be provided. However, he concluded this did not result in the complainant receiving an inadequate or inappropriate service and I am not qualified to agree/disagree with this. However, I wondered whether it might have been good practice to ensure the handover appointment with the Primary Care Mental Health Nurse was in place prior to discharging her from the Recovery Team? As stated, many patients struggle with what they see as "falling off the cliff edge" when discharged from services. I also wondered whether a personalized care plan would have signposted and supported her to access the alternative, often voluntary sector services that she might have been able to access.

2.29 The tone of the CEO letter was apologetic. The letter addressed the issues raised and explained why the issues she raised occurred, providing examples of learning that had resulted from her complaint.

2.30 Organizational learning was identified but it was not clear how this would be followed up and there was no evidence of an action plan.

2.31 **Conclusion of the auditor**

2.32 In respect of timeliness the response was 4 weeks later than promised and I had no evidence to suggest that the reasons had been conveyed to the complainant. I would offer full assurance for the quality of the investigation and in particular the meeting with the complainant in which issues could be explored and explained far more easily than in a formal letter. I would offer full assurance for the CEO letter in that it demonstrates learning for the organization even when the issues were not upheld and was appropriately apologetic for the impact on the person. I offer limited assurance in regard to the organisational learning which tended to be about systems, had no clear action plan and whilst identifying discharge of patients as a problem for many, did not seek to consider how this might be improved through personalization.

2.33 **Case 4**

2.34 **Summary of complaint**

2.35 The first complaint relating to the Wheelchair Service was emailed on 23 March 2019 by the mother of the patient. Unfortunately it was sent to the complaints email of Gloucestershire Hospitals Trust as advised by the Hospital PALS. Her original complaint related predominantly to the requirement for her to complete an extremely detailed referral form in order for somebody to visit their home to assess her 7year old son's needs for supported seating. She could not understand why she had to complete the form given he had been receiving a service all his life and the information would all be recorded in his records. She found this time consuming when she was already extremely busy looking after all his needs. She wanted to know if this was going to happen every time she asked for help and to further her frustration, she had just received another email asking her to provide yet more information. She emailed again on the 19th July 2019to say she still had had no response and added another email with the following complaint. I am presuming these

emails were then forwarded to GCS although there is nothing in the case record to say so.

2.36 Her complaint emailed on 19 July was predominantly about the considerable delays in the service identifying adaptation to his chair. They requested assistance Easter 2018 and she said at the appointment given June 2018 the service trialed support for him in an adult wheelchair even though he was only 7 years old and therefore the assessment could not take place. They were told they would see a therapist soon but 7 months later they were still trying to get an appointment. By this time, she felt his poor posture in his chair was impacting on his spine.

2.37 They finally had a lengthy appointment on 1st February 2019 at which they agreed a variety of pieces of equipment/adaptations the service would order. They were seen on 5th June 2019 and had expected the adaptations would be made. However, they found the new waist band would not fit his chair. They took a new cushion with them but were told there was no spare cover in case of an accident and there was no tray as previously agreed. They were told they would need another appointment. By this time his existing chair was becoming unfit for purpose and at the time of the complaint she was again waiting for another appointment.

2.38 The complainant felt this was one of the worst experiences she had had with the NHS. Her son spends 7 hours a day in his wheelchair and is dependent on it for any independence and she said their OT had told them the current chair was damaging his spine. She wanted the matter addressed urgently regardless of staffing issues or capacity which she said were "frankly … not my issue, my son's needs are".

2.39 **Audit findings**

2.40 The Patient Experience Officer replied by email to the complaint on 1st August 2019. She asked whether they could speak as she wanted to firstly check where the service was in relation to meeting her son's needs and then proceed with the investigation of her complaint. Following their phone conversation, the Officer emailed her again on 8th August 2019 to confirm that arrangements were now in place for him to be seen in 4 days' time and that the service would respond as swiftly as possible "but it inevitably all takes time". The email also contained information for her to make a complaint to Mary Hutton as she had expressed a desire to convey her experience as a parent to the commissioner of the service. An email was sent to her on 26th September 2019 stating that there would now be a joint investigation with the CCG and informing her that it would be undertaken by the Assistant Service Improvement and Development Manager. It stated that the anticipated date for a response would be by the end of October 2019.

2.41 Terms of reference for the investigation were provided by the Patient Experience Lead. They requested the investigator to provide a timeline of the details of the interactions with the service from around Easter 2018. There was no reference to the first complaint dated 23rd March 2019 and there is no

response to this complaint in the record or the CEO letter. She was asked to investigate whether there had been an impact on the patient's spine as a result of the delay and to determine what would be the next steps.

2.42 I believe a detailed timeline was developed but was not in the notes. However there is reference to numerous interactions between the service and the family between appointments, mainly instigated by the child's mother. The investigation report is relatively brief for such a complex set of issues, but it was very clear that all aspects of the complaint should be upheld and that the quality of care provided to the patient and family was not acceptable. The report identifies organizational issues and learning around low staffing levels due to sickness and vacancies without any arrangements for backfill. It also cites the lack of a robust standard operating procedure for receipt and triage of referrals, management of enquiries, allocation of clinic appointments, receipt of ordered equipment and good routine communication with patients/families. The Wheelchair Service had agreed the quality of the service provided had not been acceptable and since April 2019 had been working through a formal recovery plan. The learning from this complaint was being included within this plan but the investigator recommenced the need for dedicated support to ensure all the improvements were made.

2.43 The investigator also provided assurance that the problems had now been resolved and that the family were happy with the outcomes but states that she did not feel able to consider the impact on the young patient's spine as she did not have a clinical background.

2.44 The first two paragraphs of the CEO letter 19th November 2019 give a lot of background to the investigation process and the merger. It is not until the 3rd paragraph that there is any kind of apology except for the delay in responding to the concerns and for the fact she had cause to raise these concerns. The letter then sets out the findings of the investigation with the changes that are being made – as noted this did not include an investigation into the original complaint re the requirement for the parents to complete the lengthy, time consuming referral form. There are only two brief apologies in the letter and the final three paragraphs are again all about processes. There is reference to her concerns re the damage to her son's spine and that the author of the letter had asked a colleague to contact them to review this. It would have been far better if this had been included in the original investigation. The tone of the letter is very bureaucratic and lacks empathy. For such an obvious failing of a service I would have expected the apologies to be right at the beginning and throughout the letter

2.45 **Conclusion of the Auditor**

2.46 I recognise that this was shortly after the merger and I think there had been changes in the team that may have impacted on the timeliness and quality of the investigation and letter. However I would offer only partial assurance for both the quality of the investigation which appeared to fail to include the first complaint or the matter re the patient's spine and was relatively brief. I would offer partial assurance for the response letter which does quite clearly set out

the findings and learning from the investigation but lacks empathy and appropriate level of apology. I offer full assurance for the organizational learning which was quite detailed and has apparently been included within the main Service Improvement Plan but would like to receive follow-up that this learning is actually addressed in the implementation. I can give no assurance re the timeliness of the response, although accepting that in part this was due to the failure of GHFT to forward the original complaint. The original complaint was sent on 23rd March 2019, the second on 19th July 2019 which was received by the Trust on 22nd July 2019. The final letter was sent on 19th November 2019. I do agree that the priority was to ensure that immediate steps were taken to improve the service to the patient rather than investigating the complaint but there remained a significant delay before the investigation was commenced on 24th September 2019.

3.0 RECOMMENDATIONS

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

3.2 The previous Trusts had difference policies and procedures in respect of complaints. I understand that a new policy and procedures are currently being developed to include the best aspects of each. I believe this will strengthen our responses and identification of learning. However I am still uncertain how we intend to close the quality loop by assuring ourselves the learning is shared and change embedded. I have included a description of the planned approach for information.

3.3 When a complaint is received the Patient Experience Team (PET) will arrange to contact the complainant to discuss their concerns and establish if they want to proceed with a formal complaint or for their issues to be managed as concerns. Complainants on occasions will be offered the opportunity to meet with the service manager and senior clinicians. Such meetings will provide the opportunity for complainants to discuss their concerns in detail and may resolve some of their concerns/complaint at a local level.

3.4 If a complainant wishes their issues to be treated as a formal complaint a member of the PET will be allocated to oversee the management of the complaint. This will include clarifying and drafting the complainant's concerns ("issues"). The issues will then be included in a formal acknowledgement letter. Complainants are then offered 7 days to respond to the PET if they do not agree with the content of the issues. A further opportunity will be offered to agree their issues if necessary.

3.5 Terms of reference (ToR) will, at the same time the proposed TOR will be provisionally set by the allocated member of the PET who is co-ordinating the management of the complaint in order to focus the investigation and ensure a timely response and that all aspects are considered. The TOR will be revised if appropriate. The ToR will be agreed by a senior manager in the Clinical

Governance Team (e.g. Ian Main) prior to allocation of an appropriate investigator by a senior manager in operations.

3.6 When the compliant investigation is completed the investigation report will be returned to the PET. The allocated member of the PET co-ordinating the management of the complaint will then draft the final response letter (FRL) which is reviewed by the Patient Experience Manager. A copy of the FRL will also be sent to the investigator to check the content for accuracy etc and then Ian Main for review. The FRL is then sent to a senior manager in the Nursing, Therapies and Quality Directorate (e.g. Michael Richardson –physical health or Gordon Benson – mental health (interim, Lauren Edwards)) for review before final approval and sign off by John Trevains on behalf of Paul Roberts.

3.7 If the complainant does not feel their complaint has been fully addressed in the FRL, they will be offered the opportunity to attend a "resolution meeting". Notes/minutes will be taken during the meeting and complainants offered the opportunity to receive a copy of the minutes.

3.8 Throughout the process complainants will be informed of independent advocacy support that is available to them. In Gloucestershire this is POhWER. The contact details of the PHSO are also included in the FRL if complainants do not feel we have fully addressed their complaint.

3.9 Local and organisational learning from complaints will be summarised in "practice notes – "a complaint on a page" - by the PET, which will then be forwarded to the appropriate service manager and service directors for dissemination.

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 21/0320

REPORT TO:	Trust Board - March 2020
PRESENTED BY:	Sandra Betney, Director of Finance
AUTHOR:	Chris Woon, Associate Director of Business Intelligence
SUBJECT:	**COMBINED PERFORMANCE DASHBOARD FEBRUARY 2020**

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

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

The purpose of this report is to
This *combined* performance dashboard report provides a high level view of key performance indicators (KPIs) in exception across the organisation.

To offer reader clarity, the visualisation is separated into the following reporting sections;

- MH National Requirements (NHS Improvement & DoH
- MH - Local Contract Gloucestershire (including Social Care)
- MH – Local Contract Herefordshire
- Community - National Requirements (Gloucestershire)
- Community - Local Requirements (Gloucestershire)

Performance covers the period to the end of February (month 11 of the 2019/20 contract period). Where performance is not compliant, operational service leads are addressing issues and work is ongoing in accordance with their agreed Service Recovery Action Plans to address the underlying issues impacting performance.

Recommendations and decisions required

The Board are asked to:

- Note the aligned Performance Dashboard Report for February 2020.
- Note the report as a **significant level of assurance** that our contract and regulatory performance measures are being met or that appropriate service recovery action plans are in place to address areas requiring improvement.

Executive summary
The Board's attention is requested to review the 6 **mental health** key performance thresholds listed in the dashboard (with associated narrative) that were not met for February 2020. It is of note that all indicators have been in exception previously in

2019/20.

In addition your attention is drawn to the 31 key **physical health** performance thresholds listed in the dashboard (with associated narrative) that were not met for February 2020. It is of note that all indicators with the exception of '*15. Number of MRSA bacteraemia'* have been in exception previously in 2019/20.

It is of note that some of operational Performance and Finance (P&F) meetings have been cancelled and senior operational management are managing critical service delivery which is beginning to impact responsiveness and narrative detail.

Although there have been some unforeseen tasks which are now competing with the BI work plan, major items within our BI transition developments are being prioritised and predominantly still on track for delivery. Some smaller items are being re-evaluated.

Risks associated with meeting the Trust's values

Where appropriate and in response to significant and wide reaching performance issues (such as Eating Disorder Services or Wheelchair Services); operational services have initiated Service Recovery Action Plans (SRAP) which additionally outline appropriate risk levels and mitigation steps. A revised template of SRAP is due to be reviewed to ensure that they consider the Trust's proposed risk stratification approach and risk appetite domains.

Corporate considerations	
Quality Implications	Some indicators include a clinical quality or experience component therefore the information provided in this report can be an indicator into the quality of care patients and service users receive. Where services are not meeting performance thresholds this may also indicate an impact on the quality of the service/ care we provide.
Resource Implications	The Business Intelligence Service provides the support to operational services to ensure the robust review of performance data and co-ordination of the combined performance dashboard and its narrative.
Equality Implications	Equality information is included as part of performance reporting.

Where has this issue been discussed before?

Business Intelligence Management Group (BIMG) and within operationally led Performance and Finance (P&F) meetings.

Appendices:	Performance dashboard – Page 4 onwards.

Report authorised by: Sandra Betney	**Title:** Director of Finance

with you, for you

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Performance Dashboard Report

Aligned for the period to the end February 2020 (month 11)

The Resources Committee is asked to:

- Note the aligned Performance Dashboard Report for the 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.

with you, for you

Performance Dashboard: *Mental Health - National Requirements (NHS Improvements & DOH)*

NHS Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Mental Health - National Requirements Gloucestershire

		February	YTD	
1.04	Care Programme Approach - formal review within12 months	94.3% -0.7%	97.3% 2.3%	
2.21	No children under 18 admitted to adult in-patient wards	98.1% -1.9%	99.0% -1.0%	

Mental Health - National Requirements Herefordshire

		February	YTD	
1.04	Care Programme Approach - formal review within12 months	95.1% 0.1%	97.9% 2.9%	
2.21	No children under 18 admitted to adult in-patient wards	93.7% -6.3%	98.8% -1.2%	

Performance Thresholds not being achieved in Month - *Note all indicators have been in exception previously in 2019/20.*

1.04: CPA Approach – Formal review within 12 months
Gloucestershire is non-compliant with the majority of cases within the Recovery Service (27), CPI service (7) and EI service (6). Although requested, unfortunately supportive commentary hasn't yet been received by the service at this point.

2.21: No children under 18 admitted to adult in-patient wards
There were 2 admissions during February, 1 in Gloucestershire and 1 in Herefordshire. In Gloucestershire a 17 year old was admitted to Wotton Lawn as they were only a month away from turning 18. Transition plans between CAMHS and Adult services were in place at time of admission

In Herefordshire a 16 year old in the Children's ward in Wye Valley Trust was detained under Section 2 to Mortimer ward with immediate Section 17 leave. Despite assertive pursuit it took 14 days to access a Tier 4 bed.

with you, for you

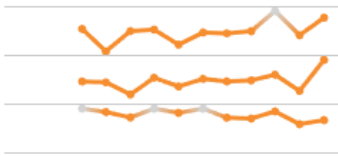
Performance Dashboard: *Mental Health - Local Contract (Including Social Care) Gloucestershire*

NHS Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Mental Health - Local Contract Gloucestershire

		February	YTD
3.35	Adolescent Eating Disorders - Routine referral to NICE treatment start within 4 weeks	83.3% -11.7%	52.0% -43.0%
3.39	Eating Disorders - Wait time for adult assessments will be 4 weeks	71.0% -24.0%	37.7% -57.3%
3.40	Eating Disorders - Wait time for adult psychological interventions will be 16 weeks	74.1% -20.9%	85.1% -9.9%



Mental Health - Social Care Gloucestershire

There are no Social Care indicators in exception this period.

Performance Thresholds not being achieved in Month - *Note all indicators have been in exception previously in 2019/20.*

3.35: Adolescent Eating Disorders: Routine referral to NICE treatment within 4 weeks
There were 3 non-compliant cases in February. One client was offered 2 appointments within 4 weeks but did not accept them due to holiday. Treatment started at the next available appointment which was on day 29. One client was assessed within 4 weeks but as the required treatment was CBT, could not commence treatment at this appointment and began treatment within 7 to 8 weeks at the first available CBT appointment. The third client was offered an assessment outside of the 4 weeks, CBT was required and so treatment began at the next available appointment which was again within 7 to 8 weeks of referral.

3.39: Eating Disorders: Wait time for Adult Assessments will be 4 weeks
There were 11 non-compliant cases in February. The service has carried out a review and in all 11 cases the delay in assessment is due to patient cancellations and DNAs.

3.40: Eating Disorders: Wait time for Adult psychological interventions will be 16 weeks
There were 6 non-compliant cases in February. The service is currently investigating the reasons for non-compliance.

3.35, 3.39 & 3.40 Additional Commentary:
An increase in adult ED referrals continues but the service has recognised that more can be done to improve process, waiting list management tools are being better utilised and the service trajectory model has being updated to support the established recovery plan. This trajectory modelling will be used to inform new threshold targets for these indicators for 20/21.

with you, for you

Performance Dashboard: *Mental Health - Local Contract Herefordshire*

NHS Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Mental Health - Local Contract Herefordshire

		February	YTD	
5.15	Zero inappropriate admissions of Herefordshire patients to hospitals outside of Herefordshire and Worcestershire STP area / or 2g bed base	0.0% 0.0%	0.0% 0.0%	

Performance Thresholds not being achieved in Month - *Note this indicator has been in exception previously in 2019/20 .*

5.15: Zero inappropriate admissions of Herefordshire patients to hospitals outside of Herefordshire and Worcestershire STP area/or GHC bed base
There were 2 *inappropriate* placements during February. Both patients were transferred to PICU facilities which Herefordshire does not have. 1 patient was transferred to a unit in Manchester and the other to a unit in Berkshire after being assessed in the 136 suite.

"An inappropriate "out of area placement" is nationally defined (Oct, 2018) as a situation in which a person with assessed acute mental health needs, who requires adult mental health acute inpatient care, is admitted to a unit that does not form part of the usual local network of services (an inpatient unit that does not usually admit people living in the catchment area of the persons local community mental health service), and where the person cannot be visited regularly by their care co-ordinator".

with you, for you

Performance Dashboard: *Physical Health - National Requirements Gloucestershire*

NHS Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Physical Health - National Requirements Gloucestershire

		February	YTD
15	Number of MRSA bacteraemias	100.0% 100.0%	100.0% 100.0%
31	Bed days lost due to delayed discharge as percentage of total beddays	5.0% 2.5%	3.0% -0.5%
31a	HPV Immunisation coverage for girls aged 12/13 years old - Immunisation 2	48.1% -51.9%	115.8% 15.8%
31b	HPV Immunisation coverage for girls aged 12/13 years old - Immunisation 1	104.9% 4.9%	74.3% -25.7%
31c	Percentage of children in Reception Year with height and weight recorded	93.6% -6.4%	87.1% -12.9%
31d	Percentage of children in Year 6 with height and weight recorded	83.9% -16.1%	91.6% -8.4%
38	Time to initial assessment for patients arriving by ambulance (95th percentile)	146.6% 46.6%	93.3% -6.7%
80	SUS+ (Secondary Uses Service) Data Quality Validity (available in arrears)		81.6% -14.6%
82	% of eligible children who receive vision screens at or around school entry.	89.8% -10.2%	78.4% -21.6%
83	Number of AnteNatal visits carried out	51.0% -49.0%	82.2% -17.8%
84	% of live births that receive a face to face New Birth Visit within 7- 14 days by a Health Visitor	92.1% -2.9%	91.3% -3.7%
85	% of children who received a 6-8 weeks review	93.7% -1.3%	94.6% -0.4%
86	% of children who received a 9-12 month review by the time they turned 12 months	80.4% -14.6%	84.2% -10.8%
87	% of children who received a 12 month review by the time they turned 15 months	90.5% 4.5%	89.8% -5.2%
88	% of children who received a 2-2.5 year review by 2.5 years	81.9% -13.1%	83.3% -11.7%
91	% of infants being totally or partially breastfed at 6-8wks(breastfeeding prevalence)	57.7% -0.3%	55.3% -2.7%

National Performance Thresholds not being achieved in Month - *All indicators have been in exception previously in 2019/20 with the exception of Number of MRSA Bacteraemia*

15. Number of MRSA Bacteraemia
There was one MRSA Bacteraemia reported in February 2020. This was recorded at Cirencester Hospital. Post incident review meeting scheduled for 19th March to identify lessons and actions regarding this.

31: Bed days lost due to delayed discharge as percentage of total bed days
The 3.5% target was missed in February (6.1%). This exceeds SPC chart upper control limit.
Community Hospitals that recorded bed days lost due to delayed transfer of care in excess of 3.5% in February were Stroud (11.0%), Cirencester (10.8%) and Tewkesbury (8.6%). Lydney and The Vale hospitals recorded zero bed days lost due to delayed transfer of care in February. Data quality and validation are high priority with more challenge from the Demand and Capacity team on the weekly Wednesday conference calls leading to more accurate reporting of DTOC. DTOC are monitored and escalated as appropriate both internally and externally with other partner organisations (e.g. adult social care). All stays over 30 days are reviewed.

31a: HPV Immunisation coverage for girls aged 12/13 years old - Immunisation 2
The monthly trajectory for 2nd HPV immunisation was not achieved in February however cumulative position is ahead of internal trajectory.

31b: HPV Immunisation coverage for girls aged 12/13 years old - Immunisation 1
The monthly and cumulative trajectory for 1st HPV immunisation have not been achieved. Plans are in place to catch-up HPV 1. The focus to date has been on HPV2.

31c: Percentage of children in Reception Year with height and weight recorded
The original trajectory of 65% of children in reception year to have height and weight measured by the end of February 2020 (cumulatively) has not been achieved (56.7%).

31d: Percentage of children in Year 6 with height and weight recorded
The original trajectory of 65% of children in year 6 to have height and weight measured by the end of February 2020 (cumulatively) has not been achieved (59.5%).

38: Time to initial assessment for patients arriving by ambulance (95th percentile)
The target of initial assessment within 15 minutes was missed in February 2020 (95th percentile 22 minutes). This is the second consecutive month that the target has been missed since March 2019. There were 12 ambulance arrivals to Minor Injury and Illness Units and two arrivals at Stroud Hospital were recorded as in excess of 15 minutes due to the department being busy. This performance is outside of SPC chart control upper control limits.

80: SUS+ (Secondary Uses Service) Data Quality Validity (available in arrears)
Performance has improved following resubmission of data. Latest report from NHS Digital shows performance of 89.6% compared to target of 96.3%. There are a number of data quality issues within the Emergency Care Data Set data (missing investigation and treatment codes) and Admitted Patient Care Data Set (missing clinical coding diagnoses) which will be reviewed to improve future performance.

82: Proportion of eligible children who receive vision screens at or around school entry
The internal trajectory of 65% of eligible children to receive vision screens at or around school entry by the end of February 2020 (cumulatively) has not been achieved (51.0%).

83: Number of Ante-Natal Visits
The target based on 2018/19 outturn (92) was not achieved in February (47). A significant number of failed visits have been recorded in February. This is being reviewed to establish reasons.

84: Percentage of live births that receive a face to face NBV (New Birth Visit) within 7- 14 days by a Health Visitor
The target (95%) was not achieved in February (92.1%). 411 out of 446 visits were completed within the timeframe. All babies eligible within this cohort, received an offer of NBV contact or the Health Visitor was aware that the baby was in NICU, who were then visited on discharge which was out of the timeframe.

There was a slight decrease in the numbers of parents who chose to have their visit outside of the timeframe. There was also a decrease in the number of visits that were completed out of timeframe due to increase in staffing capacity.

85: Percentage of children who received a 6-8 weeks review
The target (95%) was not achieved in February 2020 (93.78%). 422 out of 450 reviews were completed within the timeframe. All babies eligible within this cohort, received an offer of 6-8 week contact. There was a decrease in the number of initial 'no access' visits as well as a decrease in parents choosing to have their appointments out of timeframe.

86: Percentage of children who received a 9-12 month review by the time they turned 12 months.
The target (95%) was missed in February 2020 (80.4%). 399 out of 496 reviews were completed within the timeframe. The parents of all children within the cohort were offered the opportunity to receive a 9-12 month review, however there are always a number that decline. Some children were not brought to the first booked appointment, therefore the 2nd appointment was out of timeframe because of parental choice.

The Community Nursery Nurses forecast the number of clinics that are required to complete developmental reviews in the coming months and add on a 10% margin to allow for DNA's and re-booking. This can be implicated at times if venues are not available.

87: Percentage of children who received a 12 month review by the time they turned 15 months.
The target (95%) was missed in February 2020 (90.5%). 486 out of 537 reviews were completed within the timeframe. The parents of all children within the cohort were offered the opportunity to receive a 12 month review, however there are always a number that decline. Some children were not brought to the first booked appointment, therefore the 2nd appointment was out of timeframe because of parental choice.

The Community Nursery Nurses forecast the number of clinics that are required to complete developmental reviews in the coming months and add on a 10% margin to allow for DNA's and re-booking. This can be implicated at times if venues are not available.

88: Percentage of children who received a 2-2.5 year review by 2.5 years.
The target (95%) was missed in February 2020 (81.96%). 509 out of 621 reviews were completed within the timeframe. The parents of all children within the cohort were offered the opportunity to receive a 2-2.5 year review, however there are always a number that decline. Some children were not brought to the first booked appointment, therefore the 2nd appointment was out of timeframe because of parental choice.

The Community Nursery Nurses forecast the number of clinics that are required to complete developmental reviews in the coming months and add on a 10% margin to allow for DNA's and re-booking. This can be implicated at times if venues are not available.

The Health Visiting Service is currently working with Early Years, in order to promote the importance of the 2 year review with an aim of increasing the number of children that are brought to the appointments and to increase the opportunity for public health and developmental advice to be shared with parents.

91: Percentage of infants being totally or partially breastfed at 6-8 weeks (breastfeeding prevalence)
The target (58%) was missed in February 2020 (57.7%). 261 out of 452 infants were recorded as totally or partially breastfed. Reasons for not meeting the target include parents declining the review, children moved into the county which would have been seen and had their review at the earliest opportunity, DNA appointments and then rebooked out of timeframe, movement out, parental choice to have review out of timeframe.

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Performance Dashboard: *Physical Health - Local Requirements Gloucestershire*

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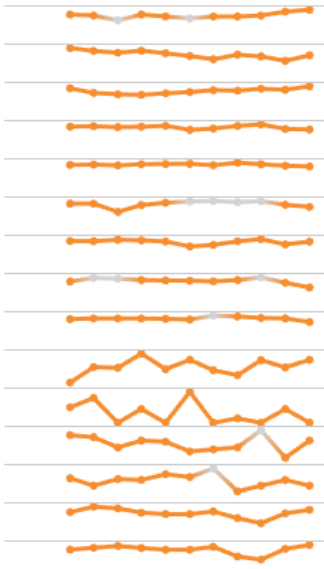
KPI Breakdown

Physical Health Community - Local Requirements Gloucestershire

		February		YTD	
27	Inpatients - Average Length of Stay	128.5%	28.5%	107.4%	7.4%
41	Podiatry - % treated within 8 Weeks	70.0%	-25.0%	72.1%	-22.9%
43	MSK Physiotherapy - % treated within 8 Weeks	85.6%	-9.4%	73.7%	-21.3%
44	ICT Physiotherapy - % treated within 8 Weeks	73.8%	-21.2%	79.3%	-15.7%
45	ICT Occupational Therapy Services - % treated within 8 Weeks	78.6%	-16.4%	83.2%	-11.8%
52	Paediatric Speech and Language Therapy - % treated within 8 Weeks	81.6%	-13.4%	89.5%	-5.5%
53	Paediatric Physiotherapy - % treated within 8 Weeks	85.4%	-9.6%	83.8%	-11.2%
60	Social Care ICT - % of Referrals resolved at Referral Centres and closed	36.2%	-12.8%	46.6%	-2.4%
63	Single Point of Clinical Access (SPCA) Calls Offered (received)	82.3%	-17.7%	92.6%	-7.4%
67	Wheelchair Service: Adults: New referrals assessed within 8 weeks	37.5%	-52.5%	29.3%	-60.7%
68	Wheelchair Service: Adults: Priority referrals seen within 5 working days	0.0%	-95.0%	13.0%	-82.0%
69	Wheelchair Service: Under 18s: New referrals assessed within 8 weeks	70.0%	-20.0%	58.0%	-32.0%
71	Wheelchair Service: Under 18s: Equipment delivered within 18 weeks of referral	50.0%	-42.0%	64.4%	-27.6%
93	Chlamydia Screening of Gloucestershire residents aged 15-24 (minimum positivity rate)	71.2%	-28.8%	63.6%	-36.4%
94	Chlamydia Screening - Number of Positive Screens	77.5%	-22.5%	66.5%	-33.5%



Local Performance Thresholds not being achieved in Month - *Note all indicators have been in exception previously in 2019/20.*

27: Inpatients - Average Length of Stay
Average length of stay continues to show an increasing trend and in February 2020 (36 days) continued to exceed SPC chart upper control limit. Tewkesbury (51.4 days), Cirencester (42.6 days), Stroud (37.7 days) North Cotswolds (36.4 days) and The Vale (35.9 days) all exceeded 28 days (target based on 2018/19).
There were two patients discharged with length of stay over 100 days from Cirencester Hospital (119 and 101 days).

The number of patients discharged in February 2020 was the lowest in 2019/20 (152 compared to average of 191 in previous 10 months) and the proportion of patients discharged within 0-14 and 15-24 days combined was also the lowest in 2019/20 (40.8% of discharged patients compared to average of 50.2% in previous 10 months). This has skewed the average.

All stays over 30 days are reviewed on an ongoing basis.

41: Podiatry - % treated within 8 Weeks
Performance continues to be below 95% target (70% February 2020) and has not been achieved since March 2019. 209 out of 698 patients were seen outside of 8 weeks. The current action plan, which is ongoing work has a focus on three main areas:

1. SystmOne process review and redesign to improve data quality and performance reporting.
2. Review and redesign care pathway by speciality level to improve efficiency including;
a. triage process
b. flexible rota's to meet specialist and locality need
c. a focus on rebooking cancellation slots
d. innovation in delivery models e.g. telephone assessments and MDT clinics
3. Redesign of workforce model based on demand and capacity modelling.

43: MSK Physiotherapy - % treated within 8 Weeks
Performance remains below target (95%) at 85.6% in February 2020. 200 out of 1,391 patients were seen outside of the 8 week target, of which 4 were seen outside of 18 weeks.
Ongoing discussions continue regarding the mismatch of demand versus capacity, noting this is a similar issue across both Community MSK therapy providers.
Performance continues to show improvement, although the SPC chart upper control limit is below the 95% target indicating that this target is unlikely to be achieved.

44: ICT Physiotherapy - % treated within 8 Weeks
In February 73.8% of patients were seen within 8 weeks compared to target of 95%.
88 out of 337 patients were seen outside of 8 weeks, of which 42 were seen outside of 18 weeks.
In the first 11 months of 2019/20, the ICT Physiotherapy service saw 63.4% of patients within 4 weeks of referral and 95% of patients within 18 weeks. When the activity in the referral centre is included, February performance increases to 78.3%.
There is an ongoing issue with vacancy recruitment, with overall pressure across all localities. Locum cover now available in some places, new allocations now distributed by management. Locums catch up with patients waiting which in turn affects the longest waiters and Referral to Treatment.

45: ICT Occupational Therapy Services - % treated within 8 Weeks
In February 78.6% of patients were seen within 8 weeks compared to target of 95%.
87 out of 417 patients were seen outside of 8 weeks, of which 25 were seen outside of 18 weeks.
In the first 11 months of 2019/20, the OT service saw 65.8% of patients within 4 weeks of referral. 95% of patients seen year to date were seen within 14-15 weeks. When the activity in the referral centre is included, February performance increases to 88.5%.
Vacancies, particularly in Gloucester locality and in more junior roles (i.e. Band 5) have also impacted on target achievement. The service has secured clinicians via temporary contract and are actively seeking locums, recognising there is a further 2 years in the re-structuring of the service model to align to the revised commissioning intentions and resources available. Recruitment difficulties continue due to the OT review.

52: Paediatric Speech and Language Therapy - % treated within 8 Weeks
The 95% target has been missed in February 2020 (81.6%). 32 out of 174 patients were seen outside of 8 weeks. Performance has dropped below SPC chart lower control limits.

Capacity is an ongoing issue with 2 members of the team currently on maternity leave, a further 2 posts have been vacant since November. Actions include recruitment with 1 new starter commencing in post in March and 1 in June/July and a plan to increase availability of drop-in sessions if accommodation can be sourced.

53: Paediatric Physiotherapy - % treated within 8 Weeks
The 95% target continues to be missed with performance of 85.4% in February and has not been achieved since October 2018. 40 out of 275 patients were seen outside of the 8 week target. However, performance remains within SPC chart control limits. Action plan in place, monitored by service lead and clinician actions reviewed in supervision. Additional capacity (1 WTE) in post until June 2020. The service continues to work with Business Intelligence team to further develop Demand and Capacity modelling.

60: Social Care ICT - % of Referrals resolved at Referral Centres and closed
The 49.0% threshold (based on 2018/19) was not been achieved in February 2020 (36.2%) and is below SPC chart control limits.
This measure is an indication of the role of the referral centre in supporting the Adult Social Care demand management strategy. Adult Social Care colleagues and ICT managers are not seeking to actively drive this figure up (or down). A low figure might indicate a failure to signpost away when appropriate; a high figure may suggest failure to properly respond to referrals or perhaps a % of inappropriate referrals. Performance should be 40 – 50%.
Note that when comparing with previous years the 2020 data will be lower due to a change in process, whereby the Adult Social Care helpdesk complete an initial triage of referrals and then send the referrals they consider to be appropriate, rather than referrals being fed to the referral centres via the ERIC system. From January 2020 onwards the ERIC system referrals will not be included in these figures.

63: Single Point of Clinical Access - Calls Offered (received)
The threshold (based on 2018/19) of 3,279 calls was missed by 580 calls in February 2020. Calls received dropped below the lower control limit for the first time.

67: Wheelchair Service: Adults: New referrals assessed within 8 weeks
Target continues to be missed. 9 out of 24 referrals were assessed within the 8 week timeframe.

68: Wheelchair Service: Adults: Priority referrals seen within 5 working days
Target continues to be missed. 8 priority referrals were received in February, 0 were seen within 5 working days.

69: Wheelchair Service: Under 18s: New referrals assessed within 8 weeks
Target continues to be missed. 7 out of 10 referrals were assessed within the 8 week timeframe.

71: Wheelchair Service: Under 18s: Equipment delivered within 18 weeks of referral
Target continues to be missed. 4 out of 8 patient's had equipment delivered within 18 weeks of referral.

Additional Commentary for 67, 68, 69 and 71
The wheelchair service has recognised performance and data quality issues which are being addressed through a service improvement plan. As such it is difficult to confidently comment on this data.

93: Chlamydia Screening of Gloucestershire residents aged 15-24 via the Chlamydia Screening Service (minimum positivity rate)
The minimum positivity rate for Chlamydia Screening of Gloucestershire residents aged 15-24 continues to be below threshold compared to 2018/19. The rate remains within SPC chart control limits and is close to the recalculated mean.

94: Number of Positive Screens - GCS and Joint responsibility
Number of positive screens continue to be below threshold compared to 2018/19. This remains within SPC chart control limits and is close to the recalculated mean. This influences the (reducing) positivity rate (metric 93).

Additional Commentary for 93 & 94
A change in coding was introduced in the Sexual Health clinical system in April 2019. This has reduced the number of positive screens, some of which were incorrectly coded previously. However some online positives are still not being recorded correctly and this will continue to be reviewed with the service to improve the reporting.

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AGENDA ITEM: 22/0320

REPORT TO: Trust Board – 25 March 2020

PRESENTED BY: Stephen Andrews, Deputy Director of Finance

AUTHOR: Sandra Betney, Director of Finance

SUBJECT: **FINANCE REPORT FOR PERIOD ENDING 29 FEBRUARY 2020**

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

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

The purpose of this report is to
Provide an update of the financial position of the Trust.

Recommendations and decisions required

The Board is asked to **note** the month 11 position.

Executive summary

- The month 11 position is a surplus of £2.027m which is slightly better than the planned surplus.
- The month 11 forecast outturn of £2.256m is £135k better than the Trust's control total. PSF accounts for £2.042m of this.
- The Trust has an Oversight Framework segment of 1 as at February 2020.
- The agency cost forecast is £6.230m which is £1.980m above the agency ceiling
- The cash balance at month 11 is £42.1m which is £6.3m above the plan.
- Capital expenditure is £2.834m at month 11, with the forecast at £6.625m.
- The Cost Improvement Plan (CIP) target for the merged Trust is £5.402m. The CIP amount removed so far is £1.924m.

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

Corporate considerations	
Quality Implications	Any implications are referenced in the report.
Resource Implications	Any implications are referenced in the report.
Equality Implications	Any implications are referenced in the report.

Where has this issue been discussed before?
Resources Committee meeting – 27 February 2020.

Appendices:	Finance report

Report authorised by: Sandra Betney	**Title:** Director of Finance

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Finance Report
Month 11

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Gloucestershire Health & Care Overview

Gloucestershire Health and Care
NHS Foundation Trust

- This first half of this report outlines the financial position for Gloucestershire Health and Care NHS Foundation Trust (GHC) covering months 1-12 for [2]gether NHSFT and 7-12 for Gloucestershire Care Services (GCS). The second half of the report outlines the final position for Gloucestershire Care Services, months 1-6.
- The year to date surplus for GHC is slightly above plan at £2.027m. The full year forecast is a surplus £135k better than the control total. The Trust is confident it will meet its financial control total. PSF accounts for £2.042m of the control total surplus.
- The revised agency ceiling for GHC is £4.250m. The year to date actual is £5.635m which is over the ceiling by £1.833m. The full year forecast spend is £6.230m, the same as last month, which is £1.980m, or 47%, above the agency ceiling and puts the Trust £144k below the agency ceiling threshold of 50% above target where the Trust would score 4 on the agency metric.
- The Cost Improvement Plan (CIP) target for the merged Trust is £5.402m. The CIP amount removed so far is £1.924m. The forecast is £3.2m.
- Capital spend for GHC is £2.834m. The forecast for the merged Trust is £6.625m. The purchase of IT and medical equipment items is being monitored on a weekly basis to ensure the forecast is met and a further £0.5m was spent at the start of March.
- Cash balance at the end of month 11 for GHC is £6.3m above the plan at £42.1m. All of the increase in cash relates to underspends on capital against plan.
- The Trust has completed the sale of 18 Denmark Road at £560k. There was a £40k profit on the sale of the asset.

GHC Income and Expenditure

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The year to date performance at Month 11 is above plan at £2.027m surplus.

The Trust anticipates it will meet its full year planned surplus including PSF of £2.190m.

A number of operational directorates are in deficit YTD, including Social Care, Entry Level (IAPT & Primary Mental Health nurses) and the Medical Directorate. A small number of Corporate directorates are in deficit YTD and forecast. This is predominantly due to the asset lives cost pressure, agreed non-recurrent costs funded by Trust underspends, and still to be identified savings.

	Aggregated 2g & GCS		2g months 1-11 and GCS mths 7-11			2g months 1-12 and GCS mth 7-12		
Statement of comprehensive income £000	2017/18	2018/19	2019/20			2019/20		
	Full Year Actual	Full Year Actual	Plan	Actual	Variance	Plan	Full Year Forecast	Variance
Operating income from patient care activities	220,232	228,678	156,033	158,873	2,840	175,304	178,336	3,032
Other operating income exc PSF	8,415	9,390	5,564	8,100	2,536	6,149	9,815	3,666
Provider sustainability fund (PSF) income	5,557	6,444	1,738	1,738	0	2,042	2,042	0
Employee expenses	(163,685)	(169,910)	(121,633)	(121,021)	612	(136,592)	(137,594)	(1,002)
Operating expenses excluding employee expenses	(74,613)	(63,303)	(37,119)	(43,535)	(6,416)	(41,805)	(47,599)	(5,794)
PDC dividends payable/refundable	(3,973)	(3,345)	(2,698)	(2,370)	328	(3,034)	(3,026)	8
Other gains / losses	9	120	51	242	191	57	282	225
Surplus/(deficit) before impairments & transfers	**(8,067)**	**8,074**	**1,936**	**2,027**	**91**	**2,121**	**2,256**	**135**
Add back impairments	15,731	(283)	0	0	0	0	0	0
Remove capital donations/grants I&E impact	105	(212)	61	75	14	69	105	36
Surplus/(deficit) inc PSF	**(2,405)**	**7,579**	**1,997**	**2,102**	**105**	**2,190**	**2,361**	**171**

GHC Balance Sheet

NHS
Gloucestershire Health and Care

STATEMENT OF FINANCIAL POSITION (all figures £000)		Aggregated 2g & GCS	2g months 1-11 and GCS mths 7-11			2g months 1-12 and GCS mth 7-12		
		2018/19	2019/20 Year to Date			2019/20		
		Full Year Actual	Plan	Actual	Variance	Plan	Forecast	Variance
Non-current assets	Intangible assets	2,819	2,331	2,306	(25)	2,269	2,238	(31)
	Property, plant and equipment: other	114,893	116,679	113,223	(3,456)	117,855	115,960	(1,895)
	Total non-current assets	**117,712**	**119,010**	**115,529**	**(3,481)**	**120,124**	**118,198**	**(1,926)**
Current assets	Inventories	288	288	245	(43)	288	245	(43)
	NHS receivables	9,051	8,659	20,686	12,027	8,511	9,456	945
	Non-NHS receivables	8,066	7,606	6,219	(1,387)	6,224	5,723	(501)
	Cash and cash equivalents:	32,474	35,773	42,124	6,351	33,682	42,496	8,814
	Property held for sale	500	500	0	(500)	500	0	(500)
	Total current assets	**50,379**	**52,826**	**69,274**	**16,448**	**49,205**	**57,920**	**8,715**
Current liabilities	Trade and other payables: capital	(1,780)	(1,155)	(350)	805	(1,655)	(1,619)	36
	Trade and other payables: non-capital	(11,184)	(12,048)	(20,216)	(8,168)	(11,190)	(16,652)	(5,462)
	Borrowings	(76)	(2)	(164)	(162)	(2)	(2)	0
	Provisions	(371)	(371)	(643)	(272)	(371)	(643)	(272)
	Other liabilities: deferred income including contract liabilities	(10,259)	(11,050)	(15,552)	(4,502)	(9,044)	(9,044)	0
	Total current liabilities	**(23,670)**	**(24,626)**	**(36,925)**	**(12,299)**	**(22,262)**	**(27,960)**	**(5,698)**
Non-current liabilities	Borrowings	(1,821)	(1,689)	(1,526)	163	(1,638)	(1,638)	0
	Provisions	(616)	(726)	(1,023)	(297)	(451)	(451)	0
	Total net assets employed	**141,984**	**144,795**	**145,329**	**534**	**144,978**	**146,069**	**1,091**
Taxpayers Equity	Public dividend capital	126,956	126,956	127,416	460	126,956	127,526	570
	Revaluation reserve	7,098	7,098	6,896	(202)	7,098	7,098	0
	Other reserves	(1,241)	(1,241)	(1,241)	0	(1,241)	(1,241)	0
	Income and expenditure reserve	9,171	11,982	12,258	276	12,165	12,686	521
	Total taxpayers' and others' equity	**141,984**	**144,795**	**145,329**	**534**	**144,978**	**146,069**	**1,091**

Year to Date NHS Receivables and Trade and other payables : non-capital are both high due to the internal transfer of costs between the two financial ledgers. Gloucestershire Hospitals NHSFT have paid £1.4m of their outstanding debt over 90days.

Capital – Multi-Year Plan

Gloucestershire Health and Care
NHS Foundation Trust

	2gether mths 1-12 and GCS mths 7-12								
	GHC Plan		YEAR TO DATE	FORECAST OUTTURN	Plan	Plan	Plan	Plan	Plan
£000s	2019/20		2019/20	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
Land and Buildings									
Buildings	2,071		537	865	4,259	4,000	2,500	2,500	1,000
Forest of Dean	750		90	911	500	7,000	3,400		
Backlog Maintenance	1,874		913	1,772	1,393	1,300	1,050	1,050	250
Urgent Care	1		0	0	475	0	0	0	0
Information Technology									
IT Device and software upgrade	299		119	689	600	600	600	600	600
IT Infrastructure	1,575		888	1,545	1,681	1,409	1,400	1,300	1,300
Medical Equipment	**512**		287	843	1,037	1,030	1,030	1,030	3,330
Total	**7,082**		**2,834**	**6,625**	**9,945**	**15,339**	**9,980**	**6,480**	**6,480**

Year to Date capital spend is £2,834k, an increase of £523k on month 10. In the first two weeks of March a further £500k has been spent. The future years plan spends have been adjusted by the Capital management Group.

Cash Flow Summary

Gloucestershire Health and Care
NHS Foundation Trust

Statement of Cash Flow £000	ACTUAL YTD 19/20		FORECAST 19/20	
Cash and cash equivalents at start of period		**33,553**		**33,553**
Cash flows from operating activities				
Operating surplus/(deficit)	4,157		5,044	
Add back: Depreciation on donated assets	79		36	
Adjusted Operating surplus/(deficit) per I&E	**4,236**		**5,080**	
Add back: Depreciation on owned assets	4,514		4,553	
Add back: Impairment	0		0	
(Increase)/Decrease in inventories	0		0	
(Increase)/Decrease in trade & other receivables	(9,555)		2,111	
Increase/(Decrease) in provisions	(108)		47	
Increase/(Decrease) in trade and other payables	11,984		7,637	
Increase/(Decrease) in other liabilities	254		(1,074)	
Net cash generated from / (used in) operations		**11,325**		**18,354**
Cash flows from investing activities				
Interest received	202		242	
Purchase of property, plant and equipment	(2,869)		(6,736)	
Sale of Property	560		560	
Net cash generated used in investing activities		**(2,107)**		**(5,934)**
Cash flows from financing activities				
PDC Dividend Received	460		570	
PDC Dividend (Paid)	(1,000)		(3,890)	
Finance Lease Rental Payments	(107)		(157)	
		(647)		**(3,477)**
Cash and cash equivalents at end of period		**42,124**		**42,496**

Risks

Gloucestershire Health and Care
NHS Foundation Trust

Risks to delivery of the 2019/20 position are as set out below:
Those risks that have been dealt with have been removed. There are no significant risks remaining at month 11 for 2019/20.

Gloucestershire Health & Care Risks	19/20 Risk at month 11	Made up of: Rec		Likelihood
Delivery of Cost Improvements incl. Challenge Scheme CIPs	0	2,207		Almost Certain
VAT changes impacting recovery on Systm1 19/20 (FY £80k in position)	0	80		Almost Certain
QIPP risk share and milestones	0	0		Unlikely
Asset lives depreciation impact - 2g	0	350		Possible
Asset lives Dep'n & PDC impact - GCS acceptance (FY £540k in position)	0	540		Certain
Transfer of Herefordshire services	0	908		Certain
A failure to control costs due to some risks materialising leads to the Trust to miss its FTC and lose PSF	0	0		Unlikely
	0	**4,085**		

Health Economy Risks	Probability	Risk £000)	Opportunity (£000)
Delivery of GHFT control total	Likely	3,000	
Delivery of CCG control total	Likely	3,000	
System Control Total PSF Risk	Unlikely	99	
		6,099	

Single Operating Framework Ratings

Current FT Financial Risk Rating - Single Oversight Framework
Use Of Resource

Finance and use of resources rating Metric	Audited PY 31/03/2019 Year ending	Plan 31/03/2020 Year ending	Actual 31/01/2020 YTD	Forecast 31/03/2020 Year ending
Capital service cover rating	1	1	1	1
Liquidity rating	1	1	1	1
I&E margin rating	1	1	1	1
I&E margin: distance from financial plan	1	1	1	1
Agency rating	3	1	3	3
Risk ratings after overrides	1	1	1	1

Gloucestershire Health and Care
NHS Foundation Trust

Gloucestershire Care Services

Finance Report

April – September 2019

Overview

- No amendments to the reported position of GCS have occurred this month.
- The Final Accounts for GCS, months 1-6, have been approved by the Audit Committee subject to final check being completed by External Audit.
- No significant issues were identified by the audit.
- The Trust ended the period with a surplus of £0.903m, in line with the plan.
- The agency ceiling was £1.116m and the GCS spend for months 1-6 was £1.116m.
- Cost Improvement Plan (CIP) target for GCS months 1-6 was £2.268m and the amount of savings delivered was £2.848m.
- Capital spend was £1,055k against a six month plan of £1.737m.
- Cash balance at the end of month 6 was £0.4m above plan at £18.9m. All of the increase in cash related to underspends on capital against plan.

Gloucestershire Care Services Income & Expenditure

Gloucestershire Health and Care NHS Foundation Trust

Statement of comprehensive income £000	2018/19	2019/20 Month 1 - 6		
	Full Year Actual	Plan	Actual	Variance
Operating income from patient care activities	112,668	56,834	57,131	297
Other operating income exc PSF	2,099	759	895	136
Provider sustainability fund (PSF) income	3,962	569	569	0
Employee expenses	(80,782)	(42,331)	(42,141)	190
Operating expenses excluding employee expenses	(31,719)	(13,926)	(14,689)	(763)
PDC dividends payable/refundable	(1,739)	(1,032)	(905)	127
Other gains / losses	(56)		(5)	(5)
Surplus/(deficit) before impairments & transfers	**4,433**	**873**	**855**	**(18)**
Add back impairments	885			
Remove capital donations/grants I&E impact	(249)	30	48	18
Surplus/(deficit) inc PSF	**5,069**	**903**	**903**	**0**
Surplus/(deficit) exc PSF	**1,107**	**334**	**334**	**0**
Control total including PSF	**3,078**	**903**	**903**	**0**

GCS Balance Sheet

Gloucestershire Health and Care
NHS Foundation Trust

STATEMENT OF FINANCIAL POSITION (all figures £000)		2018/19	2019/20 Year to Date		
		Full Year Actual	Plan	Actual	Variance
Non-current assets	Intangible assets	829	658	667	9
	Property, plant and equipment: other	63,315	63,475	62,794	(681)
	Total non-current assets	**64,144**	**64,133**	**63,461**	**(672)**
Current assets	Inventories	288	288	245	(43)
	NHS receivables	5,800	5,355	5,263	(92)
	Non-NHS receivables	2,978	2,978	3,667	689
	Cash and cash equivalents:	17,837	18,435	18,916	481
	Total current assets	**26,903**	**27,056**	**28,091**	**1,035**
Current liabilities	Trade and other payables: capital	(1,454)	(829)	(116)	713
	Trade and other payables: non-capital	(9,518)	(9,518)	(9,325)	193
	Borrowings	(76)	(76)	(200)	(124)
	Provisions	(371)	(371)	(751)	(380)
	Other liabilities: deferred income including contract liabilities	(389)	(389)	(1,291)	(902)
	Total current liabilities	**(11,808)**	**(11,183)**	**(11,683)**	**(500)**
Non-current liabilities	Borrowings	(1,593)	(1,487)	(1,368)	119
	Total net assets employed	**77,646**	**78,519**	**78,501**	**(18)**
Taxpayers Equity	Public dividend capital	80,276	80,276	80,276	0
	Revaluation reserve	4,679	4,679	4,679	0
	Other reserves	(2,398)	(2,398)	(2,398)	0
	Income and expenditure reserve	(4,911)	(4,038)	(4,056)	(18)
	Total taxpayers' and others' equity	**77,646**	**78,519**	**78,501**	**(18)**

Capital and Cost Improvement Programmes

Gloucestershire Health and Care
NHS Foundation Trust

Gloucestershire Care Services NHST CAPITAL PROGRAMME	Months 1-6		
	Plan £000's	Actual £000's	Variance £000's
Buildings	1,136	859	277
Backlog Maintenance	50		50
Urgent Care	25		25
Network Replacement	0	11	(11)
Laptops	100		100
Medical Equipment	426	132	294
Forest of Dean	0	53	(53)
TOTAL	**1,737**	**1,055**	**682**

Gloucestershire Care Services NHST COST IMPROVEMENT PROGRAMME	Months 1-6		
	Plan £000's	Actual £000's	Variance £000's
Trust 1.25% Scheme	1,372	1,372	0
Differential - Hospitals	84	178	94
Differential - ICTs	199	93	(106)
Differential - Countywide	318	446	128
Differential - CYPS	256	256	0
Differential - Urgent Care	2	4	2
Differential - Human Resources	32	32	0
Differential - Executive	1	1	0
Differential - Finance Directorate	4	4	0
Challenge Schemes - TBC	0	462	462
TOTAL	**2,268**	**2,848**	**580**

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AGENDA ITEM: 23/0320

REPORT TO: Trust Board

PRESENTED BY: Lavinia Rowsell, Head of Governance and Trust Secretary

AUTHOR: Lavinia Rowsell, Head of Governance and Trust Secretary

SUBJECT: **PROPOSED CHANGES TO THE CONSTITUTION**

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

The purpose of this report is to

To take forward the required revisions to the Constitution to reflect the transition of Herefordshire Mental Health Services from the Trust.

Recommendations and decisions required

The Board is asked to **APPROVE** the following revisions of the Trust Constitution:

(i) remove the Herefordshire Category of Public Governors and Appointed Governors for Herefordshire Council and Herefordshire Clinical Commissioning Group.

(ii) remove references to the reservation of staff governor roles specifically for Gloucestershire Care Services NHS Trust staff for the first election post the merger with Gloucestershire Care Services NHS Trust.

Executive summary

The transfer of Herefordshire Mental Health Services from the Trust to Worcestershire Health and Care NHS Trust (WHCT) with effect from 1st April 2020 results in the need for minor amendments to the Trust's Constitution as follows:

- the removal of the Herefordshire Public Constituency and the resulting removal of the 2 governors (Annex 1 and 2)
- the removal of the Appointed Governors for Herefordshire Council (1 governor) and Herefordshire Clinical Commissioning Group (1 governor) (clauses 10.5 & 10.7)

This reduces the number of Total Governors to 25.

Communication with the Herefordshire governors is ongoing to keep them up to date

with the changes and there have been discussions with WHCT about ways to continue to benefit from their experience.

Additionally minor housekeeping changes are proposed:

- remove references to the reservation of staff governor roles specifically for Gloucestershire Care Services NHS Trust staff for the first election post the merger with Gloucestershire Care Services NHS Trust – given this period has passed (Annex 3, 1.5).
- related changes to numbering to reflect the changes detailed

The approval of the revised Constitution is a two stage process which requires the approval by both more than half the members of both the Council of Governors and the Board. Once approved the revised Constitution will then be updated on the Trust's website and to NHSI.

The equivalent paper to this one will be considered by the Council of Governors at its meeting on 19 March 2020.

These changes do not preclude further changes following the work of the Governors relating to the review and refresh of its work.

Risks associated with meeting the Trust's values

A constitution is one of the most important documents within a foundation trust, ensuring clarity around the remit of the trust, its governance arrangements and how it will operate. There is a risk that within an up to date constitution, patients and service users cannot be assured that the governance of the trust is sound.

Corporate considerations	
Quality Implications	None
Resource Implications	None
Equality Implications	None

Where has this issue been discussed before?
Council of Governors – 19 March 2020

Appendices:	Revised constitution

GLOUCESTERSHIRE HEALTH AND CARE NHS FOUNDATION TRUST

Constitution

1 April 2020

GHC NHS Foundation Trust Constitution

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1. Introduction

1.1 The name of the foundation trust is Gloucestershire Health and Care NHS Foundation Trust (the Trust). The Trust is a public benefit corporation authorised under the NHS Act 2006, with effect from 1 July 2007 under its former name of 2Gether. The functions of the Trust are conferred by this legislation.

1.2 The headquarters of the Trust is Edward Jenner Court, 1010 Pioneer Avenue, Brockworth, Gloucester GL3 4AW.

1.3 As a statutory body, the Trust has specified powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable.

2. Principal purpose

2.1 The principal purpose of the Trust is the provision of goods and services for the purposes of the health service in England.

2.2 The Trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

2.3 The Trust may provide goods and services for any purposes related to:

(a) the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and

(b) the promotion and protection of public health

2.4. Other purposes

2.4.1 The Trust may fulfil the social care functions of Gloucestershire County Council as specified by an agreement under Section 75 of the 2006 Act.

2.4.2 The purpose of the Trust is to provide goods and services, including education, training and research and other facilities for purposes related to the provision of health care, in accordance with its statutory duties and the terms of its Authorisation

2.4.3 The Trust may carry out research in connection with the provision of health care and make facilities and staff available for the purposes of education, training or research carried on by others.

2.4.4 The Trust may also carry on activities other than those mentioned above subject to any restrictions in the terms of authorisation. These activities must be for the purpose of making additional income available in order to carry on the Trust's principal purpose.

3. Powers

3.1 The powers of the Trust are set out in the 2006 Act.

3.2 The powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust.

3.3 Any of these powers may be delegated to a committee of directors, or to an executive director who may delegate to another officer as set out in the Trust's scheme of delegation.

4. Membership and constituencies

4.1 The Trust shall have members, each of whom shall be a member of one of the following constituencies:

(a) a public constituency or

(b) a staff constituency

5. Application for membership

5.1 An individual who is eligible to become a member of the Trust by virtue of living in the Public Constituency may do so on application to the Trust.

5.2 It is the responsibility of members to ensure their eligibility and not the Trust, but if the Trust is on notice that a member may be disqualified from membership, they shall carry out all reasonable enquiries to establish if this is the case.

6. Public Constituency

6.1 An individual who lives in the area specified in Annex 1 as the area for a Public Constituency may become or continue as a member of the Trust.

6.2 Those individuals who live in an area specified as an area for any public constituency are referred to collectively as the Public Constituency.

6.3 The minimum number of members in each area for the Public Constituency is specified in Annex 1.

6.4 An eligible individual shall become a member upon entry to the membership register pursuant to an application by them.

6.5 On receipt of an application for membership and subject to being satisfied that the applicant is eligible the Trust shall cause the applicant's name to be entered in the Trust's register of members

Termination of membership

6.6 A member shall cease to be a member of the Public Constituency if he/she –

(a) submits his/her resignation in writing to the Trust

(b) ceases to live in the area specified as the Public Constituency

6.7 At the discretion of the Trust, where a member consistently fails to respond to requests to confirm interest in continuing membership the Trust may remove the member's name from the register of members

7. Staff Constituency

7.1 An individual who is employed by the Trust under a contract of employment with the Trust may become or continue as a member of the Trust provided:

(a) He/she is employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or

(b) He/she has been continuously employed by the Trust or a recognised predecessor under a contract of employment for at least 12 months.

7.2 Those individuals who are eligible for membership of the Trust by reason of the previous provisions are referred to collectively as the Staff Constituency.

7.3 The Staff Constituency shall be divided into 3 descriptions of individuals who are eligible for membership of the Staff Constituency, each description of individuals being specified within Annex 2 and being referred to as a class within the Staff Constituency.

7.4 The minimum number of members in each class of the Staff Constituency is specified in Annex 2.

Automatic membership by default – staff

7.5 An individual who is eligible to become a member of the Staff Constituency shall become a member of the Trust as a member of the Staff Constituency and appropriate class within the Staff Constituency without an application being made, unless he/she informs the Trust that he/she does not wish to do so.

7.6 On being satisfied that the applicant is eligible the Trust shall cause the applicant's name to be entered in the Trust's register of members

Termination of membership

7.7 A member shall cease to be a member of the Staff Constituency if he/she –

(a) submits his/her resignation from membership in writing to the Trust

(b) leaves the Trust's employment

7.8 Members who are no longer eligible to be members of the Staff Constituency by virtue of having left the employment of the Trust may apply to become members of the appropriate Public Constituency.

8. Restriction on membership

8.1 An individual member of a constituency, or of a class within a constituency, may not while membership of that constituency or class continues, be a member of any other constituency or class.

8.2 An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a member of any constituency other than the Staff Constituency.

8.3 An individual must be at least 11 years old to apply to become a public member of the Trust

9. Annual General Meeting

9.1 The Trust shall hold an annual meeting of its members (Annual General Meeting). The Annual General Meeting shall be open to members of the public.

10. Council of Governors – composition

10.1 The Trust is to have a Council of Governors, which shall comprise both elected and appointed governors.

10.2 The composition of the Council of Governors is specified in Annex 3.

10.3 The members of the Council of Governors, other than the appointed members, shall be chosen by election by their constituency or, where there are classes within a constituency, by their class within that constituency. The number of governors to be elected by each constituency, or, where appropriate, by each class of each constituency, is specified in Annex 3.

Local Authority Governors

10.4 Gloucestershire County Council may appoint an elected member of the Council as a Local Authority Governor by nomination in writing.

~~10.5 Herefordshire Council may appoint an elected member of the Council as a Local Authority Governor by nomination in writing.~~

Clinical Commissioning Group Governors

10.6 The Accountable Officer of the Gloucestershire Clinical Commissioning Group may appoint a representative of that group as a Clinical Commissioning Group Governor by nomination in writing.

~~10.7 The Accountable Officer of the Herefordshire Clinical Commissioning Group may appoint a representative of that group as a Clinical Commissioning Group Governor by nomination in writing.~~

11. Council of Governors – election of governors

11.1 Elections for elected members of the Council of Governors shall be conducted in accordance with the Model Rules for Elections.

11.2 The Model Rules for Elections, as published by the Department of Health, shall be deemed part of this constitution.

11.3 A variation of the Model Rules by the Department of Health shall not constitute a variation of the terms of this constitution for the purposes of paragraph 46 of the constitution (Amendment of the Constitution). For the avoidance of doubt, the Trust cannot amend the Model Rules.

11.4 An election, if contested, shall be by secret ballot.

12. Council of Governors – tenure

12.1 An elected governor may hold office for an initial period of up to 3 years.

12.2 An elected governor shall be eligible for re-election at the end of his/her term for one further period of up to 3 years. He/she may not hold office for longer than 2 consecutive terms, regardless of the length of each term.

12.3 An elected governor who has completed two consecutive terms of office at the Trust shall be eligible to stand again for election following a break of at least 3 years.

12.4 An elected governor shall cease to hold office if he/she ceases to be a member of the constituency or class by which he was elected.

12.5 An appointed governor may hold office until they are replaced by the organisation which nominated them, or until the appointing organisation withdraws its sponsorship, whichever is the sooner.

13. Council of Governors – disqualification and removal

13.1 The following may not become or continue as a member of the Council of Governors:

13.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

13.1.2 a person who has made a composition or arrangement with, or granted a Trust deed for, his/her creditors and has not been discharged in respect of it;

13.1.3 a person who within the preceding five years has been convicted in the British Isles of any offence where a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him/her.

13.1.4 a person who has within the preceding two years been dismissed, other than for reasons of redundancy or sickness, from any paid employment with a health service body.

13.1.5 a person whose tenure of office as the chairman or as a member or director of a health service body has been terminated on the grounds that his/her appointment is not in the interests of the health service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest

13.1.6 a person who is an executive or non-executive director of the Trust.

13.1.7 a person who is an executive director or non-executive director of another health service body.

13.1.8 a person who is a governor of another health service body within the same Integrated Care System as the Trust, save where the Chair and Chief Executive are satisfied that any proposed or existing concurrent appointment would not constitute a conflict of interests which could not be managed or avoided.

13.1.9 a person who is the spouse, partner or close relative of a member of the Trust's Board of Directors

13.1.10 a person who is undergoing a period of disqualification from a statutory health or social care register. This provision shall not apply where a person's registration lapses or their name has been removed at their own request, for example following retirement.

13.1.11 a person subject to a director's disqualification order made under the Company Directors Disqualification Act 1986

13.1.12 a person who has been disqualified from being a member of a relevant authority under the provisions of the Local Government Act 2000

13.1.13 a person who has not attained the age of 16 at the date they are nominated for election or appointment.

13.1.14 in the case of an appointed governor, a person whose appointing body withdraws its sponsorship of the governor.

13.1.15 in the case of an elected governor, a person who ceases to be a member of the constituency or class of constituency that he/she represents.

13.1.16 a governor who has failed to abide by the Trust's Code of Conduct for Governors, and any relevant Code of Values that the Trust may publish from time to time.

13.1.17 a person who is the subject of an Order under the Sexual Offences Act 2003, or any subsequent legislation.

13.1.18 a person who is included in any barred list maintained by the Disclosure and Barring Service (or any successor body) or any equivalent list maintained under the laws of Scotland or Northern Ireland

13.1.19 a person who is a vexatious complainant as determined in accordance with the Trust's complaints procedure

13.2 Following election or appointment, and henceforth on an annual basis, governors shall be required to confirm that they are not disqualified from the office of Governor under any provision within section 13 of this Constitution.

13.3 Where a person has been elected or appointed to be a governor and subsequently becomes disqualified for appointment he/she shall notify the Trust Secretary in writing of such disqualification at the earliest opportunity.

14. Termination of tenure

14.1 If it comes to the notice of the Trust Secretary (either at the time of the governor's appointment or later) that the governor is disqualified under the provisions of paragraph 13 of this constitution, he shall immediately declare that the person in question is disqualified and notify him in writing to that effect. Upon receipt of any such notification, that person's tenure of office, if any, shall be terminated and he/she shall cease to act as a governor.

14.1 A governor may resign from office at any time during the term of that office by giving notice in writing to the Trust Secretary.

14.2 If a governor fails to attend three consecutive general meetings of the Council of Governors his/her tenure of office is to be terminated at the next meeting unless the other governors (by a simple majority) are satisfied that:-

(a) the absence was due to a reasonable cause; and

(b) he/she will be able to start attending meetings of the Council of Governors again within such a period as they consider reasonable.

14.3 The Council of Governors may terminate the tenure of a governor (regardless of his/her record of attendance), by a three quarters majority of the Council of Governors voting, if it is satisfied that he/she:

14.3.1 has failed to sign and deliver to the Trust Secretary a statement in the form required confirming acceptance of the Code of Conduct for Governors

14.3.2 has expressed opinions which are incompatible with the values of the Trust

14.3.3 has acted or persists in acting in a manner prejudicial to the best interests of the Trust.

14.4 Standing Orders shall provide for the procedure to be adopted in connection with motions to terminate the tenure of governors.

15. Vacancies

15.1 Where membership of the Council of Governors ceases within 12 months of election, public and staff governors shall be replaced by the candidate in the same constituency and class with the next highest number of votes at the last election. If the vacancy cannot be filled by this method the governor will be replaced by holding a by-election, in accordance with the Election Rules.

15.2 Appointed governors are to be replaced in accordance with the processes set out in the relevant paragraphs of this constitution.

16. Council of Governors – duties and responsibilities

16.1 The general duties and responsibilities of the Council of Governors are –

(a) to hold the non-executive directors individually and collectively to account for the performance of the Board of Directors, and

(b) to represent the interests of the members of the trust as a whole and the interests of the public

16.2 The trust will take steps to ensure that governors are equipped with the skills and knowledge they require in their capacity as such.

16.3 The specific powers and duties of the Council of Governors are:

16.3.1 in a general meeting to:

(a) appoint or remove the Chair of the Trust and the other non-executive directors. The removal of the Chair or a non-executive director shall require the approval of three quarters of the total number of governors;

(b) approve the appointment of the Chief Executive of the Trust by the non-executive directors;

(c) decide the remuneration and allowances and the other terms and conditions of office of the non-executive directors;

(d) appoint or remove the Trust's auditor;

(e) receive and consider the Trust's annual accounts, any auditor's reports on those annual accounts, and the annual report of the Board of Directors no later than September each year;

(f) appoint one of the non-executive directors to be the deputy Chair of the Trust, following a recommendation by the Trust Chair.

16.3.2 to be consulted by the Board of Directors regarding the information to be included in the Trust's annual plan;

16.3.3 to respond as appropriate when consulted by the Board of Directors;

16.3.4 to require one or more directors to attend a meeting of the Council of Governors for the purpose of obtaining information about the trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the Trust's or the directors' performance);

16.3.5 to approve the entering into of any significant transaction;

16.3.6 to authorise an application for a merger, acquisition, separation or dissolution of the Trust;

16.3.7 to exercise such powers and to discharge such other duties as may be conferred on the Council of Governors under this constitution.

16.4 Where the Council of Governors believes it to be necessary it may appoint co-opted advisors. It may seek nominations for co-opted advisors from voluntary

and community sector organisations operating in any field connected to the work of the Trust.

16.5 Co-opted advisors may speak at meetings of the Council of Governors but may not vote and will not count towards any quorum.

16.6 The co-opted advisors are to be appointed by the Council for such period and in accordance with such process as may be approved by the Council of Governors at a general meeting.

17. Council of Governors – meetings of governors

17.1 The Trust Chair (i.e. the Chair of the Board of Directors, appointed in accordance with the appropriate provisions of this constitution) or, in his/her absence the Deputy Chair (appointed in accordance with the appropriate provisions of this constitution), shall preside at meetings of the Council of Governors. In the absence of the Trust Chair and Deputy Chair a non-executive director nominated by the Trust Chair shall preside at meetings of the Council of Governors.

17.2 An absent governor may not vote at a meeting of the Council of Governors, save in exceptional circumstances where alternative arrangements have been agreed in advance with the Trust Chair on advice of the Trust Secretary as provided for in the Standing Orders. Absence is defined as being not present (either physically or via teleconference, video conference or other electronic means) at the time of the vote.

17.3 Meetings of the Council of Governors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons.

17.4 The Council of Governors is to hold up to 6 scheduled meetings per year.

18. Council of Governors – committees and sub-committees

18.1 The Council of Governors may appoint committees consisting of its own members to assist in carrying out the functions of the Council of Governors. A committee appointed under this paragraph may appoint a sub-committee where permitted by that committee's terms of reference.

19. Council of Governors – referral to the Panel

19.1 In this paragraph, 'the Panel' means a panel of persons appointed by NHS Improvement to which a governor of an NHS foundation trust may refer a question as to whether the Trust has failed or is failing –

(a) to act in accordance with its own constitution

(b) to act in accordance with the provision made by or under Chapter 5 of the 2006 Act

19.2 A governor may refer a question to the Panel only if more than half of the members of the Council of Governors voting approve the referral.

20. Standards of business conduct

Canvassing of, and recommendations by, governors in relation to appointments

20.1 Canvassing of governors directly or indirectly for any appointment with the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the constitution shall be included in application forms or otherwise brought to the attention of candidates.

20.2 A governor shall not solicit for any person any appointment with the Trust or recommend any person for such appointment: but this paragraph of this Constitution shall not preclude a governor from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

20.3 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, and which are not part of the recruitment process must be declared to the panel or committee.

Relatives of Governors

20.4 Candidates for any staff appointment shall, when making application, disclose in writing to the Trust whether they are related to any governor. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him/her liable to dismissal.

20.5 Every governor shall disclose to the Trust Secretary any relationship between himself/herself and a candidate of whose candidature that governor is aware.

20.6 On election or appointment, governors should disclose to the Trust whether they are related to any other governor or holder of any office in the Trust.

21. Declarations of Governors' interests and register of interests

21.1 Each governor has a duty to avoid a situation in which the governor has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust.

21.2 Each governor has a duty not to accept any benefit from a third party by reason of being a governor (save for low value gifts and hospitality as permitted by the Trust's policy on Managing Conflicts of Interest) for doing (or not doing)

anything in that capacity. Where such a benefit is offered to a governor, the governor must decline that offer and report the matter to the Trust Secretary.

21.3 If a governor has a pecuniary, personal, family, loyalty or other interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the governor must declare such interests in accordance with policies agreed from time to time by the Trust in respect of conflicts of interest.

21.4 Examples of interests which should be declared include, but are not limited to:

(a) directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).

(b) ownership, part-ownership or directorship of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.

(c) majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.

(d) an office or position of authority in another organisation in the field of health and social care.

(e) any connection with a voluntary or other organisation contracting for NHS services.

(f) research funding/grants that may be received by an individual or their department.

(g) interests in pooled funds that are under separate management.

(h) any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust, including but not limited to, lenders or banks.

(i) membership of clubs, societies or organisations whose purpose may include furthering the business or personal interests of their members by undeclared or informal means. Such organisations include Masonic lodges and societies whose membership consists of professional and business people.

(j) any other commercial interest in a matter under discussion at a meeting of the Council of Governors.

(k) any other employment or business or other relationship of his/hers, or of a member of his/her family or of someone with whom he/she has a close personal relationship, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

21.5 At the time any interest is declared, it should be recorded in the Council of Governors minutes as appropriate. Any changes in interests should be declared at the next Council of Governors meeting following the change occurring. Governors must inform the Trust Secretary in writing within 7 days of becoming aware of the existence of any relevant or material interest.

21.6 Governors' directorships of companies or ownerships/directorships in companies likely or possibly seeking to do business with the NHS should be published in the Trust's annual report. The information should be kept up to date for inclusion in subsequent annual reports.

21.7 The Chair may exclude a Governor from a meeting (or part thereof) of the Council of Governors, or any committee of the Council of Governors, where any contract, proposed contract or other matter in which he/she is determined by the Chair to have an interest, is under consideration.

21.8 In the case of family or close personal relationships the interest of one party shall, if known to the other, be deemed for the purposes of this paragraph 21 to be also an interest of the other.

21.9 If Governors have any doubt about the relevance or materiality of an interest, this should be discussed with the Chair or Trust Secretary. Influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

Register of governors' interests

21.10 The Trust Secretary will ensure that a register of interests is established to record formally declarations of interests of governors. In particular the register will include details of all directorships and other relevant and material interests which have been declared, as defined in the relevant Trust policy on conflicts of interests.

21.11 The details of governors' interests recorded in the register will be kept up to date by the Trust Secretary who will ensure any changes to interests declared are incorporated promptly.

21.12 The register will be available to the public and the Chair will take reasonable steps to bring the existence of the register to the attention of the local population and to publicise arrangements for viewing it.

22. Council of Governors – travel expenses

22.1 The Trust may pay travelling and other reasonable expenses to members of the Council of Governors at rates determined by the Trust.

23. Council of Governors – remuneration

23.1 Governors are not permitted to receive remuneration.

24. Code of Conduct for Governors

24.1 The Council of Governors will adopt its own Code of Conduct for Governors.

25. Council of Governors – Standing Orders

25.1 The Council of Governors will adopt Standing Orders for the practice and procedure of the Council of Governors. Such Standing Orders will NOT form part of this constitution and any amendments to Standing Orders shall not constitute a variation of the terms of this constitution for the purposes of the paragraph relating to amendment of the constitution.

26. Board of Directors – composition

26.1 The Trust is to have a Board of Directors, which shall comprise both executive and non-executive directors.

26.2 The Board of Directors is to comprise:

(a) a non-executive chair; and,

(b) no fewer than 5 but no more than 7 other non-executive directors; and

(c) no fewer than 5 but no more than 7 executive directors.

26.3 One of the executive directors shall be the Chief Executive.

26.4 The Chief Executive shall be the Accounting Officer.

26.5 One of the executive directors shall be the finance director.

26.6 One of the executive directors is to be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984).

26.7 One of the executive directors is to be a registered nurse or a registered midwife.

26.8 The aggregate number of non-executive directors (including the Trust Chair) is to be more than half of the Board of Directors.

27. Board of Directors – general duty

27.1 The general duty of the Board of Directors and of each director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

28. Board of Directors – qualification for appointment as a non-executive director

28.1 A person may be appointed as a non-executive director only if –

(a) he/she is a member of the Public Constituency, and

(b) he/she is not disqualified by virtue of any other provision set out in the constitution.

29. Board of Directors – appointment and removal of the Trust Chair and other non-executive directors

29.1 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Trust Chair and the other non-executive directors.

29.2 The Trust Chair and other non-executive directors are to be appointed by the Council of Governors following a process of open competition.

29.3 Non-executive directors (including the Trust Chair) shall be appointed for an initial term of up to three years, and may be reappointed at the end of that term for further terms of up to three years, subject to a maximum of six consecutive years save where paragraph 29.4 of this constitution applies.

29.4 Where an existing non-executive director of the Trust is appointed to the Shadow Board he/she may, following completion of six consecutive years of office (calculated from the date of first appointment to the Trust Board of Directors), serve for a further period of up to three years, subject to annual review and reappointment by the Council of Governors.

29.5 A non-executive director (including the Trust Chair) who has completed six consecutive years of office in accordance with paragraph 29.3 or such other consecutive period in accordance with paragraph 29.4 of this constitution, as applicable, shall be eligible to apply again for appointment following a break of at least 3 years.

29.6 An existing non-executive director who is not appointed to the Shadow Board and who has served the maximum of six consecutive years as set out in paragraph 29.3 may be reappointed by the Council of Governors for a further term of office, where such a reappointment is for the purposes of retention of capacity and resilience pending any merger transaction taking effect. Such reappointments are limited to an additional period of one year over and above the normal maximum term of six consecutive years as set out, and will in any case cease on the effective transaction date.

29.7 Removal of the Trust Chair or another non-executive director shall require the approval of three-quarters of the members of the Council of Governors.

29.8 For the purposes of this paragraph 29, "Shadow Board" shall mean the directors appointed to the Board of Directors in anticipation of the Trust's

acquisition of Gloucestershire Care Services NHS Trust under section 56A of the National Health Service Act 2006.

30. Board of Directors – appointment and powers of Deputy Chair

30.1 The Council of Governors at a general meeting of the Council of Governors shall appoint one of the current non-executive directors as Deputy Chair, on recommendation of the Trust Chair.

30.2 Any director so appointed may at any time resign from the office of Deputy Chair by giving notice in writing to the Chair. The Council of Governors may thereupon appoint another non-executive director as Deputy Chair in accordance with the provisions of this Constitution.

30.3 Where the Chair has ceased to hold office, or where they have been unable to perform their duties as Chair owing to illness or any other cause, the Deputy Chair shall act as Chair until a new Chair is appointed or the existing Chair resumes his/her duties, as the case may be; and references to the Chair in this constitution shall, so long as there is no Chair able to perform those duties, be taken to include references to the Deputy Chair.

31. Board of Directors - appointment and removal of the Chief Executive and other executive directors

31.1 The non-executive directors shall appoint or remove the Chief Executive.

31.2 The appointment of the Chief Executive shall require the approval of the Council of Governors.

31.3 A committee consisting of the Trust Chair, the Chief Executive and the other non-executive directors shall appoint or remove the other executive directors.

32. Board of Directors – disqualification

32.1 The following may not become or continue as a member of the Board of Directors:

32.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged.

32.1.2 a person who has made a composition or arrangement with, or granted a Trust deed for, his/her creditors and has not been discharged in respect of it.

32.1.3 a person who within the preceding five years has been convicted in the British Isles of any offence where a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him/her.

32.1.4 in the case of a non-executive director, a person who is no longer a member of the public constituency.

32.1.5 a person whose tenure of office as a chairman or as a member or director of a health service body has been terminated on the grounds that his/her appointment is not in the interests of public service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;

32.1.6 a person who is undergoing a period of disqualification from a statutory health or social care register. This provision shall not apply where a person's registration lapses or their name has been removed at their own request, for example following retirement.

32.1.7 a person who has within the preceding two years been dismissed, otherwise than by reason of redundancy or ill health from any paid employment with a health service body.

32.1.8 a person who has been disqualified from being a member of a relevant authority under the provisions of the Local Government Act 2000

32.1.9 a person subject to a director's disqualification order made under the Company Directors Disqualification Act 1986

32.1.10 a person who is the subject of an Order pursuant to the Sexual Offences Act 2003.

32.1.11 a person who is included in any barred list maintained by the Disclosure and Barring Service (or any successor body) or any equivalent list maintained under the laws of Scotland or Northern Ireland

32.1.12 a person who does not meet, either upon appointment or subsequently, the Fit and Proper Person Requirements for directors

32.1.13 a person who is a governor of this or another NHS foundation trust.

32.1.14 a person who is a director of an NHS trust or another NHS foundation trust. This exclusion shall not apply in the context of any joint appointments in contemplation of a merger or acquisition in accordance with section 56/section 56A of the 2006 Act, or in the context of a joint local health system-wide appointment, or where the Chair and Chief Executive are satisfied that any proposed or existing concurrent appointment would not constitute a conflict of interests which could not be managed or avoided.

33. Board of Directors – meetings

33.1 Meetings of the Board of Directors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons.

33.2 Before holding a meeting in public, the Board of Directors must send a copy of the agenda to the Council of Governors. As soon as practicable after holding a meeting, the Board must send a copy of the minutes to the Council of Governors.

34. Board of Directors – standing orders

34.1 The Board will adopt Standing Orders for the practice and procedure of the Board of Directors. Such Standing Orders will NOT form part of this constitution and any amendments to Standing Orders shall not constitute a variation of the terms of this constitution for the purposes of the paragraph relating to amendment of the constitution.

35. Declarations of directors' interests and register of interests

35.1 The duties that a director of the Trust has by virtue of being a director include in particular –

35.1.1 A duty to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust.

35.1.2 A duty not to accept a benefit from a third party by reason of being a director, (save for low value gifts and hospitality as permitted by the Trust's policy on Managing Conflicts of Interest) for doing (or not doing) anything in that capacity. Where such a benefit is offered to a director, the director must decline that offer and report the matter to the Trust Secretary.

35.1.3 If a director has a pecuniary, personal, family, loyalty or other interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Board, the director must declare such interests to the Trust Secretary and to the Board in accordance with policies agreed from time to time by the Trust in respect of conflicts of interest.

35.2 Examples of interests which should be declared include, but are not limited to:

(a) directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).

(b) ownership, part-ownership or directorship of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.

(c) majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.

(d) an office or position of authority in another organisation in the field of health and social care.

(e) any connection with a voluntary or other organisation contracting for NHS services.

(f) research funding/grants that may be received by an individual or their department.

(g) interests in pooled funds that are under separate management.

(h) any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust, including but not limited to, lenders or banks.

(i) membership of clubs, societies or organisations whose purpose may include furthering the business or personal interests of their members by undeclared or informal means. Such organisations include Masonic lodges and societies whose membership consists of professional and business people.

(j) any other commercial interest in a matter under discussion at a meeting of the Board.

(k) any other employment or business or other relationship of his/hers, or of a member of his/her family or of someone with whom he/she has a close personal relationship, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

35.3 At the time any interest is declared, it should be recorded in the Board minutes as appropriate. Any changes in interests should be declared at the next Board meeting following the change occurring. Directors must inform the Trust Secretary in writing within 7 days of becoming aware of the existence of any relevant or material interest.

35.4 Directors' directorships of companies or ownership/directorship of companies likely or possibly seeking to do business with the NHS should be published in the Board's annual report. The information should be kept up to date for inclusion in subsequent annual reports.

35.5 Where the Trust Chair or chair of a Board committee determines that a director has an interest in any contract, proposed contract or other matter under consideration, the director may be excluded from that meeting or part thereof.

35.6 The Trust Board may exclude the Chair or a director of the Board from a meeting of the Board while any contract, proposed contract or other matter in which he/she has an interest is under consideration.

35.7 In the case of family or close personal relationships the interest of one party shall, if known to the other, be deemed for the purposes of this paragraph 35 to be also an interest of the other.

35.8 If directors have any doubt about the relevance or materiality of an interest, this should be discussed with the Chair or Trust Secretary. Influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

35.9 The duty to avoid a conflict of interest is not infringed if the matter has been authorised in advance by the Trust Board.

35.10 In relation to the duty not to accept a benefit from a third party, 'third party' means a person other than:

(a) the Trust, or

(b) a person acting on its behalf.

35.11 If a declaration under this paragraph proves to be, or becomes, inaccurate or incomplete, a further declaration must be made.

35.12 Any declaration required by this paragraph must be made before the Trust enters into the transaction of arrangement.

35.13 This paragraph does not require a declaration of an interest of which the director is not aware or where the director is not aware of the transaction or arrangement in question.

35.14 A director need not declare an interest –

35.14.1 If, or to the extent that, the directors are already aware of it;

35.14.2 If, or to the extent that, it concerns terms of the director's appointment that have been or are to be considered –

(a) by a meeting of the Board of Directors, or

(b) by a committee of the directors appointed for the purpose under the constitution.

35.15 Any remuneration, compensation or allowance payable by the Trust to the Chair or a director shall not be treated as a pecuniary interest for the purpose of the provisions of this constitution.

Register of directors' interests

35.16 The Trust Secretary will ensure that a register of interests is established to record formally declarations of interests of directors. In particular the register will include details of all directorships and other relevant and material interests

which have been declared, as defined in the relevant Trust policy on conflicts of interests.

35.17 The details of directors' interests recorded in the register will be kept up to date by the Trust Secretary who will ensure any changes to interests declared are incorporated promptly.

35.18 The register will be available to the public and the Chair will take reasonable steps to bring the existence of the register to the attention of the local population and to publicise arrangements for viewing it.

35.19 The register of directors' interests will be reviewed by the Audit Committee at least annually.

36. Interest of officers in contracts

36.1 Any officer or employee of the Trust who comes to know that the Trust has entered into or proposes to enter into a contract in which he/she or any person connected with him/her has any pecuniary interest, direct or indirect, shall declare their interest by giving notice in writing of such fact to the Trust Secretary as soon as practicable.

36.2 An officer should also declare to the Trust Secretary any other employment or business or other relationship of his/her, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

36.3 The Trust will require interests, employment or relationships so declared to be entered in a register of interests of staff.

37. Canvassing of and recommendations by directors in relation to appointments

37.1 Canvassing of directors of the Trust Board or of any committee of the Trust directly or indirectly for any appointment with the Trust shall disqualify the candidate for such appointment. The contents of this paragraph 37 shall be included in application forms or otherwise brought to the attention of candidates.

37.2 Directors of the Trust Board shall not solicit for any person any appointment with the Trust or recommend any person for such appointment; but this paragraph 37 shall not preclude a director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

37.3 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, and which are not part of the formal recruitment process (other than genuine requests for information about the organisation by a prospective employee, or participation in discussion groups) must be declared to the panel or committee.

38. Relatives of directors or officers

38.1 Candidates for any staff appointment under the Trust shall, when making an application, disclose in writing to the Trust whether they are related to any director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him liable to instant dismissal.

38.2 The Chair and every director and officer of the Trust shall disclose to the Trust Board any relationship between himself and a candidate of whose candidature that director or officer is aware. It shall be the duty of the Chief Executive to report to the Trust Board any such disclosure made.

38.3 On appointment, directors (and prior to acceptance of an appointment in the case of executive directors) should disclose to the Trust whether they are related to any other director or holder of any office in the Trust.

39. Board of Directors – remuneration and terms of office

39.1 The Council of Governors at a general meeting of the Council of Governors shall decide the remuneration and allowances, and the other terms and conditions of office, of the Trust Chair and the other non-executive directors.

39.2 The Trust shall establish a committee of non-executive directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other executive directors.

39.3 The remuneration and allowances for non-executive directors, as set by the Council of Governors, are to be published in the annual report.

40. Registers

40.1 The Trust shall have:

(a) a register of members showing, in respect of each member, the constituency to which he/she belongs and, where there are classes within it, the class to which he/she belongs;

(b) a register of members of the Council of Governors;

(c) a register of interests of governors;

(d) a register of directors; and

(e) a register of interests of the directors.

41. Registers – inspection and copies

41.1 The Trust shall make available for inspection by members of the public the registers specified in paragraph 35, except in the circumstances set out below or as otherwise prescribed by regulations.

41.2 The Trust shall not make available for inspection by members of the public any part of its registers which shows details of any member of the Trust (other than a governor or a director), if the member so requests.

41.3 So far as the registers are required to be made available:

(a) they are to be available for inspection free of charge at all reasonable times; and

(b) a person who requests a copy of or extract from the registers is to be provided with a copy or extract.

41.4 If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

42. Documents available for public inspection

42.1 The Trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:

(a) a copy of the current constitution;

(b) a copy of the latest annual accounts and of any report of the auditor on them, and

(c) a copy of the latest annual report;

42.2 The Trust shall also make the following documents relating to a special administration of the Trust available on the Trust website for inspection by members of the public free of charge at all reasonable times:

(a) a copy of any order made under Section 65D (appointment of trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report, 65L (trusts coming out of administration) or 65LA (trusts to be dissolved) of the 2006 Act.

(b) a copy of any report laid under section 65D (appointment of trust special administrator) of the 2006 Act.

(c) a copy of any information published under section 65D (appointment of trust special administrator) of the 2006 Act.

(d) a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act.

(e) a copy of any statement provided under section 65F (administrator's draft report) of the 2006 Act.

(f) a copy of any notice published under section 65F (administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J power to extend time), 65KA (Monitor's decision), 65KB Secretary of State's response to Monitor's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (secretary of State's response to re-submitted final report) of the 2006 Act.

(g) a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act.

(h) a copy of any final report published under section 65I (administrator's final report) of the 2006 Act.

(i) a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act

(j) a copy of any information published under section 65M (replacement of trust special administrator) of the 2006 Act.

42.3 Any person who requests a copy of or extract from any of the above documents is to be provided with a copy.

42.4 If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

43. Auditor

43.1 The Trust shall have an auditor.

43.2 The Council of Governors shall appoint or remove the auditor at a general meeting of the Council of Governors.

44. Audit committee

44.1 The Trust shall establish a committee of non-executive directors as an audit committee to perform such monitoring, reviewing and other functions as are appropriate.

45. Accounts

45.1 The Trust must keep proper accounts and proper records in relation to the accounts.

45.2 NHS Improvement (or any successor body) may with the approval of the Secretary of State give directions to the Trust as to the content and form of its accounts

45.3 The accounts are to be audited by the Trust's auditor.

45.4 The Trust shall prepare in respect of each financial year annual accounts in such form as NHS Improvement may, with the approval of the Secretary of State, direct.

45.5 The functions of the Trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

46. Annual report, forward plans and non-NHS work

46.1 The Trust shall prepare an Annual Report and send it to NHS Improvement.

46.2 The Trust shall give information as to its forward planning in respect of each financial year to NHS Improvement.

46.3 The document containing the information with respect to forward planning (referred to above) shall be prepared by the directors.

46.4 In preparing the document, the directors shall have regard to the views of the Council of Governors.

46.5 Each forward plan must include information about:

(a) the activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes to carry on, and

(b) the income it expects to receive from doing so

46.6 Where a forward plan contains a proposal to conduct activities other than the provision of goods and services for the purposes of the health service in England the Council of Governors must:

(a) determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Trust of its principal purpose or the performance of other functions, and

(b) notify the directors of the Trust of its determination

46.7 A Trust which proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England may implement the proposal only if more than half the members of the Council of Governors of the Trust voting approve its implementation.

47. Presentation of the annual accounts and reports to the governors and members

47.1 The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors:

(a) the annual accounts

(b) any report of the auditor on them

(c) the annual report.

47.2 The Trust may combine a meeting of the Council of Governors convened for this purpose with the Annual General Meeting.

47.3 The documents shall also be presented to members of the Trust at the Annual General Meeting by at least one member of the Board of Directors in attendance.

48. Instruments

48.1 The Trust shall have a seal.

48.2 The seal shall not be affixed except under the authority of the Board of Directors.

49. Amendment of the constitution

49.1 the Trust may make amendments to the constitution only if –

(a) More than half the members of the Council of Governors of the Trust voting approve the amendments, and

(b) More than half of the members of the Board of Directors of the Trust voting approve the amendments.

49.2 Amendments made under paragraph 49.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the constitution would, as a result of the amendment, not accord with Schedule 7 of the 2006 Act.

49.3 Where an amendment is made to the constitution in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust) –

(a) At least one member of the Council of Governors must attend the next Annual General Meeting and present the amendment, and

(b) The Trust must give the members an opportunity to vote on whether they approve the amendment.

49.4 If more than half of the members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the Trust must take such steps as are necessary as a result.

49.5 Amendments by the Trust of its constitution are to be notified to NHS Improvement. For the avoidance of doubt, NHS Improvement's functions do not include a power to determine whether or not the constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

50. Mergers etc. and significant transactions

50.1 The Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the Council of Governors.

50.2 The Trust may enter into a significant transaction only if more than half of the members of the Council of Governors of the Trust voting approve entering into the transaction.

50.3 'Significant transaction' means any transaction with a value equal to or greater than 20% of the Trust's income, assets or capital.

51. Dispute Resolution Procedures

51.1 In the event of dispute between the Council of Governors and the Board of Directors:

(a) In the first instance the Trust Chair on advice of the Trust Secretary, and such other advice as the Trust Chair may see fit to obtain, shall seek to resolve the dispute.

(b) If the Trust Chair is unable to resolve the dispute he/she shall appoint a special committee comprising equal numbers of directors and governors to consider the circumstances and to make recommendations to the Council of Governors and the Board of Directors with a view to resolving the dispute.

(c) If the recommendations (if any) of the special committee are unsuccessful in resolving the dispute, the Trust Chair may refer the dispute to an external mediator appointed by the Centre for Dispute Resolution or such other organisation as he/she considers appropriate

52. Indemnity

52.1 Members of the Council of Governors and Board of Directors who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their Council or Board functions, save where they have acted recklessly. Any costs arising in this way will be met by the Trust.

53. Dissolution of the Trust

53.1 The Trust may not be dissolved except order of NHS Improvement, in accordance with section 57A of the 2006 Act, following authorisation of a relevant application by the Council of Governors in accordance with the relevant paragraph of this constitution, or by order of NHS Improvement under section 65LA of the 2006 Act.

54. Relationship with the County Council

54.1 Where the Trust has entered into a partnership agreement pursuant to the Health Act 1999 with a County Council:

(a) it will be contractually accountable to the County Council for the performance of County Council functions under such agreement

(b) it may establish a joint committee pursuant to regulation 10 of the partnership regulations, or such other board or officer group with delegated authority from the Board of Directors to oversee the arrangements as the Board of Directors see fit.

54.2 Subject to any delegation of functions to any group established under the paragraphs above, the function of supervising the management of the County Council functions shall vest in the Board of Directors or a single director nominated by the Board.

54.3 In the event that any such partnership agreement establishes a pooled fund within the meaning of the partnership regulations, then subject to the terms of the agreement and the provisions of the Partnership regulations regarding the role of the Pooled Fund Manager. The responsibility for any pooled fund hosted by the Trust shall be vested in the Board of Directors.

55. Interpretation and definitions

55.1 Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in this constitution shall bear the same meaning as in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012.

55.2 Words importing the masculine gender only shall include the feminine gender; words importing the singular shall import the plural and vice-versa.

55.3 References in this constitution to legislation include all amendments, replacements or re-enactments made.

55.4 In this constitution:

the 2006 Act is the National Health Service Act 2006

the 2012 Act is the Health and Social Care Act 2012

NHS Improvement is the organisation (or any successor body) responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care.

voluntary organisation is a body, other than a public or local authority, the activities of which are not carried on for profit.

the **Accounting Officer** is the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act. The Chief Executive is the Accounting Officer.

Director means executive or non-executive director of the Board as the context permits. For the avoidance of doubt, the Chair is a non-executive director.

Executive director means a director who is an officer of the Trust.

ANNEX 1 – THE PUBLIC CONSTITUENCY

Name of constituency	**Area**	**Minimum no. of members**	**Number of governors**
Cheltenham	The electoral area of Cheltenham Borough Council	100	2
Cotswold	The electoral area of Cotswold District Council	100	2
Forest	The electoral area of Forest of Dean District Council	100	2
Gloucester	The electoral area of Gloucester City Council	100	2
Stroud	The electoral area of Stroud District Council	100	2
Tewkesbury	The electoral area of Tewkesbury Borough Council	100	2
~~Herefordshire~~	~~The electoral area of Herefordshire Council~~	~~100~~	~~2~~
Greater England and Wales	All other electoral wards in England and Wales save those electoral wards that fall within the Cheltenham, Cotswold, Forest, Gloucestershire, Stroud, Tewkesbury and Herefordshire constituencies.	100	1

ANNEX 2 – THE STAFF CONSTITUENCY

Name of Staff Class	**Description**	**Minimum no. of members**	**Number of governors**
the medical dental and nursing staff class	Staff who are registered with the General Medical Council; or Staff who are registered with the General Dental Council; or Staff who are registered with the Nursing and Midwifery Council	100	4
the health and social care professions staff class	Staff who are either: allied health professionals and psychologists who are registered with the Health and Care Professions Council or any successor body; or social workers registered with the Health and Care Professions Council or Social Work England, or any successor body; or individuals who are employed wholly or mainly in direct clinical and care roles but not eligible for membership of those classes described above	100	3
the management, administrative and other staff class.	individuals who are management or administrative staff or others entitled to be members of the staff constituency who do not come within those classes described above	100	3

ANNEX 3 – COMPOSITION OF COUNCIL OF GOVERNORS

1.1 The Trust will have a Council of Governors consisting of public, staff, local authority and Clinical Commissioning Group governors.

1.2 The Council of Governors is to comprise:

Elected Governors:

Category of Governor	Number of Governors
Public governors:	
• Cheltenham	2
• Cotswold	2
• Forest	2
• Gloucester	2
• Stroud	2
• Tewkesbury	2
~~• Herefordshire~~	~~2~~
• Greater England and Wales	1
Staff governors:	
• Medical Dental and Nursing staff class	4
• Health and Social Care Professions staff class	3
• Management, administrative and other staff class	3
Appointed governors:	
• Gloucestershire County Council	1
~~• Herefordshire Council~~	~~1~~
• Gloucestershire Clinical Commissioning Group	1
• ~~Herefordshire Clinical Commissioning Group~~	~~1~~
Total	~~29~~25

1.3 Subject to paragraph 1.4 below, of the four (4) Staff Governors in the Medical Dental and Nursing class:

1.3.1 two (2) seats shall be reserved for a nurse;

1.3.2 one (1) seat shall be reserved for a doctor; and

1.3.3 one (1) seat shall be reserved for either a doctor or a dental professional.

1.4 ~~Subject to paragraph 1.5 below, the~~The electoral constraints set out herein will apply to all Staff Governor seats in the Medical Dental and Nursing staff class, regardless of the number of Staff Governors being elected from that staff class at any particular time.

1.5 ~~In respect solely of the first election (whether such first election is a general or by-election) for each of the Staff Governor classes following the Trust's acquisition of Gloucestershire Care Services NHS Trust under section 56A of the National Health Service Act 2006, where a vacancy or vacancies exist, one such vacancy in each staff class shall be reserved for qualifying staff employed by Gloucestershire Care Services NHS Trust immediately prior to the acquisition.~~

with you, for you

Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 24/0320

REPORT TO: Trust Board - 25 March 2020

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

AUTHOR: Lavinia Rowsell, Head of Governance & Trust Secretary

SUBJECT: **TERMS OF REFERENCE FOR: CHARITABLE FUNDS COMMITTEE AND MENTAL HEALTH LEGISLATION SCRUTINY (MHLS) COMMITTEE**

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

The purpose of this report is to

To present revised terms of reference to the Board for approval.

Recommendations and decisions required

The Board is asked to:

- **Approve** the Charitable Funds Committee Terms of Reference
- **Approve** the MHLS Committee Terms of Reference

Executive summary

Charitable Funds Committee:
The Charitable Funds Committee met for the first time since the merger on 27th February 2020. The Committee discussed and reviewed the Committee's Terms of Reference and amendments were made regarding the purpose and role of the Committee.

Mental Health Legislation Scrutiny Committee (MHLS):
The MHLS Committee met on 5th March and reviewed the Committee terms of Reference. The Committee agreed on amendments to be made which included the Committee membership which was updated to reflect the transfer of Herefordshire services.

Risks associated with meeting the Trust's values
Up to date Terms of Reference for the Committees ensures clarity on decision making and delegated authority.

Corporate considerations	
Quality Implications	Reflects governance requirements
Resource Implications	-
Equality Implications	-

Where has this issue been discussed before?
Charitable Funds Committee – 27th February 2020 MHLS Committee – 5th March 2020

Appendices:	N/A

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

GLOUCESTERSHIRE HEALTH & CARE NHS FOUNDATION TRUST
CHARITABLE FUNDS COMMITTEE

TERMS OF REFERENCE

1.0 CONSTITUTION

1.1 The Board hereby resolves to establish a committee of the Board to be known as the Charitable Funds Committee. The Committee has no executive powers other than those delegated by these Terms of Reference.

1.2 The Chair and Deputy Chair of the Committee will be Non-executive Directors appointed by the Board.

2.0 MEMBERSHIP

2.1 **Core Membership:**

- 3 Non-Executive Directors, one of whom will be appointed Chair
- Director of Human Resources and Organisational Development
- Director of Finance
- Director of Nursing, Therapies and Quality
- Director of Strategy and Partnerships

2.2 Given the Board's position as Corporate Trustee all Trust Board members may attend any Charitable Funds Committee Meeting.

2.3 **IN ATTENDANCE:**

- Trust Secretariat
- Head of Estates – if required
- Head of Financial Accounts
- Head of Communications and Marketing – if required

2.4 Other Officers or Directors of the Trusts may attend at the discretion of the Chair.

3.0 QUORUM

3.1 Three members of the Board of Trustees Board, at least one of whom should be a Non-Executive Director.

3.2 In the event that a member of the Committee is unable to attend a meeting, that member may nominate a deputy who will count towards the quorum at that meeting.

4.0 FREQUENCY OF MEETINGS

4.1 The Committee will normally convene as often as is necessary, but normally 2 meetings will be scheduled each year.

5.0 AUTHORITY

5.1 The Committee is authorised by the Board to consider any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the committee. The committee is authorised by the Board to obtain outside legal or other independent advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

5.2 The Committee has full delegated authority to manage the Trust's Charitable Funds on behalf of the Board of Trustees and acts as the governing body of the charity. It is authorised to approve strategies, local policies, procedures and annual reports and plans that relate to its areas of responsibility.

5.3 The committee may establish sub committees or working groups as required.

6.0 PURPOSE

6.1 The purpose of the Charitable Funds Committee is to direct the management of charitable funds income and any associated funding raising activities ensuring that the activities and expenditure aligns to the Trust's vision, values and strategic aims and in line with the *Investment and Resources* Strategy to provide the Board of Trustees with assurance regarding compliance with statutory obligations.

6.2 **The following activities are within the remit of the Committee**:

- Ensure compliance with all legal and regulatory requirements, including NHS guidance and Charity Commission guidance
- Approve policies and procedures for the control of charity income, investments and expenditure and establish/maintain monitoring and review systems to ensure that procedures are correctly applied,
- Approval of the annual financial statements and Charitable Fund annual report,
- Approve the registration and objects of the all Trust charities; ensuring such registrations meet the needs of the Trust's charitable purposes.
- Consider applications from the fund managers for the creation of new funds and approve the governing documents under which these will be administered.
- Nominate NHS officers to have delegated authority for the commitment of expenditure, management of VAT implications and liaison with the investment broker for deposits and withdrawals.

- Ensure legacy income is monitored and approve the actions of the legacy officer to ensure receipt of all legacy entitlements.
- Oversee the development of an investment policy for Board of Trustees approval as required.
- If directed by the Board of Trustees, oversee the appointment of an investment manager and the implementation of appropriate procedures to monitor the investment arrangements and ensure compliance with the current relevant legislation.
- Act as the control mechanism for any approved fund-raising appeals which may be initiated, and ensure that the appointment and control of fund-raisers is in line with current regulations and guidance
- Ensure appropriate liaison with the Charity Commission and/or legal advisors to confirm/support any recommendation or action that the Trustees may wish to make.
- Oversee the development of plans to increase awareness amongst staff and the wider community of the availability and potential uses of charitable funds.
- Receive and consider bids for the application of monies in accordance with the Standing Financial Instructions.
- Commission and review audit reports on charitable funds and initiate appropriate action.
- Oversee the development of a fund raising strategy for approval by the Board of Trustees as required.

7.0 REPORTING AND RECORDING

7.1 The Trust Secretary will minute the proceedings and resolutions of the meetings including recording the names of those present and in attendance.

7.2 The Chair of the Committee will submit a short report of each meeting to the next Board meeting for information or decision, as appropriate.

7.3 The Trust Secretary shall ascertain at the beginning of each meeting the existence of any conflicts of interests and record them accordingly.

7.4 Minutes of Committee meetings shall be agreed by the Chair prior to being circulated promptly to all members of the Committee unless a conflict of interest exists.

8.0 OTHER MATTERS

8.1 The Trust Secretary will provide administrative support to the Committee, including:

- Agreement of agenda
- The collation of papers
- Ensuring the minutes are taken and a record of matters arising kept and issues carried forward
- Ensuring that Committee reports are made available to the Board

9.0 MONITORING ARRANGEMENTS

9.1 The Board will review the Committee's Terms of Reference at least once every two years.

9.2 Annually the Committee will review its own performance and recommend any changes it believes are necessary to the Trust Board for approval.

Version control

Version 1	27.02.20	Draft for consideration by Committee
Version 2	25.03.20	Submission to Trust Board for approval
Version 2		Approved at Trust Board

AGENDA ITEM 24/0320

GLOUCESTERSHIRE HEALTH & CARE NHS FOUNDATION TRUST
MENTAL HEALTH LEGISLATION SCRUTINY COMMITTEE

TERMS OF REFERENCE

1.0 CONSTITUTION

1.1 The Board hereby resolves to establish a committee of the Board to be known as the Mental Health Legislation Scrutiny Committee. The Committee has no executive powers other than those delegated by these terms of reference.

1.2 The Chair and Deputy Chair of the Committee will be Non-executive Directors appointed by the Board.

2.0 MEMBERSHIP

2.1 **Core Membership:**

- Two Non-Executive Directors
- Chief Operating Officer
- Deputy Medical Director

2.2 Ex-officio Member

- Trust Chair
- Chief Executive

2.3 **IN ATTENDANCE:**

- One section 12 approved doctor
- Deputy Director of Nursing
- One senior operational in-patient nurses
- Head of Health Records & MHA Administration
- MHA Administrator/Health Records Manager
- Head of Corporate Governance
- MCA/DOLS Organisational Lead
- Community Services Manager(s)
- Chair of the IAMG
- AMHP Representative
- Gloucestershire CCG Representative
- Board Committee Officer

Observers:

- 2 representatives of the Council of Governors

3.0 QUORUM

3.1 Two members, including at least one Non-Executive Director and one Executive Director.

3.2 In the event that a member of the Committee is unable to attend a meeting, that member may nominate a deputy who will count towards the quorum at that meeting.

4.0 FREQUENCY OF MEETINGS

4.1 The Committee will meet not fewer than four times annually.

5.0 AUTHORITY

5.1 The Committee is authorised by the Board to review and consider any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the committee. The committee is authorised by the Board to obtain outside legal or other independent advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

5.2 On behalf of the Board, the Committee is authorised to approve local policies, procedures and annual reports and plans that relate to its areas of responsibility.

6.0 PURPOSE

6.1 The purpose of the Mental Health Legislation Scrutiny Committee is to hold the Executive to account and provide assurance to the Trust Board that the Trust establishes, monitors and maintains appropriate integrated systems, processes and reporting arrangements to ensure continued compliance with the Mental Health Act, Mental Capacity Act and Human Rights Acts and associated codes of practice.

7.0 DUTIES OF THE COMMITTEE

7.1 The duties of the Committee are as follows:

a. To seek assurance that the Trust complies with the Mental Health and Human Rights Acts and any associated codes of practice in relation to patients detained under the MHA or subject to supervised community treatment.

b. To seek assurance that the Trust complies with the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS) requirements and monitor their interface with the Mental Health Act and Human Rights Act.

c. To seek assurance there is a robust performance and compliance framework and effective arrangements for the ongoing review and monitoring of statistical information on MHA activity.

d. To receive integrated performance and benchmarking information on Mental Health Act activity

e. To seek assurance that all Trust staff acting on the Hospital Managers' behalf under the Scheme of Delegation are competent to undertake their delegated tasks and to monitor their performance.

f. To seek assurance that appropriate arrangements are in place and are operating satisfactorily for the completion and review of relevant legal documentation relating to the compulsory admission and detention of patients and automatic referrals to the Mental Health Review Tribunal.

g. To seek assurance that procedures are in place and operating satisfactorily to inform detained patients and their nearest relatives about the applicable provisions of the Mental Health Act and of their rights.

h. To review and ratify policies and procedures relating to the Mental Health Act and Mental Capacity Act. Policies relevant to this Committee are:
    - MHA Information Policy
    - Receipt and Scrutiny of Documents Policy
    - Allocation of RCs Policy
    - CTO– Concerns of Relatives Policy
    - Scheme of Delegation
    - Renewal of Detention
    - MHA Managers' Policy.

i. To consider through exception reports and other appropriate updates, any matters referred from the Mental Health Act Managers' Forum to ensure that appropriate action is taken.

j. To review issues raised through Care Quality Commission visits and Annual Reports and to receive reports on any recommendations and action plans resulting from them.

k. To review incidents designated as 'Serious Incidents' in respect of the Trust's actions under the Mental Health Act or Mental Capacity Act, and ensure that learning is identified and disseminated appropriately throughout the Trust and to partner organisations, where appropriate

l. To review issues arising from Managers' Hearings, ensuring that any lessons learned are identified and disseminated throughout the Trust and to partner organisations where appropriate

m. To seek assurance that appropriate training programmes are in place for
    - Trust staff, and
    - MHA Managers.

n. To receive reports from the Interagency Monitoring Group (Gloucestershire) regarding any issues associated with either the Mental Health Act or the Mental Capacity Act.

o. Receive reports from the Mental Capacity Act Governance Group (Gloucestershire) regarding any issues associated with the Mental Capacity Act which the Mental Health Operational Group considers necessary to bring to the Committee's attention.

p. Receive reports from the Mental Health Operational Group on matters within that group's terms of reference and which the Group considers necessary to bring to the Committee's attention.

q. Through monitoring of allocated corporate and strategic risks from the trust's risk register, seek assurance that potential threats at strategic and operational levels are systematically identified, assessed and, as far as is reasonably practicable, mitigated.

r. To raise issues for action and review by the Executive Committee, other Board Committee, group or partner organisation as appropriate.

s. To produce an annual assurance report on relevant matters for Directors of Adult Social Care.

t. To produce an annual report on the Committee's activity for the Trust Board.

8.0 REPORTING AND RECORDING

8.1 The minutes of the Mental Health Legislation Scrutiny Committee meetings shall be formally recorded. The Chair of the Committee will draw to the attention of the Board any issues that require disclosure to the full Board or require executive action.

9.0 OTHER MATTERS

9.1 The Committee shall be supported administratively by the Trust Secretariat, whose duties in this respect will include:

- agreement of agenda with Chair and attendees and collation of papers;
- Issuing papers at least 5 working days in advance of each Committee meeting, with late papers being issued at the Chair's discretion
- ensuring the minutes are taken and a record of matters arising kept and issues carried forward;
- advising the Committee on pertinent areas.

10 The Trust Secretariat will produce an annual plan for the Committee which will outline the business to be discussed at each meeting.

11 Members of the Committee will aim to achieve at least 75% attendance.

Version control

Version 1	05.03.20	Draft for consideration by Committee
Version 2	25.03.20	Submission to Trust Board for approval
Version 2		Approved at Trust Board

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 25/0320

QUALITY COMMITTEE SUMMARY REPORT

HELD 6TH FEBRUARY 2020

COMMITTEE GOVERNANCE	• **Committee Chair – Maria Bond / Non-Executive Director** • **Attendance (membership) – 83.3%** • **Quorate – Yes**

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

RISK UPDATE

The Committee reviewed those risks assigned to it from the corporate risk register. An update on progress was provided by the Risk Manager.

CLINICAL PRESENTATION – SPEECH AND LANGUAGE THERAPY IN THE YOUTH JUSTICE SYSTEM

The Committee received a presentation on Speech and Language provision within the Youth Support Team. The presentation focused on how poor communication impacted on a young person's behaviour, mental health, employability and criminality, amongst other factors.

MONTHLY SIRI PRESENTATION

The monthly SIRI presentation was received by the Committee. Variations between localities were noted and further work commissioned to ensure that the reasons behind this were understood.

PRESSURE ULCERS

The Committee was provided with an illustration of how the Trust measured quality improvement in pressure ulcer data and progress in the trajectory for the reduction of acquired avoidable pressure ulcers. It was noted that a contributing factor to worsening pressure ulcers was a delay with equipment provision and that this would be considered further.

LEARNING FROM DEATHS – 6 MONTHLY UPDATE

The Learning from Deaths report was received by the Committee and it was noted that this was the first report which included both physical and mental patients. The Committee was informed that a resource gap for reviewing physical health deaths had been identified but resources had been reallocated to ensure a retrospective review of all cases.

QUALITY REPORT

The Committee received the December 2019 Quality Summary Report that had been previously submitted to the Board and noted progress on the achievement of the quality priorities and indicators for physical and mental health.

CORONAVIRUS UPDATE

The Committee received a verbal update on Coronavirus and was informed that national guidance was being updated regularly and proactive communications were sent out to all staff internally. The Committee was notified that Coronavirus had been identified as a level 2 incident within the Trust and was being managed accordingly. The Committee was informed

that the Acute Trust was in the process of setting up assessment pods for potential Coronavirus patients and that local swab teams would be set up across the region.

CQC OUTSTANDING PROGRAMME

The Committee received a presentation on CQC Outstanding Programme, which highlighted the Trust's plan to achieve an outstanding CQC rating. The Trust was currently in phase one of the programme with focus being on Gloucestershire and Herefordshire's self-assessments being completed. Learning would be taken from Worcestershire's recent CQC visit and implemented within the programme.

ACTIONS REQUIRED BY THE BOARD

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

DATE OF NEXT MEETING	**05 March 2020**

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 25/0320

QUALITY COMMITTEE SUMMARY REPORT

HELD 5TH MARCH 2020

COMMITTEE GOVERNANCE	• Committee Chair – Maria Bond / Non – Executive Director • Attendance (membership) – 83.3% • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

RISK UPDATE

The Committee received an update on the key risks relating to the work of the Quality Committee. The Committee was informed that since the previous meeting of that the top five risks had been approved by the Executive and an additional risk relating to Covid-19 had been added.

DEEP DIVE – WOUND ASSESSMENT

The Committee received a report on a deep dive on wound assessment noting that the management of wound care was a significant proportion of the caseload for GHC Community Nursing. The Committee was informed that in addition there was a CQUIN focussed exclusively on wound assessment in 2017-2019.

The Committee noted work underway including the production of visual guidance to aid clinical decision making and a full review of GHC tissue viability education provision. A further audit would be undertaken in Autumn 2020 to review progress.

CLINICAL PRESENTATION – HOMELESS HEALTHCARE

The Committee received a presentation on homeless mental health in Gloucestershire.

QUARTERLY PATIENT SAFETY REPORT

The Quarterly patient safety report was received by the Committee including a summary of all mental health and physical health safety incidents reported in Q3. A detailed analysis of the high frequency incidents was considered noting that medication and drug errors were in the top three at 6.6% of all incidents. A future deep dive on medication incidents was requested for future meeting.

It was noted that there had been an increase in the number of incidents reported for Q3 from the previous quarter. The Committee requested further analysis be undertaken in order to understand the reasons behind this increase including consideration of the 18/19 full year data against projected 19/20 figures.

SAFE STAFFING LEVELS REPORT

The Committee received the Safe Staffing Levels report. It was reported that the formula for reporting staffing for mental health was being revisited. For community services, whilst there was not a standard safe staffing proforma for community staffing this was being considered as part of the Quality Team's work plan.

An update was provided on specific issues affecting community based staff in, particular

district nursing. This included IT difficulties which were impacting on productivity which were being considered as part of a wider review of connectivity.

QUALITY IMPROVEMENT DEVELOPMENT

The Committee was updated on the progress to date regarding specific QI developments within the organisation. This included work on embedding QI training across the organisation and work with University partners. The QI strategy was under development and would be finalised in Q1 of 2019/2020. It would then be shared with the Committee.

ACTIONS REQUIRED BY THE BOARD

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

DATE OF NEXT MEETING	**09 April 2020**

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 26/0320

AUDIT AND ASSURANCE COMMITTEE SUMMARY REPORT

HELD 13TH FEBRUARY 2020

GOVERNANCE	• Committee Chair – Marcia Gallagher / Non-Executive Director • Attendance (membership) – 66.6% • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

INTERNAL AUDIT PWC

The Committee was informed that PwC had completed the first stage of their corporate governance review, which had involved conversations with the majority of Board members and an observation of the Quality Committee. It was reported that there were strong themes coming through the discussions to date and that a detailed report would be available the end of March 2020.

INTERNAL AUDIT PWC – REVIEW OF RISK MANAGEMENT

The Committee received the Risk Management report from PwC which highlighted that the report was rated medium risk, with three medium and two low risk findings. The Committee was informed that the audit demonstrated that the Trust had the appropriate processes and procedures in place for managing risk but that more work could be done to embed a culture of risk management within the Trust.

EXTERNAL AUDIT

The Committee received the KPMG external audit plan for 19/20 which highlighted the significant risks and areas of audit focus which included the valuation of land and building assets.

KPMG confirmed that group and Trust materiality had increased as a result of the increase in revenue. Anything above the reporting threshold of £240k would be brought to the attention of the Committee. No issues were anticipated in relation to going concern or value for money.

COUNTER FRAUD, BRIBERY & CORRUPTION – PROGRESS REPORT

The Committee received the Progress report from Counter Fraud, Bribery & Corruption. It was reported that the NHS Counter Fraud Authority Standards had been issued and a work-plan for 20/21 was under development and would be presented to the next Committee meeting for approval. The Committee were informed that for 20/21 the standards would be replaced by Government Counter Fraud Profession Standards which were issued by the Cabinet Office.

The Committee noted ongoing investigations and closed cases since April 2019. It was noted that a number of allegations related to false representation in relation to mileage claims and working elsewhere whilst sick.

REVIEW OF RISK REGISTER

The risk register was received by the Committee and it was confirmed that a risk relating to Coronavirus (COVID-19) and the potential impact on operations had been added to the Trust

risk register. It was reported that teams were actively involved in the management of the risk position. The Committee was assured that the position was being closely monitored by the Executive team and plans were in place to deal with the type of situation as part of business continuity planning. The Committee was informed that Michael Richardson, Deputy Director of Nursing was the lead on Coronavirus.

GCS HALF YEAR ANNUAL REPORT & ACCOUNTS

The Committee received the Annual Report and Accounts for Gloucestershire Care Services up to 30 September 2019. The Committee approved the accounts subject to the finalisation of the audit and the agreement that the Chair would be notified of any material changes to the accounts presented.

Post meeting note: the signing of the accounts will take place in late March with an AGM held at a later date.

COMPLIANCE REPORT

The Committee received the Compliance report and discussed the aged debtors noting that the Trust had a provision for bad and doubtful debts of £1,289,842 at the end of December 2019.

FINANCIAL SHARED SERVICES

The Committee received a verbal update from the Director of Finance on Financial Shared Services. The internal audit report on payroll in 19/20 had no high risk recommendations but an issue had been raised issue relating to the speed at which managers were submitting new starter and leaver forms to payroll; which was resulting in overpayments. As none of the samples chosen for the audit had been from GHC, it was not possible to draw any conclusions relating to the activities of the Trust. The Shared Services Auditors would now deliberately sample from GHC forms on the next audit.

ACTIONS REQUIRED BY THE BOARD/COMMITTEE

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

DATE OF NEXT MEETING	**07 May 2020**

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 27/0320

RESOURCES COMMITTEE SUMMARY REPORT

HELD 27TH FEBRUARY 2020

GOVERNANCE	• Committee Chair – Graham Russell / Non-Executive Director • Attendance (membership) – 66.6% • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

FINANCE REPORT – MONTH 10

The Committee received the month 10 finance report and noted that the month 10 position was a surplus of £1.782m, a slight improvement on the planned surplus. It was reported that the full year forecast surplus was £137k better than the control total with PSF accounting for £2.042m of the control total surplus. The Committee noted that the Cost Improvement Plan (CIP) target for the Trust was £5.402m with £1.655m removed so far. The forecast CIP was £3.495m. The Committee noted the cash position at £5.4m above plan.

The Committee considered the capital spend for the Trust which was £2.311m. The plan for the merged Trust was £6.586m, an increase of £311k on last month due to actions taken to complete the procurement of a number of equipment and IT items.

The Committee reviewed the risks of the delivery of the 2019/2020 position and the potential impact of the Coronavirus; which may have an impact if no additional funding was available.

PERFORMANCE REPORT – MONTH 10

The Committee received the performance report for month 10 and considered the exceptions. Progress on the development of a KPI dashboard was noted which would allow differing levels of information to be provided depending on the audience and their governance/assurance requirements.

BUDGET SETTING – 20/21 AND BUSINESS PLANNING

The Committee received a presentations on the budget setting process for 2020/2021 and the business planning process both of which were to be presented to the Board in March.

In relation to the budget, the Committee was informed that there was no control total for the year but an initial 'trajectory' of £590k, which the Trust proposed to out-perform by £600K. This had later been reviewed by NHSI to reflect changes in CNST. There would be no Provider Sustainability Fund.

STAFF SURVEY/ FFT RESULTS

The Committee gave initial consideration to the Staff Survey results for the two legacy Trusts and the national benchmark data. It was noted that the survey had come out during the merger which would have had a significant impact on the results; however the overarching results were generally positive with some exceptions for former 2g staff.

OTHER MATTERS

The Committee received a presentation on the Mental Health Investment Standard and considered those corporate risks assigned to it. Summary reports from those groups

reporting to the Committee were noted.

ACTIONS REQUIRED BY THE BOARD The Board is asked to **note** the contents of this summary.

DATE OF NEXT MEETING	**23 April 2020**

AGENDA ITEM: 28/0320

CHARITABLE FUNDS SUMMARY REPORT

HELD 27 FEBRUARY 2020

GOVERNANCE	• Committee Chair – Sumita Hutchison / Non-Executive Director • Attendance (membership) – 60% • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

TERMS OF REFERENCE

The Committee reviewed its Terms of Reference which would allow it to operate with oversight of the two legacy charitable funds from Gloucestershire Care Services and 2Gether in the short term. The Committee noted that the intention was to merge the two funds. It was agreed that the amended Terms of Reference would be submitted to Trust Board for approval by the Board in March. An additional paragraph would be added detailing the Committee's purpose.

2GETHER - FINANCE REPORT FOR THE PERIOD 1 APRIL – 31 DEC 2019 AND STATEMENT OF ACTIVITIES

The Committee received the 2gether Finance Report for the period 1st April – 31st December 2019 and was informed that the balance as of month 9 was £133k with approximately £20k of approvals, for which invoices had not yet been received. It was noted that 10 approvals for over £1000k had been approved in the period and that 14 donations of over £100 had been received.

The Committee discussed the Herefordshire donations received and whether these would be transferred to Worcestershire Health and Care Trust (WHCT) following the transfer of Herefordshire services at the end of March 2020.

Post meeting, following a discussion with the Executive, it was agreed that funds 55041 and 55043 which are those funds directly relating to Herefordshire would be transferred to WHCT.

GHC - FINANCE REPORT FOR THE PERIOD 1 APRIL – 31 DECEMBER 2019

The Committee received the GCS Finance Report for the period 1st April – 31st December 2019 and were informed that the balance at 31st December 2019 had increased by £3k since 31st March 2019. The Committee noted that the overall Awards for All Fund was £7k as at 31 December 2019; however £10k related to a legacy which was ring-fenced for Stroud General Hospital leaving a negative of £3k.

BROCKENBOROUGH UPDATE (LAND AT MALMESBURY)

The Committee received a verbal update on the land in Malmesbury that had been donated with the specific purpose of benefiting the health and wellbeing of the people of Malmesbury and Cirencester. A public consultation on potential development options for the site would be held on 1st April 2020. Once the land had been disposed of, the GHC proportion of the funds received would sit within the charitable fund and then reinvested as part of the Trust's Estates Strategy.

NEW HIGHWAY CHARITABLE FUND FINANCE REPORT

The Committee received the New Highway Charitable Fund Finance Report and it was noted that there had been no movement in the fund in the period between 1 April and 31 December 2020. The balance of the fund at 31 December was approximately £34k.
The Trustees would need to consider the use of the remaining funds.

FUTURE OF THE COMMITTEE

The Committee intends for the funds to be used for the maximum benefit of staff, patients and communities, in line with GHC strategy. Specific discussion on this will take place at the next Committee. In the meantime the necessary legal and administrative processes will take place to consolidate the funds.

ACTIONS REQUIRED BY THE BOARD

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

DATE OF NEXT MEETING	**05 November 2020**

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 29/0320

MENTAL HEALTH LEGISLATION SCRUTINY COMMITTEE SUMMARY REPORT HELD 5TH MARCH 2020

GOVERNANCE	• Committee Chair – Jan Marriott / Non-Executive Director • Attendance (membership) – 50% • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

REVIEW OF CQC MONITORING VISITS

The Committee received full assurance of the processes and structures that were in place regarding CQC Monitoring visits and was informed that far fewer recommendations had been received. The recent visit to Montpelier Ward resulted in only one small action and highlighted much positive practice from which other areas can learn. The report from the visit to Berkeley House is pending.

SCHEME OF DELEGATION

The Committee received the Scheme of Delegation and it was noted that the purpose was to set out who was authorised to act and make decisions on behalf of the Hospital Managers. The Committee endorsed the policy subject to recommended minor amendments being made.

REPORTS POLICY

The Committee received the Tribunal and Mental Health Act Managers' Report Policy which +brings together the legislation, guidance, Tribunal rules and practice directions in relation to reports for First-Tier Tribunals and MHA Managers' Hearings. The Committee was informed that there had been issues with quality and timeliness of reports.

The policy provided guidance on the required individual responsibilities, report formats and deadlines to assist with the development of consistent good practice. It includes a flowchart which the Committee felt would be helpful to colleagues. The Committee was assured that the correct systems were in place and the policy was approved.

UPDATE ON Approved Mental Health Professional (AMHP) COVER

The Committee was provided with an update on the roles and responsibilities, activity and performance of the AMHP service, which the Trust provides on behalf of Gloucestershire County Council. Since August 2019 this has been a 24/7 service. The Committee was assured by the preliminary data provided for this period and as the data collection improved felt it would be useful in supporting changes recommended in the Wesley Report

ACTIONS REQUIRED BY THE BOARD/COMMITTEE

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

DATE OF NEXT MEETING	**TBC May 2020**

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 31/0320

Gloucestershire Health and Care NHS Foundation Trust

COUNCIL OF GOVERNORS MEETING
Tuesday, 21st January 2020

ABBEYDALE COMMUNITY CENTRE, GLEVUM WAY, GLOUCESTER

PRESENT:	Ingrid Barker (Chair)	Karen Bennett	Mervyn Dawe	Faisal Khan
	Vic Godding	Miles Goodwin	Said Hansdot	June Hennell
	Jenny Hincks	Nic Matthews	Anneka Newman	Jo Smith
	Anne Roberts	Simon Smith (Interim Lead Governor)		

IN ATTENDANCE:

Sandra Betney, Director of Finance
Maria Bond, Non-Executive Director (part)
Hazell Braund, Programme Director: Better Care Together
Simon Crews, Interim Trust Secretary
Marcia Gallagher, Non-Executive Director
Sumita Hutchison, Non-Executive Director
Marianne Julebin, Trust Secretariat
Jeremy Marchant, Governor of Gloucestershire Hospitals Trust (observing)
Kate Nelmes, Head of Communication
Angela Potter, Director of Strategy
Paul Roberts, Chief Executive
Lavinia Rowsell, Head of Corporate Governance
Graham Russell, Non-Executive Director (Vice Chair)
Neil Savage, Director of HR and Organisational Development
Gillian Steels, Trust Secretariat
John Trevains, Director of Nursing, Therapies and Quality (part)

1. WELCOMES AND APOLOGIES

1.1 Apologies were received from Bren McInerney, Katie Clark, Cherry Newton, Amjad Uppal, John Campbell, Lawrence Fielder, Colin Merker.

1.2 The Chair opened the meeting by welcoming all and introducing two newly-elected Staff Governors from the management/admin constituency: Anne Roberts and Karen Bennett. The Chair introduced Jeremy Marchant, a Governor of the Gloucestershire Hospitals Trust who was there to observe. Paul Roberts advised he would cover the Herefordshire item for Colin Merker.

2. DECLARATION OF INTERESTS

2.1 Mervyn Dawe (MD) reported that he would be representing a family member in an inquest involving the Trust.

3. COUNCIL OF GOVERNOR MINUTES

3.1 The Chair advised that written comments and an update had been received from Bren McInerney (BM). These included a typographical amendment to the minutes regarding

Bren's initials.

3.2 Subject to the correction of BM's initials, the minutes of the Council meeting held on 14th November 2019 were agreed as a correct record.

4. MATTERS ARISING AND ACTION POINTS

4.1 The Council reviewed the actions arising from the previous meeting. MD confirmed that he was still experiencing computer problems and his outstanding action remained a work in progress. An update would be provided to the next meeting.

4.2 Jenny Hincks (JH) queried whether the patient experience group had been renamed the patient and carers experience group (Minutes Item 12.3). John Trevains (JT) confirmed that it had.

4.3 Lead Governor, Simon Smith (SS) reported that the new framework for the scrutiny of committees by Governors had been discussed in the pre-meeting and two points had emerged: 1) Governors requested a programme of Committee dates; 2) Governors had volunteered for all Board Committees including the Mental Health Act Committee, if required. The Chair confirmed that two Governor Observer places were vacant for the Mental Health Act Committee. SS requested that Governors volunteering to observe committees should get in touch with the new Head of Governance, Lavinia Rowsell (LR). The Chair advised that Simon Crews, Interim Trust Secretary, was standing down at the end of the week and thanked him for his contribution to the Council and to the Trust.

4.4 Simon Crews (SC) confirmed that the Staff Governor election process was underway. An update would be given in the formal business of the meeting.

4.5 The Chair noted the generally positive comments received from the Meeting Evaluation from 14 November, apart from the choice of venue and the early start time. The Chair invited Governors' feedback on this new venue.

ACTION: Programme of dates for each committee meeting to be circulated to Governors.

ACTION: Governors to contact Lavinia Rowsell to indicate their interest in committee observation.

5. FORMAL BUSINESS

Appointment of GP Associate NED

5.1 The Chair reported that Dr Steve Alvis, who is a recently retired GP and a member of the local medical community, had been appointed as Associate NED and starts next week. There remained a 7th NED vacancy. Additionally, Duncan Sutherland was to step down from the Board at the end of October. After discussion, the board and the Nomination & Remuneration Committee had decided to look for a NED with commercial and business experience. IB invited Council support for this. MD noted that changing times now require a NED with that kind of experience and would support using an external search agency to find the right candidate. Neil Savage (NS) highlighted there was a formal NHS framework for using external national executive search agencies and a number of agencies were being reviewed this week.

5.2 **Nomination and Remuneration Committee**

SS reported that the imminent standing down of a member of the Committee had been

discussed at the pre-meeting. The Council supported a reconstitution of the Nom & Rem Committee, understanding that the Lead Governor was a required member. The Chair thanked the Council for this contribution and recommended a separate discussion outside the meeting to take the reformulation forward as part of the Governor Review and Refresh.

ACTION: SS, NS, LR and IB to consider a reconstitution of the Nom & Rem Committee as part of the Review and Refresh process.

6. **Appointment of Governor Observers**

The Chair noted that Governors had now volunteered to cover each of the Committee vacancies. IB added that we were looking to develop a common framework to streamline Governor feedback on committees. SS reported that Vic Godding (VG) was doing very interesting work on this subject through scrutiny of the Quality Committee and would present his findings to Governors shortly. The Chair thanked VG for his contribution and welcomed learning from this.

6.1 The Chair invited Governor Observers to report back on Committees observed since November. Nic Matthews (NM) reported that he had attended the Resources Committee and was reassured that the Committee was working very well, with appropriate content and conversation. Marcia Gallagher (MG) was pleased to hear there was a volunteer for the Audit Committee and commented that there was a good Induction which would cover everything a Governor needed to know. VG and Jo Smith (JS) attended the Quality Committee and reported no criticisms with the workings of this Committee with full Governor involvement encouraged, clearly-presented papers and information. SS advised that there was an extensive list of Governors ready to take up positions on this popular committee.

7. **ELECTION UPDATE**

The Chair advised that we were now recruiting for three governor vacancies (two for nursing within medical/dental, one for AHP/social work). There were three points to note about this election. 1) SC reported that the election started on 27 December, nominations were requested on 13 January and voting will conclude on 9 March. Responses were disappointing previously but this time nominations have been received. GCS nominations were being encouraged to ensure appropriate representation across the two historic Trusts.

7.1 Miles Goodwin (MG) noted that with two Governors leaving next month and two appointed Governors from Herefordshire standing down, we would have vacancies for four Governors. The Chair responded that we would be covering this issue as part of the Review and Refresh process and work is being carried out by LR and Gillian Steels (former Trust Secretary of GCS). The Chair confirmed that Kate Atkinson (Cotswolds), Mike Scott (All England), Dr Stephen Wright and Carole Allaway-Martin had resigned all due to different reasons. Carole has taken up an alternative position within Gloucestershire Council who would appoint a new representative. The Chair invited comments on when and how to approach covering these vacancies. SS recommended that it would be sensible to review the Governor role descriptions before any further recruitment. MD proposed that we prioritise this as an item on the Agenda of the March meeting. This was AGREED.

7.2 **Lead Governor**

The Chair noted that SS kindly stepped into the Lead Governor role after Robert Blagdon stepped down and thanked SS for his contribution. In view of the ongoing Review & Refresh process, the Chair felt this was not a good time for a change and

asked Council if the Interim Lead Governor role could be extended. SS confirmed that in their pre-meeting, Governors had kindly proposed to extend his tenure for a further six months. This was AGREED.

ACTION: A Paper on the Recruitment of Public Governors to be discussed at March meeting as part of the Review & Refresh work

8 CHIEF EXECUTIVE'S REPORT

Paul Roberts (PR) provided an update on the five priorities identified in his last report to Council: consolidation of the merger; instigating a strategy process; the Herefordshire transition; quality improvement; and establishing our position within the Gloucestershire Integrated Care System, Integrated Locality Partnerships and Primary Care Networks.

8.1 Consolidation

This had been our major focus as we bring new teams together, establishing new roles, introducing a new Director of Therapies and creating a new directorate, led by Angela Potter, for strategy and development. Phase II work is complete apart from one area and Lauren Edwards, Deputy Director of Therapies and Quality and Rebecca Shute, Assistant to the Chief Operating Officer and are now on board. We are developing extensive policies and procedures, making sure we have the right support in place for staff as we implement them. The biggest challenge has been IT and adopting a new email system, with the added difficulty of inherent problems within the network.

PR reported on specific service improvements particularly in Learning Disability and vaccinations, and John Trevains (JT) commented that the Immunisation Team provided an excellent example of new teams working well together, with particularly good cross-working supporting the most vulnerable patients at Berkeley House who have access to Stroud Hospital more easily. MD raised the issue of cancer screening for vulnerable groups and those with Learning Disabilities. JT confirmed there was a working group with GHT looking at this and he has data on this issue if anyone would like it. It was worth noting that Wootton Lawn received an industry award for their Well Woman cervical screening programme.

8.2 Herefordshire

PR reported that discussions were ongoing with Worcestershire Health & Care to ensure continuity of service post transition, with the involvement of HealthWatch and other public bodies. The transfer was lined up for 1st April and we are concentrating on technical issues within the clinical information systems. However, our main focus is to get communications right with colleagues and the leadership network, and Worcestershire Health & Care were involved in this. Worcestershire Health & Care had its CQC report published today, retaining its overall Good rating, with CAMHS achieving an Outstanding rating but their community mental health services were rated Inadequate, and this related to one particular team, which was being addressed.

MD asked if there were funding issues relating to Worcestershire Health & Care. PR commented that the Board had required PR to seek assurance that future funding would be maintained for specific services of the Trust and we did receive those assurances from the CCG.

8.3 Better Care Together

There had been a number of events looking at community assets and partnerships in November, with excellent involvement from colleagues and the public. We hosted an inaugural event in November on how Research would be incorporated within the Trust.

We are focusing on leadership and organisational development and in November introduced a reciprocal mentorship programme which was a national pilot for this work. However, our leadership programme had been affected by colleague illness and hospitalisation and we will push this programme forward as colleagues returned to work.

8.4 **Fit for the Future**

PR reported that now the general election was over, the ICS is resuming its work on Fit for the Future. Themes include the acute hospitals as centres of excellence, the distribution of services between Gloucester and Cheltenham, and the future of A&E in Cheltenham. For GHC, it was about the nature and future of our community urgent care services. We hope soon to be able to go into the public arena about our options and plans to push forward in these areas. We have also submitted our long-term plan for the NHS. Our biggest challenge will be how we manage the expected growth in demand for our services against a static income stream. This will require some innovative thinking. Angela Potter will be discussing strategy in the final part of this meeting. SS voiced the Council's appreciation for the work done by the Board to realise benefits from the merger and it would be helpful to hear from the Chief Executive in future meetings on progress.

ACTION: Chief Executive to report on benefits realisation at future meetings

9 CHAIR'S REPORT

9.1 The Chair took her report as read, adding that since November, there had been two meetings in December and January on Board Development which focussed on strategy. IB had also attended regional and national sessions particularly in her role as Board member of NHS Providers. IB had continued to work with partners on the Integrated Care System and was working closely with Gill Morgan, newly-elected Chair of ICS, and who was keen on NED and Governor involvement in this arena.

9.2 The Chair and Amjad Uppal have had meetings with their counterparts at the University of Worcester regarding the prospective new medical school and the Chair has renewed links with the University of Gloucester. The Chair was also in conversation with the Chair of Worcestershire Health & Care, particularly around Governors and the management of mental health.

9.3 The Chair provided information about "The Treasure Seekers" contained in her report in response to a question from MD and provided an explanation for the initials NHSLA, the NHS Litigation Authority. MD queried who Jan Marriott was meeting and PR responded that these meetings are part of JM's NED portfolio responsibilities.

9.4 **Better Care Together**

The Chair mentioned the next event was on 19th February which would focus on strategic priorities and digital innovation. There would be an Experts by Experience panel, Christopher Woolley, CEO University Hospitals Bristol NHS Trust (which had transformed from Requires Improvement to Outstanding), the Chief Executive of the South West Academic Health Sciences network alongside many exhibitors. Hazel Braund (HB) invited Governors to attend and will provide details via email.

ACTION: HB to circulate details of 19th February Better Care Together event to Governors who have an interest in attending.

9.5 **Review and Refresh Update**

The Chair reported on outputs from the workshop which took place in November. These had been circulated to participants with the main emerging themes representing a major

piece of work. Gillian Steels (former GCS Trust Secretary) has been appointed to focus on this work with LR. Work with GovernWell to set up a development programme for Governors working with NEDs was underway, and working groups on membership, reviewing the constitution of the Council and its standing orders would be established. We are looking at pairing NEDs who have a locality interest to work alongside Governors of that locality on how we engage with our communities. Information about this initiative would be circulated to Governors within the next few weeks.

ACTION: GS and LR to circulate information about the next steps in the Review and Refresh process.

10 GOVERNOR VISITS

10.1 NM reported back on his visit to Cirencester where staff had noted challenges regarding how lack of provision for social care was impacting on service delivery. NM queried what actions Governors can take to help and how we can report back effectively on issues reported to us at site visits. The Chair commented that we would look at developing a common framework of reporting around visits to address issues such as these, similar to what is being developed around our committee work.

10.2 The Chair requested that Governors indicate their interest for the visits outlined in Paper E to Marianne Julebin (MJ) in the Trust Secretariat.

ACTION: LR and GS to develop a common framework for Governor visits.

ACTION: Governors to indicate their interest in site visits from Paper E to MJ in the Trust Secretariat.

11 ANY OTHER BUSINESS

Rebranding

11.1 MD requested details about the programme and cost of the re-branding exercise. PR commented that we had a talented graphic design team in-house within Comms. Kate Nelmes (KN) outlined the staggered approach to replacing material. Sandra Betney confirmed that not all areas needed re-branding (such as Herefordshire) and that the signage and branding costs were less than £10k.

Standing down of a lapsed Governor

11.2 The Chair reported that we had a Governor who had missed three formal meetings without giving apologies, had failed to attend a 1:1 meeting and had not responded to letters or telephone calls. According to the Constitution we would ask him to stand down if there were no objections. Council had no objections. MD asked if we would approach the second place nominee from that election as a replacement and the Chair confirmed we would check the Constitution on timing requirements to see if that were possible.

ACTION: LR to check rules on eligibility regarding recruiting the second-place nominee to replace the position of lapsed Governor.

12. DEVELOPING OUR TRUST STRATEGY

12.1 Angela Potter (AP) introduced the process for developing our Trust strategy which

encompassed on-line surveys, workshops and sessions for staff, service users, experts by experience and external stakeholders, as well as enlisting the senior leadership network.

The Council of Governors had a unique and valuable contribution in helping to shape the strategy and future direction of this Trust to ensure that the voice of our members was heard. AP prepared a short presentation and then posed a number of questions for Group work, which the Board of Directors had completed recently.

A range of activities and conversations would continue until March after which we would present initial findings. We would then undertake a Stage II engagement process to ensure we have captured correctly our stakeholders' input. Finally, we would approach key external stakeholders with approximately 30 in-depth interviews to test our assumptions and draw out their comment and input.

Council then participated in round-table workshop sessions to identify a collective view of the main priorities and aspirations for our new Trust over the next five years and what actions will help us to achieve them.

AP thanked the Council for their input. The Chair thanked Council for their attendance and contribution and closed the meeting.

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Council of Governors

Main Meeting Action Points

Item	Action	Lead	Progress
21 January 2020 Main meeting			
4.5	Programme of dates for each committee meeting to be circulated to Governors.	**Trust Secretariat**	Completed
4.5	Governors to contact Lavinia Rowsell to indicate their interest in committee observation.	**Governors**	Ongoing
5.2	Set up a working group to reconstitute the Nom & Rem committee as part of the Review and Refresh process.	**SS, NS, LR and IB**	
7.1	Recruitment of Public Governors to be a main agenda item for the March meeting and a Paper prepared	**Lavinia Rowsell and Gillian Steels**	

8.4	Reports on benefit realisations from the merger	**Chief Executive**	Verbal, on-going
9.4	Details of 19th February Better Care Together event emailed to Governors who have an interest in attending	**Hazel Braund**	Completed
9.5	Next steps in the Review and Refresh process to be circulated	**Lavinia Rowsell and Gillian Steels**	
10.1	Develop a common framework for Governor visits	**Lavinia Rowsell and Gillian Steels**	Part of Review and Refresh process
10.2	Governors and NEDs to indicate their interest in site visits outlined in Paper E to MJ in the Trust Secretariat	**Governors and NEDS**	Ongoing
11.2	Check the rules regarding recruiting the second-place nominee to replace the lapsed Governor being stood down.	**Lavinia Rowsell**	Completed: Item 15 of the Trust's Constitution states: 15.1 Where membership of the Council of Governors ceases within 12 months of election, public and staff governors shall be replaced by the candidate in the same constituency and class with the next highest number of votes at the last election. If the vacancy cannot be filled by this method the governor will be replaced by holding a by-election, in accordance with the Election Rules. This applies to Dr Stephen Wright (Forest) but there was no second candidate for Craig Pryce (Gloucester)

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Gloucestershire Health and Care
NHS Foundation Trust

TRUST BOARD MEETING

PUBLIC SESSION
Wednesday 25 November 2020
10.00 – 13.00pm
To be held via Microsoft Teams

AGENDA

TIME	Agenda Item	Title	Purpose		Presenter
Opening Business					
10.00	01/1120	Apologies for absence and quorum	Assurance	Verbal	Chair
	02/1120	Declarations of interest	Assurance	Verbal	Chair
10.05	03/1120	Annual Report from the Director of Public Health	Assurance	Presentation	Sarah Scott, DPH
10.30	04/1120	Patient Story Presentation	Assurance	Verbal	Chair
10.55	05/1120	Draft Minutes of the meeting held on 30 September 2020	Approve	Paper	Chair
	06/1120	Matters arising and Action Log	Assurance	Paper	Chair
	07/1120	Questions from the Public	Assurance	Verbal	Chair
Strategic Issues					
11.00	08/1120	Report from the Chair	Assurance	Paper	Chair
11.05	09/1120	Report from the Chief Executive and Executive Team	Assurance	Paper	CEO
11.10	10/1120	System Wide Update	Assurance	Paper	DoSP
11.20	11/1120	Diversity Network Update Report	Assurance	Paper	DoHR&OD
11.30	12/1120	Board Assurance Framework	Approve	Paper	HoCG
11.35am - BREAK – 10 Minutes					
Performance and Patient Experience					
11.45	13/1120	Covid Programme Update	Assurance	Verbal	COO
11.55	14/1120	Quality Report	Assurance	Paper	DoNQT
12.05	15/1120	Patient Safety Report (Q2)	Assurance	Paper	MD
12.15	16/1120	Guardian of Safeworking (Q2)	Assurance	Paper	MD
12.20	17/1120	Learning from Deaths (Q2)	Assurance	Paper	MD
12.25	18/1120	Finance Report	Assurance	Paper	DoF
12.35	19/1120	Performance Report	Assurance	Paper	DoF
12.40	20/1120	Freedom to Speak Up Report	Approve	Paper	Sonia Pearcey

TIME	Agenda Item	Title	Purpose		Presenter
Governance					
12.50	21/1120	Change to the Trust Constitution	Approve	Paper	HoCG
Note	22/1120	Council of Governor Minutes (Sept)	Assurance	Paper	HoCG
Board Committee Summary Assurance Reports					
Note	23/1120	Resources Committee Summary (22 Oct)	Assurance	Paper	Resources Chair
Note	24/1120	Quality Committee Summary (3 Nov)	Assurance	Paper	Quality Chair
12.55	25/1120	Audit & Assurance Committee Summary (5 Nov) • Terms of Reference Review	Assurance Approve	Paper Paper	Audit Chair HoCG
Note	26/1120	Appointments & Terms of Service Committee Summary (12 Nov)	Assurance	Paper	Chair
Note	27/1120	Charitable Funds Committee Summary (13 Nov)	Assurance	Paper	CF Chair
Note	28/1120	Mental Health Legislation Scrutiny Committee Summary (23 Sept (P) and 18 Nov (V))	Assurance	Paper & Verbal	MHLS Chair
Closing Business					
13.00	29/1120	Any other business	Note	Verbal	Chair
	30/1120	**Date of Next Meeting** **2021** Thursday 28 January Wednesday 31 March Thursday 27 May Thursday 29 July Thursday 30 September Thursday 25 November	Note	Verbal	All

Gloucestershire COUNTY COUNCIL

BEYOND COVID:

RACE, HEALTH AND INEQUALITY IN GLOUCESTERSHIRE

Report of the Director of Public Health **2020**

BAME Communities: Health Inequalities and COVID-19

Health inequalities are the avoidable and unfair differences in people's health across different population groups.

They are a result of social inequalities in the conditions in which people are born, grow, live, work and age.

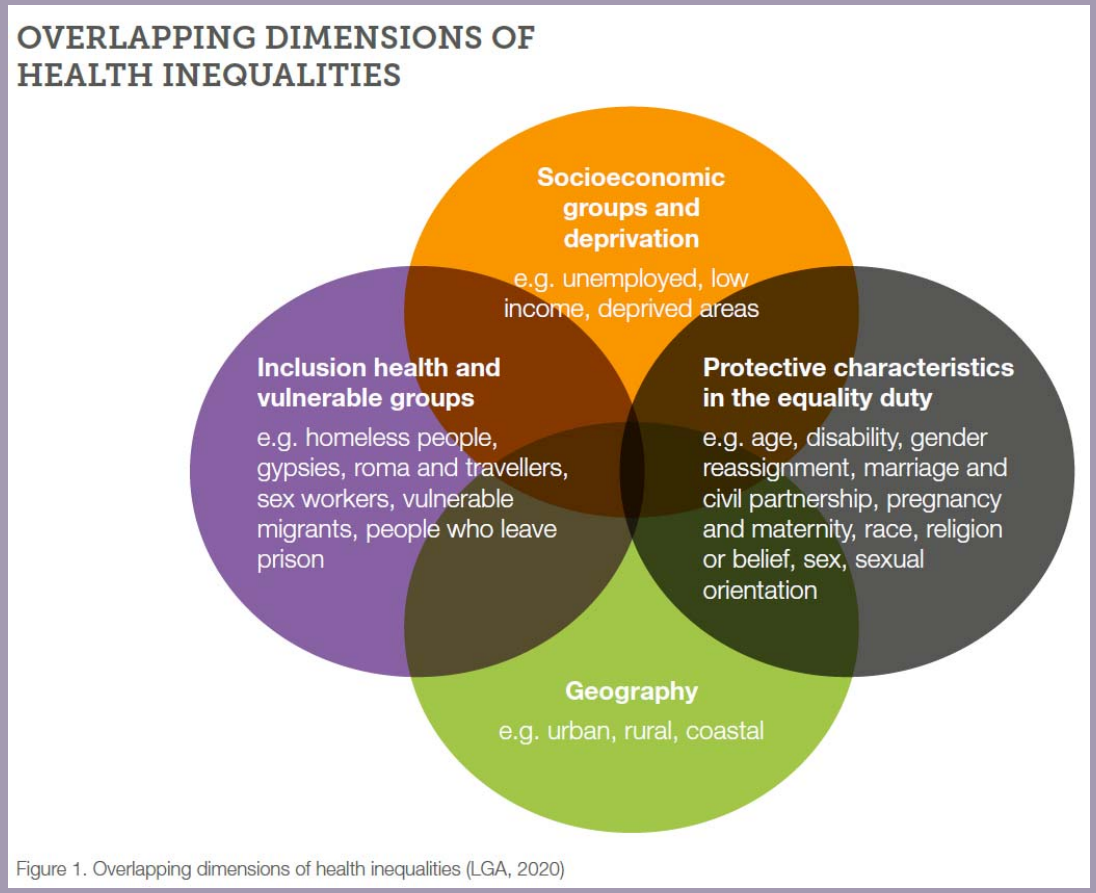
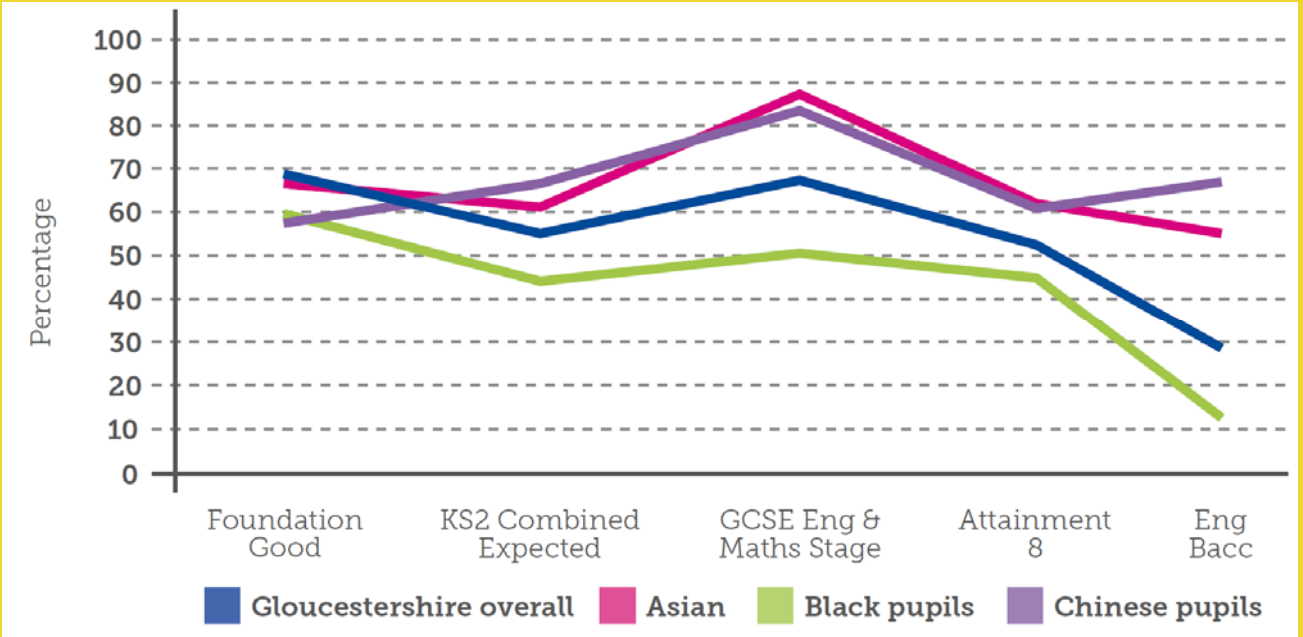


Figure 1. Overlapping dimensions of health inequalities (LGA, 2020)

In Gloucestershire

Education - Black pupils in Gloucestershire perform below other ethnic groups and below the average for Black pupils in England.



Housing - BAME people are more likely to live in poor-quality, overcrowded private-rented housing than White British people.

Employment - BAME adults aged 25-49 are more likely to be unemployed than White British adults of the same age. For Black people, the rate is more than double.

The Impact of COVID-19 on Gloucestershire's BAME residents

Cases:

	Contacts 29/05/20-26/08/20	**Cases** 26/02/20-25/08/20	**Population** 2011
White British	55.1%	75.2%	91.6%
White Other (including Irish)	3.6%	4.7%	3.9%
Asian	2.2%	4.4%	2.1%
Mixed/Multiple Ethnic Groups	2.2%	0.9%	1.5%
Black/African/Caribbean/ Black British	0.0%	2.4%	0.9%
Any other ethnic group	0.0%	1.3%	0.2%
Unknown/Not recorded	36.9%	11.2%	0.0%
Total	**100.0%**	**100.0%**	**100.0%**

Hospitalisations: Black and Asian people were between 2.5 and 3 times more likely to be admitted to hospital with COVID-19 than White people of the same age.

Community Resilience

“People from the area organised themselves and came together to create a street rep scheme; there are 102 streets in the area, so that’s a lot of volunteers all coordinating through social media. They distribute leaflets and organise support for anyone on their street who needs it, such as food and meal deliveries, and we are helping with this effort.”

Imran Atcha, Friendship Café

Barton and Tredworth

Workplace Health and Wellbeing

Occupational Risk Assessments

“I have a slight worry that raising concerns as a Black employee about COVID-19 risks may result in Black/BAME employees being required to have any subsequent vaccine as a condition of their employment.”

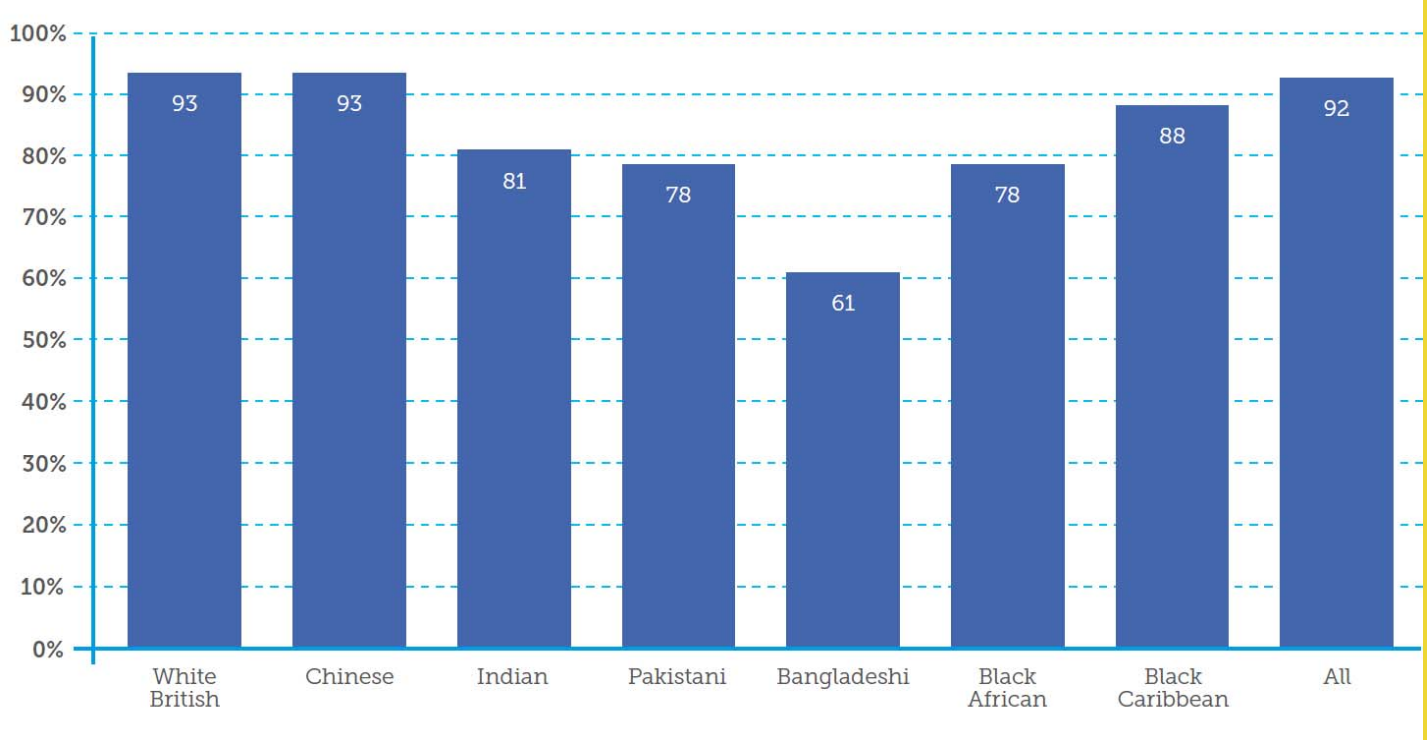
“I believe I have been expected to essentially self-mitigate any COVID-19 risks to meet the requirements of my role.”

“I didn’t understand the purpose of the assessment based on the information I was given.”

- Public sector BAME employees in Gloucestershire

COVID-19 and Communication

Awareness of public health and economic measures during COVID-19 by ethnicity



Barriers to communication:

- Fear
- Mistrust
- Language
- Digital access
- Cultural insensitivity

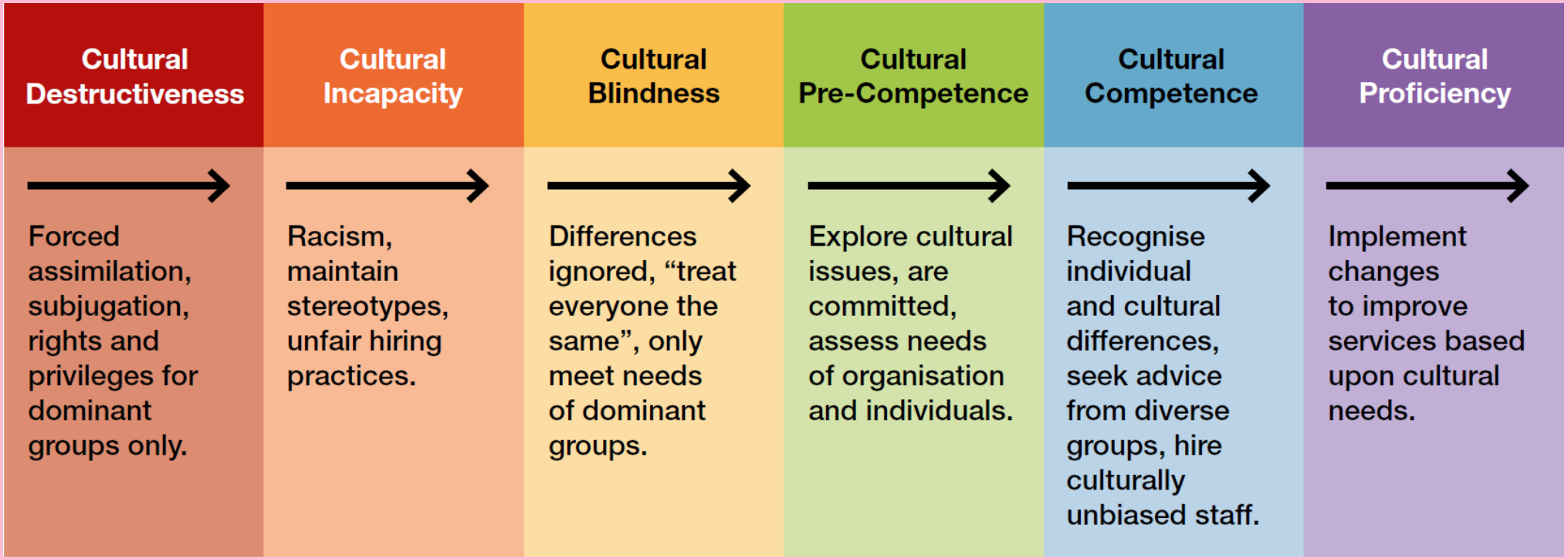
Building confidence in the messaging and public services generally, requires working with faith and BAME communities to create and disseminate culturally competent and easy to understand versions of guidance in multiple languages.

COVID-19 and Pre-existing Conditions

- Diabetes was mentioned on 21% of death certificates where COVID-19 was also included; for Asian people this rises to 43% and for Black people 45%.
- The health risk of excess weight for some BAME groups occur at a lower BMI than for White populations.

"There is a lack of awareness in the West Indian community. There is no guidance for them on diet or sleep. They feel powerless to do anything about lifestyle factors. Messages are generic and not culturally targeted. Things should be shared in other languages and in a format for ordinary people."
- Carol, Community Builder

Becoming a Culturally Competent Organisation



Gloucestershire County Council has set up a BAME COVID-19 Task and Finish Group who are working with agencies to build their cultural competence. If you would like to find out more please contact bwn@gloucestershire.gov.uk

Co-operation and Co-production

Need identified → Intervention or service planned

Members of communities with lived experience of discrimination and structural racism should be a part of this process at every stage.

Public consultation and Equality Impact Assessment completed

Meaningful changes made to improve delivery for marginalised groups

Beyond COVID-19 in Gloucestershire - Recommendations

1. a) Require comprehensive and good quality ethnicity data collection in all public services (directly provided and commissioned), including at death registration.
   b) Put in place culturally competent training and messaging to improve response rates
2. a) Provide the capacity and resource for collaborative research with BAME employees, organisations and community representatives to understand the social, cultural, structural, economic, religious, and commercial factors related to COVID-19.
   b) Using the output from this research, co-produce and fund interventions to reduce the risk of catching COVID-19 and improve health outcomes.
3. Review commissioning procedures and practice to make sure that Equality Impact Assessments, BAME service user data and feedback are routinely used in a meaningful way to inform services. Training for commissioners should explicitly cover the differences in access, experience and outcomes for BAME residents and their responsibilities in addressing these.

Recommendations

4. System-wide commitment to the implementation of culturally competent occupational risk assessment tools, including assigning the required capacity and resource. Use our influence in the pubic sector to gather knowledge and share best practice to support the occupational health of key workers in the private sector.
5. Proactively work with BAME and faith community representatives to develop and distribute culturally competent COVID-19 prevention and health improvement communication plans at an organisation level and through Local Resilience Forum infrastructure.
6. Ensure that COVID-19 recovery strategies actively reduce inequalities caused by the wider determinants of health. The Recovery Coordination Group should regularly review the equality implications within its remit and seek input from BAME staff, residents and other marginalised groups.

Recommendations

7. Undertake a stocktake of the BAME voluntary sector, examining further the contribution that it makes towards reducing health inequalities in Gloucestershire. Seek to build capacity and sustainability longer term within this sector.
8. Establish a Race Equality Panel for Gloucestershire, complementing the work of Gloucester City Council, to drive forward this agenda and create long term sustainable change.

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NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 05/1120

MINUTES OF THE TRUST BOARD MEETING

Wednesday, 30 September 2020

Via Microsoft Teams

PRESENT:
Ingrid Barker, Trust Chair
Dr. Stephen Alvis, Associate Non-Executive Director
Sandra Betney, Director of Finance
Maria Bond, Non-Executive Director
Steve Brittan, Non-Executive Director
John Campbell, Chief Operating Officer
Marcia Gallagher, Non-Executive Director
Sumita Hutchison, Non-Executive Director
Jan Marriott, Non-Executive Director
Angela Potter, Director of Strategy and Partnerships
Paul Roberts, Chief Executive
Graham Russell, Non-Executive Director
Neil Savage, Director of HR & Organisational Development
Duncan Sutherland, Non-Executive Director
John Trevains, Director of Nursing, Therapies and Quality
Dr. Amjad Uppal, Medical Director

IN ATTENDANCE:
Caroline Hanman, Member of the Public
Anna Hilditch, Assistant Trust Secretary
Ruth McShane, Trust Governor
Kate Nelmes, Head of Communications
Lavinia Rowsell, Head of Corporate Governance/Trust Secretary
David Smith, Transition Director
Hannah Williams, Deputy Director of Nursing
Chris Witham, Trust Governor

1. WELCOME AND APOLOGIES

1.1 The Chair welcomed everyone to the meeting. Apologies for the meeting had been received from Helen Goodey, Director of Locality Development and Primary Care.

2. DECLARATIONS OF INTEREST

2.1 There were no new declarations of interest.

3. PATIENT/STAFF EXPERIENCE PRESENTATION

3.1 The Board welcomed Lisa Dervan, Community Partnerships Manager to the meeting, who had been invited to share her personal experience of Covid, and her journey through the illness since becoming unwell in March 2020.

3.2 Lisa informed the Board that it had been difficult to navigate services, with fragmented communications between primary and acute services. Following a number of visits to A&E Lisa was finally diagnosed with a heart condition, Post-Covid myocarditis. Lisa had received some rehabilitation but this was directly

from Trust colleagues, not from services and she had sought professional support and advice. She was finally offered rehabilitation at the end of August which was almost 5 months after becoming ill.

3.3 Lisa advised that she wanted to share her story and the impact of the illness, noting that the importance of morbidity also needed to be discussed, as well as mortality. She had struggled to get heard and for people to listen to her concerns.

3.4 Jan Marriott noted that she had watched Lisa's video of her story at the recent Senior Leadership Network and thought this should be shared widely as it was such an important and powerful message around recovery but also for younger people to see how Covid could impact on fit and healthy young people. The Board noted that the ICS Rehabilitation Group was focusing on the longer-term conditions being developed post-Covid and it was suggested that Lisa's video be shared with that group. Lisa said that she was very happy for her story to be shared widely.

3.5 Ingrid Barker said that Lisa's story did highlight the need as a system to look further at the attitude and communication from services.

3.6 Sandra Betney asked Lisa whether she felt that there was anything further as an employer the Trust could have done to support her. Lisa said that she had received excellent support from her team, however, better access to Working Well would have helped. Lisa was keen to stress that she did not feel that she should have received any services above or beyond what a normal member of the public would have received, despite being an employee. Angela Potter supported Lisa's sentiment about getting fair and equitable access to services, but it was important for staff to get the best possible care. She said that there were areas that needed to improve, noting that trying to access services and support for Lisa was not straightforward and there were some important lessons to be learned.

3.7 Paul Roberts thanked Lisa for agreeing to share her story, and he apologised for the experience that she had had on behalf of the NHS, for the gaps and delays in services. He said that it gave the Trust a good insight for people who were less able and knowledgeable about the NHS system and trying to navigate services.

4. MINUTES OF THE MEETING HELD ON 22 JULY 2020

4.1 The Board received the minutes from the previous meeting held on 22 July 2020. These were accepted as a true and accurate record of the meeting.

5. MATTERS ARISING AND ACTION LOG

5.1 The Board reviewed the action log and noted that all actions were now complete or included on the agenda. There were no further matters arising.

6. QUESTIONS FROM THE PUBLIC

6.1 No questions from the public had been received in advance of the meeting.

7. CHAIR'S REPORT

7.1 The Board received the Chair's Report which highlighted the activity of the Trust Chair and Non-Executive Directors for the period end of July to Mid-September 2020.

7.2 The Board noted that this was Non-Executive Director Duncan Sutherland's last day of office. Duncan was appointed as a Non-Executive Director by 2gether NHSFT in 2016 and following the merger of 2gether and Gloucestershire Care Services in October 2019, kindly agreed to stay with the merged Trust for a further year. Duncan's strategic and commercial insights, along with his warmth for colleagues and service users, had been invaluable during this time. Board colleagues joined Ingrid Barker in expressing their thanks and best wishes to Duncan.

7.3 It was noted that the final stage in the appointment process for Associate NED Steve Brittan took place on 26th August and he has now been confirmed as a full Non-Executive Director, with approval having been received at the recent Council of Governors meeting.

7.4 A huge amount of work continued with the Trust's Governors, focussing on the review and refresh of the Council. This has been aided by the recent appointment of 7 new Public Governors at the beginning of September and details of the new appointments were set out in the report.

7.5 The Board noted the content of the Chair's Report, which also highlighted Board Development activity, partnership working with system partners and engagement with national networks.

7.6 Graham Russell informed the Board that the Council of Governors at their September meeting had also approved the reappointment of Ingrid Barker as the Trust Chair for a final 3-year term.

8. CHIEF EXECUTIVE'S REPORT

8.1 The Board received the Chief Executive's Report which highlighted the activity of the Chief Executive and Executive Directors for the period end of July to Mid-September 2020. The content of this report was noted.

8.2 Paul Roberts highlighted some key senior Team changes, noting the departure in October of Sian Thomas, Deputy Chief Operating Officer and Matthew Edwards, Deputy Director of Quality and Workforce Transformation. It was noted that the Trust was also saying farewell to David Smith, Transition Director whose contract would finish at the end of September. Paul Roberts expressed his thanks to all colleagues for their support, advice and expertise.

8.3 A number of changes were being proposed for the Trust's operational team following the departure of Sian Thomas on 16 October. An interim Deputy COO had been appointed, Hilary Shand, who would be commencing in post from 12 October, with some induction and handover sessions scheduled in advance of this. The contract was until 31 March 2021. The Team structure would revert back to having two Deputy COOs and a managed process was underway to

agree this, with an external advert going out for 1 post and an internal management of change process for the 2nd. Board members welcomed this update.

8.4 The Trust continues to keep up to date with the latest Brexit updates as we move ever closer to the end of the Brexit transition period. John Campbell, Chief Operating Officer, will be the Senior Responsible Officer for the EU Exit for GHC as it is crucial that this work is fully coordinated with the Covid response and winter planning. The Executive, led by John, will continue to monitor guidance from NHS England and NHS Improvement to inform the Trust's preparations for 'deal', 'light deal' or 'no deal' scenarios.

9. ORGANISATIONAL PRIORITIES FOR THE TRUST

9.1 This paper set out the proposed priorities for the Trust until the end of the 2020/21 financial year, which were agreed by the Board at an informal meeting on 11th August 2020.

9.2 The report also provided an update on framing the strategic programme post-merger and capacity in the context of Covid. The Board had discussed and agreed a realistic set of 23 priorities for the Trust to pursue over the next six months; and these were set out in the report.

10. SYSTEM WIDE UPDATE

10.1 This paper provided an update on the activities that were taking place across the Gloucestershire Integrated Care System (ICS). The Sustainability and Transformation plan is now in its fourth year (from April 2020) and the ICS continues to play a key role in improving the quality of Health and Care by working in a more joined up way as a system.

10.2 The ICS has continued to co-ordinate the system wide Recovery Response to the Covid pandemic and to start the activities associated with the system wide winter plan and the phase 3 planning returns. Service change proposals were presented to the Health Overview and Scrutiny Committee on the 15th September 2020.

10.3 The Integrated Locality Partnerships have now also re-commenced their activities and started to revisit their priority actions moving forward, taking into account the impact of Covid.

10.4 The Fit for the Future programme work programme continues to progress with a proposed public consultation in the autumn (subject to usual assurance and governance requirements).

10.5 The development of the new hospital in the Forest of Dean also requires a final phase of consultation on the proposed service models. Whilst this is not tied to the FFTF programme to enable the smooth running of the consultation and maximise the use of the available resources this will run concurrently with the FFTF consultation commencing mid-October.

10.6 There have been a number of engagement and survey activities to continue to understand the impact that the pandemic has had on our population.

10.7 Angela Potter informed the Board that the format for this System Wide Report had been widened in scope and perspective to reflect the connections that GHC has as an organisation. The Board was very supportive of this new format.

11. OPERATIONAL RESILIENCE AND CAPACITY PLAN (inc. Winter Plan)

11.1 The Operational Resilience and Capacity Plan embraces the Trust Winter Planning, Surge Management and Covid-19 arrangements for the Trust. As part of the governance and assurance process the document has followed, the Trust Board assurance is the final element prior to submission to the Gloucestershire Clinical Commissioning Group in October.

11.2 The Trust is required to have a robust resilience and capacity plan in place with particular emphasis on the winter period (November – March).

11.3 In order to take a system-wide approach to managing operational issues the NHS recognises the need to establish sustainable year-round delivery. This will require the Trust's capacity planning to be on-going, robust and aligned with other organisations' plans across the Health and Social Care system, with a move towards a proactive system of year-round operational resilience.

11.4 The 2020/21, Operational Resilience and Capacity Plan includes additional assurance and planning around Covid-19 and general incident/surge response. The plan ensures learning from the Covid-19 experiences is fully captured and included within future planning arrangements, identifying new ways of working as we enter the winter period.

11.5 The Board endorsed the Operational Resilience and Capacity plan.

12. MENTAL HEALTH DEVELOPMENTS

12.1 This report provided the Board with an update on a range of mental health developments within the Trust, which we aim to progress, following a period where many have been paused due to the Covid pandemic. It is increasingly recognised that the mental health needs of the population are being impacted by the Covid situation, particularly the level of change creating new societal norms and on-going anxiety in relation to Covid.

12.2 The Board noted that a number of these mental health developments were supported by additional funding from the Mental Health Investment Standard (MHIS). This standard was brought in to address funding disparity which favored physical health services which left mental health services significantly underfunded. The standard requires CCGs to increase investment in mental health services at a faster rate than their overall increase in funding allocation each year.

12.3 John Campbell advised that the range of developments within mental health, are fully aligned to our aspirations of prevention and early intervention as the

main provider of specialist mental health services in Gloucestershire. We deliver many of our services in partnership with other statutory organisations and the Voluntary, Community and Social Enterprise (VCSE) sector.

12.4 The Covid pandemic has magnified issues in relation to health inequalities. It will be important as we move forward as a Trust, to understand the role that we can play in tackling issues relating to equality, diversity and inclusion particularly in relation to mental health. This will include how we work with the diverse range of community groups who have played a key role in supporting communities during the pandemic

12.5 The Mental Health developments highlighted in the report included: Improving Access to Psychological Therapies (IAPT) 'Let's Talk', Perinatal MH Services, Psychiatric Liaison services, the complex emotional needs service, Gloucester City First Contact Mental Health Practitioners, The Gloucestershire Mental Health Trailblazer 4WW Programme and a review of complex children and young people.

12.6 In terms of IAPT, John Campbell advised that the recovery rate had dropped nationally, with GHCs rate moving from 53% to 52%. The Trust would be looking to increase its access rate to 20.5% by the end of the year, noting the need to convert trainee positions into qualified therapists to meet demand. Jan Marriott noted that cases of stress and anxiety were increasing due to Covid, and suggested that some people were struggling to access IAPT. John Campbell advised that the IAPT service was for mild to moderate presentations. Other services were available for people and the Trust ensured that people were signposted to those services if IAPT was not felt to be the appropriate service for them. Sumita Hutchison made reference to diversity and supporting people from different communities to access IAPT. John Campbell said that a lot of work continued to be carried out to ensure equitable access to services, both by IAPT and the Trust's social inclusion teams.

12.7 Duncan Sutherland asked whether the Trust had plans to forge links with businesses. There was still a stigma around mental health, and mental health in the workplace and it was suggested that GHC could work through the ILPs to look at how businesses and their workers were supported, before there was a need to access services.

12.8 The Board noted and welcomed this report.

13. STAFF HEALTH AND WELLBEING AND PEOPLE PLAN

Staff Health and Wellbeing

13.1 This report set out the feedback and results from the Trust's voluntary participation in the National NHS People Pulse Survey between the months of July to August 2020. The feedback has been used to suggest recommended priorities going forwards. The report also provided an update on progress with Covid risk assessments and highlights the next actions to continue to improve completion.

13.2 With regard to the Pulse Survey, the Trust has performed very well in comparison with other organisations, and in the majority of cases, consistently above average. The feedback trend from responses confirms that colleagues rate the Trust higher than the national average in response to a number of keys areas, including: colleagues feeling informed, feeling supported, feeling able to have a work/life balance, feeling calm, feeling motivated and feeling confident in local leaders.

13.3 Of note, the most common responses to the question 'What support would make the biggest difference to help you at work?' was 'more updates on changing operations/ways of working' (31.46%) and 'more frequent team huddles/virtual check ins or other ways to maintain team connection ' (30%). Sumita Hutchison asked whether the Trust had anything further planned to help teams to connect better. Neil Savage advised that there was a huge amount of support already in place and it was vital that individual teams worked together with their staff to identify what they needed and wanted. He said that teams had developed their own ways of working to include daily group and 1:1 calls, socially distanced walks with colleagues and the introduction of buddying systems within larger teams to ensure people looked out for each other and their wellbeing. Dave Smith added that the NHS Leadership Academy was running master classes on remote working and management, and colleagues were looking to explore this further.

13.4 Steve Alvis made reference to staff financial support and said that he was really encouraged by the work that the Trust was doing to ensure colleagues had access to the right information and guidance.

13.5 Going forwards, particularly in light of Covid and the new NHS People Plan, it was important that the Board, the Executives, the Health and Well-being Hub, line managers, Working Well and HR continue to put strong and regular focus on the importance of health and well-being within the organisation.

13.6 The Trust continued to make good progress in uptake of its comprehensive Covid risk assessment arrangements. Neil Savage informed the Board that this had been a sizeable project which needed sustained and continued focus.

13.7 The first focus through May and June 2020 was on ensuring that Black and Minority Ethnic (BAME) colleagues were assessed and fully supported to mitigate the higher risks from Covid. A risk assessment tool with algorithm and record of the assessment, based on national advice, was developed by Working Well colleagues, tested with senior colleagues and rolled out for BAME colleagues and continues to be used for new BAME appointees. The second key focus of activity through July and August 2020 has then been on risk assessing and supporting those "shielding" colleagues identified as higher risk from Covid. The third focus of activity through July, August and September 2020 has been to supplement this by focussing on rolling out Covid risk assessments for more latterly identified other higher risk colleagues, including All Males and White Europeans who are 60 years of age or over. Finally, the fourth focus has been on offering an on-line risk assessment tool for all colleagues irrespective of their background, age or situation.

13.8 As of 11th September, 99% of BAME risk assessments had been completed and 100% for Shielding colleagues. Work was continuing to communicate out to colleagues the importance of completing the risk assessments. Neil Savage informed the Board that GHC was one of only a handful of Trusts who were offering a risk assessment tool to all colleagues.

People Plan

13.9 The Board noted that "We are the NHS: action for us all" was published of the end of July 2020 by NHS England/NHS Improvement & Health Education England. This sets out what NHS staff can expect from their leaders, their employers and each other. The Plan builds on previous interim NHS plans and the central themes of more staff, working differently and a compassionate & inclusive culture. It also includes a brand new "Our People Promise" which sets out national ambitions for what people working in the NHS will ideally say about it by 2024.

13.10 The Trust has pre-existing general and specific equalities duties and obligations and these have been further added to with Equality, Diversity & Inclusion (EDI) requirements from the Long-Term Plan, the recent Public Health England recommendations and the NHS People Plan and Our People Promise. As a result, there are a number of additional asks for NHS providers on EDI for the workforce. Delivering the requirements will be a significant ask and resource commitment.

13.11 The Trust's emerging strategy puts EDI at its heart, and the Executives have agreed to the creation of a new Equality, Diversity & Inclusion lead role within the Trust. The aim is to offer the post initially as a secondment or fixed term, to drive forward the EDI agenda both within the Trust and more widely with ICS and Regional partners. The Board supported the creation of this new role, subject to taking on board the learning and experiences from other organisations in ensuring the role is fully supported. Neil Savage advised that the post would follow the same structure as the Freedom to Speak Up Guardian, and would cut across all aspects of the organisation.

13.12 Marcia Gallagher asked how GHCs local plan would work alongside the ICS plan and how the two would work together and feed in. It was noted that a more detailed report was being prepared for the Resources Committee in October which would set out how it all fit together.

13.13 Neil Savage advised that guidance received had recommended the appointment of a Health and Wellbeing Guardian for the Board. It was agreed that the NEDs would discuss this further at their next meeting, with the aim of agreeing a nominated NED lead.

ACTION: NEDs to discuss and nominate a NED Lead for Health and Wellbeing

13.14 The Board welcomed the Staff Health and Wellbeing and People Plan report, acknowledging the huge amount of work that had, and continued to be carried out.

14. COVID ACTIVE RECOVERY UPDATE

14.1 This item provided an update on the Trust's active recovery work, including progress to date with service and operational recovery. Key points of learning have been highlighted alongside some of the successes and achievements.

14.2 The Board noted that significant progress had been made with active recovery and a huge amount of learning has been captured.

14.3 Second surge plans were in place and more detailed discussion would be taking place at both the Covid Programme Board and the Executive Team meetings.

14.4 Jan Marriott asked about the Trust's Live Well Feel Better service. John Campbell advised that this service was being brought together with the Recovery College approach to hopefully bring more resilience around how the service was provided.

14.5 Steve Brittan noted that the Trust had a number of waiting lists for services and asked whether this was due to Covid. John Campbell advised that some did relate to Covid but others were historical waiting lists. He provided assurance that work was underway to fully review and manage these as part of the recovery work.

14.6 The Board noted the excellent work that was being carried out across the Trust by colleagues.

15. QUALITY DASHBOARD REPORT

15.1 This report provided an overview of the Trust's quality activities for August 2020. It was noted that key data was now reported under the relevant CQC Domains – caring, safe, effective, responsive and well-led.

15.2 John Trevains highlighted those Quality issues for priority development to the Board.

- Work is required to understand in more detail the reduction in the number of calls received into Single Point of Clinical Access (SPCA). It is possible this is as a result of altered system flow but this needs to be clarified and any impact on patients understood.

- The number of bed days for adult mental health inappropriate out of area placements has risen in the month of August. The reasons for this and impact on patients' needs to be fully understood and monitored.

- The data associated with the cardio-metabolic assessment and treatment for people with psychosis is currently not available. Further work will be undertaken in month with the business intelligence team to re-establish reporting.

- The Quality directorate will work with Children's Services to understand the recovery of a universal antenatal service to ensure that those identified as most at risk are being proactively managed.

15.3 Quality issues showing positive improvement were also highlighted.

- No healthcare associated Covid-19 infections attributable to the Trust's care for the third month in a row
- Referral to treatment times for physical health services identified within the Quality Dashboard have all exceeded the required thresholds for the first time this year.
- The quality directorate have progressed plans to deliver the "Civility & Patient Safety" programme and the "Embedding learning following investigations project" are making good progress,

15.4 The Board noted that incident reporting rates had now returned to pre Covid levels, the Trust was fully assured on current and future supply of all PPE stock items via local and national supply routes and there was good assurance that safe staffing levels had been maintained throughout the month in our inpatient services.

15.5 John Trevains informed the Board that future iterations of the Quality Dashboard would incorporate the Non-Executive Directors Complaints audit report and summary detail of Non-Executive Director quality visits.

15.6 The Board welcomed this report, and the assurances provided.

16. FINANCE REPORT

16.1 The Board received the month 5 Finance Report for the period ending 31 August 2020.

16.2 There was a Covid interim financial framework for the NHS in place for April to September and a revised financial framework would be put in place for October to March.

16.3 The Trust's position at month 5 was break even. All Trusts are required to show a break even position by NHSI. To reach a break even position the Trust has requested a retrospective top-up of £1.484m for Apr to August. £1.072m of this has been approved by NHSI for April to July.

16.4 To support the creation of a Service Director post in CYPs the Trust was proposing to invest £110k of merger savings in the Operations directorate. Sandra Betney noted that when the merger took place, the Board agreed to hold back any savings to be used to cover any shortfalls related to the merger and subsequent resourcing. The savings held back from the merger had been made through corporate/Board streamlining. The Board approved the funding for the post.

16.5 The cash balance at month 5 was £71.453m.

16.6 Capital expenditure was £0.978m at month 5. The Trust has a capital plan for 20/21 of £10.045m. Duncan Sutherland asked for assurance that the capital forecast outturn was still deliverable. Sandra Betney advised that there had been significant slippage with the capital plan due to Covid, with no capital expenditure in the first 4 months of 2020/21. The Capital Management Group had carried out a detailed review and it was hoped that the target would be achieved. It was noted that a few schemes needed further discussion in terms of the interplay with the wider system and winter plans. Sandra Betney advised that the Montpellier work was now underway and all IT expenditure commitments were in place. The capital plan was not without risk; however, it was being carefully monitored and the Trust had some schemes that could be brought forward if required.

16.7 The revised recurring Cost Improvement Plan (CIP) target for the Trust is £4.352m and the amount delivered to date is £3.277m.

17. PERFORMANCE DASHBOARD

17.1 Sandra Betney presented the combined Performance Dashboard to the Board for the period August 2020 (Month 5 2020/21). This report provided a high level view of key performance indicators (KPIs) in exception across the organisation.

17.2 At the end of August, there were 10 mental health key performance thresholds and 20 physical health key performance thresholds that were not met. It was noted that all indicators had been in exception previously within the last 12 months. Sandra Betney informed the Board that there were a large number of exceptions but offered assurance that many of these related to data quality issues and this was starting to improve following Covid. Relevant services and teams had been contacted and asked to start looking at service recovery plans. There were no new issues to raise with the Board.

18. FLU VACCINATION SELF ASSESSMENT

18.1 The purpose of this report was to inform the Board of the role of GHC in the operational delivery of the seasonal flu vaccination and to present the GHC self-assessment against the NHS England healthcare worker flu vaccination, best practice management checklist.

18.2 The national flu vaccination programme is essential to protecting vulnerable people and supporting the resilience of the health and care system. To support the maximum uptake of flu vaccination across Gloucestershire, the Gloucestershire Integrated Care System (ICS) has developed a seasonal flu group. GHC is actively engaged in the Operational Subgroup of this group which has an operational focus on the arrangements and delivery of seasonal flu vaccinations across the system to improve uptake. GHC are involved in a number of the operational work streams, including:

- Vaccination of frontline health care workers employed/engaged by GHC
- Vaccination of GHC inpatients

- Vaccination of school age children
- Vaccination of patients on the community nursing caseload, to include carers and shielding household contacts of patients on the case load

18.3 The Board welcomed this comprehensive report which offered excellent assurance, and endorsed the submission of the completed Healthcare worker flu vaccination best practice management checklist.

19. LEARNING FROM DEATHS – Q1 2020/21

19.1 It is a regulatory requirement for all NHS Trusts to identify, report, investigate and learn from deaths of patients in their care, as set out in the National Quality Board 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, published March 2017.

19.2 The Board received the Learning from Deaths report for quarter one, noting that this was the first report which provided both mental health and physical health deaths as a combined figure.

19.3 The report showed a high number of deaths in both April and May, which were stabilising in June. In total 276 GHC patient deaths were recorded in quarter 1. The Board was assured that this was in line with the Gloucestershire death rate and previous reporting. Amjad Uppal advised that further analysis of the data would be carried out, however, there was no concern raised in regards to the deaths that occurred and none were judged to be related to problems in care.

19.4 An understanding of the impact of Covid on the Trust's mortality rates and vulnerable groups would be included in the next Learning from Deaths report submitted to the Board.

20. GUARDIAN OF SAFE WORKING – Q4 2019/20 & Q1 2020/21

20.1 Amjad Uppal presented the Guardian of Safe Working Hours report for the period's quarter 4 2019/20 and quarter 1 2020/21. The Board noted that a new guardian, Dr Sally Morgan had been appointed in July 2020.

20.2 The exception reporting process is part of the new Juniors Doctors Contract to enable them to raise and resolve issues with their working hours and training. The Guardian's Quarterly report summarises all exception reports, work schedule reviews and rota gaps, to provide assurance on compliance with safe working hours by both the employer and doctors in approved training programs, and will be considered by CQC, GMC, and NHS employers as key data during reviews.

20.3 It was reported that no exception reports were received in the final quarter of 2019/20, with six received for the period April – June 2020. In terms of themes, Amjad Uppal advised that when people were new in post it would take time to get used to the new systems and ways of working. There were therefore no overarching themes for the exceptions raised; however, he offered the Board full assurance that any exceptions raised were addressed and actioned appropriately.

21. BOARD COMMITTEE SUMMARY REPORTS

21.1 Audit and Assurance Committee

The Board received the summary report from the Audit and Assurance Committee meeting held on 6 August 2020. This was noted.

The Board also received the Audit and Assurance Committee Annual Report. The report provided an overview of the Committee's work in the last financial year, from 1 October 2019 to 31 March 2020 in sections which reflect the headings in the Committee's terms of reference. The report also provided an overview of the work of the Committee in overseeing internal control mechanisms in the Trust as reflected in the Annual Governance Statement. No issues had been highlighted as areas of concern. The Board welcomed this report.

21.2 Resources Committee

The Board received the summary report from the Resources Committee meeting held on 27 August 2020. This summary was noted. An extraordinary meeting of the Resources Committee had taken place on 5 August to discuss the delivery options for the new Forest of Dean Hospital.

21.3 Quality Committee

The Board received the summary report from the Quality Committee meeting held on 1 September 2020. This summary was noted.

21.4 Mental Health Legislation Scrutiny Committee

The Board received a verbal report from the MHLS Committee meeting which had taken place on 23 September. A written summary would be provided to the next Board in November.

The Board noted the recommendation regarding the reappointment of two Mental Health Act Managers. Jan Marriott informed the Board that these were two highly experienced managers who continued to perform at a high standard, with no performance issues. The Board was happy to approve the reappointments.

22. COUNCIL OF GOVERNOR MINUTES

22.1 The Board received and noted the minutes from the Council of Governors meeting held on 22 July 2020.

23. ANY OTHER BUSINESS

23.1 There was no other business.

24. DATE OF NEXT MEETING

24.1 The next meeting would take place on Wednesday 25 November 2020.

Signed: ……..….. **Dated: ……**

Ingrid Barker (Chair)
Gloucestershire Health and Care NHS Foundation Trust

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 06/1120

PUBLIC SESSION TRUST BOARD: Matters Arising Action Log – 25 November 2020

Key to RAG rating:

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

Meeting Date	Item	Action Description	Assigned to	Target Completion Date	Progress Update	Status
30 Sept 2020	13.3	Guidance received had recommended the appointment of a Health and Wellbeing Guardian for the Board. It was agreed that the NEDs would discuss this further at their next meeting, with the aim of agreeing a nominated NED lead.	NEDs	25 November 2020	**Complete** Sumita Hutchison nominated as Health and Wellbeing Guardian.	

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 08/1120

REPORT TO: **TRUST BOARD – 25TH NOVEMBER 2020**

PRESENTED BY: Ingrid Barker, Chair

AUTHOR: Ingrid Barker, Chair

SUBJECT: **REPORT FROM THE CHAIR**

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

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

The purpose of this report is to
To update the Board and members of the public on my activities and those of the Non-Executive Directors to demonstrate the processes we have in place to inform our scrutiny and challenge of the Executive and support effective Board working.

Recommendations and decisions required

The Board is asked to:

- **Note** the report and the assurance provided.

Executive summary

This report seeks to provide an update to the Board on the Chair and Non-Executive Directors activities in the following areas:

- Board developments
- Governor activities
- Working with our system partners
- Working with our colleagues
- National and regional meetings attended and any significant issues highlighted

Work to improve and further develop the work of the Trust and the Board continues through Board sessions and external partnership meetings and sector update sessions as set out below. Key areas of focus remain ensuring effective system working, ensuring equality, diversity and inclusion are at the heart of how we work as a Trust and that the voice of our Trust is heard locally and nationally to ensure the needs of our community are understood and inform policy and practice.

Risks associated with meeting the Trust's values
None.

Corporate considerations	
Quality Implications	None identified
Resource Implications	None identified
Equality Implications	None identified

Where has this issue been discussed before?
This is a regular update report for the Trust Board.

Appendices:	**APPENDIX 1** Non-Executive Director – Summary of Activity – 1st September to 31st October 2020

Report authorised by:	**Title:**
Ingrid Barker	Chair

REPORT FROM THE CHAIR

1.0 INTRODUCTION AND PURPOSE

This report seeks to provide an update to the Board on the Chair and Non-Executive Directors activities in the following areas:

- Board developments
- Governor activities
- Working with our system partners
- Working with our colleagues
- National and regional meetings attended and any significant issues highlighted

2.0 BOARD

2.1 Non-Executive Director Update

The Non-Executive Directors and I continue to meet regularly. Virtual meetings were held on 15th October and 12th November and we will continue to have monthly meetings going forward. These meetings have been helpful check in sessions as well as enabling us to consider future plans.

I also continue to have regular individual meetings with all the Non-Executive Directors.

2.2 Board Updates:

Congratulations to **Sonia Pearcey**, the Trust's Freedom to Speak Up Guardian, who has been awarded an **MBE** for services to the NHS in the Queen's Birthday Honours. I am delighted that the way Sonia has taken forward this key role, embedded it across the Trust and supported its development across the region and nationally has been recognised.

Board Development

We continue to devote significant time to considering our Board ways of working and how we ensure that transformation remains central to the way we work, whilst the necessary focus is maintained on ensuring clinical safety and colleagues' wellbeing. The following sessions have taken place:

- **13th October** – Board development session facilitated by the King's Fund

- **21st October** – Board Seminar - sessions included Improved Health and Place and Equality, Diversity and Inclusion – two key areas that we are determined will be at the heart of how the Trust works.

A number of Executive and Non-Executive Directors have met in trios to progress work on Strategic Aims of Quality, Sustainability, People and Better Health. This will be further discussed separately at today's meeting.

3.0 GOVERNOR UPDATES

Council of Governors – 19th November where matters discussed included the Forest Hospital Development Consultation, Membership and Election Report, changes to the Constitution (which are on our agenda today) and Review and Refresh activities to take forward the Council of Governors in line with best practice and reflecting the expanded remit of the Trust.

I met with the **Lead Governor, Dr. Faisal Khan** on 22nd October for a regular 1:1. Dr Khan has confirmed that when his term of office comes to an end on 31st December that he will step down from his roles as Governor and Lead Governor and I would like to formally thank him for the contribution he has made to the Council. His thoughtful inclusive approach has been much appreciated.

One to One introductory meetings with new Governors Ruth McShane, Tracey Thomas, Dawn Rooke, Chris Witham, Dan Brookes and Juanita Paris have taken place. I am very pleased to welcome all of them to the Trust.

Membership and Engagement Strategy Working Group – two meetings have taken place on 28th October and 5th November. These focused on how we can ensure our membership is vibrant, engaged and represents our wider community, an area we will be building into the way the Council of Governors works, building on existing work.

The **Governors' Nomination and Remuneration Committee** met on 3rd November

A New Governor Induction Session took place on the afternoon of 12th November.

4.0 NATIONAL AND REGIONAL MEETINGS

Since the last meeting of the Trust Board in September, I have attended the following national meetings:

- **NHS Providers Annual Conference** took place on 6th, 7th and 8th October. The Trust was represented by a number of Board colleagues for the first ever virtual NHSP annual conference. This year's theme was 'reflect and recover' exploring the challenges of confronting the Coronavirus pandemic and the impact it has had on the healthcare sector. Sessions included Diversity in NHS Leadership; Supporting the workforce after the pandemic; Recovery and beyond; Regulation as an enabler; NHS supply chain; CQC forthcoming strategy.

- **NHS Confederation Mental Health Network** – I have been invited to attend weekly meetings when my diary permits and I attended on 1st October. I do hope to attend more of these meetings going forward.

- **NHS Providers Board** - 14th October and 4th November where we discussed important policy and national operational issues and current challenges and opportunities.

- **NHS Confederation NHS Reset Webinars** held on 12th October and 9th November were attended by some of the Non-Executive Directors. These recognise the continuing challenges faced by the NHS and the need to move effectively to a new normal taking with us the learnings from the last 6 months.

- **South West and South East Regional Meeting** – 9th October – due to annual leave I was unable to attend this meeting, but was represented by Vice-Chair Graham Russell. Simon Stevens (NHS CEO) and Amanda Pritchard (NHS Chief Operating Officer) talked about priorities around restoration of services, continued response to COVID 19 and national support available to Trusts

- **NHS England and NHS Improvement** – **Chairs Advisory Group** – I was very pleased to be invited by Lord David Prior, CEO of NHS England, to join the **NHSE/I Chairs' Advisory Group** and attended a meeting on 27th October 2020. The meeting considered forthcoming potential legislative changes through the draft NHS Bill. A further meeting will be held in the New Year.

- **South West Chairs meeting** – 28th October. It is hoped that a further meeting of the South West Chairs can be held prior to Christmas.

- **NHS Providers Community Network** – 28th October – the meeting included a national policy update from Danny Mortimer, CEO, NHS Confederation; an update on community health services and digital improvement from Matthew Winn, Director of Community Health and SRO for the Ageing Well Programme for NHS England and NHS Improvement; and a digital health service case study from Karen James, CEO, Tameside and Glossop Integrated Care NSHFT.

- I was invited by Professor Andrew Corbett-Nolan to co-chair a **Good Governance Institute (GGI) webinar** on Weds 11th November regarding Integrated Care Plans (ICPs) : the at pace development of Place that will make Integrated Care Systems (ICSs) succeed. The GGI have arranged a series of weekly breakfast webinars relating to ICSs and ICPS over the next 6 weeks for Non-Executive Directors.

5.0 WORKING WITH OUR PARTNERS

I have continued my regular meetings with key stakeholders and partners where views on the working of the health and care system and the way we can mutually support each other are key issues for consideration. Highlights are as follows:

- Along with the Chief Executive and the Director of Strategy and Partnerships, I attended two meetings of the County's **Health Overview and Scrutiny Committee** (HOSC) as follows:

22nd October where the Committee considered proposals and an outline plan for consultation relating to the next phase of the **Fit for the Future Programme**. It also considered proposals and an outline for the consultation relating to the development of the **new community hospital for the Forest of Dean**.

17th November where matters discussed included an update on changes to community phlebotomy services, including recent revisions to the arrangements in the Cirencester area; an overview of performance by Gloucestershire Clinical Commissioning Group; an update on ambulance service response times during the COVID-19 pandemic; an update from the Director of Public Health; an update from the One Gloucestershire Integrated Care System (ICS) Partnership; and an update from the Gloucestershire Clinical Commissioning Group Clinical Chair and Accountable Officer.

- On **11th November** the Trust held its **Annual Briefing Meeting with Members of the Health Overview and Scrutiny Committee** where items discussed included an overview of the Trust's activities over the last year; planning preparations for winter and flu; the Trust's response to COVID-19, including an example of service recovery; along with updates on Pillar 1 testing; First Contact Physio; School Immunisations Programme and Mental Health and Learning Disability developments.

- I met with the **County's Health Chairs** on 17th November – these sessions are very helpful in supporting our partnership working.

- As a **Governor** of the **University of Gloucestershire Council** I have attended several meetings over the last couple of months. This link will assist with some of the workforce challenges faced by the Trust and the wider system, as well as developing research and other potential links between our two organisations.

- The **Chair of Gloucestershire Hospitals NHSFT**, Peter Lachecki, and I continue to meet virtually on a regular basis to discuss matters of mutual interest.

- I also continue to have regular meetings with the **Independent Chair of the ICS Board (Integrated Care System), Dame Gill Morgan.**

- The **ICS Board** has continued to meet virtually and meetings were held on 15th October and 19th November where we discussed a number of important operational and strategic issues. Partnership work was a key aspect of the County's response during the pandemic and this group helps ensure effective working is supported.

- I attended the **Gloucestershire GP Education Trust (GGPET) AGM** on Weds 11th November

6.0 WORKING WITH THE COMMUNITIES AND PEOPLE WE SERVE

On 18th November, I was very pleased to be invited by Bren McInerney BEM to pay a virtual visit to **The Shire** based in Northgate Street in Gloucester. The Shire is a purpose-built hub that has a particular focus on young people offering a wide range of activities and youth programmes intended to enrich and develop young people's physical, mental and emotional well-being. I am hoping to visit in person in the new year.

The dream, vision and reality of the Shire has been taken forward by Kirstie O'Connor Farrant, Director of Streetzahead, with no grants or claim to public monies. It is an extraordinary testament to what can be achieved.

7.0 ENGAGING WITH OUR TRUST COLLEAGUES

Along with several other Board members, I attended the first meeting of the Trust's **Diversity Network** on 19th October. This new forum brings together members from the BAME, LGBTQ, Disability and Women's networks.

As part of my rotational attendance at Board Committees, I attended a meeting of the **Quality Committee** on 3rd November and gained assurance on the way we are progressing our focus on quality across the Trust's services at the same time as ensuring preparedness for COVID-19.

Armistice Day events - 11 November:

- **Trust Remembrance Ceremony** – because of the COVID restrictions, this year the Trust's annual Remembrance ceremony and two-minute silence was held on line via Microsoft Teams, but nevertheless it remained a poignant and heartfelt ceremony led by CEO Paul Roberts. We were honoured to have Team Manager Rebecca Walder reading the poem Taking a Stand by John Bailey and Quality Improvement Manager Tracey King marked the two-minute silence at 11am with the playing of the Last Post and signalled its end with The Rouse.

- **Nicola Shilton**, Partnership and Inclusion Assistant Development Worker, and a veteran, laid a wreath on behalf of the Trust and the NHS at Gloucester Railway Station on the morning of 11th November as part of the 'Poppies to Paddington' initiative. Swathes of poppy wreaths were placed on Great Western Railway trains and carried to London Paddington station for Remembrance Day.

As part of my regular activities, I also continue to have a range of 1:1 meetings with Executive colleagues, including a weekly meeting when possible with the Chief Executive and the Head of Corporate Governance.

8.0 NED ACTIVITY

A **briefing for Non-Executive Directors** on the Trust's response to COVID-19 took place on 9th November. Updates were given by the Chief Executive, Chief Operating Officer,

Director of Nursing, Deputy Chief Operating Officer and the Head of Children and Young People's Services.

The Non-Executive Directors continue to be very active, attending virtual meetings across the Trust and where possible visiting services.

See Appendix 1 for the summary of the Non-Executive Directors activity for September and October 2020.

9.0 CONCLUSION AND RECOMMENDATIONS

The Board is asked to **NOTE** the report and the assurance provided.

Appendix 1

Non-Executive Director – Summary of Activity – 1st September to 31st October 2020

NED Name	Meetings with Executives, Colleagues, External Partners	Other Meetings	GHC Board / Committee meetings
Graham Russell	Joint Director of Primary Care etc. PwC Internal Auditors Trust Chair and NED Director of Finance and Director of HR/OD Director of Finance Trust Chair	Good Governance Institute Audit Committee evaluation South West Chairs Meeting with King's Fund NHS Providers Annual Conference (3 days)	Nomination and Remuneration Committee NEDs meetings Informal Trust Board Board Development and Board Seminar ICs Board Trust AGM Trust Board Resources Committee Charitable Funds Seminar
Marcia Gallagher	Head of Corporate Governance (2) Trust Chair (2) Chair of Quality Committee ASC Partnership Board (2) Senior Leaders Network PriceWaterhouseCooper Director of HR	Meeting with Prof Andrew Corbett-Nolan, Good Governance Institute NHS Confederation / NHS Reset Audit of Complaints Good Governance Institute Seminar Audit Committee Review of Effectiveness NHS Providers Annual Conference (3 days)	Nomination and Remuneration Committee Quality Committee Council of Governors Informal Board meeting Trust Board Governors meeting MHAM Forum

NED Name	Meetings with Executives, Colleagues, External Partners	Other Meetings	GHC Board / Committee meetings
	Women's Leadership Forum GHFT AGM Health & Safety Meeting with Deputy Head of Corporate Gov. Diversity Network Director of Finance	NHS Confederation – Chairs/NEDs NHS Providers Community Network	MHLS Committee NEDs meetings Board Development and Board Seminar MHAM Section 3 Hearing Charitable Funds Workshop
Jan Marriott	LD team meeting / away day Senior Leaders Network ICs Clinical Council 2 NED Trust Chair Cheltenham Know Your Patch meeting	Bevan Brittan Mental Health Act Update Webinar Audit Committee evaluation MHA Operations Group Cheltenham Population Health Management Development Programme	Quality Committee Board meeting Council of Governors Board Development and Board Seminar MHLSC Trust AGM Trust Board NEDs meetings Mental Health Act Manager Forum Resources Committee Governors Membership and Engagement Steering Group

NED Name	Meetings with Executives, Colleagues, External Partners	Other Meetings	GHC Board / Committee meetings
Maria Bond	NTQ virtual catch up Trust Chair NED Director of Strategy and Partnerships Senior Leadership Network Meeting with Internal Audit Deputy Chief Operating Officer Deputy Director of Nursing Head of Corporate Governance Director of Nursing (2) Director of Strategy and Partnerships	NHS Chairs Reset meeting Learning Difficulties away-day NHS Providers Annual Conference (3 days)	Quality Committee NEDs meetings MHAM Forum Informal Trust Board Board Development and Board Seminar Trust AGM Trust Board
Sumita Hutchison	Trust Chair Medical Director Director of HR and Consultant Gloucester Governor Senior Leadership Network NQT Team Talk	NHS Providers Annual Conference (3 days)	Quality Committee Board Development and Board Seminar Trust Board Informal Board meeting Council of Governors Trust AGM Resources Committee

NED Name	Meetings with Executives, Colleagues, External Partners	Other Meetings	GHC Board / Committee meetings
			Charitable Funds Workshop NEDs meetings
Dr. Stephen Alvis	Trust Chair Chair and NED meeting Senior Leadership Network Cheltenham ILP Director of Finance Medical Staffing Officer NED Gloucester ILP	NHS Providers NED Induction (2 days) Consultant Psychiatrist Interview Panel member (2 days) Mental Health Act Webinar NHS Chairs Reset	Quality Committee NEDs meetings Mental Health Legislation Committee Trust AGM Trust Board MHAM Forum Board Development and Board Seminar
Steve Brittan	Trust Chair Director of Nursing (2) Head of Research	NHS Chairs Reset Meetings NHS Providers NED Induction (2 days) NHS Providers Annual Conference (3 days) Introductory meeting ref technology project Audit Committee evaluation	NED meetings Council of Governors Informal Board Meeting Board Development and Board Seminar Trust Board Meetings Resources Committee Trust AGM

AGENDA ITEM: 09/1120

REPORT TO: **TRUST BOARD – 25 NOVEMBER 2020**

PRESENTED BY: Chief Executive Officer and Executive Team

AUTHOR: Paul Roberts, Chief Executive Officer

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

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

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

The purpose of this report is to

Update the Board and members of the public on my activities and those of the Executive Team.

Recommendations and decisions required

The Board is asked to note the report.

Executive summary

The activities reported inevitably continue to be heavily impacted by the response to the pandemic but we are also moving forward other projects, for example the Forest of Dean hospital proposals and looking at ways to ensure continuous improvement across our operation, involving services users and staff to inform us.

An update on changes of Team within the Deputy Executive tier is provided, as well as updates on our Flu Programme and EU Exit plans.

Risks associated with meeting the Trust's values
None identified

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

Where has this issue been discussed before?
N/A

Appendices:	Report attached

Report authorised by: Paul Roberts	**Title:** Chief Executive Officer

CHIEF EXECUTIVE OFFICER AND EXECUTIVE TEAM REPORT

1.0 CHIEF EXECUTIVE ENGAGEMENT

Over the last two months we have started to see a steady increase in the number of Covid positive cases in the local community, and more recently we have seen a marked increase in admissions to local acute hospitals and now into community hospitals too. The ongoing management of Covid-19, particularly since the NHS was put back onto "level4" incident response, is a significant and challenging focus for the Trust including the adjustment to the recent 'lockdown' restrictions, but the organisation is also working to move forward other projects, for example the public consultation on the Forest of Dean Hospital proposals and continuous service improvements.

In recent weeks, Black History Month has again provided an opportunity to reflect on our Equality, Diversity and Inclusion (EDI) agenda. Our Trust is committed to having an inclusive and compassionate workplace, and as a public body we have a duty to work with our partners to develop fair and cohesive communities. We now need to look beyond Black Lives Matter and Black History Month and make promoting equality and diversity and ending discrimination 'business as usual'. We continue to work hard on developing our EDI strategy and, within the body of my report, I provide an update on the work being undertaken with our local BAME (Black Asian and Minority Ethnic) community to further this aim. Our Diversity Network continues to gather pace and the work streams/networks (BAME, LGBQTI+, Disability and Women's) have all been well attended, as has the overall network itself.

The Covid-19 Pillar 1 testing team at Edward Jenner Court (EJC) is back in full swing and we have now reached an agreement with our system partners to extend the service provided to meet the ever-increasing demand in the county. There are now three testing pods (with a possible option to introduce a fourth) and the service is providing testing for staff and household contacts for GHC and Gloucestershire Hospitals Foundation Trust (GHFT) and testing for adult social care – pre-placement and pre-operation for GHC, GHFT and certain out of county services.

I have visited a number of our service centres over the last few months. I value the opportunity to hear first-hand how different colleagues are experiencing their new ways of working and how they are coping with the ever-changing challenges presented to them. Recently I have visited the Vale Community Hospital and Wotton Lawn hospital, where I was able to safely meet with colleagues and patients and be on hand to discuss any topics or issues that they wished to raise.

In light of the challenging times facing our staff and communities, the Trust has been working hard to promote the different forums colleagues can use to ensure their voice is heard. The spotlight has been shone on the need to speak up against racism, discrimination and poor practice to ensure accountability and the opportunity to continually improve. It takes courage and strength to speak up, and we need to be pro-active in ensuring colleagues feel comfortable to speak up on any topic of concern to them. The adaptions of our practices in response to the pandemic have, in this instance, supported this engagement as colleagues are able to join these forums on

line without needing to build in additional time for travel and the level of involvement has been very encouraging.

I would like to take this opportunity to congratulate Sonia Pearcey, our Freedom to Speak Up Guardian, who has been awarded the MBE in the Queen's Birthday Honours List. Sonia has been a nurse for 32 years and her MBE is in part due to her work in supporting Trust staff to speak up about anything that gets in the way of providing good care. We are delighted that one of our colleagues has received such recognition and thank Sonia for her ongoing contribution to our Trust and our communities.

Wednesday 14th October marked national AHP Day a day to celebrate the major contribution our collective Allied Health Professionals make to patient care and improving the quality of people's lives. To mark the event, myself and some of our heads of profession, leads, directors and executives recorded video messages to say a huge 'thank you' to all our fabulous AHPs for the amazing work they do, each and every day. Reflecting the key role AHPs play not just within our Trust but across the county I am pleased to highlight that Sarah Morton, our Head of Profession for Physiotherapy, has been appointed to the part-time role of Chief Professional Lead for Allied Health Professions for Gloucestershire Integrated Care System (ICS) and will be helping shape the future of AHP development in the county.

The NHS and the military have always had close links and therefore it was particularly appropriate and poignant on Armistice Day to mark the two-minute silence via Teams for the whole Trust with Tracey Moss playing the Last Post and the Reveille live and Rebecca Walder, a services veteran, reading a poem.

I am truly grateful to our entire workforce, both clinical and support, who have worked brilliantly and flexibility to serve our patients and communities. I am incredibly proud of all of my colleagues for their hard work and dedication throughout this tough year and I am confident that our Trust team will continue to work together and rise to the challenges being thrown at us.

I have continued to attend a range of meetings, including:

1.1 Internally

A **Board Development Seminar** was held on 13th October, which was facilitated by the Kings Fund, an English health charity that shapes health and social care policy and practice, provides NHS leadership development, and hosts health care events, who we have been working with for a period of time. The seminar focused on reflecting on our experience of our first year as a Trust and on reviewing the Board's diverse membership in order to maximise effectiveness and identify learning and development opportunities. A **Board Seminar** was also held on 21st October, during which the Board explored the topics of – **Improved Health and Place** and **Equality, Diversity and Inclusion.** The second session included talks from Dr Habib Naqvi MBE, who has recently taken on a new role as the Director of NHS Race and Health Observatory, and Sonia Pearcey MBE, GHC's Freedom to Speak Up Guardian and Ambassador

for Cultural Change. The sessions provided invaluable time to facilitate leadership development, helping to achieve our core value of always improving.

Monthly **Team Talk** sessions continue to be held as digital events and are led by an Executive or a deputy. They are open for all Trust employees to attend and provide an opportunity for the Executive Team to share the latest Trust news and for staff to share their thoughts, feelings and concerns. The sessions typically cover an update on the latest Covid and Workforce news, amongst other recent items of interest, such as the annual NHS staff survey and the Appreciation and Long Service Recognition Evening. The programme helps to ensure effective communication across the Trust and provides an opportunity for the staff voice to be heard directly by the Executive Team.

A **Senior Leadership Network** (SLN) meeting was held on 3rd November as a virtual event. The meetings provide an excellent opportunity to update the SLN on Trust and national developments. The November session had a particular focus on staff health and wellbeing, including an update on from the National Guardian, Dr Henrietta Hughes, and from Sonia Pearcey on our local Freedom to Speak Up work. We were delighted to have a presentation from the Memory Services and a presentation on resus updates and developments.

Corporate Induction continued to be run via weekly face-to-face sessions (during the 4-week lockdown the sessions have been moved online), with reduced numbers to allow adequate social distancing. Each session is attended by either myself or a member of the Executive Team to welcome personally new colleagues and provide an overview of the Trust and how we live our values. It is important that the Executive Team are visible from day one, so that all staff members feel able to approach us with comments, concerns or new ideas. In light of Covid, there was a need to review alternative ways of delivering training and a great deal is now available as eLearning.

The Trust remains committed to **recruiting a highly skilled and dedicated workforce** and I was recently interviewed for a new recruitment video to be used at virtual career fairs. Our staff are fundamental to delivering high-quality services and patient care and the Trust's recruitment team regularly attends virtual recruitment events to encourage candidates to apply to work for our diverse and exciting Trust. In recent weeks, I have had a number of one to one meetings with candidates for senior positions and recently appointed senior managers to provide a more comprehensive understanding of the aspirations of the Trust, and expectations of the roles.

The Trust has reinstated its daily **Covid-19 Briefing calls** for senior and on call managers. These calls provide daily national, regional and local updates and data on the number of Covid positive patients in Gloucestershire hospitals. They also provide an update on the GHC testing team, number of staff isolating and any PPE stock updates. These calls ensure we can respond quickly to changes, and are able to assess resilience in these key areas on a daily basis and put it place any actions required.

I attended the **JNCF** meeting on 11th November to provide the Chief Executive update on national, system and Trust level priorities and issues. Other members of the Executive team presented verbal updates on their areas and Sarah Birmingham,

Deputy Chief Operating Officer, provided a Trailblazer update. General updates on finance and HR were provided, with Neil Savage, Director of HR & OD, also presenting the recent Resources Committee report. Attendees, as usual, had an opportunity to raise any concerns or issues and to comment on any of the items raised. The thoughtful and thorough way colleagues engage with the meetings is much appreciated.

I attended a **Council of Governors meeting** on 19th November, which is reported on in more detail in the Chair's report.

I attended the regular meetings of the **Medical Staffing Committee** on 2nd October and 6th November and the **Local Medical Council** on 12th November, both via virtual forums.

The **Enhanced Independence Offer (EIO) Working Group,** which was set up some time ago to support the taking forward of the Reablement Strategy across Gloucestershire, has been re-established, following a short break due to the onset of the Covid pandemic. Positive progress has been made with the longer-term aspirations around the new delivery model of EIO and Reablement services. The group will facilitate discussions regarding how the delivery of the longer-term transformation can be achieved, whilst also meeting this year's priority around delivery. I will be chairing the working group for the time being, assisted by Angela Potter, Director of Strategy and Transformation, as we move forward with this important piece of work.

The **Walk In My Shoes (WIMS) Community Lead Mentoring Programme** continues to gain momentum. Community members, led by Valerie Simms, who initiated and lead the project met with NHS leaders on 15th October, this was chaired by Dame Gill Morgan, independent Chair of the Gloucestershire ICS. The purpose of the meeting was to facilitate group introductions, to brief NHS colleagues on the WIMS Programme and to explain the role of the ICS and its commitment to the Equality Diversity and Inclusion (EDI) agenda. We are due to meet again shortly to hear in more detail the experiences and priorities of the community members of this partnership...

The **reverse mentoring sessions** have now commenced and I am positive that the NHS Leaders involved in the programme will gain invaluable insight and knowledge by "walking in the shoes" of local BAME community advocates. The WIMS programme was featured on BBC Points West on Sunday 18th October, which highlighted the aims and aspirations of the programme and promoted the excellent work being done by the BAME advocates.

I also had meetings with two Trust colleagues, Vinod Mani and Dominika Lipska-Rosecka, who have recently been successful in their applications to join NHS England's **Workforce Race and Equality Standard (WRES) Experts Programme**. It is excellent news to have two WRES experts within our workforce as we strive to improve our organisation in terms of race equality.

I am involved, along with other GHC Directors, in the **Reciprocal Mentoring Scheme** and have continued to have meetings with my reciprocal mentoring partners. The

scheme is based on the concept of reverse mentoring, with the addition of the relationship between the mentor and mentee being reciprocal in nature, enabling allies and equal partnerships designed to create systemic transformational change. A workshop was held on 4th November, which was run by the **Leadership Academy**, to help revive and refresh the programme. The Trust is committed to focussing on and supporting our underrepresented colleagues and we are committed to continue with this excellent programme and tackle inequalities in our Trust.

1.2 ICS (Integrated Care System) and System Partners

Our Trust plays an important role in the Gloucestershire system with colleagues working committedly to meet the needs of our community. I have regular meetings with the **CEO of Gloucestershire Hospitals NHS Foundation Trust (GHFT)** and the **Accountable Officer for Gloucestershire Clinical Commissioning Group (GCCG)** to keep abreast of any issues facing our partner organisations so that mutual help and support can be provided. I also continue to have regular meetings with senior officers and Leaders at Gloucestershire County Council and recently had an introductory meeting with William Warrender, newly appointed **CEO of South Western Ambulance Service NHS Foundation Trust**.

I have recently agreed to take on the role of lead CEO for equality as the partnership seeks to develop its approach to systematically tackling inequality and co-ordinate its response to the recent DPH Annual Report: Beyond Covid (summarised below and which we have considered earlier in this meeting).

I have attended the monthly **ICS Board**, **ICS Executive** and **ICS CEO Meetings**, which continue to focus on system-wide planning and resilience, and provide updates on organisational matters and projects such as Fit for the Future. The regular meetings, held with senior colleagues across the health system, help ensure joined up working and provide a forum to discuss items affecting multiple partners.

I attended the **Health Overview and Scrutiny Committee** on 22nd October and 17th November, where the committee discussed various matters including an update on the Fit for the Future Programme, which allowed consideration of the proposals and outline plan for the next phase of consultation, and an update on the Forest of Dean Community Hospital.

The **public consultation** for the new **Forest of Dean Hospital** was launched on Thursday 22nd October and will run until Thursday 17th December. Our Trust announced the site as the Lower High Street Playing Field in Steam Mills Road, Cinderford, in December 2019 and has been working with Gloucestershire Clinical Commissioning Group since then to reach the stage where we can put a proposal about the new hospital to the public.

The proposal is for a hospital which includes a 24-bed inpatient unit, urgent care facility, x-ray, ultrasound and endoscopy, and a range of consultation and treatment rooms for outpatient appointments. Experiences of providing care throughout the ongoing COVID-19 pandemic will influence the final design, to minimise the

risk of infections spreading and to allow for social distancing between staff and patients. The proposals can be found at www.fodhealth.nhs.uk or getinvolved.glos.nhs.uk

The **GHC Annual Briefing with Gloucestershire County Council Health Overview and Scrutiny Committee** was held on 11th November. Angela Potter provided an overview of the Trust Annual Review and look ahead, and colleagues provided an update on the Trust's response to Covid-19 and other service news, including the winter and flu campaigns.

The system **Gold Health System Strategic Command CEOs** call has continued to be in operation over the last three months as part of the **Gloucestershire ICS Covid-19 Response Programme**; albeit recently at a reduced frequency of twice or three times a week. This forum has proved essential in overseeing the system response to the Covid pandemic and in providing a regular liason point between senior leaders in the NHS system.

On 20th October, Bren McInerney invited me to attend the **opening of the 'Shire'**, a purpose built hub in Gloucester City, aimed at providing young people with a safe, creative, and inspiring environment. The hub is truly impressive and offers a wide range of activities and youth programmes intended to enrich and develop young people's physical, mental and emotional wellbeing. The dream, vision, and reality of the Shire has been taken forward by Kirstie O'Connor Farrnat, Director of Streetzahead, and now offers an excellent space in the heart of Gloucester for young people to flourish. I always welcome the opportunity to visit and engage with the communities our organisation serves and to learn more about the other services available in the local area.

I have attended the bi-weekly **Gloucestershire MP briefings**, led by CEOs of the Gloucestershire NHS organisations and senior County Council officers and Leaders. These have focussed on the latest developments in the management of the Covid-19 pandemic and, in particular providing updates on acute service issues, PPE, testing and public health updates.

1.3 National and Regional Meetings

There has been a plethora of national and regional meetings held virtually throughout the Covid-19 pandemic to support the valiant efforts of all the NHS Trusts in the region. Amongst others, these have included:

- MH/LDA (Mental Health/Learning Difficulties and Autism) Covid-19 Response webinar for Trust CEOs;
- SW Regional Chief Executive meetings, chaired by Elizabeth O'Mahony;
- SW MH (Mental Health) CEO's meetings, chaired by Anne Forbes; and
- Gloucestershire Phase 3 Recovery Planning meeting, chaired by Elizabeth O'Mahony.

I attended the **South West & South East Regional Roadshow** meeting, chaired by Elizabeth O'Mahony, on 9th October. Simon Stevens (NHS Chief Executive) and Amanda Pritchard (NHS Chief Operating Officer) also participated in the meeting. The call allowed a discussion on the priorities around restoration of services, the continued response to Covid-19 and national support available.

I have recently been appointed Chair of the West of England **Patient Safety Collaborative Board** and I chaired a meeting of the Board on 20th October. An update on the National Patient Safety Commission was presented, as well as a verbal update on Patient Safety Specialists. Dr Matt Inada-Kim, Acute Physician and National Clinical Lead-Deterioration / Sepsis, attended the meeting to provide a welcome update on national guidance and virtual ward wave 1 pilots around the country, and Dr Hein Le Roux provided a presentation on the Gloucestershire COVID Virtual Ward.

On 22nd October I attended the **South West Imaging Network Event**. The network has been established, in part, due to the recent publication of Professor Sir Mike Richards' report: Diagnostics: Recovery and Renewal, which sets out the case for the transformation of NHS diagnostics services, to build capacity and drive productivity in order to meet the rising demand for certain critical services. The meeting saw interesting discussions on how NHS diagnostic services could be managed and run moving forward to support Trusts in delivering the improvements and high impact interventions identified. As a result of my input I have now been asked to join the South West Imaging Regional Focus Group to steer the development of this programme.

The **NHS Providers Annual Conference and Exhibition** ran from 6th to 8th October, facilitated through an online platform with interactive sessions and debates. The highlights from the conference included a panel discussion around inclusive leadership within the NHS and an informative Q&A discussion on the CQC's forthcoming strategy. The NHS England Chief Executive, Sir Simon Stevens, and the social care minister, Matt Hancock, delivered key note addresses and there was a number of interesting and lively discussions on a range of current topics.

2.0 FLU PROGRAMME

Our flu vaccination programme is well underway and, despite a slight delay due to a vaccine shortage, the service is now back up and running. We have already received more than 2,000 online bookings from colleagues and our peer vaccinators are also doing a fantastic job of vaccinating colleagues and teams across our sites.

This year the vaccination is more important than ever. We know that if someone contracts both flu and Covid the health consequences could be very serious. We don't yet have a vaccine for Covid, but we can have the flu jab to protect ourselves, our patients, colleagues, friends and family members.

3.0 TEAM CHANGES

John Campbell, Chief Operating Officer (COO), is working to build more resilience into a revised operational structure. This will include moving to a **two Deputy COO model**,

enhancing leadership within the Children's and Young People's service directorate, given the significant amount of transformation within this area, and retaining the revised community service configuration, introduced during Covid, that has worked effectively.

Sarah Birmingham, previously Associate Director of Operations for GHC**,** has been permanently appointed into one of the Deputy COO roles (Service Group 2) which includes Children and Young People Services; Mental Health and Learning Disability Community Services and Covid Operational Services. On behalf of the Board, I would like to formally congratulate Sarah and wish her every success with her new role.

Hilary Shand joined the Trust in the week commencing 12th October as **Interim Deputy Chief Operating Officer.** Hilary undertook a brief induction period with Sian Thomas, prior to her departure, to ensure a smooth handover. It is intended that Hilary will be with us to the end of March 2021 whilst we recruit to the second role of Deputy Chief Operating Officer.

Hilary's previous assignment was working for Cornwall Partnership NHS Foundation Trust for the last 2 years, who operate a similar range of services to GHC. She managed a range of community services and led on Discharge 2 Access and implementation of the 'Home First' model. She has also worked in North West London on developments to improve urgent care flow and capacity within a challenged system and as an Interim DCOO for North Bristol NHS Trust, an Acute provider with over 860 beds**.** I would like to take this opportunity to warmly welcome Hilary to the Trust.

4.0 RECENT NATIONAL AND LOCAL REPORTS

4.1 Care Quality Commission – Annual Assessment of the state of health and social care in England

The **Care Quality Commission (CQC)** recently published its **annual assessment** of the **state of health and social care in England**, which looked at the quality of care over the past year - https://www.cqc.org.uk/publications/major-report/state-care. The report looks at the trends, shares examples of good and outstanding care, and highlights where care needs to improve. The report includes the period before the full impact of COVID-19 began to be felt and CQC's routine inspections were suspended as a result of the pandemic.

This year's main findings were summarised into four areas – 1) Quality of care before the pandemic; 2) The impact of the coronavirus pandemic; 3) Collaboration between partners; and 4) Looking forward, the challenges and opportunities ahead.

Pre-COVID-19, care was generally good, but with little overall improvement and some specific areas of concern highlighted. Since the arrival of COVID-19, the areas of concern remain, but so much else has changed.

The progress achieved in transforming the way care is delivered has been extraordinary. In a matter of days, services developed new procedures and ways of

working, often taking advantage of technology. Changes which were expected to take years – like the switch to more flexible GP consultations by phone and online – took place almost overnight. This report highlights many examples of collaboration among services which have made a real difference to people's care. The challenge now will be to keep and develop the best aspects of these new ways of delivering services while making sure that no one is disadvantaged in the process.

At the start of the pandemic, the focus on acute COVID-19 care was driven by the urgent imperative that the NHS should not be overwhelmed. Decisions were made in order to ensure capacity as quickly as possible – but now priorities need to be reset in a more sophisticated way to ensure that the longer-term response includes everyone, regardless of what kind of care they need, or where they receive it.

This resetting of priorities starts with local leaders seizing the opportunity to collaborate and building capacity to respond together to the needs of their area. The fact that the impact of Covid has been felt more severely by those who were already more likely to have poorer health outcomes – including people from Black and minority ethnic backgrounds, people with disabilities and people living in more deprived areas – makes the need for health and care services to be designed around people's needs all the more critical.

Over the summer, CQC reviewed the way health, social care and other local services worked together in 11 parts of the country. There were differences in the way they responded to the pandemic but there was evidence that the places with established working relationships and an understanding of need in their local areas were better able to care for the local population in a time of crisis.

The reviews have brought into focus the learning that needs to be used to help plan for a longer-term response to the virus. It is essential that the right support is available for all parts of a local health and social care system to drive improvements where they are needed, and to involve voluntary and community organisations in promoting health and wellbeing.

In social care, COVID-19 has not only exposed but exacerbated existing problems. The sector, already fragile, faced significant challenges around access to PPE, testing and staffing – and coordinated support was less readily available than for the NHS. The long-standing need for reform, investment and workforce planning in adult social care has been thrown into stark relief by the pandemic.

The report makes clear that these issues need to be urgently addressed – underpinned by a new deal for the care workforce, which develops clear career progression, secures the right skills for the sector, better recognises and values staff, invests in their training and supports appropriate professionalisation.

In the NHS, emergency departments now face the prospect of a winter which combines pre-existing pressures with the urgent demands of the pandemic. As other services restart, physical distancing will provide significant challenges, both logistically and in terms of managing capacity, alongside a backlog of people who were unable to access care during lockdown.

The impact of COVID-19 on the NHS in terms of elective, diagnostic and screening work has been enormous. Some life-changing operations have still not been rescheduled and there are people whose cancer has not been diagnosed or treated. As we enter a second wave, there must be learning to ensure that non-COVID-19 patients are not left behind. The NHS is already working hard to develop innovative solutions – collaborative partnerships between providers could help to protect services so people get the care they need.

It will also be particularly important that those services where improvement was already not quick enough – for example mental health and maternity – do not fall further behind. Concerns about these service areas have led to risk-based inspections during the pandemic with enforcement action taken as a result. With the recognition that COVID-19 has fundamentally changed so much, it is important to recognise what has not changed. Problems that existed before the pandemic have not gone away – and people are still more likely to receive poorer care from some types of services for reasons that pre-date COVID-19.

This recent report will be informing our thinking going forward. It highlighted the seismic shift achieved in response to the pandemic but also indicated clearly further work, particularly in relation to inequalities which needs to be taken forward.

4.2 Director of Public Health Annual Report 2019/20: Beyond Covid: Race, Health and Inequality in Gloucestershire

The **Director of Public Health Annual Report 2019/20: Beyond Covid: Race, Health and Inequality in Gloucestershire** has recently been published and you can read the full report here: https://www.gloucestershire.gov.uk/gloucestershire-county-council-news/news-october-2020/public-health-report-calls-for-action-on-health-inequalities-faced-by-bame-residents/. This year the report has been co-authored by **Sarah Scott, Director of Public Health** and **Gloucestershire County Council Black Worker Network.**

The report, which will be presented at this meeting, looks at the long-standing health inequalities faced by people of a BAME background in Gloucestershire and the impact of the COVID-19 pandemic.

The COVID-19 pandemic and lockdown has affected everyone in profound ways this year but a disproportionate share of the burden has fallen on those who already experienced health inequalities. Even after accounting for the effect of sex, age, deprivation and region, people of Bangladeshi ethnicity had around twice the risk of death than people of White British ethnicity during the first wave. People of Chinese, Indian, Pakistani, Other Asian, Caribbean and Other Black ethnicity had between 10% and 50% higher risk of death when compared to White British.

These disparities are largely the result of long-standing structural racism which produces social and economic inequalities in the conditions in which BAME people are educated, work and live. The strength of feeling demonstrated in the wake of

George Floyd's death shows the hurt felt by many on our county that these inequalities are not meaningfully addressed.

The pandemic has also highlighted the strength and resilience within our diverse communities. People have come together to donate and deliver food, check in on neighbours and collect their prescriptions. Working together in partnership, listening, and using these strengths will be key to tackling the systemic and structural issues this report highlights.

5.0 EU EXIT UPDATE

The Trust continues to keep up to date with the latest Brexit updates as we move ever closer to the end of the Brexit transition period date of 31st December 2020. **John Campbell, Chief Operating Officer, will be the Senior Responsible Officer for the EU Exit for GHC** as it is crucial that this work is fully co-ordinated with the Covid response and winter planning.

The NHS held a National Webinar, chaired by Professor Keith Willetts, on 4th November 2020, the purpose was to update NHS Colleagues on the current position and future planning assumptions. The NHS have advised for all Trusts to prepare for a no-agreement situation, this is the default position whilst negotiations still continue. The NHS is to remain agile while planning for the default scenario, in case an agreement is reached.

Following on from the webinar the Trust EU Exit Oversight Group was convened on 12th November 2020, the purpose was to update members from all directorates with the current National picture and seek assurance on the Trust level of preparedness prior to the end of the transition period.

The key points for the Trust planning and Assurance are in line with the previous arrangements of 2019. These points are:

- Continuity of Supply
- Improved trader readiness
- Winter pressures
- Increased complexity for reciprocal and cost recovery
- Staffing Resilience
- Data
- Ongoing review of Government planning assumptions

The planning and assurance for the Trust will be managed in line with Covid-19, Winter and Surge, which is also following the National NHS arrangements. Such as:

- Escalation of issues through the EPRR routes as used presently for Covid-19 Response
- Local response should be system-wide working with partner agencies within STPs
- A single unified response structure
- SitRep reporting will be aligned to Covid and Winter
- There will be National Incident Co-ordination

- There will be a National Commercial and Procurement Cell
- Includes EPRR and Shortage response

Time line

- October – November: Time to make ready the NHS system to ensure a resilient operational response. Plans developed (reviewed) and tested.
- December – January: Finalise planning and test system robustness.
- January 2021 – Continuous response.

All members of the Trust EU Exit Oversight Group provided their updates as no issues to report, robust arrangements in place as all are linked to their respective NHS service reporting lines.

The EU Exit strategy remains vitally important to all NHS Trusts and GHC are working hard, led by the national guidance, to ensure we have all the necessary preparations in place by the beginning of next year.

6.0 CONCLUSION AND RECOMMENDATIONS

The Board is asked to **NOTE** the report and the assurance provided.

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AGENDA ITEM: 10/1120

REPORT TO: **TRUST BOARD – 25 NOVEMBER 2020**

PRESENTED BY: Angela Potter, Director of Strategy & Partnerships

AUTHOR: Angela Potter, Director of Strategy & Partnerships

SUBJECT: **INTEGRATED CARE SYSTEM UPDATE**

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

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

The purpose of this report is to
This paper provides an update on the activities that are taking place across the Gloucestershire Integrated Care System (ICS).

Recommendations and decisions required

- Trust Board is asked to **note** the contents of this report.

Executive Summary

Ongoing dialogue with the Health Overview and Scrutiny Committee took place on the 17th November 2020 and included updates on community phlebotomy and the system wide performance.

The Integrated Locality Partnerships have now also re-commenced their activities and started to revisit their priority actions moving forward, taking into account the impact of COVID.

Public Consultations - The public consultations on the Fit For the Future proposals and the development of the new hospital in the Forest of Dean have now commenced on the 22nd October following successful stage 2 assurance by NHSE/I and support by HOSC for both schemes. There is a mid-term review on the 18th November to assess progress to date, review the interactions that are occurring in the new socially distanced format and the impact of the national lockdown. We will be providing an update to the Council of Governors at its meeting on the 19th November and all Trust members have been contacted by post to ensure people have the opportunity to participate in the respective consultations.

Ongoing System response to COVID – the report provides an update on ongoing planning activities and the initiatives that are being taken forward to continue to operate safe and sustainable services and undertake planning towards the management of future surges of activity. The **Director of Public Health has released their annual report** for 2020 which has a focus on the disproportionate impact of COVID19 across BME populations in Gloucestershire and helps build understanding of the impact the pandemic has had on our population.

Risks associated with meeting the Trust's values **None**

Corporate considerations	
Quality Implications	There have been changes to previous programmes of work in light of COVID-19. This may impact on agreed timelines and delay some changes coming forward which may have an impact on the Trust's programme of change and service delivery and this ultimately may impact on the quality of care to our population.
Resource Implications	None specific to the Trust
Equality Implications	COVID19 has highlighted that some sectors of our population are disproportionally impacted and the need for ongoing understanding and consideration is highlighted

Where has this issue been discussed before?
Regular report to Trust Board

Appendices:	*The One Gloucestershire ICS Lead report is available in the reading room*

Report authorised by: Angela Potter	**Title:** Director of Strategy & Partnerships

INTEGRATED CARE SYSTEM UPDATE REPORT

INTRODUCTION

This paper provides Board Members with an overview and update on the activities that have been taking place across the Gloucestershire Integrated Care System.

1. Health Overview and Scrutiny Committee Activities

GHC held its annual informal development session with HOSC members on the 11th November. This proved a good opportunity for councillors to explore areas of interest with Trust colleagues but also for a number of our services to give updates on the work that the Trust has been taking forward. The session was well received with updates provided on the Trust's recovery from COVID, Pillar 1 testing and service updates from MSK Physio, School Aged Immunisation and First Contact Physio teams.

The formal Health Overview and Scrutiny Committee took place on the 17th November 2020 and included updates on community phlebotomy and the system wide performance.

2. Public Consultations

The public consultations on the Fit for the Future proposals and the development of the new hospital in the Forest of Dean commenced on the 22nd October following successful stage 2 assurance by NHSE/I and support by HOSC for both schemes. There is a mid-term review on the 18th November to assess progress to date and review the impact of the new socially distanced format and the impact of the national lockdown.

Because of the current COVID-19 situation, we are reaching out to people in a number of ways and offering a wider range of consultation activities, including additional on-line and telephone options, to support a socially distanced consultation. The CCG have also launched a new online participation space called *Get Involved in Gloucestershire*, where you can share your views about the new hospital and many other health projects which can be accessed via the following link https://getinvolved.glos.nhs.uk/

It is important to us that we hear the views of as many people as possible and ensure that everyone has the opportunity to comment on the proposals. We will also be providing an update to the Council of Governors at its meeting on the 19th November and all Trust members have been contacted by post to ensure people have the opportunity to participate in the respective consultations.

Further detailed information about Fit for the Future are available at www.onegloucestershire.net/yoursay and at www.fodhealth.nhs.uk for the Forest of Dean Community Hospital consultation.

3. Population Health Management Steering Group

The Gloucestershire Population Health Management (PHM) Development Programme Closing Event, was held on the 9th October. This event drew to a conclusion the NHS England and Improvement (NHSE/I) Population Health Management Wave 2 Development Programme that our system has been taking forward with the three Primary Care Networks (PCNs) in Cheltenham.

The aim of the PHM Development Programme is to support systems to improve health outcomes for selected local population cohorts through the real-time application of advanced analytics and intelligence-led care design. The outcomes presented in the session demonstrated that this approach is proving beneficial with regards relationship development and greater cross system working and the PCNs have begun to implement interventions for the identified cohorts.

The PHM steering group are now considering how to take forward the spread of PHM as a way of working to support our wider ICS Place based approach and proactively support our populations.

4. Phase 3 Planning – COVID Recovery

The system continues to develop its plan to ensure that it can operate at the highest possible capacity whilst continuing to keep staff and patients safe. Scenario planning continues to be refined as we adjust our planning to take account of the latest national guidance and the anticipated impact of the national lockdown. The system has seen high levels of surge activity from the 11th November onwards and measures have been taken to safeguard essential service delivery and working to being on board additional support where this is deemed appropriate.

System planning is anticipated to continue over the coming months with potentially further planning guidance anticipated before Christmas.

An important service development which was established in response to the learning from the initial phase of the pandemic is the provision of a COVID virtual ward. This service is a response to the cohort of patients who were managed at home, under the care of their GP, whose outcomes could be improved by earlier detection of any deterioration in their condition and particularly those who present with “silent” symptoms at the onset of their deterioration.

The service enables patients, to have their oxygen levels monitored whilst remaining at home and thus, in the absence of their deterioration manifesting through worsening visible symptoms, can be identified and admitted to hospital sooner than might otherwise be the case. This will not only improve overall outcomes but is expected to reduce the number of patients who require admission to critical care services.

5. Integrated Locality Partnerships

The ILP’s continue to focus on the priorities previously reported and the Trust is continuing to input and support these developments. The Strategy & Partnership team are now starting to take a lead role in support the projects and our newly appointed service development managers have met with the CCG Locality leads on the 5th November to understand how we work together in our support of the 6 ILP’s and ICS

projects and programmes and build on the partnership working ensuring consistency of approaches to support opportunities and known ILP priorities.

The focus for ILPs will continue to be assessing the impact of COVID on their populations and working with partners to support the reduction in health inequalities particularly in Gloucester City.

One area that has a focus in Gloucester City is the Stronger Safer Gloucester Partnership (SSGP) which is the strategic group of various agencies responsible for the wider wellbeing, health and community safety agenda. Together with the Gloucester City ILP, SSGP have co-sponsored a task and finish group with the aim to gather information and data on what we know, and what is currently being done, about health inequalities in the city of Gloucester. This will help the system and communities to identify further targeted interventions such as service design and development, better connectivity of existing support, or new initiatives, all with the aim of reducing the health inequalities gap in the city.

Care Homes Support - The Enhanced Health in Care Homes service in the Network Contract commenced on 1 October 2020. However, a significant amount of work has been conducted prior to this date by the Clinical Commissioning Group (CCG), Primary Care Network (PCNs) and Providers.

There is a multi-agency Enhanced Health in Care Homes working group who have been working through the requirements. GHC are working well with PCNs to develop new ways of working to support Care Homes to ensure there is aligned service delivery and avoid duplication.

6. Wider ICS and Partnership Updates

The **Health and Well-being Board** (HWB) was due to have a workshop session to look at health inequalities and priority action planning but this was unfortunately postponed due the national lockdown coming into effect.

Anchor Institutions - A task and finish group has now been established to work on behalf of the Gloucestershire HWB to:

- Establish a shared understanding of how a Gloucestershire anchor institution approach / framework could support efforts to reduce inequalities, particularly as they affect BAME groups
- Understand what is already happening in Gloucestershire (whether or not it is badged as anchor institution activity)

- Identify where further work could be undertaken, particularly where the leadership of the Health & Wellbeing Board could add value, and make recommendations to the Board on the next steps.

Representation for the Trust has been identified through the Strategy & Partnerships team and we will support how we can tie this into the development of our ongoing strategic priorities moving forward.

7. Director of Public Health Annual Report 2019/20: Beyond Covid: Race, Health and Inequality in Gloucestershire.

This report has been co-authored between the Director of Public Health at Gloucestershire County Council (GCC) with the GCC Black Worker Network. It looks at the long-standing health inequalities faced by people of a BAME background in Gloucestershire and the impact of the COVID-19 pandemic.

The report emphasises the proportionate share of the COVID19 burden during the first wave of the pandemic that has fallen on those who already experienced health inequalities. It goes onto identify that these disparities are largely the result of long-standing structural racism which produces social and economic inequalities in the conditions in which BAME people are educated, work and live.

The report highlights the strength of listening and working together in partnership to tackling the systemic and structural issues this report highlights. The report is available in the reading room and via the attached link https://www.gloucestershire.gov.uk/gloucestershire-county-council-news/news-october-2020/public-health-report-calls-for-action-on-health-inequalities-faced-by-bame-residents/

8. Focus on Patient, carer and staff feedback and engagement

Healthwatch Gloucestershire and Evolving Communities have published their report on people's experiences of A&E mental health care in our two local hospitals, and have made a number of recommendations to ensure mental health care in the county is on a par with physical health care. The report is available from the following link https://www.healthwatchgloucestershire.co.uk/wp-content/uploads/HWG-Mental-health-AE-report-Final-Oct20.pdf

The Trust has welcomed the report and recognises the importance of ensuring that people receive parity of esteem for both their mental and physical health care needs and supports the recommendations made. The ongoing delivery of mental health awareness training with accident and emergency department staff is vital to ensuring the completion of person-centred assessments which include people's mental and physical health care needs.

Angela Potter
Director of Strategy & Partnerships

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NHS Foundation Trust

AGENDA ITEM: 11/1120

REPORT TO: **TRUST BOARD – 25 NOVEMBER 2020**

PRESENTED BY: Neil Savage, Director of HR & OD

AUTHORS: Ruth Thomas, Associate Director: OD, Learning & Development
Sonia Pearcey, Ambassador for Cultural Change & Freedom to Speak Up Guardian
Linda Gabaldoni, Head of OD
Neil Savage, Director of HR & OD

SUBJECT: **DIVERSITY NETWORK UPDATE REPORT**

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

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

The purpose of this report is to:

The purpose of this report is to provide an update to the Board of Directors on the recent creation of the Trust's first Diversity Network and related sub groups.

Recommendations and decisions required

The Board is asked to:

- **Note** the update report

Executive summary

This report provides an update on:

- progress with the recent creation of the Trust's Diversity Network
- the pre-existing Women's Leadership Network
- the BAME sub group
- the Colleagues with a Disability sub group
- the LGBTQ+ sub group

Risks associated with meeting the Trust's values
A strong well-supported and ambitious Diversity Network, with its identified sub groups, is critical to deliver the Trust's strategic aim of being a great place to word and core to our related values of: working together | always improving | respectful and kind | making a difference Failure to succeed with our Network and sub groups risk negatively impacting staff engagement, recruitment, retention and reputation.

Corporate considerations	
Quality Implications	This improves the workplace, workforce and service delivery quality within the Trust. The Diversity Network and its sub groups provide a voice, a safe space and also a place to influence Trust business and the experience of being an employee.
Resource Implications	The Network and sub groups are currently supported by existing resources within OD, HR and Communications but will be further supported by the recently approved EDI lead currently out to advert and funded from Transformation Funds
Equality Implications	This work stream helps the Trust to become a fairer, more equitable workplace, and to deliver on its statutory requirements, for example, WRES and WDES.

Where has this issue been discussed before?
July 2020 – "Update on Trust's Diversity Work" report and slide deck.

Explanation of acronyms used:		
	ICS	Integrated Care System
	OD	Organisation Development
	HR	Human Resources
	LGBTQ+ Plus	Lesbian, Gay, Bi-sexual, Trans & Queer
	BAME	Black & Minority Ethnic
	WRES	Workforce Race Equality Standard
	WDES	Workforce Disability Equality Standard

Appendices:	Nil

Report authorised by:	**Title:**
Neil Savage	Director of HR & OD

DIVERSITY NETWORK UPDATE REPORT

1. Diversity Network Background & Update

One of our four strategic aims is to be: "**a great place to work**".

To fulfil this, we are committed to: supporting, recruiting & retaining a diverse workforce at all levels, with supportive, compassionate, inclusive and effective leaders.

To assist with this aim we have created a Diversity Network with four sub groups; for BAME, LGBTQ+ colleagues, for colleagues with a Disability, alongside one for Women's Leadership.

The Network aims to help:

- us to ensure all colleagues have a **voice**, feel **equally valued and supported**
- all colleagues achieve their potential by **removing barriers** to development
- the Board & leaders to **manage and lead better, informed by lived experience**
- the organisation to develop the **WRES and WDES** action plans

Prior to creating the Network, we surveyed colleagues and held a series of focus group engagement sessions to talk about the issues & experiences of BAME, Disabled and LGBTQ+. The Women's Leadership Network was already well established under the leadership of Sandra Betney.

The Network has met twice now in July & October 2020, with circa 30 colleagues joining each meeting. Its third meeting is being planned for early January 2021, alongside dates for the rest of the New Year.

It has been chaired by Sumita Hutchinson, EDI lead NED, supported by other NED colleagues and the HR & OD Directorate, pending the election of a chair from the Network.

The Trust is providing funding & administrative support for the Network and its sub groups.

The Network's next steps are to appoint a Network Chair; create a shared space on the intranet; agree the Network's Terms of Reference & agree a work and communications plan for 2021.

2. BAME Sub Group

The sub group has been initially chaired by Sonia Pearcey, Ambassador for Cultural Change & Freedom to Speak Up Guardian.

The sub group has met twice since its inception, in September & November, with 11 colleagues joining the first meeting and over 20 joining the second most recent meeting.

Vinod Mani & Dominika Lipska-Rosecka have been nominated & voted in as **co-chairs** which is great news.

Following applications & interviews, these two sub group members have also been successful in getting on to the national **2021 Workforce Race Equality Scheme (WRES) Experts Programme**.

In terms of emerging themes, the sub group is beginning to provide a safe space for sharing experiences & challenges of being from diverse ethnic and cultural backgrounds. Discussions have focussed on inclusive culture and leadership, and how we can better support & develop that alongside the wider championing of diversity. Reciprocal mentoring and support for the planned ICS Stepping Up programme. Colleagues want to be involved supporting policy decisions and inputting their experiences at both a local and Trust level.

The sub group participated in an engagement session on the **WRES action plan** which will be coming to Resources Committee's next meeting.

A BAME colleague from the sub group has agreed to share her story about working in the organisation at a future Board, following speaking up with a positive outcome and learning.

The challenges for the group are increasing the attendance, how we feed into and contribute to wider ICS EDI work as some colleagues are involved in wider work/on development programmes that not everyone was aware of and how this can be tied together and better publicised.

The sub group's next steps and priorities include inducting and supporting the new joint chairs, creating shared space, increasing attendance and virtual contributions from those who can't attend, the development of the 2021 work plan and sub group communications, as well as supporting the WRES scheme.

3. Women's Leadership Network

The network is led and chaired by Sandra Betney, Director of Finance and Deputy Chief Executive.

This network has met three times in the last year, with a fourth meeting scheduled for 24th November, with good levels of attendance, with 34 colleagues signed up for the next meeting.

Only one meeting has been cancelled during COVID (June 2020). Guest speakers have included Vicci Livingstone-Thompson, Chief Executive Officer, Inclusion Gloucestershire in December 19, Louise Williams, Director, Campaign for the Protection of Rural England, in March 20, and then Jane Ginnever FRSA Founding Director, SHIFT in September 2020, who talked about her leadership approach as a female leader & her experience of leading in the armed forces.

In terms of emerging themes, these have been inspiring & engaging speakers, sharing good examples of colleagues sharing their personal journeys and experiences as women leaders.

The main challenge is to get volunteers more involved in taking the network and its work forwards.

The next meeting is in December 2020 has Jane Probert, Superintendent Learning & Development, Chair of Women's Initiative Network, Gloucestershire Constabulary as a guest speaker. Following that, we are planning to have GHC's Nancy Farr speak about Menopause for June 2021. The network is also considering the possibility of communications and events for World Menopause and Perimenopause Days on 11th and 18th of October 2021.

4. Colleagues with a Disability Sub Group

The sub group has initially been chaired by Ruth Thomas, Associate Director: OD, Learning and Development. It is aiming to agree a chair from the sub group this month.

The sub group has met twice, with a third meeting scheduled for 24th November, however, there have been lower levels of attendance than the other sub-groups (7 / 8) with lower representation for those with direct lived experience.

In terms of emerging themes from the sub group, as with the other groups, members want to be involved supporting policy decisions and inputting their experiences at both a local and Trust level, how to improve attendance and representation, whether to offer wider carer and service user input or attendance. Sub group members have also agreed to share stories via creation with Comms of two videos to help raise wider Trust awareness of working with a disability.

Importantly, the sub group members have participated in an engagement session on the **Workforce Disability Equality Scheme** (WDES) action plan which will be coming to Resources Committee's next meeting. This also contributed to the submission of an application for a £20,000 **Health Education England WDES Disability Innovation Fund** which is about developing the role of organisational Disability champions. This would build on a piece of work already in train & will focus initially on sensory disability and then be expanded to include a wider breadth of disabilities

Challenges identified include, stigma in society and workplaces, membership numbers and alternative ways of engaging and giving colleagues with a disability a voice, the wide range of disabilities experienced by colleagues and openness about who they are. Issues of language & assumptions with colleagues and patients/service users has also been an issue which needs further work.

The sub-group's next steps and priorities include developing messaging for International Day of Disabled Persons 2020, working with the Communications team to develop the two videos, public pages and resources for colleagues, wider communications and targeted invites to join the group. We will also be focussing on inducting and supporting a new chair, creating a confidential shared space intranet hub site for members, achieving

better attendance, developing & agreeing the 2021 work plan and communications, while supporting the WDES scheme.

5. LGBTQ+ Sub Group

The sub group has initially been chaired by Linda Gabaldoni, Head of Organisational Development.

The sub group has met twice since its inception, with its third meeting scheduled for late November, with just under 20 colleagues attending each meeting.

It is hoping to finalise co-chairs this month. Three sub group members have volunteered to co-chair and met in early November to discuss & agree how they would take this forward. They will feedback and agree final arrangements at this month's meeting.

This is a well-represented and enthusiastic group, with open and honest discussions. Colleagues report feeling the group is a safe space to talk about their challenges. As with the BAME sub group, emerging themes include that colleagues want to be involved supporting policy decisions and inputting their experiences at both a local and a Trust level. Members are explicit about their passion for raising the awareness of wider diversity in the Trust. Stonewall have been contacted for information on support available through their "power of inclusive workplaces" programme

A colleague from the sub group has agreed to share their story about working in the organisation via a video for wider awareness spreading.

Challenges identified include that members feel the difficulties in raising LGBTQ+ awareness, and ensuring the Trust truly has safe spaces where colleagues and service users can be open and honest about who they are. Language and assumptions with colleagues & patients/service users has also been raised.

The sub group's next steps and priorities include inducting and supporting the new joint chairs, creating confidential shared space intranet hub site for members. There is also a need to work with Communications team to develop public pages and resources for colleagues, maintaining high levels of attendance, developing and agreeing the 2021 work plan and communications.

6. Recommendation

The Board is asked to note the update report.

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AGENDA ITEM: 11/1120

REPORT TO: **TRUST BOARD – 25 NOVEMBER 2020**

PRESENTED BY: Lavinia Rowsell, Head of Governance and Trust Secretary

AUTHOR: Lavinia Rowsell, Head of Governance and Trust Secretary

SUBJECT: **BOARD ASSURANCE FRAMEWORK**

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

The purpose of this report is to:

To provide assurance to the Board on the management of risk. Along with the corporate risk register the BAF supports the creation of a culture which allows the organisation to anticipate and respond to adverse events, unwelcome trends and significant business and clinical opportunities. It helps to clarify what risks are likely to compromise the trust's strategic and operational objectives and assists the executive team in identifying where to make the most efficient use of their resources in order to improve the quality and safety of care.

Recommendations and decisions required

The Board is asked to:

- **receive** and **approve** the updated BAF noting key changes highlighted below

Executive summary

The BAF has been updated in consultation with members of the Executive. The corporate risks relating to each of the risk areas are highlighted in the paper and have been reviewed by the relevant governance oversight Committee. The following key changes to the BAF since Board consideration in July 2020 are highlighted as follows.

Amendments made: All risks have been reviewed and actions/additional controls added where appropriate. Changes are highlighted in red text.

Strategic risks added or removed this quarter: None

Movements in risk ratings since the last review:

The following changes have been reviewed by the Executive team and recommended by the Executive Lead:

- Risks 01: *There is a risk that we fail to support and progress effective working within the health and care system and cannot fully achieve the benefits of integration targeted within the Strategic Intent for the merged Trust and meet the NHS Long Term plan.* Risk rating **reduced from 8 to 6** due to positive progress in Fit for the Future, and the Forest of Dean project having completed stage2 assurance and confirmation that consultation will commence shortly.
- Risk 06: *There is a risk that we are unable to recruit and retain the workforce we need to meet our ambitions.* Risk rating **reduced from 16 to 12** to reflect progress that has been made with the Trust's response to the People Plan, workforce systems projects and Fast Track recruitment options. It is noted that the target date for this risk is currently December 2020 however it is acknowledged that this may be impacted on by Covid.

Risk updates

SR 00: *That the impact of Covid-19 places the Trust's services under increased clinical and operational pressure which negatively influences patient care in terms of patient safety, wellbeing and mortality outcomes and limited access to services exacerbated by lower staffing levels.* Risks relating to the Covid-19 are regularly reviewed via the Covid Programme Board. The strategic risk rating has been reviewed and **no increase in risk rating** is recommended at the current time. Local management expertise is in place, there are strong PPE supplies and Covid 19 secure controls have been established**.** An additional Board Assurance Framework for infection prevention control is being reviewed by the Nursing and Quality Directorate and compliance will be reported to the next meeting of the Board.

It should be noted that for SR 8 and SR9 relating to *Innovation and Research*, the target date for achieving target risk has been **revised to June 2021**. This is following agreement at the Board that the timeline for the enabling strategies be reviewed in the context of the pressures caused by the Covid-19 pandemic.

Further work to develop the Trust appetite will take place over the next month as the Board finalises the Trust's new strategic objectives. The BAF will be reviewed in light of the new objectives and a revised BAF presented to the Board meeting in January 2021.

Risks associated with meeting the Trust's values

As set out in the paper.

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

	paper.
Equality Implications	There are no financial implications arising from this paper.

Where has this issue been discussed before?
With the Executive and at Board Committees.

Appendices:	Full BAF

Report authorised by: Lavinia Rowsell	**Title:** Head of Corporate Governance and Trust Secretary

BOARD ASSURANCE FRAMEWORK

The design of the Board Assurance Framework (BAF), adopts the NHS standard format and identifies risks to the delivery of the new Trust's objectives and also to capture the controls and assurance in relation to strategic risks. Strategic risks are defined as those risks that, if realised, could affect the way in which the Trust exists or operates.

Strategic risks will be identified by Directors, and will be aligned to the Trust's strategic objectives. The nominated lead for each strategic risk will be responsible for identifying controls and sources of assurance to ensure that these controls operate effectively. Sources of Assurance are classified into type – Management, Board and External, reflecting the three lines of defense to enable the Board to understand how fully its assurance basis. Any gaps will be identified and action plans put in place to strengthen controls. Risks will be assigned to Board or Board committees for consideration at each meeting to provide appropriate visibility, monitoring and assurance.

The BAF will be fully reviewed by the Board three times a year, and the Audit and Assurance Committee three times a year and it will support the Chief Executive Officer in completing the Annual Governance Statement at the end of each financial year.

Strategic risks are those risks which could fundamentally affect the way in which the Trust operates, and that could have a detrimental effect on the Trust's achievement of its strategic objectives.

Corporate risks which relate to the Strategic Risks (12 or more), are detailed with their scores. The Corporate risks which are over 12 are reviewed by the Board committee which covers the related area.

1.1 **Risk Appetite** - The current risk appetite was agreed in in July 2019 and is under revision following initial discussion at the Board Seminar in September 2020- risk appetite is a key element of its risk management process.

1.2 **The Risk Management Policy** is in place and scheduled for review in 2021.

1.3 **Strategic Objectives Development** - The new strategic aims and objectives are currently being finalised. The BAF will be reviewed and realigned in light of these new objectives for approval at the January 2020 meeting of the Board.

SUMMARY OF STRATEGIC RISKS

Trust strategic objectives	Ref	Strategic risks: Risk	RAG	Exec Lead	Assurance Body	Inherent Risk Score	Current Risk Score	Target Risk Score
All Strategic Objectives	**SR00**	That the impact of Covid-19 places the Trust's services under increased clinical and operational pressure which negatively influences patient care in terms of patient safety, wellbeing and mortality outcomes and limited access to services exacerbated by lower staffing levels.	**H** ⟷	CEO/ DoNTQ	Quality	25 5x5	**16** **4x4**	12 4x3
Strong System Leader and Partner	**SR1**	There is a risk that we fail to support and progress effective working within the health and care system and cannot fully achieve the benefits of integration targeted within the Strategic Intent for the merged Trust and meet the NHS Long Term plan.	**M** ↑	CEO/ DoSP	Board	12 3x4	**6** **2x3**	4 1x4
Strong System Leader and Partner	**SR2**	There is a risk that services are not sustainable and do not continue to improve and develop to meet needs.	**M** ⟷	CEO/ DoSP	Board	12 3x4	**8** **2x4**	4 1x4
Outstanding Care	**SR3**	There is a risk that failure to: (i) meet consistent quality standards for care and support; (ii) address variability across quality standards; or (iii) reconcile conflicting quality standards or guidance, will result in poorer outcomes for patients/service user and carers and poorer patient safety and experience.	**M** ⟷	DoNTQ	Quality Committee	12 3x4	**8** **2x4** **On Target**	8 2x4
Outstanding Care	**SR4**	There is a risk that the Trust does not maintain robust focus on either/or mental and physical health.	**M** ⟷	CEO	Board	15 3x5	**10** **2x5**	5 1x5
Personalised Experience	**SR5**	There is a risk that we fail to keep service users and carers at the heart of what we do and do not deliver genuine co-production.	**M** ⟷	DoNTQ	Quality Committee	12 3x4	**8** **2x4**	4 1x4

Trust strategic objectives	Strategic risks							
	Ref	Risk	RAG	Exec Lead	Assurance Body	Inherent Risk Score	Current Risk Score	Target Risk Score
Engaged, Empowered and Skilled Workforce	**SR6**	There is a risk that we are unable to recruit and retain the workforce we need to meet our ambitions to: • provide outstanding, joined up care • maintain colleague well-being • minimise use of agency and bank staff	**M** ↑	Dir HR & OD	Resources Committee	16 4x4	**12** **3x4**	8 2x4
Engaged, Empowered and Skilled Workforce	**SR7**	There is a risk that we fail to establish a culture which: • engages and empowers colleagues engendering a sense of collective ownership • supports discretionary innovation	**M** ↔	Dir HR & OD	Resources Committee	16 4x4	**12** **3x4**	4 1x4
Innovation and Research Driven	**SR8**	There is risk that we don't enable colleagues to support Innovation and Research through appropriate funding, time and focus and strategic drivers.	**M** ↔	MD & DoSP	Quality Committee	9 3x3	**9** **3x3**	6 2x3
Innovation and Research Driven	**SR9**	There is a risk that we do not have in place structures and processes which enable colleagues to look beyond the organisation to identify leading edge practice to inform practice.	**M** ↔	MD	Quality Committee	9 3x3	**9** **3x3**	6 2x3
Best Value	**SR10**	There is a risk that the One Gloucestershire transformation plans become frustrated and impact on our individual Trust aims and objectives and the whole system plans.	**M** ↔	CEO	Board	16 4x4	**9** **3x3**	8 2x4
Best Value	**SR11**	There is a risk we **do not** maintain robust internal controls (Including financial) and governance systems; resulting in potential financial and organisational instability.	**M** ↔	Dir Finance	Resources Committee / Audit & Assurance Committee	12 3x4	**8** **2x4**	4 1x4
Best Value	**SR12**	There is a risk we do not achieve our individual organisations financial sustainability and contribute to whole system sustainability.	**M** ↔	Dir Finance	Resources Committee	12 3x4	**8** **2x4**	6 2x3

Strategic Objective:		ALL STRATEGIC OBJECTIVES
Risk Ref:	**Latest Rating and Direction of Travel**	**Risk Description**
SR00	⟷	That the impact of Covid-19 places the Trust's services under increased clinical and operational pressure which negatively influences patient care in terms of patient safety, wellbeing and mortality outcomes and limited access to services exacerbated by lower staffing levels.

Type	Quality			**Executive Lead**	**Director of Nursing**
Risk Rating	**Likelihood**	**Impact**	**Total**	**Assurance Committee**	Board
Inherent (without controls being applied) Risk Score	5	5	25	**Date Identified**	Feb 2020
Previous Meeting Risk Score	4	4	16	**Date of Review**	October 2020
Current Risk Score	**4**	**4**	**16**	**Date Next Review**	Ongoing and January 2021
Tolerable (Target) Score	4	3	12	**Date to Achieve Target**	March 2021

Key 2020 Deliverables	**Relevant Key Performance Indicators**
Continued compliance with national guidance and requirements i.e. Covid secure environments, Public Health England personal protective equipment guidance, BAME guidance and high standards of infection control, all to maintain safety and wellbeing of patients, carers and staff. Ongoing staff support and wellbeing measures to care for staff and maintain effectiveness.	

Key Controls to Manage Risk	**Assurance on Controls**	**Type of Assurance**	**Gaps in Controls**	**Key Actions to Address**	**Target to Complete**	**Action Owner**	**Action Update**
Business continuity planning and emergency response plans in place	Executive briefings. Board Assurance Committee.	Management		Regular Exec/Board briefings/	Completed	COO	Programme management approach adapted to longer term incident management. Daily briefings stood back up. BCP training underway with all teams

Key Controls to Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions to Address	Target to Complete	Action Owner	Action Update
Covid programme established with Exec work-stream leads	Weekly executive briefings.	Management		Recovery programme structure in place.		COO	Programme Structure in place reporting to Exec. Recovery plans in place for all services. Future state programme plan developed with system partners.
Engagement in local/regional/national NHS emergency guidance and protocols	Feedback from ICS/discussion with system partners to Executive.	Management	Guidance from centre on specific issues.	Continued engagement with system and wider NHS partners.	Ongoing	Executive	Demand and capacity systems for essential services in place and monitored. Trust contributing to national work on PPE supply.
Plans in place for response to second surge	Executive review	Management	Finalised surge plans Workforce surge planning	Guidance of surge planning developed and rolled out	End Oct	COO	Practical guide for surge planning for mangers in place. Surge workshops held with all services. SitRep tool redefined. BCP plans reviewed to include minimal safe staffing requirement

Key Controls to Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions to Address	Target to Complete	Action Owner	Action Update
Protocols for maintaining infection prevention and control in workplaces established for the protection of patients and staff	Executive/IPC group Quality Committee/QAG.	Management	Covid secure environments across trust.	Implementation of government guidelines. Infection prevention and control board assurance framework reviewed by QAG. Lateral flow testing for staff roll out	Ongoing	COO	Joint working with ICS partners. Regular review of PPE guidance. GHC stock management team established. Regular monitoring of stock levels – controlled 'pull model' in place. Additional PPE storage secured. Local upgrading of PPE IP&C assurance framework in place and under review. Covid secure environmental toolkit rolled out. Additional resourcing in place Additional resource for staff testing to meet increased demand.
Covid 19 vaccination of staff	Executive review	Executive	GHC working group	GHC working group to be established		DoNTQ	

Key Controls to Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions to Address	Target to Complete	Action Owner	Action Update
Maintenance of safe staffing levels	Progress reports to Executive.	Management			Ongoing	DoHR&OD/ COO	Health and Wellbeing offer in place to support all staff. Daily monitoring reporting of staffing levels across teams.
Key workforce policies and HR guidance on remote working, sickness reporting	Weekly executive discussion. Communication through internal Comms structure.	Management		HR guidance/ policies regularly updated in line with national policy developments	Ongoing	DoHR&OD	Sickness and isolation reporting in place. Home working assessment app launched. Home working policy agreed.
Risk assessments for all at risk staff	Management and Board.	Management and Board		Risk assessments for all at risk staff. Covid Secure environment project.		DoHR&OD	All at risk staff contacted. Additional support including OH and FTSU in place. Covid- secure environment toolkit developed. As of 11/09/20 – 99% of BAME colleagues have had a risk assessment. 67% of all other at-risk colleagues have been assessed inc. 100% of those shielding. Roll out of returning sheilders toolkit risk assessment and guidance.

Key Controls to Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions to Address	Target to Complete	Action Owner	Action Update
Sufficient PPE to ensure Workforce remains safe and to reduce spread of the Virus	Monthly progress reports to business continuity team and Executive.	Management		Centralised stock management team Monitoring and standard operating procedure as per national guidance	Ongoing	COO	Regular monitoring of central guidance. Stock management team in place.

Links to Risk Register
Risk 264 (Impact on GHC)/ **Risk 282** (Staff Health and Wellbeing) **/ Risk 265** (Impact on Staff) **/ Risk 278/279** (Litigation)/ **Risk 291** (Fraud)/ **Risk X** (MIIU Workforce)

Strategic Objective:		STRONG SYSTEM LEADER AND PARTNER
Risk Ref:	**Latest Rating and Direction of Travel**	**Risk Description**
SR1	↑	There is a risk that we fail to support and progress effective working within the health and care system and cannot fully achieve the benefits of integration targeted within the Strategic Intent for the merged Trust and meet the NHS Long Term plan.

Type	Strategic			**Executive Lead**	Chief Executive	DoSP
Risk Rating	**Likelihood**	**Impact**	**Total**	**Assurance Committee**	Board	
Inherent (without controls being applied) Risk Score	3	4	12	**Date Identified**	November 2019	
Previous Meeting Risk Score	2	4	8	**Date of Review**	October 2020	
Current Risk Score	**2**	**3**	**6**	**Date Next Review**	January 2021	
Tolerable (Target) Score	1	4	4	**Date to Achieve Target**	March 2021	

Key 2020 Deliverables	**Relevant Key Performance Indicators**
Overall 5 Year Trust Strategy developed.	

Key Controls to Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions to Address	Target to Complete	Action Owner	Action Update
CEO & Chair members of the Integrated Care System – engaged in all processes, regular meeting structure in place. Attendance levels and partner engagement strong	Reports to Board on ICS work, priorities & action plans. Two-way communication processes in place.	Board	ICS Governance requires further development.	ICS Memorandum of Understanding, including delegation & ways of working.	June 2020	ICS Chair	Strong engagement/ attendance at ICS meetings by Chair/Exec. Effective relationships with DDoS and Director of Transformation Effective partnerships working on both FFTF and FoD
Director of Locality and Primary Care Post – Joint post with Clinical Commissioning Group which has embedded ongoing partnership working with Primary Care, which is supporting	Reports to Board (attendance at Board by Director of Locality and Primary Care to ensure issues reviewed through this lens on ongoing basis.	Board		Active engagement with all system partners as ILPs recommence activities.	~~June 2020~~ Sept 2020	Director of Locality and PC/ Director of S&P	ILP's recommenced following COVID and the S&P directorate are making strong links Place' considered a key element for the delivery of strategy and will be considered

Key Controls to Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions to Address	Target to Complete	Action Owner	Action Update
effective cross system working							further in the emerging priorities around health outcomes.
Executive membership & leadership of key ICS Groups, Local Medical Committee, Primary Care Networks. Attendance levels and partner engagement strong	Feedback from Groups to Executive.	Management			~~June 2020~~ January 2021	CEO	LMC regularly attended by MD and COO Completion of MoC for S&P directorate now means strong alignment into each of the ILPs at engagement and partnership levels.
Effective Engagement in the Primary Care Networks (PCN). Meetings with Clinical Directors	Reports to Board & Executive.	Board	Capacity to personalise support and take forward actions from PCN.	Development of roles below directors to enhance capacity. Development processes planned.	~~Sept 2020~~ Jan 2021	CEO	Development planning ongoing. CEO meetings and regional presentations to Clinical Directors.
Long Term Plan integrated into strategic planning work	Strategic Intent & approved Merger documentation.	External – NHSE/I		Executive to consider any short- and long-term implications.	~~March 2020~~ Sept 2020	CEO	Phase 3 COVID planning and winter planning underway. Trust actively involved in all submissions

Links to Risk Register		

Strategic Objective:		STRONG SYSTEM LEADER AND PARTNER
Risk Ref:	**Latest Rating and Direction of Travel**	**Risk Description**
SR2	⟷	There is a risk that services are not sustainable and do not continue to improve and develop to meet needs.

Type	Strategic			**Executive Lead**	Chief Executive	DoSP
Risk Rating	**Likelihood**	**Impact**	**Total**	**Assurance Committee**	Board	
Inherent (without controls being applied) Risk Score	3	4	12	**Date Identified**	Nov 2019	
Previous Meeting Risk Score	2	4	8	**Date of Review**	October 2020	
Current Risk Score	**2**	**4**	**8**	**Date Next Review**	January 2021	
Tolerable (Target) Score	1	4	4	**Date to Achieve Target**	March 2021	

Key 2020 Deliverables	**Relevant Key Performance Indicators**
ICS Strategy Implemented taking forward One Gloucestershire proposals.	

Key Controls to Manage Risk	**Assurance on Controls**	**Type of Assurance**	**Gaps in Controls**	**Key Actions to Address**	**Target to Complete**	**Action Owner**	**Action Update**
ICS Board ensures focus is on sustainability across the Gloucestershire health sector. GHC Chair and CEO fully engaged in ICS Board and ICS Development to ensure forward looking agenda	Reports to Board. Non-Executive Director Sessions. Executive meetings with counterparts.	Board and management.	Sustainable Development management plan to be developed for the Trust that joins up across the wider ICS system.	Head of Sustainability post being recruited to	Dec 2020	DoSP	Fit for the Future consultation process due to commence October 2020. FoD consultation process due to commence October 2020
Fit for the Future Engagement – publication and engagement programme developed collectively with staff from across the Healthcare system delivering	Board involvement in Fit for the Future Engagement.	Board			Dec 2020	DoSP	Fit for the Future no longer impacting directly on Trust service provision. Pre-consultation paper to Sept 2020 Board

Key Controls to Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions to Address	Target to Complete	Action Owner	Action Update
Co-production central to Trust's operation and this is being built into ways of working and ways of reviewing practice	Development work of Director of Strategy and Partnerships and Chief Operating Officer.	Management	Clear approach to co-production and people participation not in place.	People Participation Committee to be established.	~~April 2020~~ Dec 2020	DoSP	Discussions commenced on People Participation agenda.
Gloucestershire Health Finance Directors meet regularly to ensure up to date understanding of the financial position across the local Health economy	Reports to Executive and Board Management Accounts.	Management and Board				DoF	ICS Financial updates given as part of Board Reports.
Executive involvement in development of key pathways within ICS	Reports to Board.	Management & Board				DoSP	DoSP attending New Models of Care Board and Fit for the Future programme to ensure alignment with key work programmes.

Links to Risk Register
Risk 1002 (Operational Resilience) / **Risk 291** (Fraud) / **Risk 293** (Software Replacement)

Strategic Objective:		OUTSTANDING CARE
Risk Ref:	**Latest Rating and Direction of Travel**	**Risk Description**
SR3	⟷	There is a risk that failure to: (i) meet consistent quality standards for care and support; (ii) address variability across quality standards; or (iii) reconcile conflicting quality standards or guidance, will result in poorer outcomes for patients/service user and carers and poorer patient safety and experience.

Type	Quality			**Executive Lead**	**Director of Nursing**
Risk Rating	**Likelihood**	**Impact**	**Total**	**Assurance Committee**	Quality Committee
Inherent (without controls being applied) Risk Score	3	4	12	**Date Identified**	Nov 2019
Previous Meeting Risk Score	2	4	8	**Date of Review**	Oct 2020
Current Risk Score	**2**	**4**	**8**	**Date Next Review**	January 2021
Tolerable (Target) Score	2	4	8	**Date to Achieve Target**	Achieved/Ongoing

Key 2020 Deliverables	**Relevant Key Performance Indicators**
Quality Strategy in place with Performance Measures.	

Key Controls to Manage Risk	**Assurance on Controls**	**Type of Assurance**	**Gaps in Controls**	**Key Actions to Address**	**Target to Complete**	**Action Owner**	**Action Update**
Patient Safety Controls: Clinical Risk Management Processes, Risk Management Strategy & Policy, Patient Safety Team processes. (for example – medication management – including Annual Report, Never Event and Serious Incidents Requiring Investigation & Never Event monitoring & learning, Mortality Review processes)	Reports to Quality Committee and sub Committees. Internal audit on Corporate and Quality Governance.	Management & Board External	Combined quality report not yet in place.	Committee work-plan in place focussing on key assurances	Ongoing	DoNTQ	Quality Committee arrangements established and functioning well. Monthly consideration of quality report at Board/Committee Positive outcome of internal audit on quality and corporate governance.

Key Controls to Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions to Address	Target to Complete	Action Owner	Action Update
Patient experience controls (including compliments, complaints and learnings identified, communicated, embedded and confirmed through audit and review)	Reports to Quality Committee Reports to Executive.	Management and Board	Experts by Experience not embedded within community services.	Experts by Experience actions to be embedded.	~~July 2020~~ ~~Oct 2020~~ Jan 2021	DoNTQ	Progress delayed due to Covid. Expert by Experience on Quality Committee. New position in DTQ team to focus on triangulation of care and increasing co-production in Quality Directions
Co-production actions – Better care together engagement events & related clinical and operational review to reflect feedback	Reports to Quality Committee Reports to Executive.	Management and Board	Co-production to be further developed across the combined Trust.	Co-production further developed and embedded across Trust.	Oct 2020	DoSP	Activities have been suspended during COVID and need to be reconsidered in light of new ways of delivery via social distanced approaches.
Workforce Controls – safe staffing processes and ways of working – defined and reported on within Quality reporting processes	Reports to Resources Committee and Quality Committee. Reports to Executive.	Management and Board	Staff turnover and staff sickness which may lead to increased use of agency staff that have less knowledge of Trust processes and procedures.	Staff recruitment and Retention actions.	Ongoing	Dir HR & OD DoNTQ	Use of practices such as Safety huddles to update staff within working day. Use of GHC Bank and Master Vendor Contract to ensure greater consistency of staffing. Agency Management Group.
Freedom to Speak Up and Whistleblowing processes fully embedded across Trust	Reports to Board (covering processes, volumes, types of issues, resolution practices, benchmarking & good practice guidance and internal audit report.	Board		Internal Audit and action plan	March 2020	DoNTQ	New policy in place. Incorporated Guardian in senior team. Board development session in October. 6 monthly reports to the Board.
Links to Risk Register							
Risk 562 (pressure ulcers)/ **Risk 609** (staff retention)/ **Risk 116** (Agency management)/ **Risk 173** (workforce)/ **Risk 258** (workforce)/ **Risk 5** (Ligatures)							

Strategic Objective:		OUTSTANDING CARE
Risk Ref:	**Latest Rating and Direction of Travel**	**Risk Description**
SR4	⟷	There is a risk that the Trust does not maintain robust focus on either/or mental and physical health.

Type	Quality			**Executive Lead**	Chief Executive	Director of Nursing
Risk Rating	**Likelihood**	**Impact**	**Total**	**Assurance Committee**	Quality Committee	
Inherent (without controls being applied) Risk Score	3	5	15	**Date Identified**	Nov 2019	
Previous Meeting Risk Score	2	5	10	**Date of Review**	Oct 2020	
Current Risk Score	**2**	**5**	**10**	**Date Next Review**	January 2021	
Tolerable (Target) Score	1	5	5	**Date to Achieve Target**	March 2021	

Key 2020 Deliverables	**Relevant Key Performance Indicators**
Quality Strategy in place with Performance Measures.	

Key Controls to Manage Risk	**Assurance on Controls**	**Type of Assurance**	**Gaps in Controls**	**Key Actions to Address**	**Target to Complete**	**Action Owner**	**Action Update**
Patient Safety Controls: Clinical Risk Management Processes, Risk Management Strategy & Policy, Patient Safety Team processes. (For example – medication management – includes Annual Report, Never Event and Serious Incidents Requiring Investigation & Never Event monitoring & learning, Mortality Review processes)	Reports to Quality Committee and sub Committees. Reports to Executive.	Management & Board			Ongoing	Director of Nursing, Therapies & Quality	Meetings embedded. Reporting process to Board defined. Agendas for Quality Committee and subgroups demonstrate good balance of mental/physical care. Positive outcome of internal audit on quality governance.
Key Controls to Manage Risk	**Assurance on Controls**	**Type of Assurance**	Gaps in Controls	Key Actions to Address	Target to Complete	Action Owner	Action Update

Management Structure developed through merger process ensures focus on mental and physical health, whilst not acting as a barrier to integration	Management Structure	Management	Clinical Framework	To develop Clinical framework	March 2021	Medical Director	Key appointments made in physical and mental health. Structure in place.
Co-production and engagement activities with carers, service users and staff reflect the need to ensure integration is not achieved at the expense of necessary specialism and that all relevant groupings are appropriately engaged	Co-production and engagement methodology.	Management	Quality Framework	To develop Quality Framework	~~Nov 2020~~ March 2021	DoNQT	Additional appointment in Quality Directorate to focus on embedding co-production. Quality strategy delayed due to Covid but on target.
Medical Committee and Staff Forum provide feedback mechanism from colleagues across the Trust, with different specialisms and foci, to ensure focus is maintained.	Reports to Executive Staff Engagement	Management	Membership for Trust may not currently reflect spectrum of service users.	Focus on Membership with aim balance of service users across the Trust's provision.	~~Sept 2020~~ Jan 2021	CEO	Governance mechanism in place - Senior Leadership Network, Team Talk and creation of bi-monthly Senior Leadership Team business meetings. Membership and engagement strategy being drafted.
Reporting frameworks from 2021 demonstrate equity of physical and mental health assurance	Governors, Resources Committee	Management Board	Central guidance issued w/c. 31/01		May 2020		Completed. New quality dashboard.

Links to Risk Register
Risk 112 (IAPT)/ **Risk 31** (data quality)/ **Risk 121** (Record Compliance)

Strategic Objective:		PERSONALISED EXPERIENCE
Risk Ref:	**Latest Rating and Direction of Travel**	**Risk Description**
SR5	⟷	There is a risk that we fail to keep service users and carers at the heart of what we do and do not deliver genuine co-production.

Type	Strategic			**Executive Lead**	Director of Nursing	DoSP
Risk Rating	**Likelihood**	**Impact**	**Total**	**Assurance Committee**	Quality Committee	
Inherent (without controls being applied) Risk Score	3	4	12	**Date Identified**	November 2019	
Previous Meeting Risk Score	2	4	8	**Date of Review**	Oct 2020	
Current Risk Score	**2**	**4**	**8**	**Date Next Review**	Jan 2021	
Tolerable (Target) Score	1	4	4	**Date to Achieve Target**	March 2021	
Key 2020 Deliverables				**Relevant Key Performance Indicators**		
Co-production Methodology embedded across Trust.						

Key Controls to Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions to Address	Target to Complete	Action Owner	Action Update
Patient Safety Controls: Clinical Risk Management Processes, Risk Management Strategy & Policy, Patient Safety Team processes. (for example – medication management – including Annual Report, Never Event and Serious Incidents Requiring Investigation & Never Event monitoring & learning, Mortality Review processes)	Reports to Quality Committee and sub Committees.	Management & Board			Ongoing	DoNTQ	Meeting processes embedded and demonstrate good balance across breadth of service. Positive outcome of internal audit on quality governance. New Quality Dashboard in place
Co-production and engagement activities with carers, service users and staff reflect the need to ensure integration is not achieved at the expense of	Co-production and engagement methodology	Management	Quality Strategy	To develop Quality Strategy	~~Nov 2020~~ March 2020	DoSP	Strategy development delayed due to Covid. On target to develop quality framework by revised due date.

Key Controls to Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions to Address	Target to Complete	Action Owner	Action Update
necessary specialism and that all relevant groupings are appropriately engaged							
Patient experience controls (including compliments, complaints and learnings identified)	Reports to Quality Committee.	Management	Experts by Experience not embedded within community services.	Experts by Experience actions to be embedded.	July 2020	DoNTQ	Patient experience report to the Quality Committee. DoSP focus on co-production and extension of Experts by Experience for physical health. New post within quality directorate focusing on co-production
Links to Risk Register							
RISK 559 (Mental Capacity Act)							

Strategic Objective:		ENGAGED, EMPOWERED AND SKILLED WORKFORCE
Risk Ref:	**Latest Rating and Direction of Travel**	**Risk Description**
SR6	↑	There is a risk that we are unable to recruit and retain the workforce we need to meet our ambitions to: • provide outstanding, joined up care • maintain colleague well-being • minimise use of agency and bank staff

Type	Workforce			**Executive Lead**	Director of HR
Risk Rating	**Likelihood**	**Impact**	**Total**	**Assurance Committee**	Resources Committee
Inherent (without controls being applied) Risk Score	4	4	16	**Date Identified**	Inherited risk from 2g and GCS
Previous Meeting Risk Score	4	4	16	**Date of Review**	October 2020
Current Risk Score	**3**	**4**	**12**	**Date Next Review**	January 2021
Tolerable (Target) Score	2	4	8	**Date to Achieve Target**	January 2021

Key 2020 Deliverables	**Relevant Key Performance Indicators**
Workforce Plan in place.	

Key Controls to Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions to Address	Target to Complete	Action Owner	Action Update
Workforce planning processes. (Integrated within business planning process to ensure impact considered across the range of staffing types and levels)	Reports to Resources Committee and Executive and ICS LWAB.) Workforce planning and narrative submissions.	Board	National approach to NHS pension limits impacts on recruitment & retention.	Key staff being trained in workforce planning via HEE. Lobbying at national level with NHS Providers and NHS Employers.	Ongoing	Dir. HR & OD	Workforce planning presentation to be included in annual planning workshop for the 2021. 2 additional GHC staff have completed university workforce planning qualification. Phase 3 of ICS workforce plan & narrative submitted.
Implementation of the People Plan	Reports to Resources Committee.	Board	Lack of integrated workforce planning data.	Promotion of system approach to workforce planning, including	March 2021	Dir. HR & OD	People plan released July 2020. First ICS system People Plan submission developed

Key Controls to Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions to Address	Target to Complete	Action Owner	Action Update
				shared career pathways.			and agreed. KPIs still awaited. Board, SLN, Execs, Staff Side and staff engagement sessions run on People Plan. Workforce systems projects continue. Legacy ESRs now integrated with further work related to Finance Ledger on-going for November 2020 launch.
Skills Mix Reviews	Reports to Chief Operating Officer & Executive.	Management			Ongoing	Dir. HR & OD	Skills mixes carried out. New reviews in NTQ, S&P Directorates, Podiatry, Vocational Service, Individual Placement & Support Service in Q2.
Monitoring of Agency Use & Vacancies	Reports to Executive, Agency and Bank Management & Resources Committee.	Management & Board		Refocused Agency and Bank Management Group with 3 additional workstream task and finish groups.	Ongoing	COO and Dir. HR & OD	End to end process review of recruitment re-commenced. Fast Track. Recruitment options in place for prioritised areas. Guaranteed Volume Contract reviewed and provision doubled.
Safe Staffing Reports	Reports to Quality Committee and Executive.	Board	Trust doesn't commission all training.	Completion of Staff workforce planning training and programme of workforce planning workshops with	July 2020	DNQ&T	Safe Staffing reporting in place. University of Gloucestershire RGN, RMN, & new LD nursing programmes well subscribed to for September and 2021 intakes. Blended

Key Controls to Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions to Address	Target to Complete	Action Owner	Action Update
				support from HEE.			nursing programme being explored with UoG. HEE Nursing CPD funding provided for 2020/21 to upskills clinical skills.
Recruitment & Retention Plans and actions	Reports to Resources Committee.	Board	Limited Resources for promoting Trust jobs and enabling innovative approaches to recruitment & retention.	Recruitment Action Plan and New recruitment strategy & action plan – ensuring best use of funds available.	December 2019 March 2020	Dir. HR & OD	Future State Programme Dedicated Recruitment & Retention work stream commenced Q2. New retention lead post starts in October 2020. Prioritised Fast Track Recruitment processes in place. County careers event held. Virtual RCN and MH HCSW recruitment events scheduled Oct 2020. International recruitment plan for registered nurses and medics approved by Execs subject to final contract October 2020.
Career pathway developments	Reports to Executive.	Management	Legacy succession planning and talent management processes from former GCS and 2G.		~~March 2020~~ Oct/Sept 2020	Dir. HR & OD	HEE CPD monies and 2020/21 programme agreed in Sept 2020. ICS Apprenticeship Hub in development by GHC for ICS. ICS agreed NA, ACP & HEE career development, workforce transformation funding, programmes & reporting in place.

Key Controls to Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions to Address	Target to Complete	Action Owner	Action Update
							Process for 2020/21 HEE funding & programme recommenced in June after COVID delay with review of existing programme through ICS in July to September 2020. ICS LWAB to consider 2020/21 bids October 2020.
Partnership arrangements with academic organisations	Reports to Resources Committee.	Board			Ongoing	Dir. HR & OD	Regular Glos Strategic Workforce Development Partnership Board p relaunched in Q2 and continues to progress existing and new RGN, RMN, LD, Physiotherapy, Paramedic degree programmes & new radiography and biomedical scientist programmes. Work continues with UoW on 3 Counties Medical School & scoping medical & post grad options with UoG).
Vacancy Monitoring	Reports to Resources Committee. Executive	Board			April 2020 Sept 2020	COO and Dir. HR & OD	New dashboard, monthly reported BI vacancy rates across all groups of staff. Staff Turnover reduced since April 2020. Detailed fortnightly bank and agency use

Key Controls to Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions to Address	Target to Complete	Action Owner	Action Update
							reporting to Management Grp. Business case for Track (end-to-end recruitment software package) pending.
Agency and Bank Management	Reports to Executive.	Management	Workstreams have 6/9-month lead in time for many actions.				Review of Medacs Guaranteed Volume contract to ensure best supply for need – contract varied (Oct 2020)
Flexible working, retire and return options	Reports to Executive and JNCF.	Management	Related business intelligence harmonisation.	Review 2019 Staff Survey opportunities for flexible working patterns scores and feedback and develop response.	Ongoing	Dir. HR & OD	Revised homeworking, flexible retire and return expected sign off with Staff Side October/November. Flexible Working policy revision in line with People Plan - December.
Co-production of opportunities, working patterns etc. with staff	Staff Friends and Family Test and staff survey.	External		Review 2019 Staff Survey "Staff Engagement" and "Ability to contribute to improvements" scores and feedback, develop response.	March 2020	Dir. HR & OD	Staff Forum relaunched post phase 1 COVID. E-rostering project recommenced Q2 and will provide further co-production opportunities through 2020/21.
Links to Risk Register							
Risk 48 (workforce and culture)/ **Risk 609** (staff retention)/ **Risk 173** (workforce – recruitment)/ **Risk 116** (Agency management)/ **Risk 268** (vacancy levels/hospitals)							

Strategic Objective:		ENGAGED, EMPOWERED AND SKILLED WORKFORCE
Risk Ref:	**Latest Rating and Direction of Travel**	**Risk Description**
SR7	⟷	There is a risk that we fail to establish a culture which: • engages and empowers colleagues engendering a sense of collective ownership • supports discretionary innovation

Type	Strategic			**Executive Lead**	Director of HR & OD
Risk Rating	**Likelihood**	**Impact**	**Total**	**Assurance Committee**	Resources Committee
Inherent (without controls being applied) Risk Score	4	4	16	**Date Identified**	Nov 2019
Previous Meeting Risk Score	3	4	12	**Date of Review**	September 2020
Current Risk Score	**3**	**4**	**12**	**Date Next Review**	January 2021
Tolerable (Target) Score	1	4	4	**Date to Achieve Target**	March 2021

Key 2020 Deliverables	**Relevant Key Performance Indicators**
Implementation of the People Plan and new Trust Best People Strategy. Roll Out of Pulse Surveys and responses. Design, development and implementation of new Leadership Development programmes.	Staff Survey ratings, in particular, Staff Engagement score. Pulse Survey scores.

Key Controls to Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions to Address	Target to Complete	Action Owner	Action Update
Values developed through co-production	Reports to Board.	Board	Strategic Objectives to be fully developed	Strategic Objectives to be developed using co-production principles	November 2020	CEO	Integration of values into workforce policies processes e.g. recruitment, appraisal, performance, staff awards, resolutions and disciplinary policies. Values core element of new Induction sessions, plus leadership development programme and health and wellbeing – delivery partner

Key Controls to Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions to Address	Target to Complete	Action Owner	Action Update
							appointed Q2. Co-design process in place and programme commencing late Q3/Q4.
People Plan	Reports to Resources Committee.	Board	Full implementation of Plan	Communication & implementation through future "Best People" Strategy. Respond to new national People Plan once releases	Sept 2020	Director of HR & OD	People Plan published July 2020. Series of presentations and engagement sessions in process to inform action plan and final Trust "Best People" strategy.
Better Care together engagement processes	Reports to Board.	Board	Implementation outcomes of Better Care together.	Outcomes to be built into strategies	Sept 2020	Director of Strategy & Partnerships	Ongoing Better Care Together Programme in place.
Heads of Professional Knowledge Network in place	Reports to Director of Nursing.	Management					AHP Council also now well established within the ICS.
Research Knowledge Partnership in place	Reports to Executive.	Management					
Freedom to Speak Up Guardian & supporting processes	Reports to Board (covering processes, volumes, types of issues, resolution practices, benchmarking & good practice guidance.)	Board				Director of Nursing, Quality and Therapies.	New FTSU Policy & published (Q1) Work in Confidence anonymous platform for raising issues & engaging relaunched. Civility Saves Lives programme commenced.
Colleague Communication & Engagement activities	Reports to Executive	Management				Director of HR & OD	Regular review of colleague communications. "You said, we did" comms approach with

Key Controls to Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions to Address	Target to Complete	Action Owner	Action Update
							colleagues on Survey Surveys. Paul's Open Door continuing to run. Staff Hub on intranet. BAME, LGBTQ, Disabled & Women's Networks in place with new Staff Diversity Network Launched in Q2. Sub groups now meeting (end Q2/start Q2) Long service award and recognition day in November 2020.
Staff Surveys	Reports to Resources Committee and Board.	Board		2019 Staff Survey outcomes from former GCS and 2G due February 2020 – to be used to develop plan.	June 2020	Director of HR & OD	Your Voice monthly surveys and Staff FFTs paused due to COVID. Health and Well-being Pulse Survey in place instead. Additional surveys on health, charitable funds and BAME and series of other at-risk staff on-line risk assessments run.

Links to Risk Register		

Strategic Objective:		INNOVATION AND RESEARCH DRIVEN
Risk Ref:	**Latest Rating and Direction of Travel**	**Risk Description**
SR8	⟷	There is risk that we do not enable colleagues to support Innovation and Research through appropriate: funding, time and focus and strategic drivers

Type	Quality			**Executive Lead**	Medical Director	DoSP
Risk Rating	**Likelihood**	**Impact**	**Total**	**Assurance Committee**	Quality Committee	
Inherent (without controls being applied) Risk Score	3	3	9	**Date Identified**	Nov 2019	
Previous Meeting Risk Score	3	3	9	**Date of Review**	October 2020	
Current Risk Score	**3**	**3**	**9**	**Date Next Review**	January 2021	
Tolerable (Target) Score	2	3	6	**Date to Achieve Target**	June 2021	
Key 2020 Deliverables				**Relevant Key Performance Indicators**		
Research Strategy in place with Performance Measures.						

Key Controls to Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions to Address	Target to Complete	Action Owner	Action Update
Research Actions & Activities	Reports to Quality Committee.	Board	Research and innovation strategy in development	Put in place Research Strat.	May 2021	Medical Director	Progress delayed due to Covid. Research strategy to include innovation. Strategy in draft.
Research team structure in place	Reports to Executive	Management	Medical Lead for Innovation and Lead for QI in place	Appointments confirmed	Dec 2020	Medical Director	Research team structure in place. Medical lead for innovation identified, in post in Nov.
Annual Research Conference	Reports to Executive.	Management	Conference proposal	To be developed	May 2021	MD	To be considered as part of research strategy. Need to reconsider impact of COVID and if socially distanced conference an option.

Key Controls to Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions to Address	Target to Complete	Action Owner	Action Update
Learnings from Incidents, Complaints and compliments	Reports to Quality Committee.	Board	Clinical Strategy	Develop clinical safety strategy	March 2021	MD	Assurance reports provided to the quality committee and Board (mortality review and SI reports). Quality strategy in development
Good Practice Identification & Follow Up process	CQC working group	Management	Quality Framework	Under development	March 2021	DoNQT	To be developed to align with new strategy
Training & Development Activities	Reports to Executive	Management	Training and development strategy	Under development	June 2021	MD	To be included in research strategy.
Quality Improvement Unit activities	Reports to Executive	Management	QI Strategic framework	Strategic framework under development	March 2021	DoSP	Associate Director of QI and Transformation appointed and team being recruited to
Better Care together activities	Reports to Board	Management	Plan for 2020/2021	To be developed	March 2021	DoSP	Activities have been suspended during COVID and need to be reconsidered in light of new ways of delivery via social distanced approaches

Links to Risk Register		

Strategic Objective:		INNOVATION & RESEARCH DRIVEN
Risk Ref:	**Latest Rating and Direction of Travel**	**Risk Description**
SR9	⟺	There is a risk that we do not have in place structures and processes which enable colleagues to look beyond the organisation to identify leading edge practice to inform practice.

Type	Quality			**Executive Lead**	Medical Director
Risk Rating	**Likelihood**	**Impact**	**Total**	**Assurance Committee**	Quality Committee
Inherent (without controls being applied) Risk Score	3	3	9	**Date Identified**	Nov 2019
Previous Meeting Risk Score	3	3	9	**Date of Review**	October 2020
Current Risk Score	**3**	**3**	**9**	**Date Next Review**	January 2021
Tolerable (Target) Score	2	3	6	**Date to Achieve Target**	June 2021

Key 2020 Deliverables	**Relevant Key Performance Indicators**
Research Strategy in place with Performance Measures.	

Key Controls to Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions to Address	Target to Complete	Action Owner	Action Update
Research Actions & Activities	Reports to Quality Committee	Board	Research and innovation Strategy in development	Put in place R&I Strategy	May 2021	Medical Director	Progress delayed due to Covid. Research strategy to include innovation. Strategy in draft.
Research team structure in place	Reports to Executive	Management	Medical Lead for Innovation and Lead for QI in place	Appointments confirmed	Dec 2020	Medical Director	Research team structure in place. Medical lead for innovation identified, in post in Nov.
Annual Research Conference	Reports to Executive	Management	Conference proposal	To be developed	May 2021	CEO	To be considered as part of research strategy. Need to reconsider impact of COVID and if socially distanced conference an option.

Learnings from Incidents, Complaints and compliments	Reports to Quality Committee	Board	Clinical Strategy	To be developed	March 2021	DoNTQ	Lessons learned reports within patient experience / safety team portfolios.
Good Practice Identification & Follow Up process	Improving care working group	Management	Quality Framework	To be developed	March 2021	DoNTQ	To be developed to align with new strategy
Training & Development Activities	Reports to Executive and Board Committees	Management and Board	Training and development strategy	Under development	June 2021	MD	To be included in research strategy.
Quality Improvement Unit activities	Reports to Executive	Management	QI Strategic framework	Under development	March 2021	DoSP	Associate Director of QI and Transformation appointed and team being recruited to.

Links to Risk Register		

Strategic Objective:		BEST VALUE
Risk Ref:	**Latest Rating and Direction of Travel**	**Risk Description**
SR10		There is a risk that the One Gloucestershire transformation plans become frustrated and impact on our individual Trust aims and objectives and the whole system plans.

Type	Strategic			**Executive Lead**	CEO	DoSP
Risk Rating	**Likelihood**	**Impact**	**Total**	**Assurance Committee**	Board	
Inherent (without controls being applied) Risk Score	3	4	12	**Date Identified**	Nov 2019	
Previous Meeting Risk Score	3	3	9	**Date of Review**	October 2021	
Current Risk Score	**3**	**3**	**9**	**Date Next Review**	March 2021	
Tolerable (Target) Score	2	4	8	**Date to Achieve Target**	September 2021	

Key 2020 Deliverables	**Update**
One Gloucestershire Engagement complete and clear road map in place.	

Key Controls to Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions to Address	Target to Complete	Action Owner	Action Update
Fit for the Future Engagement Plan in place	Report to Board.	Board	.		~~June 2020~~ Oct 2020	Dir Strat & Partnerships	Confirmed that FFTF and FoD no longer aligned in terms of engagement. NHSE stage 2 assurance received for both schemes
Ongoing ICS Updates to ICS Board & Board	Reports to Board to support scrutiny, challenge & openness in working.	External & Board			June 2020	Dir Strat & Partnerships	System update standing item on Board agenda.
Development of Trust wide strategic priorities and transformation programmes needs to be completed	Board Development & clinical service delivery.	Board	Strategic transformation programme needs to be finalised as part of strategy develops.	Executive and Board input agreed	March 2021	Dir Strat & Partnerships	Key aims confirmed and work to develop ambition, objectives and risk appetite underway

Key Controls to Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions to Address	Target to Complete	Action Owner	Action Update
Clinical Programme Groups developing transformation proposals	Clinical and service leads engaged fully engaged in groups.	Management			Sept 2020	Chief Operating Officer	Focus on respiratory and cardiac pathways as a result of post COVID patient needs.
Links to Risk Register							

Strategic Objective:		BEST VALUE
Risk Ref:	**Latest Rating and Direction of Travel**	**Risk Description**
SR11	⟷	There is a risk we do not maintain robust internal controls (Including financial) and governance systems; resulting in potential financial and organisational instability.

Type	Strategic	**Executive Lead**	CEO	Director of Finance

Risk Rating	**Likelihood**	**Impact**	**Total**	**Assurance Committee**	Resources/ Audit and Assurance
Inherent (without controls being applied) Risk Score	3	4	12	**Date Identified**	Nov 2019
Previous Meeting Risk Score	2	4	8	**Date of Review**	October 2020
Current Risk Score	**2**	**4**	**8**	**Date Next Review**	January 2021
Tolerable (Target) Score	1	4	4	**Date to Achieve Target**	January 2021

Key 2020 Deliverables	**Update**
Budget and CIP targets to be achieved.	

Key Controls to Manage Risk	**Assurance on Controls**	**Type of Assurance**	**Gaps in Controls**	**Key Actions to Address**	**Target to Complete**	**Action Owner**	**Action Update**
Clinical and corporate governance arrangements enable controls to be effectively managed	The Board Committee structure provides assurance on all corresponding controls to the Trust Board. Management Groups report exceptions to Committees.	Management/ Board	Evaluation of year 1 of committee effectiveness	Committee evaluation for all governance committees	November 2020	Head of Corporate Governance	
Committee / reporting structures enable controls to be monitored and reviewed	Grant Thornton Reporting Accountant Opinion. GCS and GHC External Audit Opinion. Head of Internal Audit Opinion 2019/20.	External					GCS and GCS External Audit - clean opinion 2019/2020.

Key Controls to Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions to Address	Target to Complete	Action Owner	Action Update
Internal and external audit and plans provides additional scrutiny.	Combined Internal Audit Plan Agreed Reports by Internal & External Audit to Audit Committee. Internal Audit follow up actions report.	External					
The Trust's Standing Orders, Standing Financial Instructions, Scheme of Reservation and Scheme of Delegation in place.	Based on best practice. Approved by Audit Committee. Regularly reviewed for omissions.	Management and Board	Assurance on compliance.	Internal Compliance Review to be undertaken.	~~March 2020~~ ~~Sept 2020~~ Dec 2020		Compliance Review delayed by COVID, and further delayed by COVID financial regime additional work
Robust governance framework to ensure continual monitoring and reporting with clear escalation.	Reports to Board and Executive.	Management and Board	Full range of Strategies not yet in place.	Strategies to be developed & put in place.	~~Sept 2020~~ Dec 2020	Director of Strategies & Partnerships (with Board)	Strategies delayed by COVID.

Links to Risk Register
Risk 116 (Agency usage), **Risk 1002** (operational resilience)/ **Risk 291** (Fraud)

Strategic Objective:		BEST VALUE
Risk Ref:	**Latest Rating and Direction of Travel**	**Risk Description**
SR12	⟷	There is a risk we do not achieve our individual organisation's financial sustainability and contribute to whole system sustainability

Type	Financial			**Executive Lead**	Dir Finance
Risk Rating	**Likelihood**	**Impact**	**Total**	**Assurance Committee**	Resources
Inherent (without controls being applied) Risk Score	3	4	12	**Date Identified**	Nov 2019
Previous Meeting Risk Score	2	4	8	**Date of Review**	Sept 2020
Current Risk Score	**2**	**4**	**8**	**Date Next Review**	Jan 2021
Tolerable (Target) Score	2	3	6	**Date to Achieve Target**	Jan 2021

Key 2020 Deliverables	**Update**
Budget and CIP targets to be achieved.	

Key Controls to Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions to Address	Target to Complete	Action Owner	Action Update
Financial Management	Board Reports and mid-Year Review. Budget Setting. CIP workshops completed. CIP targets 20/21 issued.	Board					Efficiency CIP delivered. Differential CIP identified and mostly delivered. CIP target revised due to COVID. Challenge schemes progressing but no longer required to deliver in 20/21
Financial reporting	Board Reports & Resources Committee Reports.	Board	Finance systems in integration.	Finance system integration processes to be completed.	~~April 2020~~ ~~Sept 2020~~ October 20	Director of Finance	Integration process delayed due to COVID, on revised Plan. Ledger merger delayed due to User Acceptance Testing finding major issues

Key Controls to Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions to Address	Target to Complete	Action Owner	Action Update
Agency Management Group	Reports to Resources Committee. Sustainable staffing paper to Board.	Board	Comprehensive plan to reduce agency reliance.	Trajectory for improvement	~~June~~ Oct 2020	Chief Operating Officer	COVID delayed trajectory, October plan for major improvements in HCA agency spend.
ICS Financial Plan Monitoring	Board Report.	Board					
Links to Risk Register							
Risk 116 (Agency usage)/ **Risk 278/279** (Litigation – Covid)							

Definitions

The overall risk ratings below are calculated as the product of the Probability and the Severity

LEVEL	INJURY / HARM	SERVICE DELIVERY	FINANCIAL / LITIGATION	REPUTATION / PUBLICITY
5 CATASTROPHIC	Fatality, Multiple fatalities or large number injured or affected.	Complete breakdown of critical service/ 'Significant under-performance' against key targets.	Losses; claims/damages; criminal prosecution, over-spending; resourcing shortfall: >£1M.	National adverse publicity/reputation irreparably damaged.
4 Major (HIGH)	Fatality/multiple serious injuries/major permanent loss of function/increased length of stay or level of care >15 days.	Intermittent failures of a critical service/'under-performance against key targets'.	£501K - £1M	Adverse national publicity
3 Moderate (MEDIUM)	Semi-permanent harm (1 month-1 year). Increased length of stay / level of care 8-15 days, >1 month's absence from work.	Failure of support services/under-performance against other key targets'.	£51K - £500K	>3 days local media publicity
2 Minor (LOW)	Short-term injury (<1 month). Increased length of stay or level of care <7 days, 3 days-1 month absence for staff.	Service Disruption	£11K - £50K	<3 days local media publicity
1 (Insignificant)	No harm. Injury resulting in <3 days' absence from work for staff.	No service disruption	<£10K	

LIKELIHOOD SCORE		
Level		
5	Almost certain	Will occur frequently given existing controls
4	Likely	Will probably occur given existing controls
3	Possible	Could occur given existing controls
2	Unlikely	Not expected to occur given existing controls
1	Rare	Not expected to occur, except for in exceptional circumstances, given existing controls

RISK RATING MATRIX

Likelihood	IMPACT				
	1	**2**	**3**	**4**	**5**
5	**5** (LOW)	**10** (MEDIUM)	**15** (HIGH)	**20** (CATASTROPHIC)	**25** (CATASTROPHIC)
4	**4** (LOW)	**8** (MEDIUM)	**12** (MEDIUM)	**16** (HIGH)	**20** (CATASTROPHIC)
3	**3** (LOW)	**6** (MEDIUM)	**9** (MEDIUM)	**12** (MEDIUM)	**15** (HIGH)
2	**2** (LOW)	**4** (LOW)	**6** (MEDIUM)	**8** (MEDIUM)	**10** (MEDIUM)
1	**1** (LOW)	**2** (LOW)	**3** (LOW)	**4** (LOW)	**5** (LOW)

Impact Score x Likelihood Score = Risk Rating:

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NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 14/1120

REPORT TO: **TRUST BOARD – 25TH NOVEMBER 2020**

PRESENTED BY: John Trevains, Director of Nursing, Therapies and Quality

AUTHOR: John Trevains, Director of Nursing, Therapies and Quality

SUBJECT: **QUALITY DASHBOARD – October 2020 DATA**

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

This report is provided for:

Decision	Endorsement	Assurance ☑	Information

The purpose of this report is to

To provide the Trust Board with a summary assurance update on progress and achievement of quality priorities and indicators across physical health, mental health and learning disability services.

Recommendations and decisions required

The Board is asked to:

- Discuss, note and receive the October 2020 Quality Dashboard

Executive summary

This report provides an overview of the Trust's quality activities for October 2020. This report is produced monthly for Board, Quality Committee and Operational Governance Forum for assurance.

Quality issues for priority development

- The prevention, identification and management of all pressure ulcers continues to be a Trust priority with agreed quality improvement activities in place. Focussed work in relation to grade 1 and 2 pressure ulcers has commenced in month as route cause analysis is beginning to highlight the additional impact from the first national lockdown with regard to those individuals who were shielding.
- Strengthening the reporting metrics and quality monitoring for those services which have joint commissioning arrangements.

Quality issues showing positive improvement

- Significant improvement noted within CPA Review. Performance is now 0.5% below the target for the first time this financial year.
- Length of Stay for Mental Health Out of Area Placements has reduced to the lowest average this financial year.
- Health visiting KPIs for new births and 6-8 weeks visits have increased to an amber level of compliance this month, the first time this year. This is due to the data now incorporating virtual methods of contact such as video and telephone.

Are Our Services Caring?

Good assurance is available to the Board that the Trust continues to undertake activity within a Covid-19 secure environment that supports the response rate to the FFT survey. In October 94% of respondents recommended Trust services. The Non-Executive Director audit of complaints for Q4 2019/20 provides significant assurance that the complaints process is managed effectively and robustly.

Are Our Services Safe?

For the first time this financial year the percentage of patient safety incidents meeting moderate, severe and death thresholds rose. There is good assurance that the Patient Safety Team monitor such activity routinely to establish if there are any emerging trends. Additional information is provided this month regarding the prevalence of pressure ulcers, to provide contextual information and the associated actions in place.

Are Our Services Effective?

Patient testing for Covid-19 continues to increase and whilst no Covid-19 deaths were reported during October, as the second wave progresses we anticipate that mortality rates associated with Covid-19 will rise in the coming months. There was one Hospital-Onset Definite Healthcare-Associated infection (HODHA) reported in October.

A focus on mental health Out of Area placements provides context to the previously reported increasing rate. This was identified as an area that required further understanding in order to provide good assurance that this service was effective. It is reassuring to note that last month's Dashboard data shows the average length of stay recorded in October to be the lowest this financial year to date.

Are Our Services Responsive?

The rate of performance in relation to timely Care Programme Approach (CPA) reviews is now showing continued month on month improvement. In addition, changes in the way in which Health Visiting contacts are now reported (virtual and telephone) demonstrates that larger numbers of patients are being supported by the service in response to the increased needs of families Covid-19 post wave one.

Are our Services Well Led?

Board are asked to note that feedback from members of the Trust's Health and Wellbeing hub and our Health and Wellbeing pulse surveys are used to inform our priorities in relation to the ongoing support offer to colleagues. A detailed update and findings of the quarterly Duty of Candour audit are provided in this month's report and the associated action plan will be monitored by the Regulatory Compliance Group.

Dashboard Developments

- Future iterations of the Quality Dashboard will include compliance levels for Resuscitation, PMVA and PBM Training.
- Antenatal visiting from October 2020 onwards will include all methods of clinical contact (virtual and face to face).

Risks associated with meeting the Trust's values
Specific initiatives that are not being achieved are highlighted in the Dashboard

Corporate considerations	
Quality Implications	By the setting and monitoring of quality targets, the quality of the service we provide will improve
Resource Implications	Improving and maintaining quality is core trust business.
Equality Implications	No issues identified within this report

Where has this issue been discussed before?
Trust Quality Committee & Quality Assurance Group

Appendices:	

Report authorised by:	**Title:**
John Trevains	Director of Nursing, Therapies and Quality

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Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 14/1120

Quality Dashboard 2020/21

Physical Health, Mental Health and Learning Disability Services

Data covering October 2020

Executive Summary

Gloucestershire Health and Care NHS Foundation Trust

This Quality Dashboard reports quality-focussed performance, activity, and developments regarding key quality measures and priorities for 2020/21 and highlights data and performance by exception. This data includes national and local contractual requirements. With regard to defined contractual or nationally-mandated quality related KPIs, the dashboard is only reporting on indicators not met. Certain data sets contained within this report are also reported via the Trust Resources Committee; they are included in this report where it has been identified as having an impact on quality matters. Feedback on the content of this report is most welcome and should be directed to John Trevains, Director of Nursing, Therapies and Quality.

Are Our Services Caring?

Numbers of complaints and concerns reduced significantly during October, the associated activity, however, remains consistent with previous months. A focus on Podiatry Services is provided this month which explores the experiences of patients in contact with this service throughout the pandemic period. The deep dive into patient experience shows that the main theme identified was regarding how the information about discharge was communicated to patients. The service has learnt from this and it taking steps to improve communication. For the purposes of assurance, details of the 2019/20 Quarter 4 NED audit of complaints is summarised, and significant assurance is provided that the governance arrangements for handling complaints are robust.

Are Our Services Safe?

Incident reporting rates increased marginally in October and are more consistent with the anticipated 'norm'. The percentage of patient safety incidents meeting moderate, severe and death thresholds rose for the first time this financial year, from September (4.71%) to October (6.53%). Of note is the work undertaken by the Patient Safety Team to complete and submit 14 SIRI final reports. Many of these were delayed initially due to Covid-19 so it is assuring that the associated backlog of SIRI reviews has been actively managed and addressed. A more detailed focus on Pressure Ulcers is provided this month, providing both contextual narrative and detail of the actions in place to promote good, responsive practice. reports are stimulating good clinical discussions across operational governance forums and the Trusts quality assurance group. Particular attention was paid at these recent meeting with regard to thematic analysis of issues to determine that Covid disruption was not noted as a theme in mental health SI's during the pandemic.

Are Our Services Effective?

System pressures are increasing demand for community hospital beds and we are also seeing delayed discharges further compounding this. No Covid-19 deaths were reported during October, but as the second wave progresses we anticipate that mortality rates associated with Covid-19 will rise in the coming months. Infection rates have risen for the first time since July. Refresh of the EIP data shows some variance in compliance rates, with August now showing as red. This is being explored by BI and operational teams to establish cause. IAPT data has been reinstated and shows consistent compliance against the KPI from June. A focus on mental health Out of Area placements is provided to provide context for the reported increasing rate for previous months this year. Encouragingly the rate has reduced this month to the shortest average length of stay recorded this financial year.

Are Our Services Responsive?

Integrated Care Team therapies activity has returned to pre Covid-19 levels. For the third consecutive month new referrals have exceeded new cases seen within the month but concerted efforts by the ICT therapists meant that the number of people waiting for an appointment was stable for Physiotherapy and fell for OT. This is the third consecutive month that the required thresholds for referral to treatment time have been exceeded. Whilst CPA compliance remains narrowly below threshold, there is month on month improvement noted. However, we remain focused on working to increase district nursing capacity as this remain an are of pressure on delivery with risk to quality of care in terms or response time.

Are our Services Well Led?

The Trust has continued to run the annual Staff Survey in 2020. Initial findings are anticipated to be available for sharing internally in late December 2020 whilst embargoed for wider sharing.

The initial pause on statutory/mandatory training was lifted in July 2020 but has had to be reinstated with the second lockdown in October. A number of courses had already been converted into on-line delivery and the first virtual Corporate Induction session took place on 9th November. However some courses, including Resuscitation and Physical Intervention training, are continuing as face to face training due to their practical natures, with a range of measures to ensure they are Covid compliant.. A deep dive for each of these courses is provided as there will continue to be challenges in delivery because of the need for face to face interaction. Compliance rates for both these courses will be reported from December's dashboard onwards. Sickness/absence rates for October are not yet available.

The staff health and wellbeing hub continues to meet fortnightly and uses feedback from members of the hub and our Health and Wellbeing pulse surveys to inform our priorities.

Following the Duty of Candour (DoC) deep dive audit undertaken for 2019/20, quarterly reviews for DoC compliance are now undertaken on a routine basis to monitor compliance and provide assurance that DoC is being applied in line with regulatory requirements. Following each review detailed reports will be submitted to the Trust Quality Governance framework for review, assurance, escalation and onward dissemination across the Trust.

A focus on the Reablement Service is provided following feedback from Gloucestershire County Council which identified areas for improvement along with information and update regarding other jointly commissioned services.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

COVID-19 (Whole Trust data, reporting nationally mandated Covid-19 focused safety and activity information)

No		Reporting Level	Threshold	2019/20 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2020/21 YTD	R A	Exception Report?	Benchmarking Report
1	No of C-19 Patient Deaths reported to CPNS	N-R			30	7	1	0	0	0	0						38			N/A
2	Total number of deaths reported as C-19 related.	L-R			65	17	2	1	0	1	0						86			N/A
3	No of Patients tested at least once	N-R			202	234	259	289	304	305	332						1925			N/A
4	No of Patients tested C-19 positive or were admitted already positive	N-R			120	65	6	1	0	0	2						194			N/A
5	No of Patients discharged from hospital post C-19	N-R			27	52	18	3	1	0	0						101			N/A
6	Community onset (Positive specimen <2 days after admission to the Trust)	N-R					0	0	0	0	0						0			N/A
7	Hospital onset (nosocomial) indeterminate healthcare associated (Positive specimen date 3-7 days after admission to the Trust)	N-R					0	0	0	0	0						0			N/A
8	Hospital onset (nosocomial) probable healthcare associated (Positive specimen 8-14 days after admission to the Trust)	N-R					0	0	0	0	0						0			N/A
9	Hospital onset (nosocomial) Definite healthcare associated (Positive specimen date 15 or more days after admission to the Trust	N-R					0	0	0	0	1						1			N/A
10	No of Staff and household contacts tested	N-R			276	521	104	57	204	342	215						1719			N/A
11	No of Staff and household contacts with confirmed C-19	L-R			85	38	0	0	0	7	12						142			N/A
12	No of Staff self-isolating new episodes in month	L-R			597	174	63	39	43	49	153									N/A
13	No Staff returning to work during month	L-R			333	118	25	10	28	30	54									N/A

Additional Information

Patient Reporting

The table above shows that the number of Covid-19 related patient deaths has reduced significantly since April 2020. No patient deaths were reported to be Covid-19 related in October 2020. The age range for inpatient deaths reported to CPNS was 70-98 years. The information is shown by hospital site/community team in the graph opposite.

Patient Testing

The numbers of patients tested in month is at its highest level since the testing regime was established. There were two positive results this month.

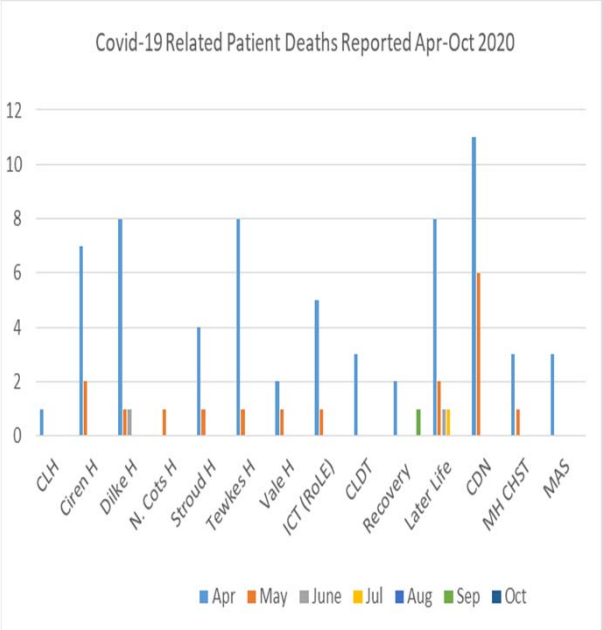
Staff and Household Contacts Testing

Numbers tested this month have reduced. The increase seen in September is thought to be due to schools returning for the first time since March 2020. The data for October is in line with that recorded in August, prior to this change in Covid-19 restrictions.

Infection Prevention and Control - Covid 19

The Trust is required to report any healthcare associated Covid-19 infections (nosocomial infections) attributable to our care. A root cause analysis is required for each infection which is coordinated by the Infection Prevention and Control Team, discussed at the Trust's Infection Prevention and Control Team meeting and the ICS Bronze System (IPC) Cell.

There was one definite hospital acquired nosocomial infection reported in October and a full investigation into this with remedial infection control learning applied has been conducted.



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

COVID-19 - KEEPING STAFF SAFE (Are services well led?)

Personal Protective Equipment (PPE)

At the current time, there are no concerns regarding stock levels of any PPE items. The Trust is fully assured on future supply of all stock items via national supply routes.

The 'controlled pull' model for key PPE product lines to fulfil the Trust's weekly requirements continues to work well. The Team completes a 'pick list' each week and submit via the Covid-19 Logistics, Finance and Supplies Cell.

The Trust continues to maintain 14 days supply of all key PPE items.

The current focus for the PPE stock team is to continue to support the recently recruited team members to understand processes, build relationships and to be winter ready.

The expected local agreement to continue to use FFP3 masks for Aerosol Generating Procedure's in Green (Low risk areas) will not negatively impact on stock levels as this was the guidance that was used for the FFP3 stock modelling activity.

The Clear Masks that were provided in small numbers via the PPE Dedicated Channel have now been deployed to teams who had requested them. Some are not able to be used in the way that teams had hoped as they would as they are not Type II Fluid Resistant and so cannot be used in lieu of those. However, they are proving useful to some teams (especially talking therapies) when it has been agreed in conjunction with IPC colleagues that these masks are clinically appropriate. There are a small number of masks sitting with the stock team at present available for deployment as future availability and delivery schedules are unclear at present..

FFP3 fit-testing

Fit testing compliance data as at 12/11/2020 shows that a total of 825 colleagues have been successfully fit-tested, representing 74% of the target number who require testing.

This is an increase of 43 colleagues tested since last month's data. Fit-testing rates are seeing only modest increases as the majority of fit testers have been repatriated, leaving only 2 people (who are not full-time) in the fit test role.

A task and finish group was established in order to review and make recommendations on the data collection and management elements of the Fit Test Programme. These recommendations have been incorporated into the revised paper that is to return to the Covid-19 Programme Management Executive for its second presentation to the group on 19/11/20. This paper will set out options for the future of the Fit Test Programme to include workforce, quantitative testing and data management processes.

2 more respiratory hoods have been ordered through the Nursing, Therapies and Quality Directorate, bringing the Trust total to 46 hoods. This is to further mitigate risks within 2 services where colleagues have failed on the range of FFP3 mask options.

Quality Dashboard

Gloucestershire Health and Care
NHS Foundation Trust

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

No		Reporting Level	Threshold	2019/20 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2020/21 YTD	R A G	Exception Report?	Benchmarking Report
	Number of Friends and Family Test Responses Received	N - T		33836	Suspended			699	496	1179	1631						4005			
	% of respondents indicating a positive experience of our services	N - R	95%	88%	Suspended			93%	93%	93%	94%						93%			
	Number of Compliments	L - R		2,938	228	58	166	74	67	159	123						875			
	Number of Complaints Received	N - R		117	5	6	1	4	6	5	1						28			
	Number of Concerns	L - R		620	31	24	44	60	31	45	25						260			
	Number of Complaints Closed									2	4									
	Number of open complaints (not all opened within month)							28	33	36	33									
	Number of re-opened complaints (not all opened within month)							5	4	4	3									
	Percentage of complaints acknowledged within 3 working days							100%	86%	100%	100%									
	Number of complaints for which the team are agreeing investigation issues with complainant							7	10	13	11									
	Number of complaints awaiting investigation							2	1	0	1									
	Number of complaints under investigation							6	9	9	6									
	Number of investigations on hold							0	0	0	0									
	Number of Final Response Letters being drafted							12	12	11	9									
	Number of Final Response Letters awaiting Exec sign-off							0	0	2	0									
	Concerns escalated to a formal complaint							2	1	0	0									
	Current external reviews							4	4	3	2									

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

RAG Key: R – Red, A – Amber, G - Green

ARE SERVICES CARING? Additional information - Patient and Carer Experience (PCET)

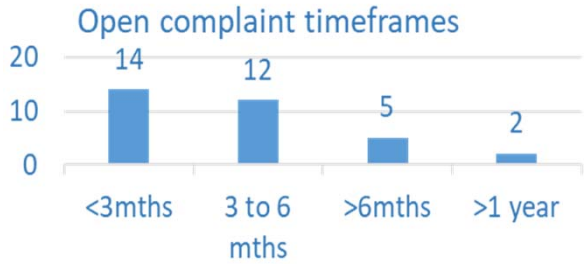
Complaints, concerns and compliments

- In addition to the **33** open complaints, there are 6 complaints relating to Herefordshire mental health services made before 1st April 2020 (previously reported as 5).
- In October, **4** complaints were closed: 1 upheld; 2 partially upheld; 1 was not upheld. The learning from these complaints has been distributed.
- In October, PCET worked with **25** patients and carers to resolve their concerns. This is a decrease from September's total and lower than the monthly average of 52 concerns in 2019/20.
- **123** compliments were recorded in October, which remains lower than the monthly average of 245 during 2019/20.

Timeframes

- PCET remains in active recovery following the national pause in the complaint management process between April and June 2020.
- Of the 33 open complaints, **16** do not have agreed response times. Of these 16:
    - **8** were received either during or close to the pause period initiated by NHSE. As a result, completion dates were not set and complainants were advised that their concerns would be progressed as soon as possible.
    - **6** are in the very early stages of the complaint process and issues have not yet been agreed.
    - **2** complaints received in 2019 were on hold for 15 months due to availability of a member of staff who was key to the investigation. Both investigations have now commenced.

- Of the **17** complaints with agreed response dates:
    - **5** are within the agreed timeframes
    - **12** exceeded the initially agreed timeframes, and of these:
        - **2** responses were due before the pause
        - **3** responses were due during the pause
        - **7** responses were due following the end of the pause
    - The delays relate to preparing the complaint for investigation (n=3), the investigation process (n=7), and the national pause in the complaints process (n=2)
    - Complainants have been contacted regularly to advise of the delay, to apologise for this, and to provide updates.
- The chart opposite shows the timeframes for all open complaints, inclusive of the 3 month national pause



Satisfaction with complaints/concern processes

- No concerns were escalated to complaints this month, suggesting that people have been satisfied with our informal resolution process.
- 1 re-opened complaint was closed in October. 3 re-opened complaints remain active. None of these were reopened in-month, suggesting that people are currently broadly satisfied with the complaints process.

External review

- There are currently **3** complaints with the PHSO for external review.
    - PHSO are investigating **2** complaints; one is a complaint from 2017 and the other from 2019 .
    - 1 complaint was originally closed by the PHSO in 2019, with no further action required. In July 2020, PHSO contacted to advise of their intention to conduct an internal review. We are awaiting notification of the outcome.

Surveys

- Friends and Family Test (FFT) email and SMS messages were reinstated on 1st July 2020. Paper copies of FFT remain suspended due to infection prevention and control measures. An increasing number of services are using the electronic method to seek feedback, resulting in a 38% increase compared to last month.
- In late September a number of services began piloting the use of the electronic FFT at the end of Attend Anywhere consultations. More services came on board in October 2020.

Reporting

- To support the effective cascade of learning, a combined PCET and Patient Safety monthly report was launched in November. Feedback is being actively sought to support the development of this key document.
- Work continues to develop local Experience Dashboards to allow services to access team-level information.

ARE SERVICES CARING? Focus on experience of Podiatry Services

WHAT HAPPENED

In response to Covid-19 , the service was closed to non-urgent referrals, all non-urgent/priority cases were discharged, and it was agreed with the CCG that the service would no longer accept self-referrals. When undertaking recovery, the service took the opportunity to review and refresh access criteria. These criteria were unchanged but consistent adherence to them meant that some people who were previously seen by the service were advised that they did not require specialist podiatry input.

WHAT OUR PATIENTS SAID

Between 23/04/20 and 01/10/20, PCET received 14 concerns and 2 enquiries regarding our Podiatry Service.

Concern theme	Number of concerns raised	Comment
Not being able to self–refer into service when it re-opened	1	-
Unhappy about being unable to receive Podiatry input whilst service was closed due to COVID	5	These were mainly from relatives of patients
Discharged from the service	8	This was a mixture of patients who were unhappy about being discharged from the service due to COVID and a couple who did not meet the criteria when the service re-opened
Relative unsure how to contact Podiatry on behalf of patient	1	-
Experience with Podiatrist (F2F) pre-Covid	1	This has been addressed with the Podiatrist concerned.

WHAT WE DID AND WHAT WE LEARNT

- A detailed review was commissioned by the Deputy Director of Therapies and Quality and was undertaken by the Head of Profession for Podiatry and the operational lead
- The proposal not to re-open the self-referral portal was agreed through the appropriate routes in GHC and the CCG. The rationale was that not all staff had been repatriated and those returning required training in new triage processes, remote working etc. (this was an attempt to manage demand in line with the clinical criteria). In addition, applying the criteria more robustly with a medical gatekeeper aimed to reduce the high volume of inappropriate referrals (e.g. for nail cutting and simple callus management).
- The main theme identified was regarding how the information about discharge was communicated to patients. The team has acknowledged this and has undertaken work to improve their communication approach based on this feedback.
- The deep-dive confirmed that a prioritisation/risk matrix was followed for discharges. Learning from Wave 1 is that a mass discharge of patients will be avoided in a second wave.
- Feedback from GP colleagues was swiftly acted upon and the self-referral portal was reopened. A telephone referral clinic has been established for those who are less digitally-enabled.
- National Guidelines were published regarding provision of Podiatry services during the Coronavirus pandemic: diabetic foot and vascular pathways should remain open. Our Podiatry Service were delivered in line with these guidelines.

FEEDBACK

"I wanted to share my experience of your podiatry services both pre- and post- Covid.

Yesterday I had nail surgery and I have had fantastic treatment from start to finish- rapid triage telephone appointment, offered a date within days for op (which was so rapid I asked for a couple more weeks), appointment yesterday with two really kind and caring colleagues (whose names have left me), they were reassuring throughout, clearly explained everything, ensured I understood and knew what to expect in the next few days. Appointments exactly on time, and Covid secure working practices were evident.

Pre-Covid whilst I can't fault my treatment, I had an appointment before then being offered another at a somewhat later date- I really valued having a telephone appointment instead on this occasion saving time and fitting into my day without need to travel.

Whilst I hope not to need the service again- I really see the value of the shift in how this element of service has been adapted for Covid and hopefully beyond."

ARE SERVICES CARING? Non-Executive Director audit of complaints Q4 2019/20

INTRODUCTION

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

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

PROCESS

- Three complaint files closed in the quarter are randomly selected by the nominated Non-Executive Director
- The Patient and Carer Experience Team completes section 1 of the audit tool and provides the auditor with copies of the initial complaint letter, the investigation report and the final response letter.
- Having studied the files, the auditor completes sections 2-4
- The auditor compiles a report of their findings, to be presented at the Quality Committee and Trust Board

SUMMARY OF FINDINGS

- Audit findings are summarized within the table on the following slide
- The Q4 2019/20 audit provides **SIGNIFICANT** assurance that the Trust is managing complaints appropriately
- No actions have been identified to improve the quality of the Trust's management of complaints

FUTURE AUDITS

- The NED audit of complaints for Quarters 1 and 2 of 2020/21 are outstanding
- The Trust Secretary's office is working to allocate the above quarters to NED colleagues
- An ongoing programme for NED audit of complaints has been established
- Audit reports will continue to be presented as an appendix to the Quality Dashboard for the Quality Committee and for Trust Board

RECOMMENDATIONS

- To note the contents of the report
- To note the **SIGNIFICANT** assurances provided regarding the Trust's management of complaints
- To endorse the progression of the audit findings to Trust Board

	TIMELINESS OF RESPONSE PROCESS	QUALITY OF INVESTIGATION	ACCESSIBILITY, STYLE AND TONE OF LETTER	LEARNING AND ACTIONS IDENTIFIED	COMMENTS
COMPLAINT 1 • MIIU • Complaint regarding: possible missed fracture	**FULL ASSURANCE**	**FULL ASSURANCE** • Thorough investigation	**FULL ASSURANCE** • Empathetic • Apologetic • Clear about findings • Clear learning and actions to be taken	**FULL ASSURANCE** • Clear organisational learning • Detailed action plan • Review of scaphoid assessment guidance to include pictures • Trauma and Orthopaedics surgeons from GHT to provide training to MIIU staff re: wrist injuries • Not possible to form conclusive opinion as to whether fracture missed	• Followed GCS process
COMPLAINT 2 • Community physiotherapy service • Complaint regarding: attitude of physio; communication of physio; arrived late with no apology; request to refer to professional regulator	**PARTIAL ASSURANCE** • Delay due to need to reinvestigate • Delay due to Christmas holiday period • Sincere apology for delay sent by Patient Experience lead, advising of revised response date	**FULL ASSURANCE** • Consent to share obtained • Terms of reference logical and clear • Initial investigation deemed to not respond to all issues and so was reinvestigated • Areas of complaint ultimately thoroughly investigated	**FULL ASSURNCE**	**FULL ASSURANCE** • Future communication by physiotherapist will take into account patients with hearing difficulties • Physio to speak more slowly to take account of accent	• Good clinical record keeping aided investigation and demonstrated good practice • No evidence of poor clinical practice or concern re: professional conduct
COMPLAINT 3 • Later Life Community MH team • Complaint regarding: concerns that mother, living in a care home, visits family home frequently and alone without liaison with the family; lack of recent capacity assessment; fluctuating capacity not taken into account	**FULL ASSURANCE** • Original timescale unable to be met due to an additional concern being raised by the complainant	**FULL ASSURANCE** • Consent to share obtained • Thorough • Clear where responsibility and information was needed from partner organisations	**FULL ASSURANCE** • Empathetic • Sincere apology • Clear that assessment had fallen below expected standards. No attempt to excuse the mistake • Made suggestions for complainant to meet with care home staff to discuss concerns	**FULL ASSURANCE** • Risk assessment regarding 'risk of accidents' was based on patient being accompanied when in community • Local learning agreed with team Manager	• Trust requested a response from Adult Social Care Team in GCC • A number of capacity assessments had been undertaken

Quality Dashboard

NHS
Gloucestershire Health and Care
NHS Foundation Trust

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

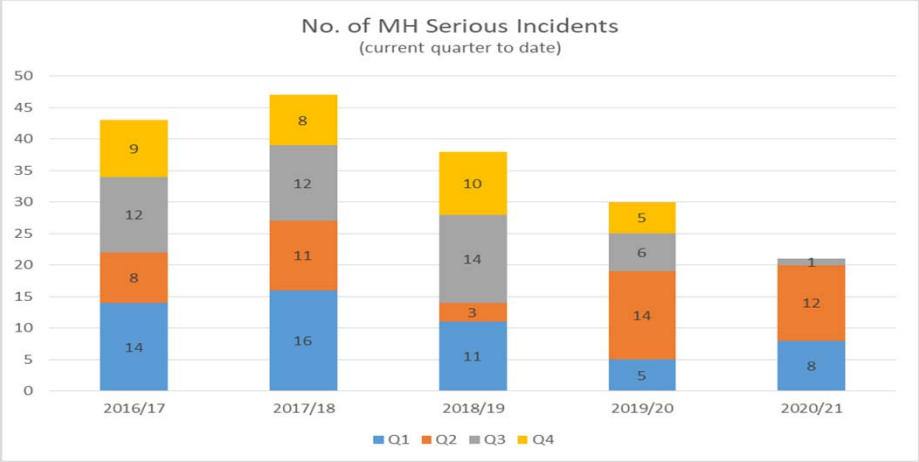
		Reporting Level	Threshold	2019/20 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2020/21 YTD	R / A / G	Exception Report?	Benchmarking Report
	Number of Never Events	N - T	0	1	0	0	0	0	0	0	0						0			N/A
	Number of Serious Incidents Requiring Investigation (SIRI)	N - R		49	4	3	3	7	2	5	1						25			N/A
	Number of Serious Incidents Requiring Investigation (SIRI) where Medication errors caused serious harm	N - R		0	0	0	0	0	0	0	0						0			N/A
	Number of Serious Incidents Requiring Investigation (SIRI) regarding falls lead to fractures	N - R		6	0	1	0	1	0	0	1						3			N/A
	Number of Serious Incidents Requiring Investigation (SIRI) regarding pressure ulcers	N - R		5	0	0	1	0	0	0	0						1			N/A
	Number of Serious Incidents Requiring Investigation (SIRI) regarding suspected suicides	N - R		18	2	0	0	4	2	3	0						11			N/A
	Number of Serious Incidents Requiring Investigation (SIRI) regarding self harm or attempted suicide	N - R		6	3	1	1	0	0	2	0						7			N/A
	Number of Serious Incidents Requiring Investigation (SIRI) regarding mental health homicides	N - R		1	0	0	0	0	0	0	0						0			N/A
	Total number of Patient Safety Incidents reported	L - R		12,109	689	866	1000	1047	1139	1082	1134						6957			N/A
	% incidents resulting in low or no harm	L - R		94.71%	90.42%	92.49%	93.10%	94.56%	94.82%	95.29%	93.47%						93%			N/A
	% incidents resulting in moderate harm, severe harm or death	L - R		5.29%	9.58%	7.51%	6.90%	5.44%	5.18%	4.71%	6.53%						7%			N/A
	% falls incidents resulting in moderate, severe harm or death	L - R		2.24%	0.96%	3.13%	2.04%	3.16%	2.44%	4.88%	3.25%						3%			N/A
	% medication errors resulting in moderate, severe harm or death	L - R		0.61%	6.06%	0.00%	0.00%	1.85%	1.82%	0%	1.96%						2%			N/A
	Embedding Learning meetings taking place to review the outputs of completed SIRI reports and consider practice implications.* **Covid Disruption**	L - R		N/A	0	0	0	0	0	0	0						0			N/A

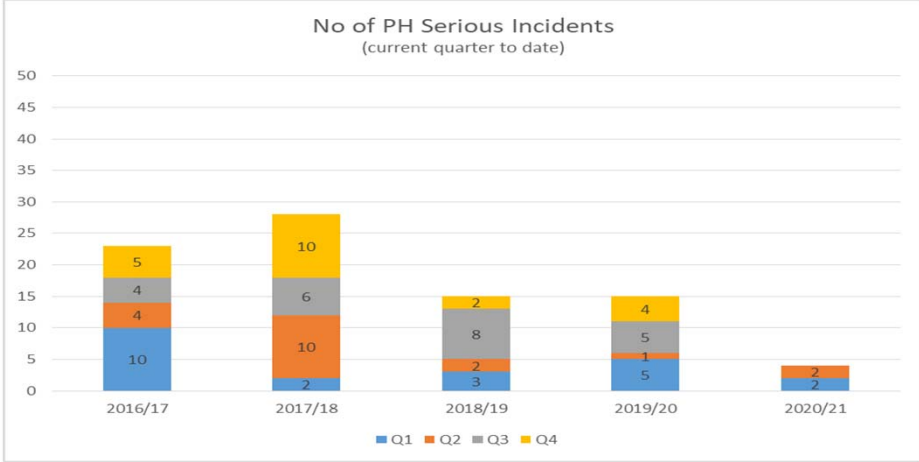
N-T	National measure/standard with target	L-I	Locally agreed measure for the Trust (internal target)
N-R	Nationally reported measure but without a formal target	L-R	Locally reported (no target/threshold) agreed
L-C	Locally contracted measure (target/threshold agreed with GCCG)	N-R/L-C	Measure that is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

RAG Key: R – Red, A – Amber, G - Green

ARE SERVICES SAFE? – additional information

One SIRI was declared in October 2020, within mental health inpatient services. All incidents were escalated in line with SIRI reporting requirements. The Patient Safety Team continue to monitor both regional and national trends in terms of suicide rates and will analyse and report significant departures from benchmarking trends. The tables below represent SIRI reporting over the past 5 years. These reports are stimulating good clinical discussions across operational governance forums and the Trusts quality assurance group. Particular attention was paid at these recent meeting with regard to thematic analysis of issues to determine that Covid disruption was not noted as theme in mental health SI's during the pandemic.





1 SIRI was declared in October 2020, within the Mental Health inpatient service: a patient was found on the floor and sustained a fractured femur.

14 SIRI final reports, 7 mental health and 7 physical health, were completed during October 2020. 6 of the 7 physical health incidents pertain to SIs which occurred in 2019/20. This push to complete final reports has been a significant undertaking, completely clearing overdue incidents resulting from the Trust-wide Covid response. There are currently 6 of 7 "Incident on a Page" documents for mental health incidents completed. 1 is outstanding. These are disseminated and discussed throughout the services to promote learning. All Incident on a Page documents are uploaded to the Trust Intranet.

There are currently 9 active SIRIs. 2 further incidents will be complete on 3 and 4 November, with a 3rd completing on 16 November 2020. None of the remaining 6 SIs will have an extended deadline for submission.

Regarding all patient safety incidents:

- The total number of patient safety incidents rose from September (1082) to October (1134), returning to the levels seen in August (1139).
- The percentage of patient safety incidents meeting moderate, severe and death thresholds rose for the first time this financial year, from September (4.71%) to October (6.53%).
- The percentage of falls resulting in moderate and above levels of harm decreased from September (4.88%) to (3.25%). The actual number of moderate+ harm falls was unchanged from September, however there was an increase in the total number of falls reported from September (82) to October (123), indicating an increase in no or low harm falls reported.
- 1 medication error resulting in moderate or above harm occurred in October, representing 1.96% of medication errors reported in October.
- To note, there has been one minor adjustment to data provided prior to October 2020 due to ongoing incident review and approval processes, reducing the total number of incidents in September from 1083 to 1082. This adjustment did not substantially change the percentages reported against different levels of harm.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

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

		Reporting Level	Threshold	2019/20 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2020/21 YTD	RAG	Exception Report?	Benchmarking Report
	VTE Risk Assessment - % of inpatients with assessment completed	N - T	95%	97.3%	94.6%	93.4%	96.2%	100.0%	96.5%	98.7%	96.7%						97.0%	G		
	Safety Thermometer - % Harm Free	N - R L - C	95%	93.2%														N/A		
	Safety Thermometer - % Harm Free (New Harms only)	L - I	98%	97.8%														N/A		
	Total number of developed or worsened pressure ulcers	L - R	61	784	62	76	82	63	63	47	65						458	R		
	Total number of Category 1 & 2 Acquired pressure ulcers	L - R	56	737	54	68	70	59	58	41	50						400	R		
	Number of Category 3 Acquired pressure ulcers	L - R	0	46	4	6	8	3	4	6	12						43	R		
	Number of Category 4 Acquired pressure ulcers	L - R	0	8	4	2	4	1	1	0	3						15	R		

Additional information

VTE Risk Assessment

The percentage of inpatients with VTE Risk Assessment completed in inpatient settings has continued to exceed the 95% target in November for the fifth consecutive month.

Safety Thermometer

Reporting remains suspended due to Covid-19 in agreement with commissioners.

Focus on Pressure Ulcers

Current Situation:

- The prevalence of pressure ulcers has increased during the year and Gloucestershire is experiencing increases in the occurrence of pressure ulcers across the care system.
- The complexity of patients discharged into our community hospitals and back home has been impacted by Covid both physiologically and psychologically with increases in anxiety and mental health issues impacting on treatment and outcomes. A DoH briefing released in July 2020 informed of the increased medical and nursing needs of patients who had contracted Covid 19; this included pressure ulcers and mental health concerns.
- We are working with the regional NHSE/I team as there is a region wide issue of increase in prevalence during the pandemic so this is not isolated to a Gloucestershire only issue
- Redeployment of specialist clinical colleagues, the clinical pathways lead, and the necessary suspension in corporate work to concentrate on addressing the pandemic in March resulted in a temporary halt in education and training.
- The patients we are caring for are increasingly frail and complex and some of the pressure ulcers reported are worsening under our care due to a range of factors including matter outside of our immediate control.

Current actions:

- Pressure ulcer quality improvement groups restarted in September with a focus on national **#StopThePressure** day on 19/11/20
- The Trust's Tissue Viability team have developed a virtual interactive awareness training package for all patient-facing clinicians. This launches in December 2020.
- Route cause analysis is beginning to highlight the additional impact from the first national lockdown in terms of changes in operational delivery pressures due to shielding (patients, carers and clinicians)
- Prevalence data continues to be collected and presented for Resources and Quality committee oversight.
- Clinical Pathways Lead reviews category 3,4 and unstageable ulcers monthly
- There is an integrated approach across operational and corporate teams to support assurance and learning from pressure ulcer incidents.
- Agreement with key system partners to develop a One Gloucestershire approach to the prevention and management of Pressure Ulcers – timescale delayed due to the system's response to the second wave of Covid 19
- Clinical Pathways Leads transferred to the Deputy Director of Nursing and Quality portfolio to provide more focus

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RAG Key: R – Red, A – Amber, G - Green

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

CQC DOMAIN - ARE SERVICES EFFECTIVE? (Whole Trust data)

		Reporting Level	Threshold	2019/20 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2020/21 YTD	RAG	Exception Report?	Benchmarking Report
Community Hospitals																				
	Bed Occupancy - Community Hospitals	L - C	92%	94.4%	76.1%	69.8%	83.3%	88.3%	86%	90.6%	94.2%						84.0%	R		90.4%
Mental Health Services																				
	Early Intervention in psychosis EIP: people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral	N - T	60%	63.4%	50.0%	66.7%	50.0%	85.7%	53.3%	100%	83.3%						69.8%	G		
	Ensure that cardio-metabolic assessment & treatment for people with psychosis is delivered routinely in the following service areas:																			
	Inpatient Wards	N - T	95%	80%																
	GRiP	N - T	92%	85%																
	Community	N - T	90%	78%																
	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	N - T	50%	50.1%	37.5%	44.4%	54.5%	56.2%	55.8%	58.8%	54.1%						51.6%			
	Admissions to adult facilities of patients under 16 years old.	N - R		0	0	0	0	0	0	0	0						0	N/A		
	Inappropriate out-of area placements for adult mental health services	N - R	average bed days	19	30	14	11	17	15	17	9.6						16.2	N/A		
Children's Services - Immunisations				2019/20 Academic Year	Academic Year 2019/20					Academic Year 2020/21										
	HPV Immunisation coverage for girls aged 12/13 years old (1st Immunisation)	N - T	90%*	73.1%		Focus on Immunisation Programme provided in July Dashboard											0.0%	R		
Childrens Services - National Childhod Measurement Programme				2019/20 Academic Year	Academic Year 2019/20					Academic Year 2020/21										
	Percentage of children in Reception Year with height and weight recorded	N - T	95%*	69.7%	66.4%	68.0%	67.9%	69.7%	69.7%	Programme commences in November 2020							0.0%	R		
	Percentage of children in Year 6 with height and weight recorded	N - T	95%*	73.9%	66.1%	70.0%	69.8%	73.9%	73.9%	Programme commences in November 2020							0.0%	R		

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CQC DOMAIN - ARE SERVICES EFFECTIVE?

Additional Information

Bed Occupancy

System pressures are increasing demand for community hospital beds and there is a lack of capacity on Discharge to Assess pathway, which is delaying the discharge of patients from the community hospital beds. These combined factors are contributing to increased bed occupancy levels.

Mental Health

The IAPT recovery rate indicator has been reinstated this month, and has continued to exceed the required threshold for five consecutive months.

Monthly and year to date data for the Early Intervention in Psychosis (EIP) service demonstrates that the service has met the target threshold for the second consecutive month and at a time when the service remains in active recovery. The figures for the Early Intervention in psychosis have changed in some previous months. This is currently being reviewed with the service as there may be data quality issues involved.

Length of stay - inappropriate out of county placements

The number of bed days for adult mental health inappropriate out of area placements reduced in October for the first time in six months. A data quality issue also caused September data to report an incorrect higher number, this has now been corrected The following focus slides explores the detail for the length of stays recorded so far this year, identifying the context of the placements and the numbers of individual placements to which the average length of stay data applies.

CQC DOMAIN - ARE SERVICES EFFECTIVE? Focus on Length of Stay (LOS) of inappropriate Acute and PICU placements

The 2020/21 data for inappropriate Acute and PICU placements during this period suggests that the average LOS for Out of Area Placements (OAP) was initially high but reduced over the summer period, only to rise again in September 2020. However, the LOS data does not reflect the actual number of OAPs or reasoning for the decisions to place Gloucestershire patients in an out of county bed.

MONTH IN 2020	NUMBER PLACEMENTS IN MONTH	AVERAGE NUMBER OF BED DAYS	COMMENTS
APRIL	1	30.0	1 patient was placed out of county who required a gender specific PICU bed that was unable to be facilitated within county
MAY	3	14.0	Average LOS reduced to 14 days but began to rise, likely due to the impact of Covid-19. Inpatient cases began to rise and bed pressures hit a peak. The Bed Management Team were able to keep most patients in county however 2 further patients required OAP; 1 PICU and 1 acute due to lack of available beds within county.
JUNE	6	11.3	The lowest LOS over the summer period but mental health inpatient admissions increased dramatically. Average LOS was 11 days. 3 patients continued to require PICU beds and 4 patients required acute OAPs. The reduced average LOS reflects the pro-active work to repatriate patients back into county.
JULY	3	17.1	The average LOS related to 2 patients in OAP PICU beds (both requiring gender specific provision due to behaviours that could not be safely accommodated in county. The acute patients were transferred back into county following a 10 day OAP.
AUGUST	5	15.2	The average LOS reduced by 2 days, however 5 patients remained in OAP within PICU placements whilst Trust PICU was full. Of the 5 patients placed OAP, 3 required a gender specific ward.
SEPTEMBER	8	17.4	Due to 5 patients continuing to require OAPs, the LOS for September increased. A further 2 patients required acute OAPs. At the latter part of the month, 3 PICU patients were repatriated back into county.
OCTOBER	5	9.6	LOS reduced, however 2 patients remained in OAP PICU placements whilst Trust PICU was full. 3 patients in OAP Acute beds. By the middle of the month all patients were repatriated into county.
	TOTAL: 31	AVERAGE: 16.4	

Challenges within the system

Due to Covid-19 in the spring and summer of 2020, the usual monitoring routes for seasonal predictions with regard to admissions was unable to be followed. Discharges in late March and April were undertaken due to the expected surge in admissions. Initially, those detained under the Mental Health Act outnumbered those who were admitted informally. From June onwards admission rates were high and more patients admitted to hospital informally. This impacted on bed capacity and resulted in some patients requiring OAPs.
During spring the discharge rates began to slow and both WLH and CLH experienced daily bed capacity of between 96%-100%, including leave beds.

Possible to solutions to reduce OAP and LOS

The Integrated Discharge Hub (IDH) within mental health hospitals is a developing service that is seeking to support discharges across the entire inpatient system, including the inpatient recovery units. Included and aligned to the IDH are Bed Managers; a clinical lead, inpatient social workers, supported accommodation management and ELIM housing. As we move away from the increased activity of the summer, we will seek to reduce OAPs by supporting inpatient discharges and working with community teams to understand activity and to formulate discharge plans.
OAPs are a high priority within the Trust and numerous proposals to support inpatient discharge and reduce OAPs are evolving via Quality Improvement schemes driven by the IDH. These include:

- Interactive White Boards (board rounds)
- Daily Dashboard (board rounds)
- Recruitment of SWs to the Integrated Discharge Hub
- Paper to be submitted for the proposal of a Quality Hotel
- PICU bed base and service review (particular attention to gender specific OAPs
- AHP reviews to support discharge pathway

Work continues to evolve contractual arrangements with Priory, Cygnet and Elysium private health care providers whilst the need for OAPs remains.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

CQC DOMAIN - ARE SERVICES RESPONSIVE?

Minor Injury and Illness Units

		Reporting Level	Threshold	2019/20 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2020/21 YTD	RAG	Exception Report?	Benchmarking Report Feb Figure
	Time to initial assessment for patients arriving by ambulance (95th percentile)	N - T	<15 m	0:14	0:17	0:11	0.13	0:17	0.15	0.14	0 .15						0.14	G		
Referral to Treatment physical health																				
	Podiatry - % treated within 8 Weeks	L - C	95%	73.6%	92.9%	97.2	100%	94.2%	97.7%	97.5%	94.7						96.5%	G		
	ICT Physiotherapy - % treated within 8 Weeks	L - C	95%	79.8%	65.1%	57.9%	84.4%	93.6%	97.5%	99.1%	98.1%						88.1%	R		
	ICT Occupational Therapy Services - % treated within 8 Weeks	L - C	95%	83.5%	79.4%	62.6%	93.6%	94.9%	98.4%	99. 5%	99.1%						92.3%	R		
	Paediatric Speech and Language Therapy - % treated within 8 Weeks	L - C	95%	88.5%	60.2%	83.1%	97.2%	99.3%	100%	100%	100%						91.0%	R		
	Paediatric Physiotherapy - % treated within 8 Weeks	L - C	95%	84.5%	72.2%	98.8%	95.2%	98.7%	98.6%	98.9%	100%						91.0%	R		
	Paediatric Occupational Therapy - % treated within 8 Weeks	L - C	95%	95.4%	99.0%	97.2%	96.2%	99.00%	98.7%	99.1%	98.3%						98.4 %	G		
	Single Point of Clinical Access (SPCA) Calls Offered (received)	L - R	3,279	35939	1787	1731	1774	1712	1702	1746	1835						12287	R		
Mental Health Services																				
	CPA Review within 12 Months	N - T	95%	96.9%	88.9%	89.8%	89.2%	90.7%	92.2%	92.8%	94.5%						91.2%	R		
	Admissions to hospital gate kept by CRHTT	N - T	95%	100.0%	96.8%	100.0%	100%	100%	100%	100.0%	100.0%						99.5%	G		

Additional information

MIIUs

- The Dilke remains closed as part of the Covid-19 response.
- Tewkesbury MIIU re-opened on 25/08/20 and remains open 8am-8pm 7 days per week
- The Vale is open from 10am-6pm as a full staffing model for this site cannot be assured.
- For patients who call ahead, the MIIU team provide telephone advice to ensure the right clinical pathway is accessed as soon as possible. MIIU are moving to Telephone Triage using the Manchester Triage Scoring in November
- System-wide work is progressing with the Think First 111 project via the ICS A&E delivery board.

ICTs

- For a third consecutive month, new referrals exceeded new cases seen in month but concerted efforts by the ICT therapists meant that the number of people waiting for an appointment was stable for Physiotherapy and fell for OT. Clinicians continue to prioritise referrals on the basis of clinical need. 77.0% of people seen by ICT Physiotherapy and 80.7% of people seen by ICT OT in October waited for 2 weeks or less.

Mental health

- Performance in relation to CPA reviews is narrowly below the required threshold, but a month on month improvement is noted and is now close to target. The impact of Covid-19 continues to be noted in relation to limited opportunities for face to face contact to support full CPA review.
- CRHTT has achieved 100% compliance with gatekeeping admissions to hospital for the sixth consecutive month this year.

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Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

Additional KPIs - Physical Health

		Reporting Level	Threshold	2019/20 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2020/21 YTD	RAG	Exception Report?	Benchmarking Report Feb Figure
	Proportion of eligible children who receive vision screens at or around school entry.		95%*	N/A	61.5%	61.5%	61.5%	61.5%	61.5%	71.9%	86.6%	Program completes in Nov					71.9%	R		
	Number of Antenatal visits carried out			944	46	42	35	24	24	40	65						276	R		
	Percentage of live births that receive a face to face NBV (New Birth Visit) within 7-14 days by a Health Visitor		95%	91.5%	43.0%	30.6%	64.1%	75.7%	82.5%	86.4%	93.8%						68.1%	R		
	Percentage of children who received a 6-8 weeks review.		95%	94.1%	29.7%	45.8%	71.8%	76.3%	86%	85.4%	94.7%						69.9%	R		
	Percentage of children who received a 9-12 month review by the time they turned 12 months.		95%	84.8%	84.1%	75.2%	67.1%	70.8%	64.4%	65.1%	68.8%						70.7%	R		
	Percentage of children who received a 12 month review by the time they turned 15 months.		95%	90.2%	89.8%	86.3%	90%	87.5%	82.2%	72.9%	69.3%						82.4.%	A		
	Percentage of children who received a 2-2.5 year review by 2.5 years.		95%	83.5%	82%	85.3%	81.7%	73.9%	61.1%	60.8%	64.2%						73.2%	R		
	Percentage of infants being totally or partially breastfed at 6-8wks(breastfeeding prevalence).		58%	54.9%	57. 1%	57.9%	58.2%	58.2%	49%	58.2%	55.3%						56.2%	A		
	Chlamydia Screening of Gloucestershire residents aged 15-24 (minimum positivity rate)		3108	1929	895	709	895	1081	1250	1047	1064						992			
	Number of Positive Screens		169	1329	53	42	53	64	74	62	63						411			
	Average Number of Community Hospital Beds Open		196	195.4	173.3	168.8	155.8	162.5	177.7	177.6	177						170.4	R		
	Average Number of Community Hospital Beds Closed		0	1.1	22.3	27.2	40.2	33.5	18.3	18.4	19						25.6	R		

Additional Information

Data shown from October 2020 onwards is now inclusive of virtual methods – video calls and clinical telephone contacts.

Vision Screening: Vision screening has recommenced and the recovery plan has seen a significant increase in screens.

Health Visiting: Antenatal sessions are delivered face to face for those who accept a targeted offer. Group universal contacts are now being offered jointly with the midwifery service as part of a pilot.

NBV 93.8%: these are being delivered predominately face to face but there is a virtual offer where families are reluctant. In addition, a small percentage of babies remain In NICU/hospital . All families who are not seen are tracked and reoffered a family health needs assessment

6-8 week review 94.7%: these are being delivered predominately face to face but there is a virtual offer where families are reluctant. All families who are not seen are tracked and reoffered a family health needs assessment

Antenatal Screening Questionnaire: families are choosing to delay appointments as they would prefer a face to face offer. The virtual offer has been reviewed to encourage uptake and ensure more are completed in timeframe. All outstanding face to face requests are being manged as part of the recovery process. There has been an increase in Covid-secure clinics to allow for an increase in the face to face offer.

Chlamydia screening: testing levels and positivity rates during October remain consistent with previous months.

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Quality Dashboard

NHS
Gloucestershire Health and Care
NHS Foundation Trust

CQC DOMAIN - ARE SERVICES WELL LED?

		Reporting Level	Threshold	2019/20 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2020/21 YTD	RAG	Exception Report?	Benchmarking Report
	Staff Friends and Family Test - Percentage of staff who would recommend the Trust as a place of work	N - R L - T	61%																	
	Staff Friends and Family Test - Percentage of staff who would recommend the Trust as a place to receive treatment	N - R L - T	67%																	
	Mandatory Training	L - I	90%	89.14%	88.8%	88.7%	85.5	86.2%	86%	85.4%	83%						86.2%	A		
	% of Staff with completed Personal Development Reviews (Appraisal)	L - I	90%	80.38%	72.7%	69.9%	65.4%	60%	60%	69.7%	**76%**						67.7%	R		
	Sickness absence average % rolling rate - 12 months	L - I	<4%	4.80%	4.77%	5.0%	5.2%	5.1%	5.1%	4.97	4.97%						5.01%	R		
	SUS+ (Secondary Uses Service) Data Quality Validity - Available in arrears	N-R	96.30%																	

Additional information

Staff Friends and Family Test (FFT)

The staff FFT has been paused nationally and the Trust has ceased internal activity inline with national guidance. As an alternative, the Trust take part in the Covid-19 People Pulse survey which seeks information and assurance regarding workforce health and wellbeing. The out-turn of this survey is reported to the Trust Board every 2 weeks.

Mandatory training, appraisal and absence

The initial pause on statutory/mandatory training was lifted in July 2020 but has had to be reinstated with the second lockdown in October. A number of courses had already been converted into on-line delivery and the first virtual Corporate Induction session took place on 9th November. However, some courses, including Resuscitation and Physical Intervention training, are continuing as face to face training due to their practical nature, with a range of measures to ensure they are Covid compliant.

Appraisal compliance has increase to 76% for October. Managers are reminded that staff appraisals must continue whenever this is possible. There is a continued emphasis on appraisal completion over the coming months, including the re-introduction of appraisal training.

Sickness absence levels have remained consistent since April 2020 but are above the Trust target of 4.00%.

Staff Health and Wellbeing

The staff Health and Wellbeing Hub (HWH) continues to meet fortnightly and uses feedback from members of the hub and our Health and Wellbeing pulse surveys to inform our priorities.
In October, GHC launched a new staff financial benefit, *Salary Finance*, which offers loans repaid through salary, advanced earned pay, savings and money insights.

Recruitment has now been made to four new posts within Working Well funded by charitable monies. These will increase individual counselling capacity and support proactive psychological wellbeing and resilience building in teams across the organisation.

Working Well have are supporting the flu vaccination programme, risk assessments, and providing advice and guidance for colleagues.

October was National Speak Up month and our Freedom to Speak Up Guardian led a successful **#SpeakUpABC** campaign, promoting a healthy working environment and having a voice.

The HWH regularly links with ICS partners to ensure the sharing of best practice. There has been a recent ICS bid for around £120K to support the development of a system-wide mental health hub for colleagues.

CQC DOMAIN - ARE SERVICES WELL-LED?

Duty of Candour – Quarter 1 2020/21 review

Duty of Candour (DoC) under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was introduced in November 2014 for NHS Trusts in response to the Francis Report (March 2013) recommendation 181, following events at Mid-Staffordshire NHS Foundation Trust. Sir Robert Francis highlighted three principles for honesty within the National Health Service (NHS):

- ***Openness*** – Enabling concerns and complaints to be raised freely without fear, and questions asked to be answered.
- ***Transparency*** – Allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators.
- ***Candour*** – Any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.

Following the DoC deep dive audit undertaken for 2019/20, quarterly reviews for DoC compliance are now undertaken on a routine basis to monitor compliance and provide assurance that DoC is being applied in line with regulatory requirements. Following each review detailed reports will be submitted to the Trust Quality Governance framework for review., assurance, escalation and onward dissemination across the Trust.

Regulation 20 components reviewed each quarter against all incidents rated as moderate harm and above:
The notification must be given in person by representative(s) of the Trust
The notification in person must be given within 10 working days of the incident being reported.
The notification in person must provide an account of all the facts known about the incident at the point that the notification is given.
The notification in person must advise what further enquiries into the incident the Trust will undertake.
The notification in person must include an apology
The notification in person must be recorded in a written record
The Trust must provide reasonable support to the relevant person in relation to the incident,
Following the notification in person a written notification must be sent to include, details of any enquiries to be undertaken by the Trust
The written notification must include the results of any further enquiries into the incident to date by the Trust
The written notification must include an apology
If the relevant person cannot be contacted in person or declines to speak to the Trust a written record is to be kept of attempts to contact or to speak to the relevant person.
The Trust must keep a copy of all correspondence with the relevant person
The Trust must share the outcomes of enquiries and investigations in writing with the relevant person if they wish to receive them.

Key findings:

- 34 cases meeting the category of moderate harm and above were critically analysed to review Trust compliance with the required components of Regulation 20 DoC.
- The review noted that the Trust Datix form had been developed since the last review to allow the inclusion of the DoC field within the “Openness and Transparency” section of the incident reporting form
- **Full assurance** was obtained that **100%** of the reported incidents meeting review criteria (n=34) were appropriately reviewed for DoC and all graded as “DoC does not apply” The review analysed each case and agreed the grading was correct.
- **Improvement work** continued in line with the 2019/20 DoC review that there is a systematic process to record that a verbal apology has been given by Trust colleagues following an incident occurring, both Datix and clinical records were reviewed in relation to this component, however the review considered this to be an administration challenge as apologies were given but not always being recorded.
- **Full assurance** was obtained that all incidents reviewed that met SIRI criteria demonstrated that “the relevant person” had been offered support by a Trust Family Liaison Officer or a member of the Patient Safety Team.
- **Improvement work** continues so that outcomes of enquiries and investigations are shared in writing with the patient/’relevant person’ if they wish to receive them, in a timely manner. Covid-19 has had a negative impact upon this area as there has been reduced capacity in the Patient Safety Team owing due to redeployment. As a result the Trust negotiated the submission date for some SIRI reports with the Gloucestershire Clinical Commissioning Group (GCCG). This has meant that there has been a delay in sharing the final reports with patients and their ‘relevant person’. This factor also has implications for the delay in drafting final DoC letters being sent. This is being addressed and is being monitored.

Next steps: assurance and embedding

- The addition of a field to add to the Datix form to capture when a verbal apology has been given will be reviewed with the Head of Patient Safety for onward progression.
- The DoC action plan will continue to be progressed and is monitored via the Regulatory Compliance Group, as a sub-committee of the Improving Care Group.
- Reviews will continue each Quarter to ascertain the Trust’s level of compliance with Regulation 20 DoC.

CQC DOMAIN - ARE SERVICES WELL-LED?

Focus on jointly commissioned services

Reablement Service The Reablement service is a Gloucestershire County Council (GCC) commissioned service which is managed by GHC. The service supports people at home helping them recover and regain function and independence following illness or injury, working through goal-based outcomes jointly agreed between the person and the service. It is managed within the Adult Community Care Directorate as part of the Integrated Community Teams. The teams comprise of GCC employed staff ranging from Coordinators to Reablement Workers. There is a close alignment to GHC Community therapy services and they frequently work together for therapy-led outcomes.

In mid-September 2020 following dialogue with commissioners issues were identified which required improvement. GHC commenced a rapid peer review process with swift appraisal and senior oversight. The peer review confirmed that in some service areas the following areas required improvement:

- Medicines administration and handling
- Record keeping and documentation deficits
- Staff competency and training records requiring improvement
- Shared Management responsibilities requiring improved clarity
- Staff supervision required improvement
- Information leaflets to be developed to include all regulatory required information
- Incident reporting procedures requiring improvement
- Eligibility criteria requiring improved clarity and local application

It is important to note that the peers review also identified good practice and safe working approaches to ensure care was deemed safe at point of delivery.

Trust Response
Priority areas from the above have been identified and a quality recovery plan developed. This is being managed by the Nursing, Quality and Therapies directorate. This aligns with a broader improvement plan which is part of the One Gloucestershire service development: the Enhanced Independence Offer (EIO), of which Reablement is a component.

Senior nurses and therapists are managing the improvement plan and leading Reablement service engagement events. The Director of Nursing, Therapies and Quality receives regular briefings with updated action plans. Assurance is provided to Commissioners at fortnightly meetings and there is monthly reporting to the One Gloucestershire EIO Programme board chaired by the Trust's CEO. Good progress has been made on delivering the improvement plan and it's completion remains an organisational priority.

Gloucestershire Wheelchair Assessment Service The Gloucestershire Wheelchair Assessment Service (GWAS) is commissioned by the Gloucestershire Clinical Commissioning Group. GWAS provides assessment for patients (adults and children) with medium, high and specialist levels of need. The team prescribe and fit wheelchair, posture and pressure relieving equipment, with the aim of stabilising and supporting posture, maximising independence of activity, and promoting well-being and quality of life for patients.
Significant improvement work has been undertaken by the service following patient and carer experience feedback in 2019. A comprehensive improvement plan was created to direct improvement and provide assurance of actions taken. This improvement work has been completed with future development actions identified to further improve and assure service quality

Telecare Services The Telecare Service aims to support people to maintain a level of independence in their usual place of residence preventing admission into long term care. The service is commissioned by GCC via the joint contracting arrangements with the CCG with patient-facing staff employed by GHC and administration staff employed by GCC.

GHC have committed to reviewing all services that are have complex commissioning arrangements where more than one commissioner is involved. This was a key recommendation from the GWAS improvement work, particularly in services where there is a mixed employment model from commissioners and providers. In line with the Trust Peer Review methodology an internal deep dive has been commissioned by the Director of Nursing, Therapies and Quality with initial findings made available later in the calendar year.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

CQC DOMAIN - ARE SERVICES WELL LED?

Safe Staffing Mental Health Inpatient – October 2020

	Code 1		Code 2		Code 3		Code 4		Code 5	
Ward Name	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions
Dean	0	0	0	0	0	0	0	0	0	0
Abbey	122.5	16	15	2	0	0	0	0	0	0
Priory	177.5	23	7.5	1	0	0	0	0	0	0
Kingsholm	47.5	6	0	0	0	0	0	0	0	0
Montpellier	82.5	10	65	7	0	0	0	0	0	0
Greyfriars	220	24	0	0	0	0	0	0	0	0
Willow	22.5	3	37.5	4	0	0	0	0	0	0
Chestnut	15	2	0	0	0	0	0	0	0	0
Mulberry	30	4	0	0	0	0	0	0	0	0
Laurel	0	0	0	0	0	0	0	0	0	0
Honeybourne	0	0	0	0	0	0	0	0	0	0
Berkeley House	0	0	0	0	0	0	0	0	0	0
Total In Hours/Exceptions	717.5	88	125	14	0	0	0	0	0	0

Definitions of Exceptions:

Code 1 =	Min staff numbers met – skill mix non-compliant but met needs of patients
Code 2 =	Min staff numbers not complaint but met needs of patients e.g. low bed occupancy ,patients on leave
Code 3 =	Min staff numbers met – skill mix non-compliant and did not meet needs of patients
Code 4 =	Min staff numbers not compliant did not meet needs of patients
Code 5=	Other

MENTAL HEALTH & LD						
Ward	Average Fill Rate	In-Post	Bank	Agency	Vacancies	Sickness
Dean Ward	158.12%	Month end data not available for time of report submission – see previous months totals below .	Month end data not available for time of report submission – see previous months totals below . However, having reviewed the usage it remains comparable to September 2020 data.		Month end data not available for time of report submission – see previous months totals below .	15.37%
Abbey Ward	127.69%					4.07%
Priory Ward	109.73%					10.03%
Kingsholm Ward	103.17%					14.04%
Montpellier	98.79%					6.92%
PICU Greyfriars Ward	111.42%					6.80%
Willow Ward	106.45%					4.15%
Chestnut Ward	100.18%					4.56%
Mulberry Ward	121.13%					3.50%
Laurel House	110.75%					0.52%
Honeybourne Unit	101.88%					3.39%
Berkeley House	105.78%					3.98%
Totals (Oct 2020)	**112.92%**					**6.44%**
Previous Month Totals	113.14%	90.55%	13.49%	9.11%	9.45%	5.53%

Mental Health & LD Inpatient

- There are currently 8 x 12wk agency contracts in place in Wotton Lawn.
- An agency Guaranteed Volume Contract (GVC) is in place in Wotton Lawn delivering 28 shifts per week. Work continues to increase this contract by 100% at Wotton Lawn to meet current demand. An equivalent GVC is being developed to include Charlton Lane and work is underway to establish demand. This contract promotes improved continuity care as these staff undertake RiO and clinical risk training so can undertake the full clinical roles.

CQC DOMAIN - ARE SERVICES WELL LED?

Safe Staffing Physical Health – October 2020

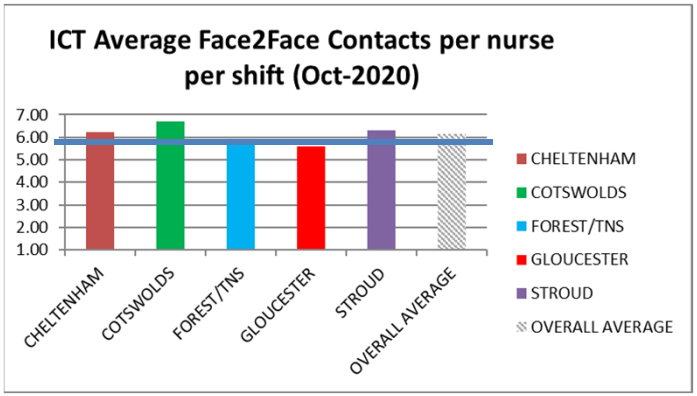
Physical Health

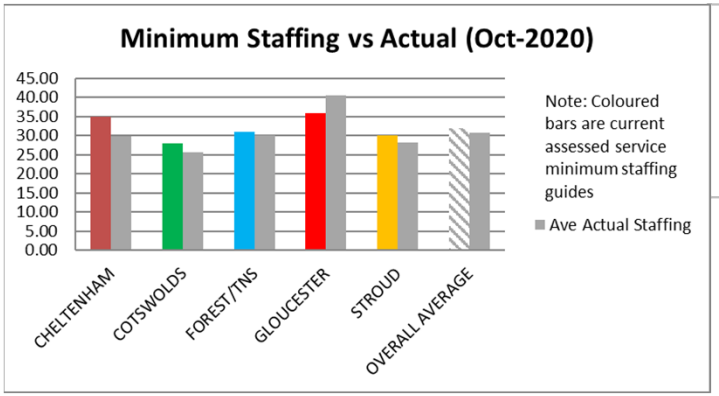
The Trust continues to work to align safe staffing reporting methods across the organisation. The Trust is able to report good levels of staffing in inpatient areas set against agreed safe staffing levels. A detailed piece of work is due to undertaken to enable the reporting of physical health exceptions in the same way as currently reported for MH and LD services (currently delayed due to Covid -19 disruption) .

PHYSICAL HEALTH						
Ward	**Average Fill Rate**	**In-Post (RGN & HCA)**	**Bank**	**Agency**	**Vacancies**	**Sickness**
Coln (Cirencester)	104.04%	Month end data not available for time of report submission – see previous months totals below .	Month end data not available for time of report submission – see previous months totals below . However, having reviewed the usage it remains comparable to September 2020 data.		Month end data not available for time of report submission – see previous months totals below .	4.74%
Windrush (Cirencester)	104.00%					4.03%
The Dilke	94.81%					7.03%
Lydney	95.94%					5.72%
North Cotswolds	100.73%					5.07%
Cashes Green (Stroud)	98.69%					4.86%
Jubilee (Stroud)	101.21%					2.92%
Abbey View (Tewkesbury)	123.46%					3.12%
Peak View (Vale)	97.83%					4.82%
Totals (Oct 2020)	**102.30%**					**4.70%**
Previous Month Totals	101.82%	89.81%	7.91%	5.31%	11.41%	5.11%

CQC DOMAIN - ARE SERVICES WELL LED?

Effective Staffing Review - Oct 2020 – Development data providing focus on ICT (District Nursing teams) activity and staffing levels





The average face to face contacts per nurse per shift is an average taken across the skill mix. The average number during Oct 2020 is 6.15 and has increased since Sept 2020 which saw an average of 4.43 face to face contacts., This increase reflects increase in individual activity to meet demand and cover vacancies/staff absences

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AGENDA ITEM: 15/1120

REPORT TO: **TRUST BOARD – 25TH NOVEMBER 2020**

PRESENTED BY: Dr Amjad Uppal, Medical Director

AUTHOR: Ian Main, Head of Patient Safety

SUBJECT: **QUARTER 2 2020/21 PATIENT SAFETY REPORT (INCLUDING SIRIS)**

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

The purpose of this report is to:

This report provides the Trust Board with high level information with regard to patient safety incidents reported through the Trust's Datix Incident Reporting System. Analysis and comment is provided where appropriate.

Recommendations and decisions required

The Board is asked to:

- Receive, review and **note** information relating to quarterly patient safety incident reporting.

Executive summary

This report provides:

- A summary of mental health and physical health Patient Safety Incidents reported during Quarter 2 2020/21 (1 July to 30 September 2020).
- A summary of the prevalence of patient safety incidents by categories including level of investigation.
- Provision of examples of data by graph for Mental Health and Learning Disability hospitals, physical health Community Hospitals, plus MIIUs and community teams for mental health and physical health.
- The data has been reviewed by the Quality Assurance Group. Feedback is positive and has guided discussion and potential internal benchmarking. Data labels are added where the charts permit.
- An overview of Serious Incidents Requiring Investigation (SIRIs) and Never Events declared in Q2 to Gloucestershire Clinical Commissioning Group (GCCG).

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AGENDA ITEM: 14/1120

Q2 Patient Safety Report 2020/21

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Report on the Trust's Patient Safety Incidents during Q2 2020/21

Presented to: – Trust Board 25th November 2020

Q2 PSR 2020/21

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NHS Foundation Trust

This report provides:

- A summary of mental health and physical health Patient Safety Incidents reported during Quarter 2 2020/21 (1 July to 30 September 2020).
- A summary of the prevalence of patient safety incidents by categories including level of investigation.
- Provision of examples of data by graph for Mental Health and Learning Disability hospitals, physical health Community Hospitals, plus MIIUs and community teams for mental health and physical health.
- The data has been reviewed by the Operational Governance Forum. Feedback is positive and has guided discussion and potential internal benchmarking. Data labels are added where the charts permit.
- An overview of Serious Incidents Requiring Investigation (SIRIs) and Never Events declared in Q2 to Gloucestershire Clinical Commissioning Group (GCCG).
- Progression of the developing governance arrangements for the management of mental and physical health patient safety incidents.

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Summary of all Patient Safety Incidents reported in Q2 2020/21

Whole Trust	Total 3269 (%)
No harm	2140 (65.5)
Low harm	961 (29.4)
Moderate harm	130 (4.0)
Severe harm	23 (0.7)
Death	15 (0.5)

Categories of harm will be aligned in combined Datix Reporting System due for launch April 2020.
MH report deaths via Datix whilst PH report deaths via MIDAS.

Q2 Sub 'Serious Incident' Incidents (moderate and above harm)

During Q2 the Patient Safety Team convened 10 initial investigation panel meetings (not including those incidents that have gone on to be declared as a SIRI which are featured on slides 12 and 13).

8 of these incidents have been from Physical Health and 2 from Mental Health.

None have been managed as a clinical incident needing additional comprehensive investigation, however local learning including evidence of good practice, have been shared via Incidents on a Page following these panel meetings.

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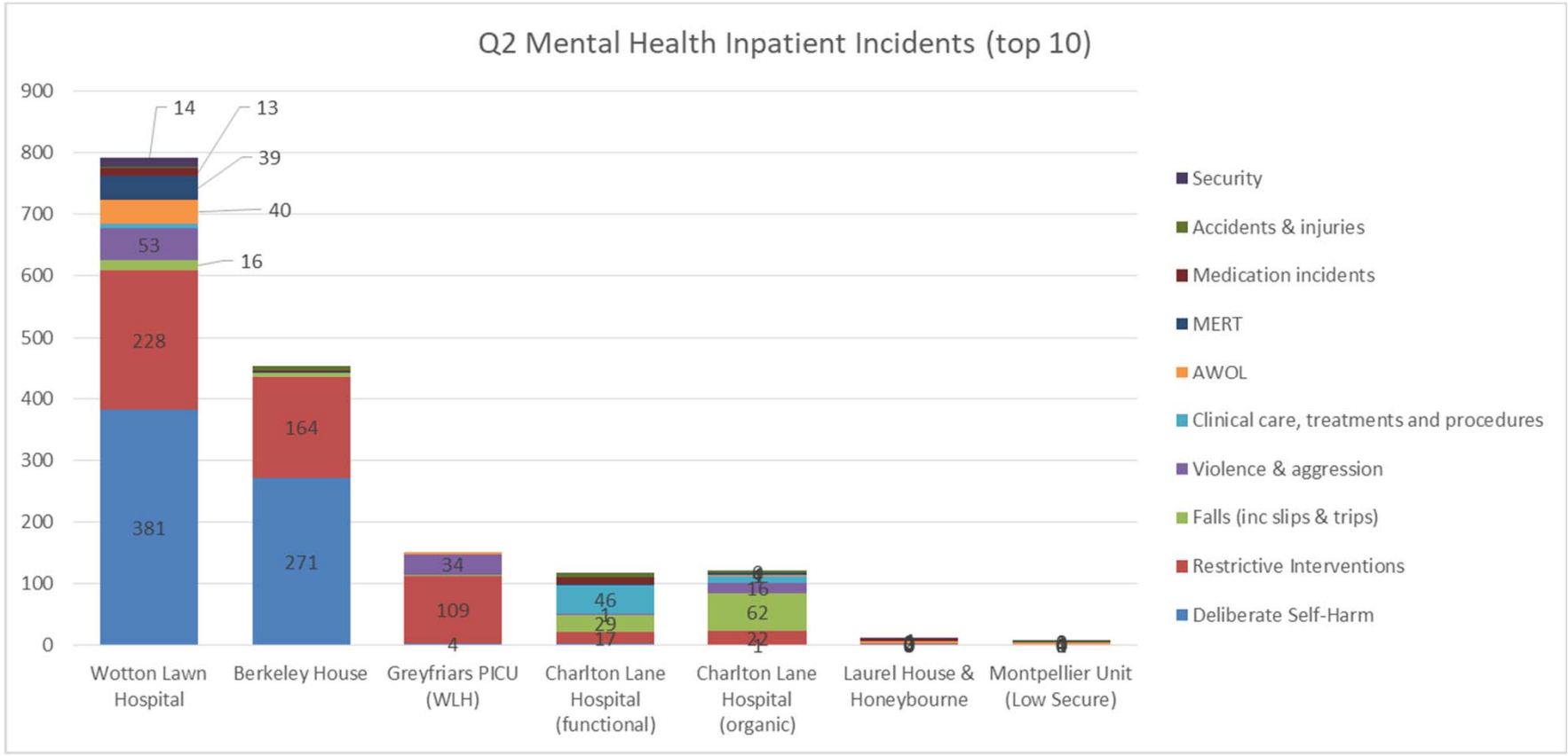
High Level Analysis of Mental Health Inpatient Incidents



Total number of MH inpatient incidents = 1724

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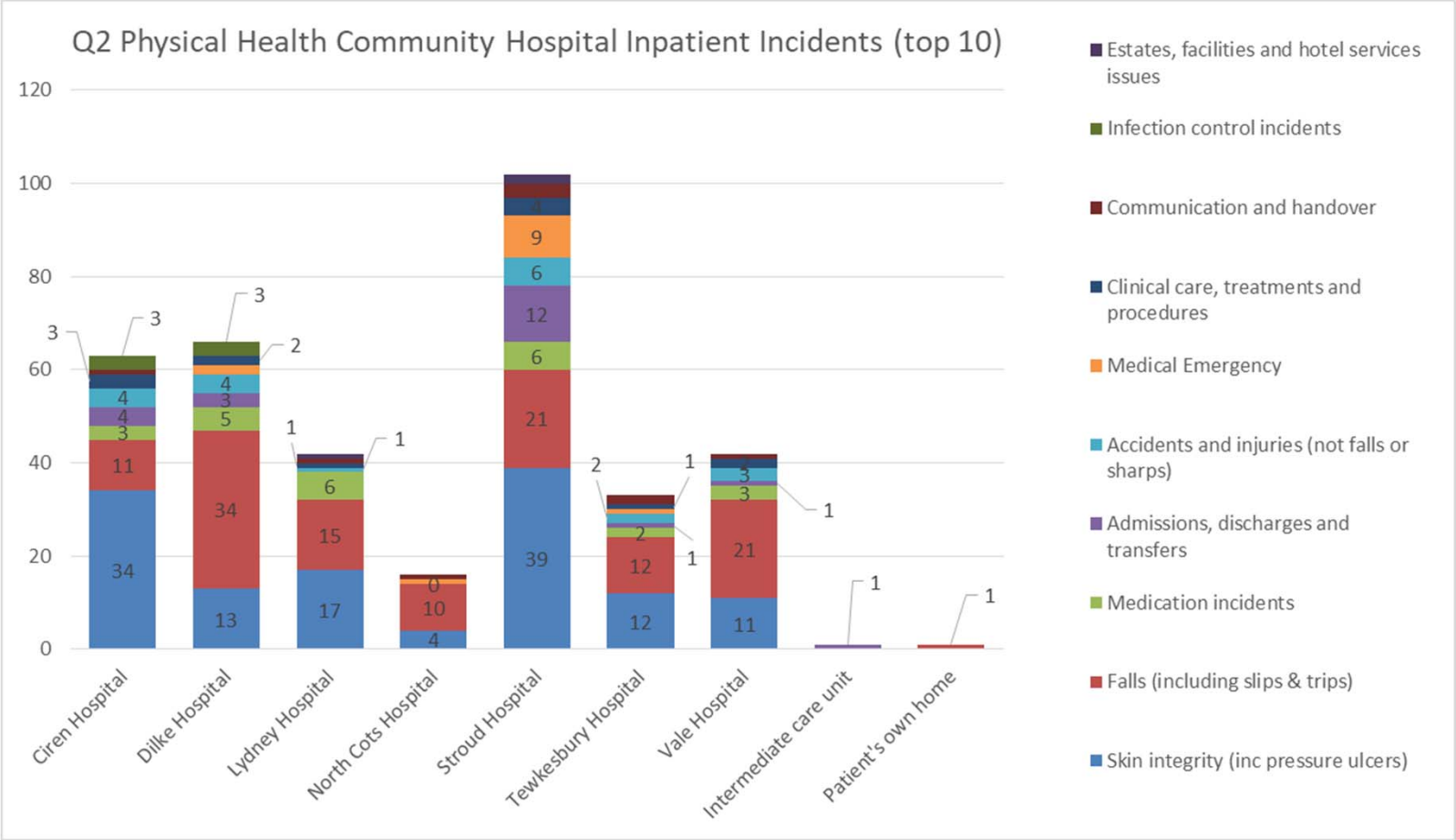
High Level Analysis of Physical Health Inpatient Incidents



Total number of physical health inpatient incidents = 378

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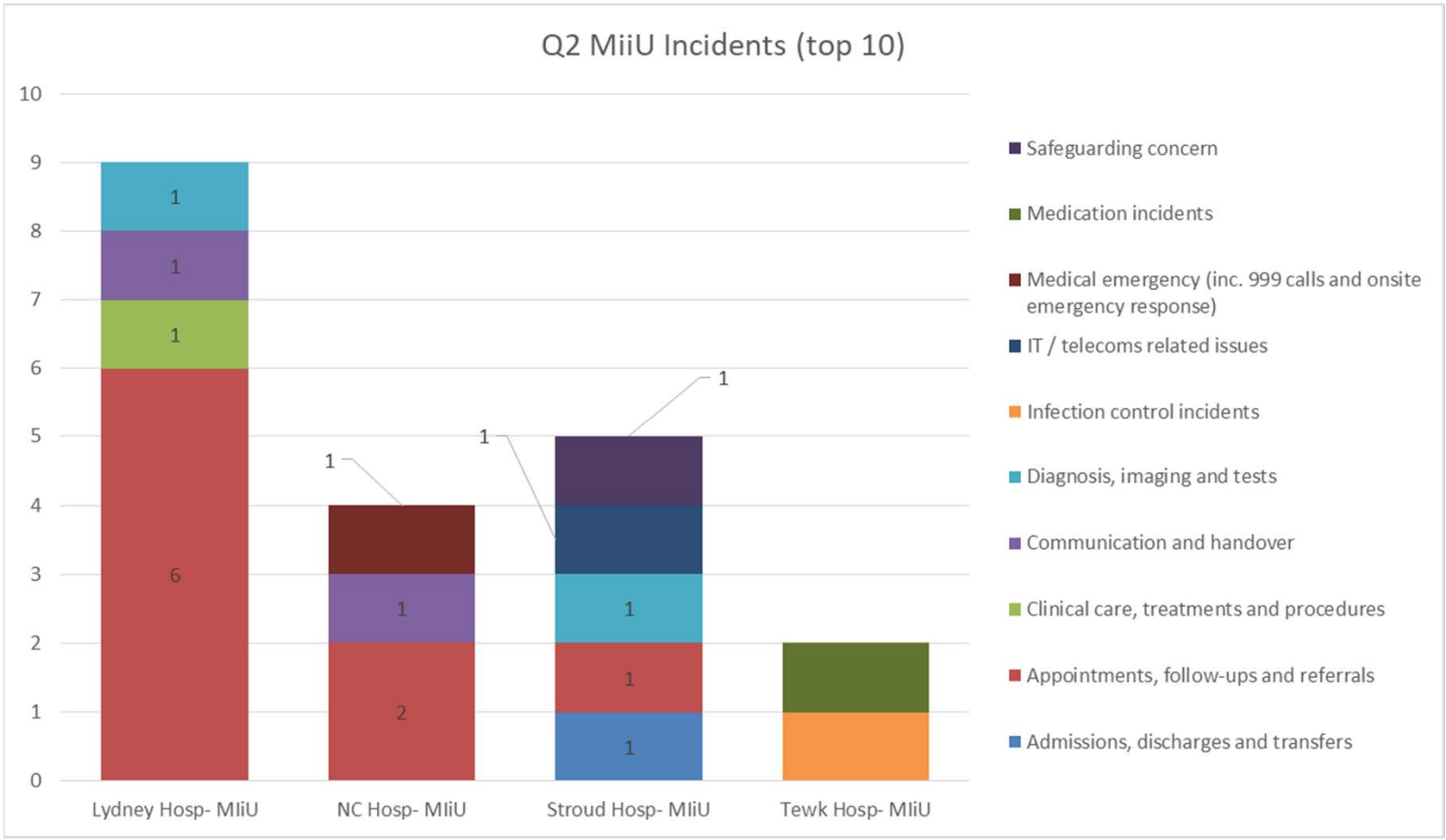
High Level Analysis of MiiU Incidents



Total number of MiiU incidents = 20

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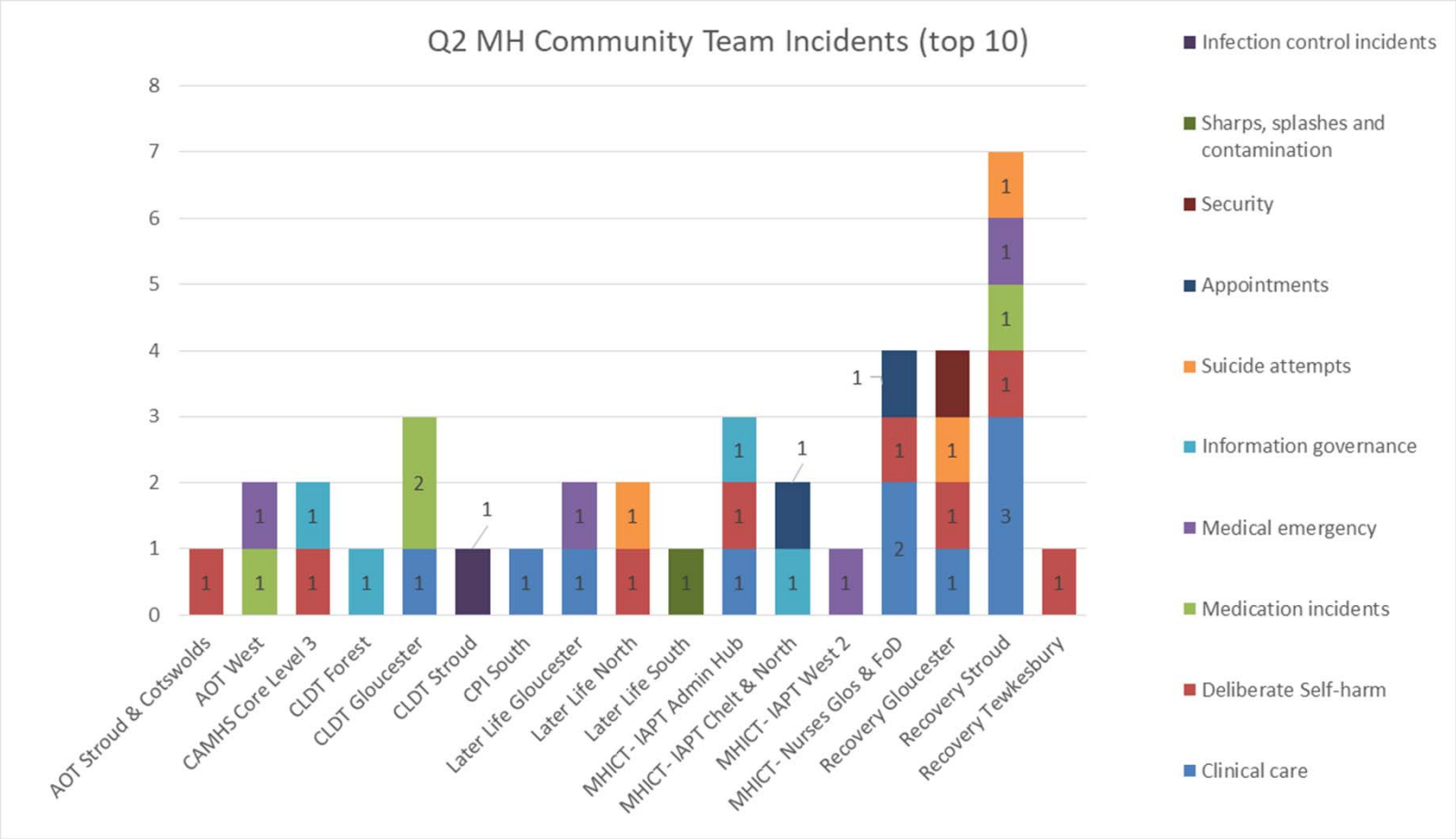
High Level Analysis of MH Community Teams Incidents



Total number of MH Community Team incidents = 38

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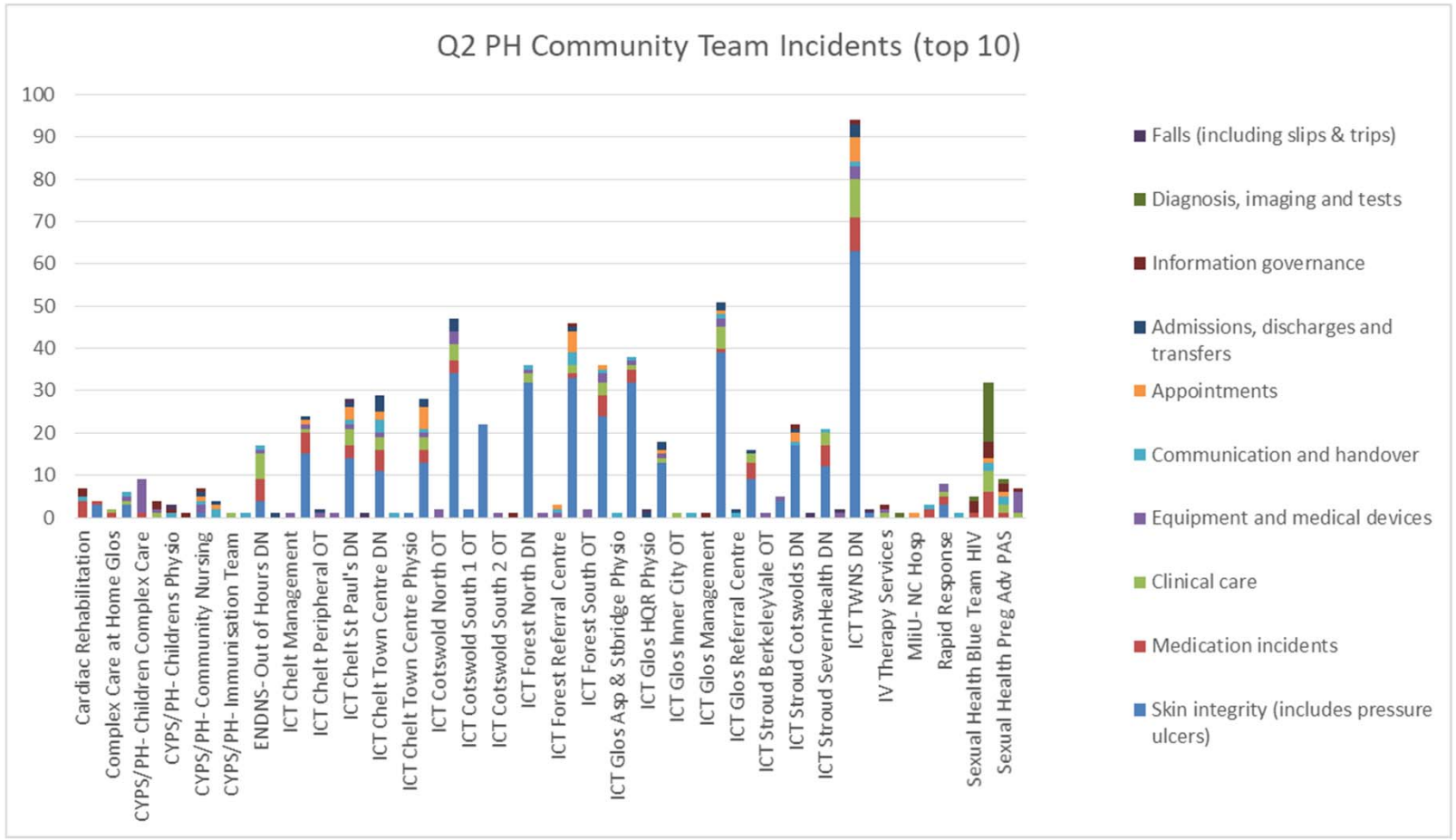
High Level Analysis of PH Community Teams Incidents



Total number of PH Community Teams incidents = 757

Detailed analysis of high frequency incidents

As services return towards normal function following the spring pandemic, Q2 does demonstrate a return to more established trends.

The high frequency incidents within Mental Health inpatient continue focus on deliberate self-harm, prevention and management of violence and aggression, and incidents relating to the violent conduct of distressed patients during the acute phase of their illness.

Physical Health hospitals, and older persons wards including Charlton Lane Hospital, report higher rates of falls and skin integrity incidents.

Similar divergence is also seen with the Community Teams: mental health community team incidents are more evenly spread across their Top 10 categories, whereas physical health community teams report large numbers of skin integrity incidents (53.5%).

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Q2 Physical Health SIRIs reported

1. **10 August 2020 – Fall & fracture, Coln Ward, Cirencester Hospital** the 89 year old male patient was found lying on the floor on his right side. His bed rails were still up.

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Q2 Mental Health SIRIs reported

1. **15 July 2020 – ingested sodium nitrite, suspected suicide** Stroud Recovery, after taking the substance the patient was taken to Gloucester Royal but sadly died.
2. **17 July 2020 – patient-patient assault** Psychiatric Intensive Care Unit, WLH Greyfriars.
3. **31 July 2020 – suspected suicide** Cheltenham Recovery, suspended ligature whilst on holiday; deceased.
4. **5 August 2020 – suspected suicide** Crisis Team, hanged at home; deceased.
5. **12 August 2020 – suspected suicide** WLH Abbey Ward, suspended ligature; deceased.
6. **15 September 2020 – suspected suicide** Gloucester Recovery, asphyxiation using helium; deceased.
7. **18 September 2020 – suspected suicide** Gloucester AOT, asphyxiation using a plastic bag.
8. **24 September 2020 – attempted suicide** Stroud Recovery, jumped from a car park, life-changing injuries including bilateral leg amputations.
9. **23 September 2020 – suspected suicide** Tewkesbury Recovery, hanged at home.
10. **30 September 2020 – attempted suicide** Gloucester Recovery, overdose, recovered.

Developments within the Patient Safety Team

- Clinical Governance and Compliance Team is being notified of **all** mental health and physical health patient safety incidents categorised as moderate and above. A process established to review a random sample of 10% no harm, low harm and near misses reported on the Datix system remains delayed.
- Work is ongoing to establish a single system from tracking and monitoring the progress of patient safety incidents, whether serious or clinical incidents. This is partially in place since 1 April 2020.
- The completion of investigations and final reports which incurred delays due to Patient Safety Team redeployments are progressing at considerable pace. There remains just 4 extended incidents which will each be completed by the end of October 2020.
- The Patient & Carer Experience Team Manager is now being notified of all mental health patient safety incidents in which Duty of Candour (DoC) applies, and ensures notification to the affected patients and/or their families/carers.
- The process for the cascade of learning from incidents continues to be developed by the Head of Patient Safety and the Operational Governance Lead.

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AGENDA ITEM: 16/1120

REPORT TO: **TRUST BOARD – 25TH NOVEMBER 2020**

PRESENTED BY: Dr Amjad Uppal, Medical Director

AUTHOR: Dr Sally Morgan, Guardian of Safe Working Hours

SUBJECT: **GUARDIAN OF SAFE WORKING HOURS Q2**

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

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

The purpose of this report is to:

It was agreed in the 2016 national negotiations that all NHS Trusts employing trainees (junior doctors) were required to appoint a 'Guardian of Safe Working Hours' in order to work with junior doctors to ensure safe working practices during their training.

As part of that agreement, the Guardian of Safe Working Hours is required to provide quarterly reports to the Trust Board for assurance and information. A national template is used for this purpose.

Further information about role and requirements can be seen under point 1 – Introduction/Context.

Recommendations and decisions required

The board is asked to note:

1. The report from the Guardian of Safe Working Hours.
2. Ongoing issues are being addressed.

Executive summary

- The exception reporting process is part of the new Juniors Doctors Contract to enable them to raise and resolve issues with their working hours and training.

- The Guardian's Quarterly report summarises all exception reports, work schedule reviews and rota gaps, to provide assurance on compliance with safe working hours by both the employer and doctors in approved training programs, and will be considered by CQC, GMC, and NHS employers as key data during reviews.

- The purpose of the report is to give assurance to the Quality Committee and Board that the doctors in training are safely rostered and their working hours are complaint with the TCS.

Risks associated with meeting the Trust's values

- Providing suitable and safe training placements for junior doctors is essential for the Trust in terms of reputation and developing workforce.
- This data is monitored by CQC and HEE.

Corporate considerations	
Quality Implications	✓
Resource Implications	✓
Equality Implications	✓

Where has this issue been discussed before?
Trust Quality Committee on 2nd November 2020

Appendices:	Appendix 1 – Q2 Report for 2020/21

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

GUARDIAN OF SAFE WORKING

1.0 INTRODUCTION / CONTEXT

1.1 The safety of patients is of paramount importance for the NHS and staff fatigue is a hazard both to patients and the staff. The 2016 national contract for junior doctors encourages stronger safeguards to prevent doctors working excessive hours. It was agreed during negotiations with the BMA that a 'Guardian of Safe Working Hours' will be appointed in all NHS Trusts employing trainees (junior doctors) to ensure safe working practice.

1.2 The role of 'Guardian of Safe Working Hours' is independent of the Trust management structure, with the primary aim to represent and resolve issues related to working hours for the junior doctors employed by it. The Guardian will ensure that issues of compliance with safe working hours are addressed, as they arise, with the doctor and/or employer, as appropriate; and will provide assurance to the Trust Quality Committee and Board or equivalent body that doctors' working hours are safe.

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

1.4 The Trust has invested in relevant software to help monitor the 'Exception Reports' in line with national guidance and the system is relatively well established in the Trust now.

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

2.0 REPORTS

These reports are made using the nationally agreed template. Please refer to the appendix for details on the exception reports made and actions taken.

2.1 Q2 report for 20/21 – 6 exception reports made. 4 of these had the initial meeting to address concern within 7 days of report being raised.

2.2 5 of the exception reports raised were due to hours worked, outcomes are now agreed and reports closed.

Quarterly Report on Safe Working Hours Data		
Reporting Time Period:		July 2020- September 2020
Trust Name:		Gloucestershire Health & Care NHS Foundation Trust
Guardian of Safe Working Hours Name:		Sally Morgan
GOSW Email Address:		sally.morgan@ghc.nhs.uk
No.of doctors/dentists in training (total)		28 (July) , 36 (August, September)
No.of doctors/dentists in training on the 2016 contract TCS (total)		28(July), 36 (August, September)
No. of lead employer trainees on the 2016 contract at your Trust		
Amount of time available in job plan for Guardian to do the role		1PA
Admin support provided to the Guardian (if any)		
Amount of job-planned time for educational supervisors		

Exception reports														Work Schedule Reviews												Fines by department	
Specialities/Site	No. GP Trainees		No. Foundation Yesars		No.at CT Level		No.at ST3+ Level		No. given TOIL or payment				No. that are on-	No. GP Trainees		No. Foundation Yesars		No.at CT Level		No.at ST3+ Level		No. given TOIL or payment			No. that are on-	No.of fines levied	Values of fines levied
	Raised	Closed	Raised	Closed	Raised	Closed	Raised	Closed	TOIL	TOIL	Payment	Please		Raised	Closed	Raised	Closed	Raised	Closed	Raised	Closed	TOIL	Payment	Please			
Gloucestershire	0	0	2	2	3	3	1	1	3	3	2	1 (no further	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
																											0	0

*If you have any additional comments, issues arising or concerns then please fully detail in the section below

We had 6 exception reports during this quarter (July, August and September), 3 by core trainees, 2 by Foundation Year 1 trainees and 1 by an advance trainee. The exception reports were all submitted within 7 days the incident.

On 4 occasions the trainee who had raised the report managed to have their initial review meetings with their supervisor within 7 days. On one occasion the review meeting was held 18 days after the incident and on another, 28 days later.

5 of the exceptions that were raised were due to hours worked . Of these, TOIL was agreed for 3 of the reports and on 2 occasions payment was agreed. (The reason for payment and not TOIL being that the trainee involved had moved into a different post and had a new work schedule in place) . All 5 of the trainees agreed with the outcome and closed the reports.

1 exception report was relating to a missed educational opportunity. The trainee has had the initial meeting and outcome agreed was no further action required. The report wasn't closed by trainee after 37 days and no concerns were raised with the Guardian regarding outcome either. The report has been closed down by the guardian and the trainee has been contacted to inform them of this. In the last quarter several of the reports were delayed in being closed down by trainees as they were unaware they had to do so to complete the process.

The main reasons for filing exception reports included incidents happening towards the end of a shift requiring doctors to stay and handover and complete paperwork relating to this and a build up of routine work needing to be completed due to lower medical staffing levels on the wards when other medics were taking leave (annual and study).

During this period there were 47 on calls which required cover due to juniors not completing on calls as usual. 6 of these were covered by agency doctors and 41 on call shifts were covered by our own doctors as locums. also there are 6 trainees who are not able to complete their on-calls as normal.

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AGENDA ITEM: 17/1120

REPORT TO: **TRUST BOARD MEETING - 25 NOVEMBER 2020**

PRESENTED BY: Dr Amjad Uppal, Medical Director

AUTHOR: Zoë Lewis, Mortality Review Officer

SUBJECT: **LEARNING FROM DEATHS 2020/21 QUARTER 2**

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

This report is provided for:

Decision ☐ Endorsement ☐ Assurance ☑ Information ☐

The purpose of this report is to:

The purpose of this report is to inform the Board of the mortality review process and outcomes during 2020/21 Quarter 2.

It is a regulatory requirement for all NHS Trusts to identify, report, investigate and learn from deaths of patients in their care, as set out in the National Quality Board *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*, published March 2017.

Recommendations and decisions required

The Board is asked to:

- **Note** the contents of this Learning from Deaths report which covers 2020/21 Quarter 2.

Executive summary

- During 2020/21 Q2, there were 129 reported GHC patient deaths. At time of writing this report (15 Oct 2020), none of the 129 patient deaths are judged to be more likely than not to have been due to problems in the care provided by the Trust.
  - Further investigation into an increased death rate amongst patients open to the Community Dementia Nurse Service during 2020/21 Q1 is also presented

Risks associated with meeting the Trust's values
There are no identified risks associated with learning from deaths associated with the Trusts values.

Corporate considerations	
Quality Implications	Required by National Guidance to support system learning
Resource Implications	Significant time commitment from clinical and administrative staff
Equality Implications	None

Where has this issue been discussed before?
Mortality review group meetings

Appendices:	None

Report authorised by:	**Title:**
Dr Amjad Uppal Ian Main	Medical Director Head of Patient Safety

LEARNING FROM DEATHS 2020/21 QUARTER 2

1.0 INTRODUCTION

1.1 The purpose of this report is to inform the Board of the mortality review process and outcomes during 2020/21 Quarter 2.

1.2 The Board is asked to note that from 1 April 2020, Gloucester Health and Care NHS Foundation Trust (GHC) reports both mental health and physical health mortality data in a combined manner; facilitated by the new joint Datix system.

1.3 During 2020/21 Q1, the Covid-19 pandemic impacted upon the reporting rate of both inpatient and community patient deaths, as previously reported in the 2020/21 Q1 Learning from Deaths paper. Further investigation into an increased death rate amongst patients open to the Community Dementia Nurse Service is presented in Section 5 of this paper.

2.0 OVERVIEW

2.1 During 2020/21 Q2, 129 GHC patients died. This comprised the following number of deaths which occurred in each month of that reporting period:

46 in July;
48 in August;
35 in September.

2.2 At time of writing, 15/10/2020, 6 case record reviews and investigations have been carried out in relation to the 129 deaths included in 2.1. The number of deaths in each month for which a case record review or an investigation was completed was:

2 in July;
3 in August;
1 in September.

2.3 Numbers in paragraph 2.2 do not include open investigations and case record reviews.

2.4 Zero representing 0.0% of the patient deaths during the reporting period are judged more likely than not to have been due to problems in the care provided to the patient. In relation to each month, this consisted of:

Zero representing 0.0% for July;
Zero representing 0.0% for August;
Zero representing 0.0% for September.

2.5 The numbers stated in paragraph 2.4 have been estimated using Structured Judgement Review (SJR). For deaths of:

- mental health patients, the RCPsych Mortality Review Tool 2019 is employed;
- LD patients, a similar Trust-developed SJR tool is utilised which pre-dates the RCPsych tool. This approach has been maintained to allow consistency with the Learning Disabilities Premature Mortality Review (LeDeR) programme;
- physical health patients, a SJR tool has been developed by the Trust to assess the standard of care provided to patients that die during an inpatient stay at a community hospital.

2.6 Case record reviews are discussed at Mortality Review Group (MRG) meetings chaired by Deputy Medical Directors / Clinical Directors and the community hospital MRG meetings are also attended by the County Medical Examiner.

2.7 For any deaths meeting Serious Incident or Clinical Incident criteria, a Comprehensive Investigation, including Root Cause Analysis, is carried out.

2.8 At time of writing this report, 17 case record reviews and investigations had been completed for deaths which took place prior to the start of 2020/21 Q2. The number of deaths in each reporting quarter, prior to 2020/21 Q2, for which a case record review or an investigation was completed was:

11 in 2020/21 Q1;
5 in 2019/20 Q4;
1 in 2019/20 Q3.

2.9 Zero representing 0.0% of the patient deaths included in paragraph 2.8 are judged to be more likely than not to have been due to problems in the care provided to the patient.

2.10 The numbers in paragraph 2.9 have been estimated using either SJR for case reviews or comprehensive investigations, including Root Cause Analysis, for any deaths meeting Serious Incident or Clinical Incident criteria.

2.11 There were zero GHC inpatient Covid-19 related deaths reported in 2020/21 Q2. There were 2 GHC mental health community patient Covid-19 related deaths reported in 2020/21 Q2.

3.0 LEARNING

3.1 Following the suspected suicide of Recovery Team patient:

i. A focused learning project will be conducted to consider the impact of all stages of menopause, to include the impact of menopause on mental state and emotional deregulation when assessing risk.

ii. A robust telephone messaging system will be implemented within the Forest of Dean team office, noting that this work has been completed and tested in the Gloucester locality.

3.2 Following the suspected suicide of Recovery Team patient:

i. The review supports the ongoing development of a personality disorder service currently commissioned and soon to be piloted in the county.
ii. It is recommended that mental health teams provide detail in the medical record with respect to timings of contact with patients.
iii. When patients are supported by the Gloucestershire High Intensity Network programme and mental health services; the review recommended to ensure that regular meetings and the development of shared care plans with shared goals and shared priorities are in place.

3.3 Following the unexpected inpatient death at Charlton Lane Hospital:

i. Difficulties in multi-agency communication between the mental health services and other providers were identified, although it was not considered to be contributory to the outcome for the patient, the review felt there to be areas for learning and improvement. The Multi-Agency communication difficulties will be to be raised at the "One Gloucestershire Patient Safety Group". The case will also be shared with the Gloucestershire Safeguarding Adult Review sub group to consider the following:

    a. Multi agency working in relation to hospital discharge planning (sharing of information)
    b. Recognising when to undertake a mental capacity assessment, particularly with someone thought of as 'eccentric'
    c. Highlighting the need to use the Safeguarding Escalation Process for example when a professional has doubts about someone's capacity to make a specific decision.

ii. A short introductory video about the Charlton Lane Centre will be prepared, which can be shared with families, carers and friends at times when access to the hospital is limited.
iii. Developments to improve communication pathways between inpatient wards and families/carers/friends will to be continued in preparation for any further restrictions or periods of lockdown due to Covid-19. This should include solutions involving the use of technology to extend visiting opportunities.
iv. The system of recording on RiO when a patient makes an allegation of abuse or neglect against a member of staff should be reviewed, to capture the evidence that patient's allegations are clearly recorded and responded

to in terms of their Care Plan and to ensure a safeguarding chronology is available.

3.4 Following the suspected suicide of a patient who had been assessed by MHLT and then referred to CHRTT, the overriding duty to attempt resuscitation for all patients who do not clearly demonstrate signs of life extinct was noted. The potential merits of including training on Recognition of Life Extinct during resuscitation training will be discussed with the Resuscitation and Training Team Lead.

3.5 Following the suspected suicide of an Early Intervention Team patient, notable practice with respect of the rapidity of response to the concerns raised by the patient's wife and discussion of the plan with the patient's wife after the patient had been assessed was highlighted. The review considered this is line with best practice as described in the Triangle of Care model.

3.6 With regards to the death of a GHC community mental health patient by homicide committed by a fellow GHC community mental health patient in 2019/20 Q1, the Coroner has made the decision not to proceed to inquest, as it was felt that there had been sufficient inquiry via the Crown Court case and the comprehensive investigation conducted by the GHC. The Coroner's Officer informed that the victim's family had been given time to reflect upon the decision and that the Coroner would further review at their request. A number of recommendations were made following the GHC comprehensive investigation. Following this incident, the Trust has updated and amended the Clozapine Policy to include Clozapine discontinuation, and global practice notices have been issued by the Medical Director stressing the importance of fully completing a contingency relapse plan, and the importance of requesting and reviewing historical notes. Further details of the full recommendations can be accessed by contacting the Head of Patient Safety.

3.7 Following review of patients on the End of Life Shared Care Pathway (EoL SCP) at Charlton Lane Hospital, the MH MRG recommends that once a patient has been put onto the EoL SCP, then the EoL SCP booklet becomes the patient's primary document, taking over from RiO notes, as agreed across the ICS. If doctors have written an in-depth and detailed account of a discussion or assessment on RiO, they should also write a short couple of sentences in the EoL SCP booklet too, and they can refer to the more detailed account on RiO, so that, if necessary, other clinicians know there is more detail to be found on RiO.

3.8 Following review of patients on the EoL SCP at Charlton Lane Hospital, the MH MRG notes the excellent decision that the Trust Ethics Committee made to allow families to visit their loved ones on the ward during the height of the pandemic, which led to much enhanced patient and family satisfaction during very difficult circumstances. The MH MRG would be keen for this policy to continue during a second wave.

3.9 Following the review of a death of a community mental health patient, which occurred at Gloucester Royal Hospital, it appeared to the MH MRG that the cause of death recorded on the death certificate was disputed. The highlighting of this disputed cause of death has facilitated the MH MRG to enquire with the Medical Examiner Service regarding training for mental health doctors that complete death certificates more frequently, i.e. those who treat patients at Charlton Lane Hospital.

3.10 The MH MRG is investigating why the GHC Trust Chaplain was not given permission to hold the funeral service for a patient who passed away at Charlton Lane Hospital, despite it being the wishes of the deceased patient and of the patient's family.

3.11 Following review of a terminally ill cancer patient death at North Cotswold Hospital after transfer from Gloucestershire Hospitals NHS Foundation Trust (GHFT) for palliative care, it was noted that the patient's husband and family were not aware of the patient's decision to decline any further treatment and request palliation only. The difference of expectation between the patient and the patient's family was not communicated either verbally or in the referral from the acute trust. The PH MRG noted the exceptional circumstances that were managed by the ward team who needed to facilitate very difficult and sensitive conversations in order to bring the expectations of the patient's family in line with those of the patient. The PH MRG will feed back to GHFT the need for full and open communication regarding referrals for palliation in sensitive cases such as this.

3.12 The PH MRG recommends that trust hospital staff employ the use of the GHC Legal Team in contacting next of kin where details are not known or incorrect / out of date and the patient is deceased or incapacitated.

3.13 The Gloucestershire specific LeDeR report for LD patient deaths occurring 1 April 2019 to 31 March 2020 has been signed off by the CCG Quality and Governance Committee, but is currently being graphically designed before it is published publicly. LeDeR have informed that the main learning points are as follows:

i. Focus on improved communications between professionals and with family/carers
ii. Focus on early detection of deteriorating physical health including sepsis. This will mean continued close partnership working with West of England Academic Health Science Network
iii. Focus on eating and drinking pathway
iv. Continued focus on improving uptake of the annual health checks and flu vaccinations.
v. Focus on encouraging the ReSPECT form to be completed earlier on for people who are considered palliative so there is a base line in place to review frailty and advanced care planning with individuals, their family and carers.

vi. Greater inclusion of people with lived experience in the work programme including attendance at steering groups, quality assurance panels and other training events.

vii. Share the learning – plans to host an action from learning event during 2020-2021.

3.14 LeDeR have made no specific recommendations regarding the care and treatment provided by GHC during 2019/20.

4.0 UPDATES FROM MRG

4.1 LD MRG notes that LeDeR have almost caught up with the back-log of cases to review in Gloucestershire. The basis for the inception of LD MRG was to review deaths in a timelier manner than LeDeR were able to manage in order to ensure there were no significant gaps in care that had been contributory to a patient's death that required immediate action. Now that LeDeR have almost caught-up, there has been discussion as to whether the requirement for LD MRG to continue to review deaths persists. LD MRG noted that that as the LeDeR contract for reviewing deaths from April 2022 is currently in question, the decision was made to continue with the current process and to continue to review all GHC LD patient deaths for the time being.

4.2 The role of the Mortality Review Administrator's responsibilities has recently been amended to remove Patient Safety Team administration. Although the Mortality Review Administrator's working hours have decreased from 37.5 to 27 hours per week in order to facilitate attendance at a college course, the significant cut in responsibilities should allow for clearing of the mental health community patient reviews backlog and facilitate more timely screening of newly reported mental health community patient deaths on Datix, which forms the initial work stream of the MH MRG process.

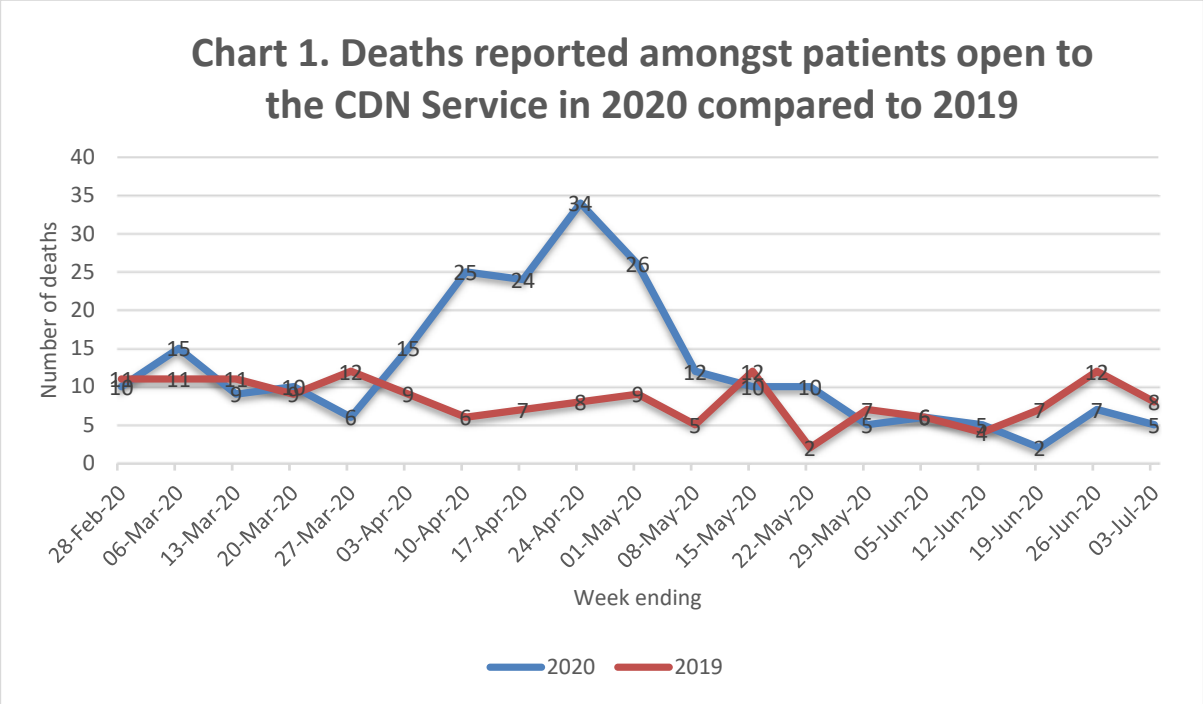
4.3 PH MRG has recently recommenced meetings following the pandemic with the new triggering process which automatically flags community hospital inpatient deaths for review by PH MRG. This process is in its infancy and will continue to be refined.

4.4 The PH MRG is planning a review of SJR questions in order to facilitate enhanced learning from community hospital inpatient deaths.

5.0 UPDATE ON THE IMPACT OF COVID-19 ON DEATHS REPORTED AMONGST PATIENTS OPEN TO THE COMMUNITY DEMENTIA NURSE SERVICE DURING 2020/21 Q1

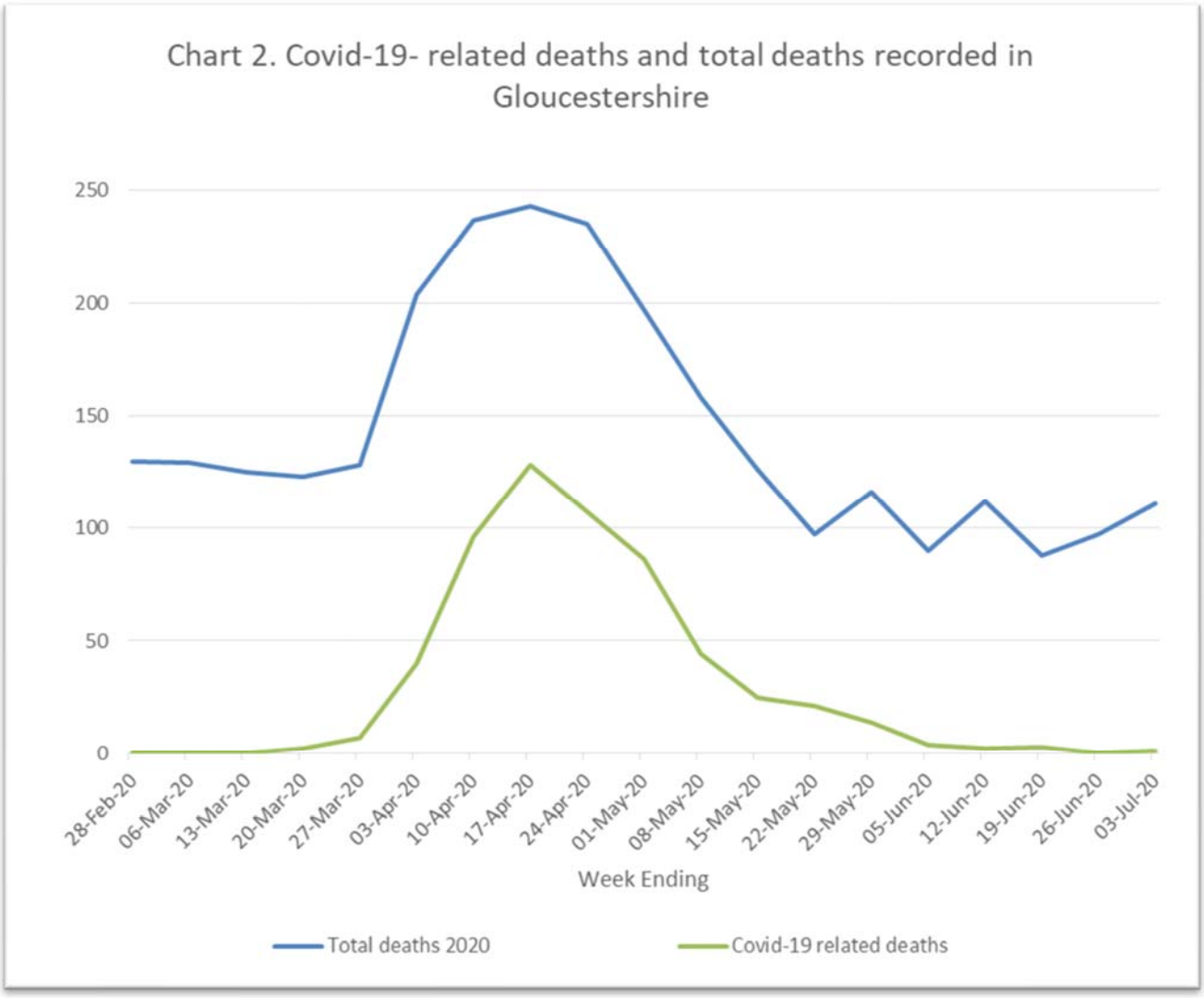
5.1 The 2020/21 Q1 Learning From Deaths paper highlighted an unusually high number of deaths reported amongst patients open to the GHC Community Dementia Nurse (CDN) Service during that quarter, particularly in the month of

April. Chart 1 shows the increase in reported deaths from the end of March 2020 until the beginning of May 2020, when compared to data from the same time period in 2019.



5.2 The 2020/21 Q1 Learning from Deaths paper also advised that further investigation would be carried out in order to establish whether the increase deaths during this period could be attributable to the Covid-19 pandemic.

5.3 Whole county death data has been obtained from publicly available ONS data to include the total number of deaths during this period and deaths recorded as Covid-19 related. This data is presented in Chart 2, which clearly shows an increase in overall deaths from the end of March until the beginning of May 2020 across the county.



5.4 The data presented in Chart 2 clearly shows an increase in overall deaths from the end of March until the beginning of May 2020. At the peak of the curve, week ending 17 Apr 2020, deaths reported as Covid-19 related accounted for 52.7% of all deaths reported across Gloucestershire.

5.5 Superimposing the CDN patient death data presented in Chart 1 onto Chart 2 shows that the increase in deaths reported amongst patients open to the CDN service follows the whole county trend of an increase in deaths from late March until early May 2020, shown in Chart 3. It can be concluded, therefore, with some degree of certainty, that the increase in deaths reported amongst patients open to the CDN Service correlates with the Covid-19 pandemic.

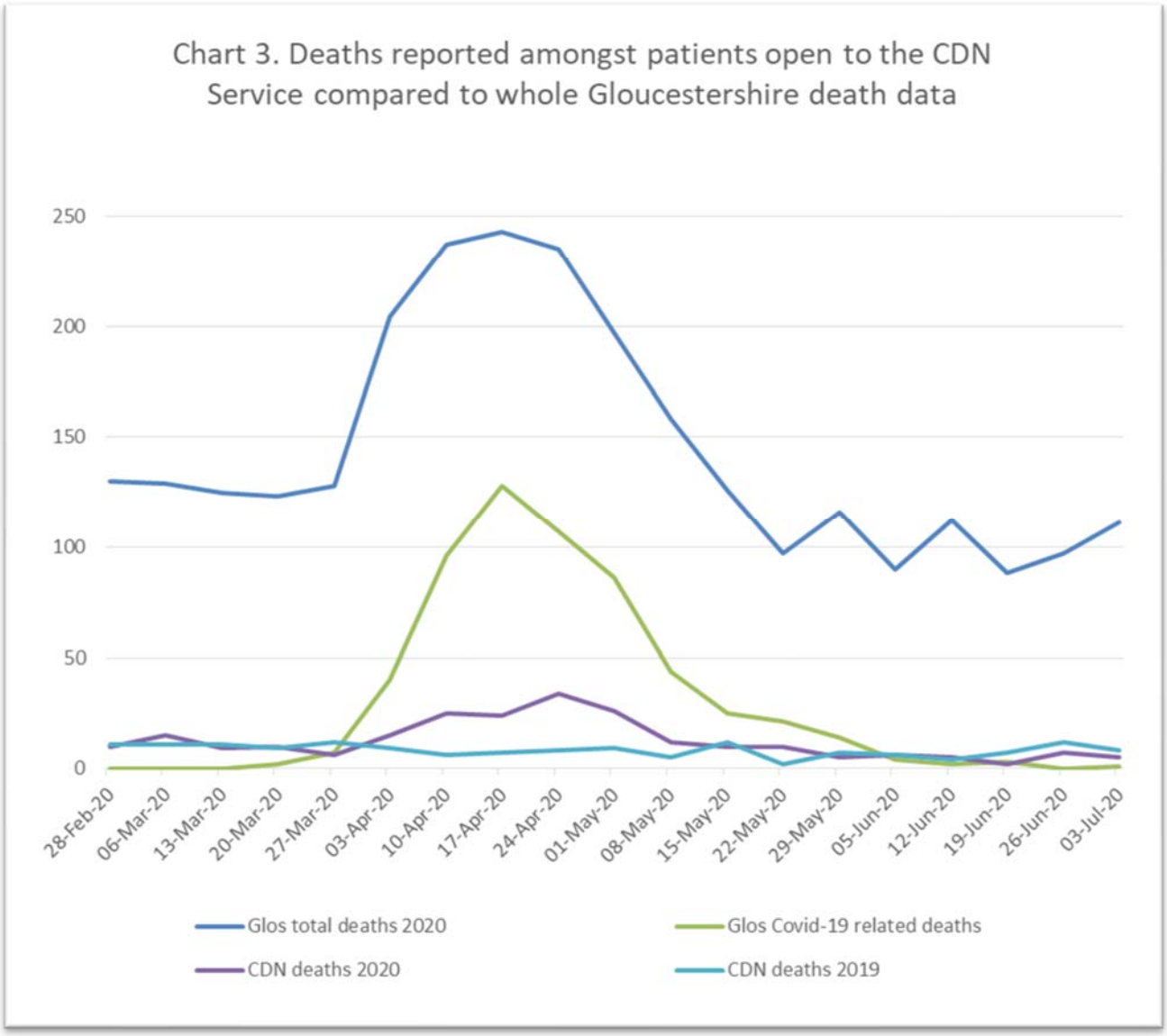


Chart 3. Deaths reported amongst patients open to the CDN Service compared to whole Gloucestershire death data
250
200
150
100
50
0
28-Feb-20
06-Mar-20
13-Mar-20
20-Mar-20
27-Mar-20
03-Apr-20
10-Apr-20
17-Apr-20
24-Apr-20
01-May-20
08-May-20
15-May-20
22-May-20
29-May-20
05-Jun-20
12-Jun-20
19-Jun-20
26-Jun-20
03-Jul-20
Glos total deaths 2020
Glos Covid-19 related deaths
CDN deaths 2020
CDN deaths 2019

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AGENDA ITEM: 18/1120

REPORT TO: **TRUST BOARD – 25TH NOVEMBER 2020**

PRESENTED BY: Sandra Betney, Director of Finance

AUTHOR: Stephen Andrews, Deputy Director of Finance

SUBJECT: **FINANCE REPORT FOR PERIOD ENDING 31st October 2020**

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

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

The purpose of this report is to
Provide an update of the financial position of the Trust.

Recommendations and decisions required

- The Board to **note** the month 7 position
- Approve the delegation of the review and approval of the Montpellier Ensuites Business Case to the Resources Committee in December

Executive summary

- There is an updated Covid interim financial framework for the NHS in place for October to March
- The Trust will receive increased block payments to cover Covid costs and some developments but will receive no further top ups
- The Trust has requested a retrospective top-up of £1.761m for April to September. £1.484m of this has been approved by NHSI for April to August
- The Trust has an interim plan of a deficit of £439k for October to March
- The Trust is introducing net spending limits to give directorates a clear understanding of their financial targets
- The Trust's position at month 7 is a deficit of £62k
- The Trust is forecasting a year end deficit of £233k
- The cash balance at month 7 is £67.0m
- Capital expenditure is £1.276m at month 7. The Trust has a capital plan for 20/21 of £10.182m.

- In order to progress the introduction of ensuite facilities into the Montpellier Ward a full business case is being completed in November
- In accordance with SFIs the Board are asked to delegate responsibility for the review of this business case to the Resources Committee to support the Trust in meeting its capital spend forecast
- The revised recurring Cost Improvement Plan (CIP) target for the merged Trust is £3.230m and the amount delivered to date is £3.419m.
- The Trust has spent £2.222m on Covid related revenue costs between April and October.

Risks associated with meeting the Trust's values

Risks identified within the paper.

Corporate considerations	
Quality Implications	
Resource Implications	
Equality Implications	

Where has this issue been discussed before?

Appendices:	Finance Report

Report authorised by:	**Title:**
Sandra Betney	Director of Finance

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AGENDA ITEM: 18/1120

Finance Report Month 7

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Overview

Gloucestershire Health and Care
NHS Foundation Trust

- From October block contract payments will continue and be increased to cover Covid costs and some developments but top-ups will cease
- Gloucestershire ICS has been given an overall funding envelope
- The Trust has been notified it will receive £1.484m of retrospective true up funding relating to April to August, and is waiting to hear if a further £277k for September has been approved
- This would bring the total retrospective true up payments to £1.761m
- The Trust has recorded Covid related expenditure of £2.222m for April to October
- The adjusted recurrent Cost Improvement Plan target for the Trust following the extension of the interim planning guidance is reduced to £3.230m
- The CIP removed so far is £3.419m which is above the revised target
- 20/21 Capital plan was approved at £9.945m, with an additional £100k for critical backlog maintenance and £137k for Covid capital. Spend to month 7 is £1.276m, Capital Management Group is monitoring forecast outturn and has informed NHSI/E that we will meet the capital plan
- A full business case for the Montpellier Ward ensuites capital scheme is being developed in November
- In accordance with the SFIs the Board are asked to approve the delegation of the consideration of this scheme to the Resources Committee to help support delivery of the capital programme
- Agency cost forecast is £5.06m which is £1.2m lower than 2019/20
- Cash at the end of month 7 is £67.0m due to the Trust receiving November's block contract payment early

Months 7-12

Gloucestershire Health and Care
NHS Foundation Trust

- As part of the revised financial framework for months 7-12 the Trust has submitted an interim plan of a deficit of £439k at year end
- The Trust has improved this position and anticipates a worst case scenario of a deficit of £233k
- To monitor financial performance against this revised plan we are introducing net spending limits for the last four months of the financial year
- Based on bottom up budget holder forecasts these limits will give directorates a clear understanding of their financial targets
- The interim financial plan commitment represents a more constrained financial plan than budgets
- Budgets remain the key financial tool for managing our finances, committing expenditure and providing the financial governance framework
- We anticipate that unless there are unforeseen circumstances/unforecasted additional covid expenditure in the last 4 months of the year then we are on course to deliver our latest submission to NHSI, a deficit of £233k

GHC Income and Expenditure

Gloucestershire Health and Care
NHS Foundation Trust

Statement of comprehensive income £000	GHC Month 7				GHC mths 1-12		
	2020/21				2020/21		
	Original Plan	Revised NHSI Interim plan	Actual	Variance	Original Plan	Revised NHSI Interim plan	Spending Limit
Operating income from patient care activities	122,639	126,638	126,341	(297)	211,417	222,533	224,052
Other operating income	5,292	3,762	3,758	(4)	9,068	6,699	6,753
True up income	0	1,761	1,761	0	0	1,761	1,761
	0	0	0	0	0	0	0
Employee expenses	(94,276)	(97,185)	(96,471)	714	(161,631)	(170,847)	(168,878)
Operating expenses excluding employee expenses	(31,290)	(33,205)	(33,631)	(426)	(53,635)	(57,264)	(60,599)
PDC dividends payable/refundable	(2,345)	(1,932)	(1,891)	41	(4,019)	(3,482)	(2,800)
Other gains / losses	7	18	10	(8)	21	48	46
Surplus/(deficit) before impairments & transfers	**27**	**(143)**	**(123)**	**20**	**1,221**	**(552)**	**335**
impairments	0	0	0	0	1	0	
Remove capital donations/grants I&E impact	0	69	61	(8)		113	102
Surplus/(deficit)	**27**	**(74)**	**(62)**	**12**	**1,222**	**(439)**	**437**
Risk allowance				0			(670)
Revised Surplus/(deficit)	**27**	**(74)**	**(62)**	**12**	**1,222**	**(439)**	**(233)**

Note. The variance compares 'Revised NHSI Interim plan' against 'Actual'

GHC Balance Sheet

Gloucestershire Health and Care
NHS Foundation Trust

STATEMENT OF FINANCIAL POSITION (all figures £000)		GHC	GHC Month 7				
		2019/20	2020/21 Year to Date				20/21
		Actual	Original Plan	Revised NHSI Interim plan	Actual	Variance	Forecast
Non-current assets	Intangible assets	2,023	2,283	1,242	1,177	(65)	847
	Property, plant and equipment: other	115,916	121,248	111,955	111,413	(542)	117,769
	Total non-current assets	**117,939**	**123,531**	**113,197**	**112,590**	**(607)**	**118,617**
Current assets	Inventories	288	245	283	283	(0)	283
	NHS receivables	11,017	8,456	3,072	3,050	(22)	13,895
	Non-NHS receivables	8,973	5,723	11,914	12,477	563	2,230
	Cash and cash equivalents:	26,619	28,469	67,853	67,017	(836)	35,025
	Property held for sale	0	500	0	0	0	0
	Total current assets	**46,897**	**43,393**	**83,122**	**82,827**	**(295)**	**51,432**
Current liabilities	Trade and other payables: capital	(2,143)	(1,784)	(509)	(366)	143	(2,366)
	Trade and other payables: non-capital	(5,580)	(10,551)	(46,867)	(8,748)	38,119	(9,949)
	Borrowings	(76)	(104)	(53)	(53)	(0)	(53)
	Provisions	(371)	(604)	(634)	(764)	(130)	(764)
	Other liabilities: deferred income including contract liabilities	(16,655)	(1,482)	0	(37,182)	(37,182)	(9,044)
	Total current liabilities	**(24,825)**	**(14,525)**	**(48,063)**	**(47,114)**	**949**	**(22,177)**
Non-current liabilities	Borrowings	(1,773)	(8,338)	(1,483)	(1,479)	4	(1,442)
	Provisions	(3,491)	(451)	(4,075)	(4,050)	25	(3,871)
	Total net assets employed	**134,747**	**143,610**	**142,698**	**142,774**	**76**	**142,559**
Taxpayers Equity	Public dividend capital	127,526	125,181	125,751	125,750	(1)	125,750
	Revaluation reserve	6,566	7,098	7,204	7,204	0	7,204
	Other reserves	(1,241)	(1,241)	(1,241)	(1,241)	(0)	(1,241)
	Income and expenditure reserve	1,896	12,572	10,984	11,060	76	10,845
	Total taxpayers' and others' equity	**134,747**	**143,610**	**142,698**	**142,774**	**76**	**142,559**

Note. £22m deferred income. November income received in October

'Revised NHSI Interim plan' against 'Actual

Cash Flow Summary

Gloucestershire Health and Care
NHS Foundation Trust

Statement of Cash Flow £000	YEAR END 19/20		ACTUAL YTD 20/21	
Cash and cash equivalents at start of period		**33,553**		**37,720**
Cash flows from operating activities				
Operating surplus/(deficit)	1,308		1,764	
Add back: Depreciation on donated assets	0		61	
Adjusted Operating surplus/(deficit) per I&E	**1,308**		**1,825**	
Add back: Depreciation on owned assets	4,944		4,075	
Add back: Impairment	3,489		0	
(Increase)/Decrease in inventories	(38)		0	
(Increase)/Decrease in trade & other receivables	(3,516)		5,346	
Increase/(Decrease) in provisions	2,485		404	
Increase/(Decrease) in trade and other payables	2,580		11,615	
Increase/(Decrease) in other liabilities	(863)		6,889	
Net cash generated from / (used in) operations		**10,389**		**30,153**
Cash flows from investing activities				
Interest received	206		3	
Purchase of property, plant and equipment	(4,835)		(1,278)	
Sale of Property	560		0	
Net cash generated used in investing activities		**(4,069)**		**(1,275)**
Cash flows from financing activities				
PDC Dividend Received	570		545	
PDC Dividend (Paid)	(2,565)		0	
Finance Lease Rental Payments	(158)		(128)	
		(2,153)		**417**
Cash and cash equivalents at end of period		**37,720**		**67,015**

Covid 1

Gloucestershire Health and Care
NHS Foundation Trust

- Urgent Covid related capital costs have been incurred in 20/21 and funding of £137k received which fully covers the expenditure.
- The Trust has submitted further capital proposals under phase 2 of the NHS recovery plan totalling £3.745m.
- Covid related revenue costs of £2.222m have been identified for April to October 2020.
- The Covid related revenue cost forecast is £3.453m for 20/21.
- Recurring costs are £1.068m in a full year.

For periods up to and including 31/10/2020 (M1-7)	TOTAL costs £	Comments (M7)
Internal and external communication costs	1,363	
Expand NHS Workforce - Medical / Nursing / AHPs / Healthcare Scientists / Other	375,843	
Sick pay at full pay (all staff types)	28,636	
COVID-19 virus testing (NHS laboratories)	120,701	
Remote management of patients	89,316	Includes £37.5k for data charges in M7.
Plans to release bed capacity	35,430	
Existing workforce additional shifts	150,186	
Decontamination	158,882	
Backfill for higher sickness absence	850,782	
Remote working for non patient activites	115,786	
National procurement areas	250,567	Includes £37.5k for data charges in M7.
Other	44,919	
TOTAL EXPENDITURE	**£2,222,411**	
Retrospective Top up paid	-1,484,000	
Retrospective Top up pending	-277,000	
Covid envelope system pot	-461,411	
TOTAL INCOME	**-£2,222,411**	
Net Expenditure over Income	**£0**	

Capital – Five year Plan

Gloucestershire Health and Care
NHS Foundation Trust

Capital 5 year Plan	Original Plan	Revised Plan	Actuals to date	Plan	Plan	Plan	Plan	
£000s	2020/21	2020/21	2020/21	2021/22	2022/23	2023/24	2024/25	Total
Land and Buildings								
Buildings	4,259	3,383	356	3,202	4,500	2,500	1,000	14,585
Backlog Maintenance	1,393	1,700	218	1,371	1,050	1,050	250	5,421
Urgent Care	475	200	0	275		0		475
Covid	0	137	118	0				137
Cirencester Scheme						5,000		5,000
Medical Equipment	1,220	587	45	1,059	730	730	3,330	6,436
IT								
IT Device and software upgrade	600	1,270	274	0	600	600	600	3,070
IT Infrastructure	1,498	2,705	162	132	1,400	1,300	1,300	6,837
Sub Total	**9,445**	**9,982**	**1,174**	**6,039**	**8,280**	**11,180**	**6,480**	**41,961**
Forest of Dean	500	200	103	6,500	6,000	300	0	13,000
Total	**9,945**	**10,182**	**1,276**	**12,539**	**14,280**	**11,480**	**6,480**	**54,961**
Disposals				(3,260)		(1,500)		(4,760)
Donation - Cirencester Scheme						**(5,000)**		(5,000)
	9,945	**10,182**	**1,276**	**9,279**	**14,280**	**4,980**	**6,480**	**45,201**

Forest of Dean - £900k spent in 2018/19 and 19/20, total planned spend £13.9m.
Additional £100k added to plan in 20/21 for backlog maintenance from Critical Infrastructure Risk funding and £137k confirmed to fund Covid schemes.
The Capital Management Group have reviewed all schemes to assess the impact of a Covid related slow start to the year and concluded that the forecast outturn is still deliverable.

Risks

Gloucestershire Health and Care
NHS Foundation Trust

Risks to delivery of the 2020/21 position are as set out below:

Risks 20/21	20/21 Risks	Made up of: Recurring	Made up of: Non Recurring	Likelihood	Impact	RISK SCORE
Interim finance for new developments - Not able to redeploy staff if National funding not available	264	264	0	2	2	4
Retrospective Top up not fully funded	277		277	2	2	4
	541	**264**	**277**			
Risks 21/22	**21/22 Risks**	**Made up of: Recurring**	**Made up of: Non Recurring**	**Likelihood**	**Impact**	**RISK SCORE**
Delivering Efficiency CIP schemes (1.1%)	2,000	2,000	0	2	4	8
Delivering Differential CIP schemes	1,000	1,000	0	3	3	9
Delivering Value (Challenge) Scheme CIPs	900	900	0	4	3	12
Delivering non recurring savings	1,600	0	1,600	2	3	6
Efficiencies need to be higher than assumed (0.9% more)	1,636	1,636	0	3	3	9
Do not sell proposed capital disposals	3,260	0	3,260	3	5	15
Insufficient Covid funding to cover recurring costs	1,068	1,068	0	3	2	6
	11,464	**6,604**	**4,860**			

Gloucestershire Health and Care
NHS Foundation Trust

Single Operating Framework Ratings

Current FT Financial Risk Rating - Single Oversight Framework
Use Of Resource

Finance and use of resources rating Metric	2019/20 Actual	20/21 Plan	20/21 Actual YTD	20/21 Forecast
Capital service cover rating	1	1	1	1
Liquidity rating	1	1	1	1
I&E margin rating	1	1	1	1
I&E margin: distance from financial plan	1	1	1	1
Agency rating*	4	1	1	1
Risk ratings after overrides	3	1	1	1

* Assuming no adjustment to existing agency ceiling

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AGENDA ITEM: 19/1120

REPORT TO: **TRUST BOARD - 25TH NOVEMBER 2020**

PRESENTED BY: Chris Woon, Associate Director of Business Intelligence

AUTHOR: Chris Woon, Associate Director of Business Intelligence

SUBJECT: **COMBINED PERFORMANCE DASHBOARD OCT 2020 (MONTH 7)**

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

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

The purpose of this report is to
This performance dashboard report provides a high-level view of key performance indicators (KPIs) in exception across the organisation.

To offer reader clarity, the visualisation is currently separated into the following sections;

- Mental Health & Learning Disabilities National Requirements (NHSI & DoH)
- Mental Health & Learning Disabilities Local Contract (including Social Care)
- Physical Health National Requirements
- Physical Health Local Requirements

Trust wide indicators will be separated in 2021.

Performance covers the period to the end of October (month 7 of 2020/21). It is of note that performance period remains aligned to our operational priority to recovery services and plan for winter/ a consecutive pandemic surge. Where possible, it has been highlighted within the indicator narrative where **Covid-19** may have contributed to in-period data quality, narrative and/ or performance.

Where performance is not compliant, operational service leads are prioritising appropriately to address issues. Service led Covid-19 recovery plans will schedule recovery trajectories, more fully account for 2020/21 performance indicators in exception and provide legacy Service Recovery Action Plans (SRAP) updates.

Recommendations and decisions required
The Board are asked to:

- Note the aligned Performance Dashboard Report for September 2020/21.

- Acknowledge the impact of **Covid-19** recovery on operational performance and data quality.
- Note the report as a **significant level of assurance** that our contract and regulatory performance measures are being met or that appropriate service recovery action plans are being developed to address areas requiring improvement - in line with the C19 Recovery Programme.

Executive summary

Mental Health & Learning Disability Services
The Board's attention is requested to review the 7 **mental health** key performance thresholds listed in the dashboard (with associated narrative) that were not met for Oct 2020. It is of note that all indicators have been in exception within the last 12 months.

The following indicators are highlighted outside of the October performance dashboard as they refer to previous periods when they were non-compliant;

- **3.20: Care Plan Audit to show dependent children living with adults known to Recovery, MHARS, Eating Disorders and Assertive Outreach Services.**
  A Quarter 2 (Sept) performance report has now been made available and is 47% against an expected performance threshold of 75%. The audit criteria were interpreted quite broadly with compliance based on whether relevant information is recorded in the care plan. It has been advised that this does make the audit quite subjective. The numbers audited are small which may, in part, contribute to variable results. The audit is based on the correct form being completed and has shown that staff need to be reminded that there is a specific section for recording. This is one of four targeted areas for improvement which the Trust is taking forward. Trust Service Directors continue to be given trajectories for improvement which will be monitored through BIMG. Audit results will be shared with Service Directors to help inform this improvement work.

- **3.21: CYPS Transition to the Recovery Service within 4 weeks.**
  CAMHS and Recovery Services have a meeting arranged in November to discuss further training needs of staff in relation to recording transitions in line with policy. The 3 non-compliant, data entry errors records for July have now been corrected on the clinical system. There was 1 case in October which is non-compliant however the service has provided reassurance that all criteria were met within 4 weeks but not recorded correctly on the clinical system – it is not therefore highlighted within the dashboard this month.

Physical Community Health Services
In addition, attention is drawn to the 15 **physical health** performance thresholds listed in the dashboard (with associated narrative) that were not met for October 2020. Within these, 7 are within CYPS and 4 within wheelchair services. In addition, there are 4 workforce indicators residing within the physical health section that now apply to all GHC services. It is of note that all of these indicators have been in exception within the last 12 months.

A number of services, such as Bone Health, Speech & Language Therapy (SaLT), Musculoskeletal (MSK) Physio, MSKAPS (Musculoskeletal Advanced Practitioner Service) and Podiatry are ensuring that clinically meaningful first contacts are accurately recorded and counted as telephone, video or face to face. This is to ensure data accuracy as well as supporting new service delivery models, understanding pathway flow, future demand/ capacity modelling and inform accurate performance monitoring.

Non-exception reporting
It is further noted that there are addition indicators outside of threshold but are either within normal, expected variation, have a proxy threshold, are formally suspended or have a confirmed data quality issue that is administrative only and is being resolved. These have not been highlighted for exception.

A high-level investigation is currently underway to ensure that all operational services have adequate quality and performance monitoring oversight. Immediate feedback suggests that all operational services are well managed with appropriate service level quality, performance or activity monitoring. As is known, a management by exception process ensures that all key performance indicators receive an audience at Committee level. Furthermore, the wider inclusion of *internal* performance monitoring within the corporate performance dashboard is being considered within a new Performance Management Framework for 2021/22.

Risks associated with meeting the Trust's values
Where appropriate and in response to significant and wide-reaching performance issues (such as Eating Disorders, Podiatry, IAPT, Children's or Wheelchair Services); operational services should have Service Recovery Action Plans (SRAP) in place which outlines appropriate risk and mitigation.

Corporate considerations	
Quality Implications	The information provided in this report can be an indicator into the quality of care patients and service users receive. Where services are not meeting performance thresholds this may also indicate an impact on the quality of the service/ care provided.
Resource Implications	The Business Intelligence Service provides the support to operational services to ensure the robust review of performance data and co-ordination of the combined performance dashboard and its narrative.
Equality Implications	Equality information is monitored within BI reporting.

Where has this issue been discussed before?	BIMG 19/11/2020
Appendices:	*None*
Report authorised by: Sandra Betney	**Title:** Director of Finance

Performance Dashboard Report & BI Update

Aligned for the period to the end October 2020 (month 7)

This performance dashboard provides a high level view of Key Performance Indicators (KPIs) in exception across the organisation for the period. Highlighted indicators are underperforming against their threshold or are outside normal variation control limits that warrant senior oversight. Additionally, confirmed data quality issues that are being imminently resolved will inform any escalation decision. A full list of all indicators (in exception or otherwise) are available within the dynamic version of this Tableau report.

Where performance is not compliant, operational service leads are prioritising appropriately to address issues. Additionally, a Covid-19 Recovery Programme will schedule service specific recovery trajectories, more fully account for 2020/21 performance indicators in exception and where appropriate, provide legacy Service Recovery Action Plans (SRAP) updates.

In spite of unplanned Covid-19 BI demands and increasing recovery activity, Business Intelligence services have continued to deliver key infrastructure development tasks to date and ensured the continuity of business critical reports during the pandemic. The following tasks have been completed since the last update;

- The development of business critical operational performance reports within Tableau
- Availability of Centros data sources for visualisation and report production
- Final system hierarchy alignment (for integrated reporting)
- Continuing data validation processing of Incident (Datix), Workforce (ESR) and Finance (Centros) data
- Service level recovery engagement, analysis and trajectory forecasting
- Covid-19 reporting review and second surge planning

The following tasks continue to be ‘in the development pipeline’;

- Key financial reporting to support the new General Ledger (GL) (TBC).
- Dashboard visualisation capability further developed to include; threshold figures in place of variances, benchmarking observation, SRAP alerts and data quality alerts (Q4 2020/21).
- Final legacy GCS reports migrated to Tableau (Q3 2020/21)
- Supplementary system sources brought into BI reporting (Datix, Service Experience, Q4 2020/21)
- Existing data source adjustments (to support data quality monitoring and historic activity) in new environment (Q4 2020/21).
- Internal service specification review, considering Commissioner led contractual KPI review (Q4 2020/21 but responsive to operational capacity)
- Data source replication (prioritisation for ESR, Integra and Datix) (Q4 2020, dependant on GL and ESR progress)
- Integrated Business Intelligence Performance Dashboard (Q4 2020/21) for Board/ Resources Committee (incorporating full BI stack).
- Birtie decommissioning (Q3 2020/21)

PLEASE NOTE THAT THE DELIVERY OF THIS BI DEVELOPMENT TIMETABLE CONTINUES TO BE RESPONSIVE TO THE DEMANDS ON CURRENT CORPORATE/ OPERATIONAL BAU & ADHOC (e.g. C19) REPORTING

Performance Dashboard: *Mental Health & Learning Disability - National Requirements (NHSI & DOH)*

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Mental Health - National Requirements Gloucestershire

		October		YTD		
1.04	Care Programme Approach - formal review within12 months	94.0%	-1.0%	91.2%	-3.8%	

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

1.04: CPA Approach – Formal review within 12 months
There has been an improvement in this indicator from the 88.8% that was reported in September (110 non-compliant records) to 94.0% in October (59 non-compliant records). The majority of cases are within the Recovery Service (32) and EI service (8). These efforts have also raised up previously reported performance levels.

The Adult community teams are currently working through the CPA reviews, which is reflected in the overall improvement in compliance this month. Team managers are working with the teams to address outstanding current and historical CPA reviews as capacity allows.

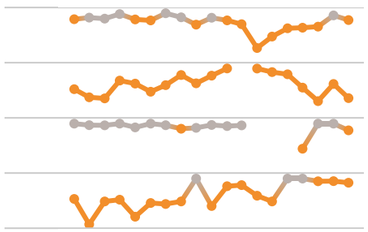
In the EI service 5 patients did not attend for their appointment during October. These have been rebooked and the service are ensuring moving forward that CPA reviews are booked earlier to avoid missing the 12-month threshold.

Performance Dashboard: *Mental Health & Learning Disability - Local Contract (Including Social Care)*

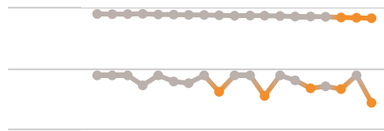
Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Mental Health & Learning Disabilty - Local Contract

		October	YTD	
3.12	IAPT access rate: Access to psychological therapies for adults should be improved	97.7% -2.3%	77.8% -22.2%	
3.25	% of CYP entering partnership (treatment) in CYPS have pre and post treatment outcomes and measures recorded	22.5% -77.5%	44.5% -55.5%	
3.32	CPI: Referral to Assessment within 4 weeks	86.6% -3.4%	88.8% -1.2%	
3.35	Adolescent Eating Disorders - Routine referral to NICE treatment start within 4 weeks	90.9% -4.1%	89.3% -5.7%	

Mental Health & Learning Disability - Social Care

		October	YTD	
4.12	Ensure that reviews of new short or long term packages take place within 12 weeks of commencement	50.0% -30.0%	85.1% 5.1%	
4.05	% of WA & OP service users on the caseload who have a carer, who have been offered a carer's assessment	87.6% -2.4%	92.1% 2.1%	

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

3.12 IAPT Access rate
October is reported at 97.7% of the expected number of people accessing treatment during the month.

The service is managing capacity based on workforce availability whilst working on a recruitment strategy to employ the required workforce to deliver increased access targets. Workforce variations were anticipated due to timings around when trainees become clinically active. <u>The service remains on track to achieve the agreed access of 19% across Quarter 3</u> (*and 20.56% in Quarter 4 assuming variables such as workforce are managed as planned*).

3.25: CYPs entering partnership have pre and post treatment outcomes and measures recorded
October is reported at 22.5% against a local performance threshold of 100%.

Compliance continues to be affected by the **<u>COVID-19</u>** pandemic and the need to deliver the majority of services via video and telephone, therefore the recording of ROMS (Reported Outcome Measures) is via a paper-based system. CAMHS is currently reliant on families returning the forms rather than being able to collect whilst in clinic. This is causing both a reduction in number returned and delays in receiving and entering the data. The service is monitoring this closely and sending reminders. CAMHS are also exploring other virtual collection solutions.

In addition, Goal-based ROMs have recently been added to RiO and are being used by clinicians and inclusion of these in the KPI calculation is still in development.

3.32: CPI Referral to Assessment within 4 weeks
October performance is reported at 86.6% against a 90% performance threshold. There were 6 non-compliant cases in October.

Due to the service being closed during the **<u>COVID-19</u>** pandemic between March and July, 2 clients with urgent referrals were assessed jointly with the Recovery Service, therefore their first appointment solely with the CPI service has fallen outside of the 4 weeks.

One client cancelled an appointment which was offered within 4 weeks and was seen within 5 weeks.

The remaining 3 non-compliant cases are due to staff availability. The service has an on-going vacancy and are reviewing staffing skill mix before re-advertising the post.

3.35 Adolescent Eating Disorders: Routine referral to NICE treatment within 4 weeks
October performance is reported at 90.9% against a performance threshold of 95%

There was 1 non-compliant case in October. The client was seen within 8 days of referral for assessment. The parent's preference was to wait for CBT (Cognative Behavioural Therapy) treatment rather than FBT (Family based therapy) which can begin at the first appointment. The first available appointment for CBT was just outside the required 4 weeks on day 29.

4.05: % of WA & OP service users on the caseload who have a carer who have not been offered a carer's assessment
Performance is reported at 87.6% for October (214 cases), The majority of cases are within the Older People services (Managing Memory Together: 80, OP Community Services: 54) and Recovery Service (38).

Teams have been working hard to ensure that data is captured and entered in the clinical system to show clients have been asked if they have a carer and Indicator 4.04 (% of WA & OP service users on the caseload asked if they have a carer) is now compliant for the first time since April. Work is ongoing to ensure that the clinical system is updated consistently to show that the carer has been offered an assessment and Team managers are currently addressing recording issues with staff.

4.12: Ensure that reviews of short or long-term packages take place within 12 weeks of commencement
There are 4 non-compliant cases in October.

One case is due to the current methodology which needs a small adjustment and another case is still being investigated as it not yet clear if an amendment is needed to the clinical record or the methodology. Once the updates have been made these cases will be shown as compliant.

The remaining case is due to a need to keep the funding in position so that a place is still available once the clients leaves hospital and there can be no review until the client is discharged.

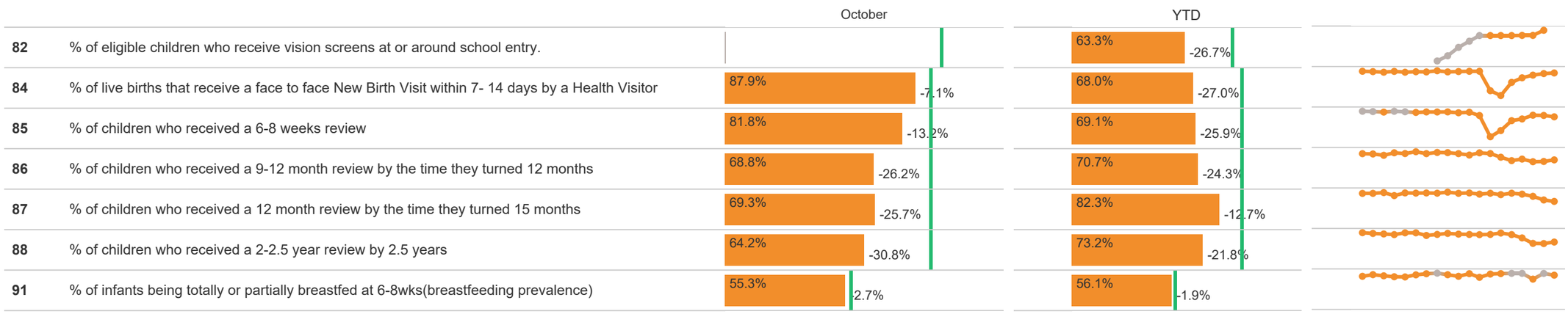
One case is due to staffing capacity as there is a vacant post at present.

Performance Dashboard: *Physical Health - National Requirements*

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Physical Health - National Requirements



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

82: Proportion of eligible children who receive vision screens at or around school entry
The cumulative performance up to *September* 2020 for the schools vision screening programme was 71.9% and remains behind the internal trajectory of 95%. Out of a cohort of 6,610, 4,751 children have been screened up to September 2020.

The service commenced a **catch up** programme for the Vision Screening programme in September 2020. These are Year 1 children (in September 2020), who were not screened in the academic year 2019-20 when they would have been in Reception year (the target cohort). We are currently investigating issues with the October catch-up data and aim to update this next month.

The 2019/20 Vision Screening Programme was suspended between March and August 2020 due to the **Covid-19** outbreak.

84: Percentage of live births that receive a face to face NBV (New Birth Visit) within 7- 14 days by a Health Visitor
The target (95%) was not achieved in October 2020 (87.9%). 436 out of 496 visits were completed within the timeframe.

All babies eligible within this cohort, have either received an offer of a new birth visit (NBV) or had a visit on discharge from the Neonatal Intensive Care Unit (NICU), where the Health visitor was aware that the child was in NICU.

There has been a slight increase from September to October of children seen for a NBV in time frame. There are plans to reinforce with teams the requirement to book contacts in as early as possible following notification to ensure the increase continues and to reinforce need to record NICU as UPP (Universal Partnership Plus).

85: Percentage of children who received a 6-8 weeks review
The target (95%) was not achieved in October 2020 (81.9%). 406 out of 496 reviews were completed within the timeframe.

All babies within this cohort received an offer of a 6-8 week contact. Parental choice requesting a telephone contact has increased this month. There are plans to reinforce the use of Attend Anywhere, revisit record keeping Health Visiting forum in November, to support staff with benchmarks (visiting in timeframe) and data recording.

86: Percentage of children who received a 9-12 month review by the time they turned 12 months.
The target (95%) was missed in October 2020 (68.9%). 354 out of 514 reviews were completed within the timeframe.

The parents of all children within the cohort were offered the opportunity to receive a 9 -12mth / 2 year review. There has been a percentage increase from September to October of children seen face to face within timeframe. There are plans to promote the Attend Anywhere offer and ensure all staff have access and are competent in using the software.

87: Percentage of children who received a 12 month review by the time they turned 15 months.
The target (95%) was missed in October 2020 (69.4%). 376 out of 542 reviews were completed within the timeframe.

The parents of all children within the cohort were offered the opportunity to receive a 9 -12mth / 2 year review. There has been a percentage increase from September to October of children seen face to face within timeframe. There are plans to promote the Attend Anywhere offer and ensure all staff have access and are competent in using the software.

88: Percentage of children who received a 2-2.5 year review by 2.5 years.
The target (95%) was missed in October 2020 (60.8%). 338 out of 526 reviews were completed within the timeframe.

The parents of all children within the cohort were offered the opportunity to receive a 9 -12mth / 2 year review. There has been a percentage increase from September to October of children seen face to face within timeframe. There are plans to promote the Attend Anywhere offer and ensure all staff have access and are competent in using the software.

Additional Commentary for 86, 87 & 88
A Community Nursing focus group is booked in November to discuss ASQ (Ages and Stages Questionnaire) delivery, health promotion and resources. SMS text reminders are now being sent out to parents prior to ASQ. The recovery plan remains in place to ensure all parents requesting an ASQ have the opportunity to receive a contact.

91: % of infants being totally or partially breastfed at 6-8wks(breastfeeding prevalence)
Breastfeeding rates have decreased by 2.9% from September to October, standing at 55.3% against the target of 58%.

The Infant Feeding Lead Health Visitor will initiate an investigation on rates to compare between localities when information is available in order to identify any particular locality in need of support.

The Gloucestershire Breastfeeding Network (GBSN) have now re-opened face-to-face support groups and continue to offer video, phone and text support.

The Health Visiting Baby Friendly Initiative Newsletter reminds staff to correctly complete feeding status, and staff are also informed of new additions to breastfeeding support groups face-to-face via Keyworkers. The Health Visiting weekly bulletin gives reminder tips of how to support mums to achieve improved breastfeeding.

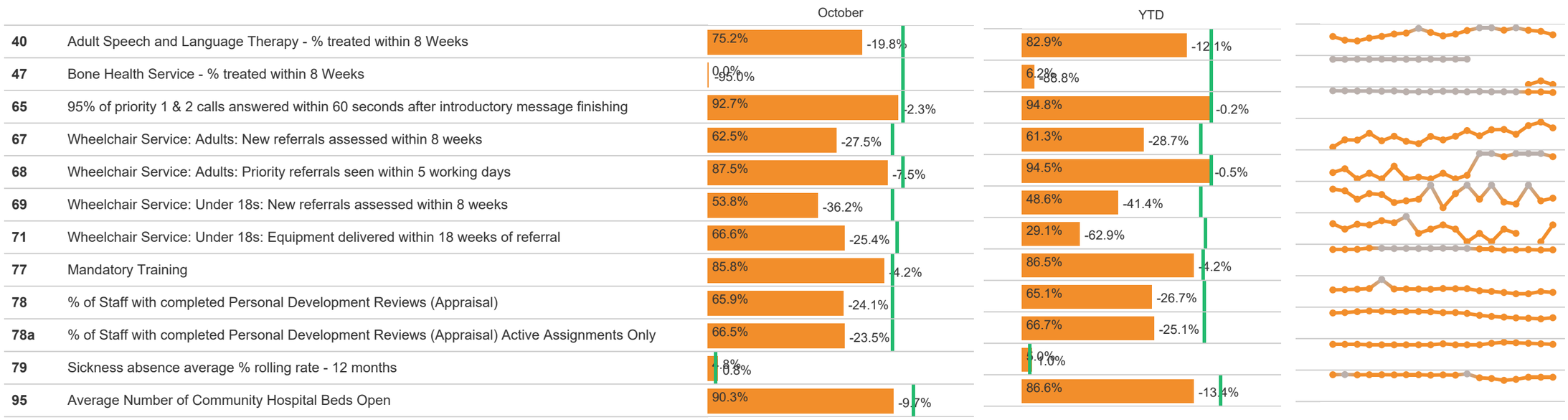
BFI (Baby Friendly Initiative) staff training updates continue via Teams video call and support recovery plan to ensure staff feel confident in supporting breastfeeding mums now staff have returned to work, and new staff are joining the service. Infant Feeding Lead Health Visitor has completed Staff BFI annual audits and is in the process of carrying out the annual BFI Mothers audits to help inform the BFI Health Visiting plan.

Performance Dashboard: *Physical Health - Local Requirements*

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Physical Health - Local Requirements



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

40: Adult Speech and Language Therapy - % treated within 8 Weeks
Performance was 75.3% in October 2020, this is below the threshold of the 95%. 24 out of 97 patients were seen outside the 8 week target.

These exceptions are due to current staff vacancies and therefore patients are experiencing longer waits for treatment. The waiting list profile at the end of October shows that 16.8% (48) of all patients were waiting longer than 8 weeks for a first contact from the service. Once the vacancies have been filled this KPI is set to improve. It was noted that one patient was awaiting a voice clinic which ceased in March due to Covid-19 and only recently recommenced.

47: Bone Health Service - % treated within 8 Weeks
In October, all of the patients (8) were seen but they were seen outside the 8 week target. The service reopened in August 2020 after being closed due to Covid-19 and have been seeing more patients by telephone (and video) which are currently not being captured in the data. The work to developed is underway. <u>This is below SPC Chart control limits.</u>

The service are clearing a backlog of referrals after reopening after the first wave, with 51% (200) of patients waiting over 8 weeks for treatment at the end of October. Delays in community hospital availability has slowed progress, however the service is making strides in reducing waiting times but a consequence of this work will be more breaches in the coming months.

The service has responded to the additional demand by changing their current working practices. Letters to patients are now giving them the option to attend a video/telephone appointment.

65: 95% of priority 1 & 2 calls answered within 60 seconds after introductory message finishing
1,205 out of 1,299 priority 1&2 calls (92.8%) were answered within 60 seconds compared to a target of 95%. <u>This is below SPC Chart control limits.</u>

SPCA currently has a reduced ratio of staff working on site due to Covid-19. This is compounded with a member of the team on long term sickness and a member of the team on redeployment. On site staff have to put incoming calls through to remote workers if they are already dealing with a call, which impacts on call waiting.

67. Wheelchair Service: Adults: New referrals assessed within 8 weeks
30 out of 48 (62.5%) of new referrals were assessed within 8 weeks, in October. This is below the target of 90%.

The Wheelchair Service has been working hard with the BI team to address data quality issues, and has in place a robust plan to establish further quality checks to verify and further improve this data. This work is reflected in the improved performance in historic (April to September) data.

October should be considered with caution as it has not yet been quality checked, specifically KPI exceptions, due to pressures in the service and annual leave so we expect these figures to improve once that work has been undertaken.

68: Wheelchair Service: Adults: Priority referrals seen within 5 working days

14 out of 16 (87.5%) priority referrals were seen within 5 working days in October. This is below the target of 95%

The Wheelchair Service has been working hard with the BI team to address data quality issues, and has in place a robust plan to establish further quality checks to verify and further improve this data. This work is reflected in the improved performance in historic (April to September) data.

October should be considered with caution as it has not yet been quality checked, specifically KPI exceptions, due to pressures in the service and annual leave so we expect these figures to improve once that work has been undertaken.

69: Wheelchair Service: Under 18s: New referrals assessed within 8 weeks
7 out of 13 (53.8%) assessments carried out in October did not meet the 8 weeks target.

The Wheelchair Service has been working hard with the BI team to address data quality issues, and has in place a robust plan to establish further quality checks to verify and further improve this data. This work is reflected in the improved performance in historic (April to September) data.

October should be considered with caution as it has not yet been quality checked, specifically KPI exceptions, due to pressures in the service and annual leave so we expect these figures to improve once that work has been undertaken.

71: Wheelchair Service: Under 18s: Equipment delivered within 18 weeks of referral
2 of the 3 (66.6%) equipment deliveries in October met the 18 week threshold (92%).

The Wheelchair Service has been working hard with the BI team to address data quality issues, and has in place a robust plan to establish further quality checks to verify and further improve this data. This work is reflected in the improved performance in historic (April to September) data.

October should be considered with caution as it has not yet been quality checked, specifically KPI exceptions, due to pressures in the service and annual leave so we expect these figures to improve once that work has been undertaken.

Additional Commentary for 67, 68, 69 & 71
The scorecard figures now show a higher number of first assessments which are now thought to be much more representative of service activity. There are further quality checks in place to verify and further improve this data.

100% performance for the adult and under 18 ‘urgent referral to assessment’ KPI, with the exception of June and a steadily improving trajectory for adult ‘routine referral to assessment’ KPI.

A fluctuating trajectory for under 18 ‘routine referral to assessment’ and ‘referral to handover’ KPI’s which will be an area for focus in the next 2 months.

No first assessments for under 18 urgent referrals took place in April, May, July, August or October. No under 18 first equipment handovers took place in August.

77: Mandatory Training
Performance was 85.9% in October 2020, higher than the previous five months, but continues to be below the target of 92%. There is increasing focus to improve compliance rates across the Trust in the coming months. Performance is outside of SPC chart normal variation based on 2018/19 data.

78: % of Staff with completed Personal Development Reviews (Appraisal)
Performance in October was 66% compared to a target of 95%. There is increasing focus to improve compliance rates across the Trust in the coming months. Performance is outside of SPC chart normal variation based on 2018/19 data.

78a: % of Staff with completed Personal Development Reviews (Appraisal) Active Assignments Only. Performance in October was 66.5% compared to a target of 95%. There is increasing focus to improve compliance rates across the Trust in the coming months. Performance is outside of SPC chart normal variation based on 2018/19 data.

79: Sickness absence average % rolling rate - 12 months
Performance is 4.9% compared to a threshold of 4% for the rolling 12 months to October 2020. Performance is outside of SPC chart normal variation based on 2018/19 data.

Additional Commentary for 77, 78, 78a and 79:
These figures show GHC totals rather than split between former 2G and GCS Trusts.

95: Average Number of Community Hospital Beds Open
The average number of beds open in Community Hospitals was 178 in October (compared to a bed stock of 196 beds) and is below SPC Chart lower control limits. This is due to reduced bed base as a result of social distancing on the wards in the wake of the Covid-19 outbreak. According to the service, there will be an increase in bed base when other covid-19 controls are in place from the end of October to stop the spread of the infection. This includes Perspex screens that will enable beds to be put back in the system and reduce the current 2m distancing rules. See also KPI no. 28.

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AGENDA ITEM: 20/1120

REPORT TO: **TRUST BOARD – 25 NOVEMBER 2020**

PRESENTED BY: Sonia Pearcey Freedom to Speak Up Guardian

AUTHOR: Sonia Pearcey Freedom to Speak Up Guardian

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

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

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

The purpose of this report is to

Provide assurance to the Trust Board:

- That speaking up processes are in place and remain open for colleagues to speak up, especially in these unprecedented times of Covid-19
- That speaking up processes are in line with national requirements
- That a positive speaking up culture is reflected in the health and wellbeing offer to colleagues.

Recommendations and decisions required

The Board is asked to:

- Note that Freedom to Speak Up processes are in place and continuing to be utilised by colleagues at these unprecedented times
- Agree to undertake a self-assessment to ensure compliance with the Guidance for Boards on Freedom to Speak Up in NHS trusts and NHS foundation trusts" updated published guidance July 2019.

Executive summary

All organisations which regulate or provide NHS healthcare should implement the principles and actions set out in the report Freedom to Speak Up: An independent review into creating an open and honest reporting culture in the NHS.

Within this paper, the results of the National Guardian Office publications, NHSE/I publications are presented alongside Trust information to provide national and regional comparisons.

42 concerns were raised in quarter 1 and 23 in quarter 2 with a concern raised by a health professional from another NHS Trust.

This paper also identifies planned actions and priorities for the Freedom to Speak Up agenda for the next six months.

Risks associated with meeting the Trust's values

All risks are clearly identified within the paper.

Corporate considerations	
Quality Implications	A positive speaking up culture within our workforce will ensure that patient safety matters are heard and that colleagues are supported.
Resource Implications	Specifics that are not being achieved are highlighted in the report
Equality Implications	Nil

Where has this issue been discussed before?
N/A

Appendices:	N/A

Report authorised by:	**Title:**
Sonia Pearcey John Trevains	Ambassador for Cultural Change/ Freedom to Speak Up Guardian Director of Nursing, Therapies and Quality

FREEDOM TO SPEAK UP GUARDIAN UPDATE

1. INTRODUCTION

1.1 This bi-annual report is to give assurance to the Trust Board that speaking up processes are in place and remain open for colleagues to speak up, especially in these unprecedented times of Covid-19.

1.2 This paper is presented in a structured format to ensure compliance with the "Guidance for Boards on Freedom to Speak Up in NHS trusts and NHS foundation trusts" updated published guidance July 2019 here.

2. ASSESSMENT OF FTSU CASES

2.1 Speaking up for Quarters 1 & 2 are detailed in Table 1. Speaking up for these periods have been received via different routes including colleagues through their managers, with advocates, online via Work in Confidence and directly with the Freedom to Speak Up Guardian. Some colleagues may also have raised more than one concern.

Table 1

Quarter	Number of concerns raised	Number of cases raised anonymously	Detriment	Speak Up again
Q1: April -June 2020-21	42	15	3	Yes-24 No-0 Maybe-2 Don't Know-1
Q2: July – September 2020-21	23	6	1	Yes-10 No Maybe-1 Don't Know

Colleagues speaking up for data comparison so far for 2020-21 compared to 2019-20 shows a marked increase.

At least half of colleagues have feedback that they would speak up again and the challenge is obtaining feedback from colleagues whether they have had a positive experience or not.

Reporting is submitted quarterly to the National Guardian Office and there has been a delay on submission of Quarter 1 and 2 data. The consolidation of the data for the year 2019-20 by the National Guardian Office was also delayed due to the

pandemic, although this has been published since the previous FTSU update to the Trust board. Some of the headlines include:

- Between 1 April 2019 to 31 March 2020, 16,199 speaking up cases were raised with Freedom to Speak Up Guardians. This was a 32 per cent increase compared with the previous year in which 12,244 speaking up cases were raised with Freedom to Speak Up Guardians
- Among NHS trusts, Freedom to Speak Up Guardians in mental health, learning disability and community trusts and ambulance trusts, on average, dealt with more speaking up cases
- Nurses continued to account for the biggest portion (28%) of cases raised with Freedom to Speak Up Guardians with administrative and clerical workers accounted for the next biggest portion of cases raised (19 %)
- 23% of cases raised with Freedom to Speak Up Guardians included an element of patient safety/quality. 36% included an element of bullying and harassment.

2.2 Themes

The Tables 2,3 & 4 below are further mandated data that is submitted to the National Guardian Office. Updated Guidance for Freedom to Speak Up Guardians Recording Cases and Reporting Data was published in October 2020 and the tables below reflect this change. Extra data reporting has been added regarding other themes and colleagues who declare a protected characteristic.

Table 2

Quarter	Number with an element of patient safety/ quality	Number with an element of bullying or harassment	Number with an element of other behaviours	Number with an element of systems and/or processes	Other	Ideas for learning and improvement
Q1: 2020-21	7	10	5	8	10	2
Q2: 2020-21	6	7	5	1	3	1

Table 3

Quarter	Worker	Manager	Senior Leader	Not disclosed	Protected characteristic
Q1: 2020-21	17	10	0	15	Disability-1 BAME-1
Q2: 2020-21	12	5	0	6	BAME-2

Table 4

	Q1: 2020-21	Q2: 2020-21
Allied Health Professionals	5	2
Medical and Dental	2	0
Ambulance (operational)	0	0
Public Health	0	0
Commissioning	0	0
Registered Nurses and Midwives	12	9
Nursing Assistants or Healthcare Assistants	0	3
Social Care	0	1
Administration, Clerical & Maintenance/Ancillary	4	1
Corporate Services	4	1
Other	0	0
Not known	15	6

When the 'Not known' is considered, this can include an instance when an individual has not disclosed their professional group to you, or where you dealing with an anonymous case.

Work in Confidence

Work in Confidence is a secure, independent platform where colleagues can raise any concern or improvement idea, day or night, with senior colleagues which is overseen by the Freedom to Speak Up Guardian. Work is ongoing with the developers of the system to be able to manage and report on all data raised through the Freedom to Speak Up Guardian. From the September 2020 colleagues are invited to disclose a either their ethnicity or disability. Table 5 below shows speaking up through this portal:

Table 5

Quarter	Number of contacts	Category
Q1: 2020-21	15	Patient safety concerns-2 Bullying & Harassment-2 Ideas for learning and improvement-2 Other -9
Q2: 2020-21	6	Patient safety concerns-3 Ideas for learning and improvement-1 Other-2

Speaking Up related to COVID-19

The National Guardian's Office has undertaken three Pulse surveys with Guardians to measure the impact which COVID-19 is having on Freedom to Speak Up. The third survey results can be found here and headlines include:

- 79% cited safety and wellbeing as the type of issue raised but behavioural issues are being raised by 74%, up from 57% in the last pulse survey
- Social distancing has taken over from PPE as the top concern raised
- The impact of COVID-19 on Black, Asian and Minority Ethnic colleagues, Guardians say that more are speaking up about this (46%)
- Freedom to Speak Up in the recovery phase - 56% of Guardians reported that they were not involved in the recovery discussions

COVID-19 related themes raised within GHC include:

- Lack of social distancing
- Accessing health and wellbeing support
- Inappropriate use of Personal Protective Equipment
- Home working discouraged
- Payment of a member of bank staff
- Redeployment
- Feeling bullied when did speak up to a manager
- Lack of health and wellbeing support
- Poor social distancing
- Inappropriate behaviours and negative team culture

3. PATIENT SAFETY AND/OR WORKER EXPERIENCE FEEDBACK

Feedback is requested from all colleagues and as highlighted above the challenge is obtaining feedback from colleagues whether they have had a positive experience or not. Some feedback from colleagues is below.

- Just to say thank you for making time out to speak to me yesterday. I found our chat very helpful and I do appreciate your support. Yes, I think I will speak up. But hopefully there won't be a need to.

- On reflection, I'm still unclear what the learning outcomes were for frontline staff, however I feel confident given my conversation with …. that the concerns have been addressed. Thank you for your email and detailed response.

- Thank you so much for all your help. That's really good to hear. I worry that I have come into an environment that does not consider change lightly, I came to the NHS to enjoy my work and hopefully be successful. Thank you again for all your help, sorry about my waffling... hopefully it does seem as though things are improving and maybe it will just take time.

- I am of course glad to hear that some positive action has been taken to improve the culture at …. for staff and patients. I am not concerned to know what these actions are, as I believe my responsibility was just to let you at the Trust know what was happening.

4. ACTIONS TAKEN TO IMPROVE THE SPEAKING UP CULTURE

To create a positive speaking up culture, colleagues need to know how to speak up and to whom. Work continues to further improve the speaking up culture especially during these times where speaking up is more important than ever. The following builds upon previous significant work.

- **Continued and targeted communications** - Regular messaging through the communications to reinforce the message that speaking up is welcomed and colleagues will always have access to the support needed. Speaking Up is located within the Staff Health and Wellbeing section ono the intranet. Learning from speaking up is feedback to the Health and Wellbeing hub and inform priorities.
- **Work in Confidence** - All colleagues can access Work in Confidence; a safe, independent, anonymous and confidential web-hosted system on our intranet page. As highlighted work is ongoing with the developers to support data recording in line with national guidance and a new case management system is available for use within our existing licence.
- **Board Development Session –** In October 2020 alongside Dr Habib Naqvi, Director of the newly launched NHS Race and Health Observatory, the Freedom to Speak Up Guardian led a session to update the Board of Directors on Freedom to Speak Up, Civility Saves Lives with a focus on how we can improve psychological safety for those speaking up.
- **Diversity Networks** - To continue to facilitate fruitful discussions and engagement**.** For those colleagues who attend the groups, to provide a safe space where they can share their experiences and challenges of being from different cultural backgrounds.
- **National Speak Up Month 2020** - In October we had a successful #SpeakUpABC campaign promoting a healthy working environment and having a voice. Colleagues from within the organisation shared 'What does Freedom to Speak Up mean to you?' Speaking Up has increased and there was lots of feedback from colleagues including how they would like to support speaking up and cultural change.
- **Senior Leadership Network** - Dr Henrietta Hughes the National Guardian for the NHS attended the Senior Leadership Network this month and discussed detriment in speak up and how as an organisation we take Freedom to Speak Up to the next level.
- **Freedom to Speak Up training for all workers** - October 27th was the national launch of the Freedom to Speak Up e-learning package for all healthcare workers. Speak Up (All), Listen Up (Managers), Follow Up (Senior Leaders) has been developed in association with Health Education England. There will be supported communications in the next week or so and will be available for anyone who works in healthcare, including volunteers and students.

5. LEARNING AND IMPROVEMENT

Since the last reporting period there has been a new case review published and the review identified areas of improvement regarding how the trust responded to speaking up cases raised by its workers. These included workers not being thanked for speaking

up, delays in responding to matters raised and the need to provide better support and information. From the review findings and actions in response following a gap analysis the following will be further developed:

- ICS Guardian network to be strengthened
- The eLearning platform for the new worker training to ne hosted in Care to Learn. This includes a link to the National Guardian Office website on the intranet
- There is guidance from the NGO and NHS Improvement (NHSI) in relation to the Freedom to Speak Up function at all levels of our Trust. The NHSI board guidance sets out the role of the board and supplemental guidance sets out specific responsibilities of directors
- Review of exit interview process with the retention team to gain further assurance that the Freedom to Speak Up Guardian will be informed when the feedback references the role
- The Freedom to Speak Up Guardian will review the staff feedback questions to include the question 'Were you thanked for speaking up?'
- The development of a new service was reviewed and positive actions to improve the support to staff and their ability to fulfil the role and outcomes this is continuing from the last reporting period
- Further training to support the appropriate use of Personal Protective Equipment
- Review of social distancing within clinical sites and at multi-disciplinary team meetings
- Lessons from redeployment have been feedback through surveys
- Enhanced communications to enable colleagues to access health and wellbeing support
- The use of Police restraint with people with mental health problems during a psychiatric emergency
- Sharing '100 Voices' across the organisation so colleagues can describe their experiences of speaking up, the impact this has had and how it has led to positive change.

6. Recommendations

Within the next 6 months, dependant on the current health landscape, recommendations are made that the following work will be conducted to ensure further development of positive speaking up approaches in the organisation:

- Scope and progress the development of the Board Self Review Tool and an implementation plan of the Freedom to Speak Up strategy in line with the strategic aims of the Trust
- Civility Saves Lives - This is a grass roots campaign aimed at raising awareness of the impact of incivility on team and individual performance. Incivility and rudeness is surprisingly common and on the rise, thus patient safety outcomes are affected and there is a negative impact on clinical performance. The proposed programme promotes our Trust values, strategic ambitions and unify ongoing transition work as a new organisation

- Following the publication of the Staff Survey analyse the Freedom to Speak Up Index data to determine further priorities
- To lead on embedding serious incident learning to ensure compassionate leadership and just culture approaches are key
- Support and have a regular presence at the planned development of staff diversity networks and work collaboratively with the Equality, Diversity and Inclusion Lead. The NHS People Plan also emphasises the importance of a

  compassionate and inclusive culture where every voice matters and counts. In relation to the Freedom to Speak Up agenda there are specific actions and references:

  1. By March 2021, NHS England and NHS Improvement will launch a joint training programme for Freedom to Speak Up Guardians and Workforce Race Equality Experts
  2. Recruitment of more Black, Asian and Minority Ethnic staff to Freedom to Speak Up Guardian roles, inline with the composition of the NHS Workforce.

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 21/1120

Report to:	**TRUST BOARD – 25 NOVEMBER 2020**
Author:	Lavinia Rowsell, Head of Corporate/Trust Secretary
Presented by:	Lavinia Rowsell, Head of Corporate/Trust Secretary
SUBJECT:	**PROPOSED CHANGES TO CONSTITUTION**

Can this subject be discussed at a public Board meeting?	**Yes**

This report is provided for:

Decision ☑ Endorsement Assurance Information

The purpose of this report is to:

Take forward the required revisions to the Constitution to reflect the agreed change in composition of the Council of Governors following the Review and Refresh work.

Recommendations and Decisions Required:

The Board is asked to **APPROVE** the amendments to the Trust Constitution as presented as an appendix to this report.

Executive Summary

As part of the recent Review and Refresh work, the Council of Governors supported the proposals around changes to the composition of the Council, in particular with regard to the reduction in Staff Governor positions and an increase in Appointed Governor posts.

During the merger process in 2019 it was agreed to increase Staff Governor numbers to enable representation from the former Gloucestershire Care Services Staff. Following the reduction of public governors with the Herefordshire Constituency ceasing, the ratio of staff to public constituencies was now significantly out of proportion in comparison to other Trusts reviewed.

The Council, whilst recognising the valuable contribution of Staff Governors also recognised the need to ensure that Public Governors are in the majority, in line with Foundation Trust requirements, supported the proposal to reduce the number of Staff Governors to 7 from the existing 10.

The Council had discussed the current overall size of the Council (25 representatives), noting that this supported effective functioning, enabled governors to be able to discuss and debate effectively, supported meaningful participation and provided sufficient number and ability to complete the role, without the role becoming burdensome. On this basis it was agreed the current size of 25 should be maintained.

It was recognised that ensuring the Council of Governors reflected a breadth of voices was important, and that in the short term increasing the number of Appointed Governors to 5 should help ensure this. With the aim of maintaining the current size of the Council, the additional 3 Appointed Governors would be phased in as the Staff Governor constituency changes were enacted. Once determined, the additional Appointed Governors would be formalised through a further change to the Constitution.

To reflect the changes set out above, amendments are required to the Trust Constitution and these changes are set out in Appendix 1.

The approval of the revised Constitution is a two-stage process which requires
(i) approval of the Council of Governors and
(ii) the Board
(more than half the members of both bodies).

The revised Constitution will then be updated to the Trust's website and to NHSI.

The equivalent paper to this one was considered by the Council of Governors at its meeting on 19 November 2020.

These changes do not preclude further changes following the work of the review and refresh strands of work.

Risks associated with meeting the Trust's values

Corporate considerations	
Quality Implications	None
Resource Implications	None
Equality Implications	None

Where has this issue been discussed before?
Council of Governor meetings

Appendices:	Appendix 1 – Proposed amendments to the Constitution - Annex 2 & 3 – November 2020

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

APPENDIX 1 **AGENDA ITEM 21/112020**

ANNEX 2 – THE STAFF CONSTITUENCY

Name of Staff Class	Description	Minimum no. of members	Number of governors
the medical dental and nursing staff class	Staff who are registered with the General Medical Council; or Staff who are registered with the General Dental Council; or Staff who are registered with the Nursing and Midwifery Council	100	3
the health and social care professions staff class	Staff who are either: allied health professionals and psychologists who are registered with the Health and Care Professions Council or any successor body; or social workers registered with the Health and Care Professions Council or Social Work England, or any successor body; or individuals who are employed wholly or mainly in direct clinical and care roles but not eligible for membership of those classes described above	100	2
the management, administrative and other staff class.	individuals who are management or administrative staff or others entitled to be members of the staff constituency who do not come within those classes described above	100	2

ANNEX 3 – COMPOSITION OF COUNCIL OF GOVERNORS

1.1 The Trust will have a Council of Governors consisting of public, staff and appointed governors.

1.2 The Council of Governors is to comprise:

Elected Governors:

Category of Governor	Number of Governors
Public governors:	
• Cheltenham	2
• Cotswold	2
• Forest	2
• Gloucester	2
• Stroud	2
• Tewkesbury	2
• Greater England and Wales	1
Staff governors:	
• Medical Dental and Nursing staff class	3
• Health and Social Care Professions staff class	2
• Management, administrative and other staff class	2
Appointed governors:	
• Gloucestershire County Council	1
• Gloucestershire Clinical Commissioning Group	1
• Additional Appointed Governors*	Up to 3
Total	**25**

** Additional appointed governors will be introduced in a phased approach in line with the changes to the staff governor numbers to ensure that the public governor cohort is the majority on the Council in line with the requirements of the constitution*

1.3 Subject to paragraph 1.4 below, of the three (3) Staff Governors in the Medical Dental and Nursing class:

1.3.1 one (1) seat shall be reserved for a nurse;

1.3.2 one (1) seat shall be reserved for a doctor; and

1.3.3 one (1) seat shall be reserved for either a doctor or a dental professional.

1.4 The electoral constraints set out herein will apply to all Staff Governor seats in the Medical Dental and Nursing staff class, regardless of the number of Staff Governors being elected from that staff class at any particular time.

GLOUCESTERSHIRE HEALTH AND CARE NHS FOUNDATION TRUST
COUNCIL OF GOVERNORS MEETING
Wednesday 16 September 2020
Held via Microsoft Teams

PRESENT:	Ingrid Barker (Chair)	Nic Matthews	Anneka Newman	Sarah Nicholson
	Brian Robinson	Anne Roberts	Jo Smith	Mervyn Dawe
	Faisal Khan	Katherine Stratton	Julie Clatworthy	Dan Brookes
	Chris Witham	Graham Hewitt	Tracey Thomas	Dawn Rooke
	Ruth McShane	June Hennell		

IN ATTENDANCE: Maria Bond, Non-Executive Director
Marcia Gallagher, Non-Executive Director
Anna Hilditch, Assistant Trust Secretary
Sumita Hutchison, Non-Executive Director
Jan Marriott, Non-Executive Director
Angela Potter, Director of Strategy and Partnerships
Paul Roberts, Chief Executive
Lavinia Rowsell, Head of Corporate Governance
Neil Savage, Director of Organisational Development
Gillian Steels, Trust Secretary Advisor (Item 11)
Wenna Tudor, Communications Manager

1. WELCOMES AND APOLOGIES

1.1 Apologies were received from Karen Bennett, Jenny Hincks, Said Hansdot, Katie Clark, Alison Feher and Juanita Paris.

1.2 Ingrid Barker welcomed everyone to the meeting, with a special welcome to the newly appointed Public Governors who had taken up post on 7 September.

2. DECLARATIONS OF INTEREST

2.1 Chris Witham informed the Council that he was the Chair of Cinderford Town Council, and as such would be involved with land transactions for the new Forest of Dean Hospital development.

2.2 Julie Clatworthy declared a professional interest in relation to her membership of the NICE QSAC 2 group.

3. MINUTES OF THE PREVIOUS MEETING

3.1 The minutes from the previous meeting held on 17 June 2020 were agreed as a correct record.

4. MATTERS ARISING AND ACTION POINTS

4.1 The actions from the previous meeting were either complete, on-going or included on this meeting's Agenda.

4.2 Mervyn Dawe made reference to the Staff Survey information session that had been held for Governors in August. He said that this had been a useful session; however, he expressed concern that more work wasn't being carried out to look at the result from the survey that a third of staff had stated that they wished to leave the Trust. Neil Savage advised that overall both organisations had done well, noting that the survey presented the results from both legacy organisations, 2gether and GCS. In terms of the Staff Friends and Family Test question of "whether or not you would recommend the place as somewhere good to work" - 70% of ex 2gether colleagues said 'yes' which was an improvement since 2015 of 6%, with 61.8% of former GCS colleagues recommending the Trust, an improvement of 10.7% over the GCS score in 2015. In relation to those thinking of leaving the organisation, it was important to note that the survey was conducted at the time of phased Management of Change processes and right in the middle of the merger in October. The results for 2gether colleagues was 30% which is in line with the average for mental health trusts. The results for GCS colleagues was also 30% which again was in line with the national community Trust average. Paul Roberts informed the Council that the Trust Board had identified staff engagement and morale as one of its top priorities going forward. A number of actions had been put in place already in response to the staff survey action plan, including the setting up of a health and well-being hub, a new Diversity Network (and 4 subgroups), and a new leadership development programme, all aiming to improve experience. Paul Roberts advised that this year's Staff Survey would be carried out in October, with the results published early in the new year. This would be the first survey carried out as one organisation so it would be interesting to see the results.

5. CHIEF EXECUTIVE'S REPORT

5.1 Paul Roberts, Chief Executive presented a verbal report to the Council.

Coronavirus update

5.2 The Council noted that the Covid Response Programme had been a dominant part of the Trust's work since February 2020. Paul Roberts advised that GHC had 400 beds in total, spread across community hospitals, and mental health and learning disability units. At the height of the pandemic, there were 100 Covid positive patients being cared for by the Trust. Trying to manage positive patients, those awaiting test results and negative patients in the same inpatient setting was very challenging; however, this was managed through identifying new ways of working and use of technology.

5.3 Paul Roberts informed the Council that between July to September, the Trust has been focussed on Recovery and the reestablishment of Trust services, noting that due to Covid some services had been scaled back or closed to new referrals. A key workstream has been the Covid Secure Environment which has been risk assessing the Trust estate and working environment to ensure that we can operate from Covid secure facilities, for the safety of both our staff and patients. It was noted that the impact of this had reduced capacity in a number of services due to more spaced out appointments and time for staff to prepare the necessary PPE.

5.4 It was noted that GHC provided staff testing facilities for local NHS and Social Care organisations, with an additional service being provided for elective patients.

5.5 The Trust's normal financial arrangements were suspended to the end of September due to Covid. New guidance has now been issued from NHSI/E for the latter 6 months of the year.

5.6 As part of the scaling back of services to manage Covid, the Trust closed 3 of its MIIUs (Minor Injuries and Illness Units). Tewkesbury had now reopened, a review of the Vale was

underway and the Dilke would remain closed for the current time. It was noted that these changes were likely to be in place until the end of March 2021.

5.7 Paul Roberts informed the Governors that focus has now moved to surge and wave 2 planning,

5.8 In response to an earlier question from Chris Witham, the Council noted that the Trust had issued very clear communications to staff to work from home, if they were not in a direct care role. There had been a huge amount of communication, guidance and support to enable this to happen, including risk assessments. It was expected that this guidance would be in place until the end of March 2021. With so many staff members now working from home, the use of technology has become even more important and a full review of the impact of news ways of working would be carried out.

5.9 Dawn Rooke asked whether visiting was now permitted for patients on inpatient wards. Paul Roberts advised that the Trust had used compassionate exceptions and had given the freedom to the hospital Matrons to make individual decisions. In July, more access was given for visiting but there were still some restrictions to this in place as it was vital that it could be done safely. He said that the Trust had tried to respond to issues around visiting in a compassionate and flexible way.

5.10 Graham Hewitt said that his charity had been providing more support to individuals for health care purposes that couldn't be given via online means. He therefore asked whether the Trust had a timeline for when services would be back up and operational. He also queried whether the thresholds for receiving certain health care services had changed. Paul Roberts advised that due to Covid, community staff and therapists were redeployed to inpatient posts. Staff are now returning to their substantive roles and hands on care was being provided with precaution. In mental health services, teams had been asked to carry out a review of caseloads. Paul said that he would welcome feedback on any areas of concern or potential gaps in the services available as this would assist with the Trust's recovery planning. Julie Clatworthy advised that a Gloucestershire wide Rehabilitation Steering Group had been set up, looking at the post-Covid cohort and the ongoing physical and mental health needs. As part of this, a scoping exercise was being carried out to see if there were any gaps in services.

People Plan

5.11 The Council noted that "We are the NHS: action for us all" was published of the end of July 2020 by NHS England/NHS Improvement & Health Education England. This sets out what NHS staff can expect from their leaders, their employers and each other. The Plan builds on previous interim NHS plans and the central themes of more staff, working differently and a compassionate & inclusive culture. It also includes a brand new "Our People Promise" which sets out national ambitions for what people working in the NHS will ideally say about it by 2024. Paul Roberts said that the plan chimed well with the Trust's priorities of looking after our staff and belonging.

5.12 Nic Matthews made reference to policy creation and culture, noting that the Trust needed to support staff with the same humanity as it did for service users. He suggested that any future policy reviews take this into account. In terms of developing staff, there were a number of clinical staff who wished to develop but to remain in clinical facing roles; however, national focus seemed to be on management and leadership roles. Paul Roberts supported these points, noting that the People Plan and Advancing Clinical Practice (ACP) plans would provide longer term options for a wider skill mix for clinical colleagues.

5.13 In terms of moving forward, the Council noted that the Trust's Resources Committee would lead on the People Plan and its implementation. Chris Witham offered his assistance with the delivery of parts of the People Plan through his role at NHSE.

6. FOREST OF DEAN HOSPITAL DEVELOPMENT

6.1 Angela Potter, Director of Strategy and Partnerships gave the Council a presentation setting out the background and the progress to date with the Forest of Dean Hospital development. A copy of the presentation would be shared with all Governors after the meeting.

6.2 The programme originally commenced with engagement in 2015. The key drivers for change were safe staffing, the need to replace old and unsustainable estate and the bringing together of the services at Dilke and Lydney. The Case for Change was signed off in July 2017 and several previous consultation exercises were carried out and decisions made to move to a new hospital and the preferred site location. In January 2020, a programme of public and staff engagement was carried out and the outcomes shared at the Health Overview & Scrutiny Committee. Some of the key themes of engagement included inpatient services & bed numbers, access to consistent urgent advice and treatment, transport, access to GPs out of hours (OOH) to support urgent care OOH and ongoing provision of outpatients and diagnostics.

6.3 Mervyn Dawe noted that the proposed bed provision for the new hospital was 24 and queried what the current provision was across the 2 hospitals. Angela Potter said that the Trust was currently operating out of 30 beds due to Covid restrictions, however, the normal operating level was 47. Julie Clatworthy assured the Council that the remodelling had considered those people in the forest locality who would need the beds, looked at previous usage and ways of working to be able to treat people in their own homes rather than having to stay in hospital.

6.4 Mervyn Dawe noted the plans for single rooms in the new hospital, but this raised concerns around isolation and vulnerable people getting lonely. Angela Potter said that the Trust was very aware of the importance of this and consideration had been given to supplementing hospital stays with daily activities.

6.5 Dawn Rooke highlighted the concerns around transport to the hospital, something that always needed consideration in the forest.

6.6 A public consultation exercise would commence on 23 October and run until 17 December. Ingrid Barker encouraged all Governors to participate. Ruth McShane noted that she lived in Herefordshire but was registered with a Gloucestershire GP and asked therefore whether she and other people in the same position would miss out on being consulted. Angela Potter confirmed that cross border population had been taken into account and had been built in to the consultation programme.

7. REPORT FROM THE NOMINATIONS AND REMUNERATION COMMITTEE

7.1 Faisal Khan, Lead Governor presented this report to the Council, summarising the key business conducted at the meeting of the Nominations and Remuneration Committee held on 1 September and setting out 2 key recommendations for approval.

7.2 **Non-Executive Director Appointment** - Steve Brittan was appointed as an Associate Non-Executive Director of the Trust on 18 May 2020. Due to the Covid-19 pandemic and requirement for social distancing, initial interviews for the position took place remotely via Microsoft Teams. As it was not possible at the time to conclude the interview process the decision was taken to offer the role on an Associate Non-Executive basis with a view to

commuting it to a standard Non-Executive Director appointment once the process could be completed. Since his appointment, Steve has been actively engaging in his induction programme and been a regular attendee and contributor to Board, Committee and strategy development sessions. The final stage of the interview process took place on Wednesday 26 August 2020. This included three focus group discussions with experts by experience/service users, colleagues/staff, and governors. Written feedback was received from all groups and the feedback received from participants was highly positive about Steve's experience, skills and approach to their discussion sessions, noting that he would add value to the Board. Based on the outcome of the final stages of the interview process, the N&R Committee recommended to the Council of Governors the appointment of Steve Brittan as Non-executive Director of the Trust for an initial three year term from 16 September 2020. This recommendation was approved.

Ingrid Barker left the meeting at this point

7.3 **Reappointment of the Trust Chair** - It was noted that the performance of the Chair had been reviewed by the Committee at its meeting in June 2020 where an extremely positive appraisal report was received. Good progress was being made around the development and refresh of the Council of Governors and the Chair had been instrumental in pushing for this which was very much welcomed. From a strategic point of view, the Committee agreed that following on from the merger and Covid, continuity of leadership at Board level was critical. The N&R Committee therefore recommended the reappointment of Ingrid Barker as Trust Chair for a final three year term from 1 January 2021 to 31 December 2023. This recommendation was approved.

Ingrid Barker returned to the meeting at this point

7.4 The Committee received a table which set out the appointment, reappointment and retirement dates of all Non-Executive and Associate Directors. The information on appointments and understanding NED reappointment intentions is a crucial part of succession planning for the Board and its wider governance arrangements. As part of the merger discussions, it was agreed by the Nomination and Remuneration Committee to stagger the appointment dates of Directors to ensure a phased and manageable turnover at Board level and a progressive refreshing of the Board. Further discussion regarding NED appointments would take at the Committee's next meeting on 3 November, which would include an annual skills audit of the Board to feed into wider discussion on succession planning and to help identify any gaps.

7.5 Faisal Khan informed the Council that he had made the decision to stand down as a Staff Governor, and Lead Governor when his first term ended on 31 December. He said that being a Trust Governor had been a huge learning experience and he had valued having had the opportunity to represent the Trust in this way.

8. DEVELOPING OUR TRUST STRATEGY

8.1 Angela Potter provided the Governors with a presentation, updating on progress with developing the Trust's strategy. The presentation would be circulated to all Governors after the meeting.

8.2 The presentation set out the key timeline of consultation and engagement with stakeholders, and it was noted that sadly work had not progressed as quickly as had been planned due to Covid. However, work had now recommenced. Angela Potter advised that work would take place over the next 6 months to:

- Communicate what we have done so far and continue to test out and listen to our staff and stakeholders
- Continue to refine our strategic aims

- Develop our Strategic Objectives and Outcome measures
- Develop our risk appetite and ongoing refinement of our Board Assurance Framework
- Develop the Enabling and Underpinning Strategies and programmes of work
- Align to our Business Planning processes

8.3 The Council received an overview of the draft strategic aims and objectives. Brian Robinson noted that currently only one of the objectives was outcomes focussed and suggested that more needed to be included. Angela Potter agreed, adding that this was work in progress and the Trust was aware of the importance of having outcome based measures. It was noted that the Board had held a development session the previous day focussing on the development of the Trust's strategy and there was a lot of work still to do.

9. CHAIR'S REPORT

9.1 The Council received the Chair's Activity Report. It was noted that this report had been written and presented to the Trust Board at their 22 July meeting and was presented to the Council for information and reference. This report and its content was noted.

10. GOVERNOR MEMBERSHIP AND ELECTION UPDATE

10.1 Anna Hilditch presented this report which provided an update on the current membership of the Council of Governors, an overview of vacant Governor positions, and future election requirements. The Council received a summary of statements from the newly appointed Public Governors who had commenced in post on 7 September 2020. The report also made reference to 3 Public Governors who had left since the last Council meeting - Vic Godding, Stephen McDonnell and Bren McInerney. Ingrid Barker led the Council in expressing its warmest thanks to them for their work, support and expertise over the past years, and wishing them all well for the future. This report was noted.

11. GOVERNOR REVIEW AND REFRESH UPDATE

11.1 Work was ongoing to support the Council of Governors' development to reflect its revised remit as the Council of Governors for a Trust which now has a remit in physical health as well as mental health services and a Trust which is committed to transforming the way it meets the needs of its communities. As an integral part of the Trust's governance it is important that the Council of Governors is informed by best practice in its operation and best use is made of the Council and the time given by the governors to support continuing good governance.

11.2 Following agreement at the June Council meeting, a working group was set up, chaired by Ingrid Barker which met several times over the summer and included public, staff and appointed governors, as well as a number of Non-Executive Directors and individuals from the Trust Secretariat and Comms Team. The working group focussed on 2 key areas – the Constitution and Membership.

11.3 This report presented the output from the working group discussions and set out a range of proposals and recommendations including changes to the size and composition of the Council, Membership, supporting Governor engagement, ways of working and Governor development.

11.4 One of the key recommendations related to the change in Council composition. The Trust would look to maintain the size of the Council of Governors at 25 members, but reduce the

Staff Governors to 7 (from 10, in line with other Trusts) and increase the Appointed Members to 5 (from 2) to ensure a breadth of diversity of voices are heard whilst a comprehensive Membership and Engagement Strategy is developed and implemented. As part of this, a skills audit had been developed and would be sent out to all Governors for completion. It was hoped that the outcome of this would help inform us of those areas where additional expertise and knowledge would be required within the Appointed Governor category. Faisal Khan advised that this recommendation had been discussed at the Governor pre-meeting. He said that Governors had supported the change in composition, but further discussion was needed as to the best way to get there. The Council of Governors formally approved the proposed change in composition, and it was agreed that further discussion take place as to the process for enacting this. The Council was asked to note that this change would require a change to the Trust's Constitution, and as such an amended section of the Constitution would be presented back to the Council, and the Trust Board in November for final approval. Graham Hewitt suggested that the change around the Appointed Governors would need to be flexible to allow for short term appointments if the Trust was looking to refresh these roles over time. This was agreed and would be considered in the revision.

ACTION: Governor Skills Audit to be circulated for completion, to help identify any gaps in knowledge and expertise which could be helpfully filled by Appointed Governors

ACTION: Trust Constitution to be amended re: composition of the Council of Governors, with a report back at the November meeting for approval

11.5 Nic Matthews had participated in the working group and he thanked Gillian Steels for this report which was comprehensive and clear, adding that he felt this had been a helpful and inclusive process.

11.6 Ruth McShane noted that the Greater England and Wales constituency had the second highest membership and queried whether consideration should be given to an additional Governor representing this area. Wenna Tudor advised that the GE&W constituency now included the Herefordshire Public members. She suggested that it would be worth waiting for a further 6 months as membership of this constituency could potentially reduce in line with the transfer of Herefordshire services to Worcestershire at the end of March.

11.7 The Council welcomed this report and the work carried out and progress made to date. The other recommendations within the report were supported, including the development of a Membership and Engagement Strategy.

12. TRUST MEMBERSHIP REPORT

12.1 This report provided an update on Trust membership to the Council, and included recent membership engagement activity and membership data.

12.2 As of 9 September 2020, the Trust had 6,039 Public members. From 1 April 2020, all Herefordshire members were moved to the Greater England and Wales constituency, following the transfer of Herefordshire services out of the Trust.

12.3 Due to Covid, the Trust has not been able to hold any face-to-face membership or Governor events; however, we have continued to recruit new members. This has primarily been achieved through the use of Trust social media, with an increase in applications after posts are made. The Trust continued to communicate with members through email about issues that might be of interest to them, keeping them up-to-date with the Trust's work around Covid, and sharing information that could support their wellbeing. A membership newsletter was

produced and sent out to all members, either by post or by email. As well as Trust updates, this also included details of the Trust's Covid response.

12.4 Mervyn Dawe asked whether the Trust still provided information to staff members who were leaving the Trust, about signing up to become a Public member on their departure. Wenna Tudor advised that staff did receive a letter and membership form; however, she agreed to speak to colleagues in the HR team to confirm that this still took place.

ACTION: Check to be carried out to ensure that leaving staff members received information about signing up as a Public member

13. TRUST ANNUAL MEETING 2020

13.1 The Council was reminded that the Trust's Annual Meeting would be taking place on Thursday 24 September. Due to Covid this would be taking place virtually at 5.00 – 6.00pm. All Governors were encouraged to attend. The invitation and link to register for the meeting would be recirculated.

ACTION: Invitation and link to join the Trust's AGM to be recirculated to all Governors

14. GOVERNOR ACTIVITY UPDATES

14.1 June Hennell reported back from the Quality Committee meeting that she had attended as an observer on 1 September. She advised that this had been a very interesting meeting and had been well chaired by Maria Bond.

14.2 Faisal Khan said that a discussion about the presentation of service updates to the Council meetings had taken place at the earlier pre-meeting. It had been agreed that it would be helpful to have a service focussed presentation at alternate meetings, and that these should be scheduled to take place at the end of the agenda. This suggestion would be built in to the Council of Governor annual work plan.

15. ANY OTHER BUSINESS

15.1 There was no other business.

16. DATE OF NEXT MEETING

16.1 The next meeting would take place on Thursday, 19 November at 2.30pm.

COUNCIL OF GOVERNORS
ACTIONS

Item	Action	Lead	Progress
17 June 2020			
3.2	Briefing for Governors on Out of County Placements to be prepared and presented at a future meeting	John Trevains	Due to current Covid workload commitments, this item will be scheduled for an early 2021 Council meeting.
16 September 2020			
11.4	Governor Skills Audit to be circulated for completion, to help identify any gaps in knowledge and expertise which could be helpfully filled by Appointed Governors	Anna Hilditch	**Complete**
11.4	Trust Constitution to be amended re: composition of the Council of Governors, with a report back at the November meeting for approval	Gillian Steels	**Scheduled** Report is scheduled for presentation at the November 2020 Council meeting
12.4	Check to be carried out to ensure that leaving staff members received information about signing up as a Public member	Comms Team	**Complete** Due to a change in HR system in early 2020, between 1 Feb and 21 Sept 2020, 348 people left the Trust who did not receive the public membership form. Letters have now been sent to those leavers, and the process of inviting people to become public members when leavers questionnaires are sent out has been reinstated.
13.1	Invitation and link to join the Trust's AGM to be recirculated to all Governors	Anna Hilditch	**Complete**

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NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 23/1120

RESOURCES COMMITTEE SUMMARY REPORT

22 OCTOBER 2020

COMMITTEE GOVERNANCE	• Committee Chair – Graham Russell, NED • Attendance (membership) – 7 of 9 members present • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

FINANCE REPORT

The Committee received the Finance Report for month 6 and noted that the Trust had achieved and exceeded its Cost Improvement Plan (CIP) target for the year. The Committee expressed its thanks and congratulations to colleagues and their teams for their efforts in contributing to the delivery of CIP.

The Trust's capital position remained challenging; however, the forecast outturn was being monitored closely by the Capital Management Group and NHSI/E had been informed that the Trust would meet the capital plan. The 20/21 Capital plan was approved at £9.945m, with an additional £100k for critical backlog maintenance and £137k for Covid capital. Spend to month 6 was £1.03m.

The Committee also received a verbal report on the updated Financial Regime and a briefing in relation the current system financial position.

PERFORMANCE REPORT – MONTH 6

The Committee received the Performance Report for month 6 and it was noted that there had been an improvement with fewer exceptions highlighted for the period, with 7 MH indicators and 17 PH indicators in exception. Services felt that they were now bringing things to a new normal position from a performance, engagement and narrative perspective. The Committee received assurance that the Trust was on track to achieve fully integrated reporting by the end of the financial year.

LOCAL SYSTEM BEST PEOPLE STRATEGY

The Committee noted the updates on the ICS People Plan response and regional and ICS governance and support arrangements. A significant amount of active partnership working had taken place with system colleagues to carry out an initial response to the NHS People Plan. Those areas for further development had been identified and would be taken forward within the System.

Sumita Hutchison, NED, was identified as the Board's Health and Well-being Guardian.

The Committee discussed the innovations and positive ways of working with the ICS, with increased collaboration and sharing between organisations. There had been a lot of positive feedback received on the Trust's Health and Wellbeing message to staff and there were some exciting opportunities around leadership development.

STAFF ENGAGEMENT UPDATE

The Committee received an update on Staff Engagement and the Staff Survey, noting that the response rate on the staff survey had exceeded previous years in both legacy Trusts and there still remained a further 5 weeks before closing.

It was acknowledged that colleagues with disabilities had reported that they did not feel that they could speak up as freely. This was being addressed with proactive and positive action being taken to update a range of attendance management and occupational health working well policies.

A Health and Well-Being Hub newsletter would be circulated to colleagues in the next week and this would focus on reminding staff to take their annual leave and providing guidance and tools to assist colleagues in maintaining their health and well-being.

BUSINESS DEVELOPMENT REPORT

The Committee received the Business Development report which highlighted the increase in activity happening post the first wave of Covid.

The Trust had received an invite to discuss with commissioners the tenders to provide the Sexual Offence Examiners (SOE) and the Sexual Assault Referral Centres (SARCs). This meeting would take place 12th November 2020.

The Committee received an update on the Reablement Service contract with the Local Authority, and discussed the Community Mental Health Transformation Funding.

EMERGENCY PLANNING ANNUAL REPORT AND CORE STANDARDS

The Committee received the Emergency Planning Annual Report and Annual Core Standards submission which provided an update on the Trust's progress and compliance with the Emergency Preparedness Resilience and Response arrangements for the 2020/21 reporting period.

It was reported that the Trust had received a 'substantial assurance' rating from the CCG, achieving 50 of the 54 standards that were applicable to the Trust under the core standards framework. A Confirm and Challenge review with the CCG had taken place on the 20/10/20.

The Committee noted that the main focus of the work moving forward would be refining the Trusts approach to incident management in terms of what can be dealt with at a local level as opposed to a Trust wide or system level; further embedding the business continuity planning, and further enhancing training (Covid permitting).

The Committee endorsed the content of this report, and approved the EPRR priorities for 2021/22 and the Annual Core Standards submission.

RISK REGISTER

The Committee received, discussed and noted the updates provided on Corporate Risks and the Board Assurance Framework.

A wider review of risk and risk appetite had begun in September, alongside the development of the Trust Strategy. The BAF would be re-mapped considering the strategic objectives which would align to the new strategic framework and this would be presented to the meeting of the Trust Board in January 2021.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary.

DATE OF NEXT MEETING	**17 December 2020**

AGENDA ITEM: 24/1120

QUALITY COMMITTEE SUMMARY REPORT

3 NOVEMBER 2020

COMMITTEE GOVERNANCE	• Committee Chair – Maria Bond, NED • Attendance (membership) – 4 out of 7 members present • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

SERIOUS INCIDENTS REQUIRING INVESTIGATION (SIRI) UPDATE

The Committee received the SIRI update providing the Committee with the Serious Incidents Requiring Investigation (SIRIs) declared and submitted to Gloucestershire CCG during the month of September 2020.

There were 5 SIRIs, all of which were reported within mental health services. Assurance was received that all SIRIs had been discussed with the CCG and investigations in order to establish events that had taken place were underway.

A review would be undertaken to look in more detail at medication errors. Five medication incidents had occurred in the previous 12 months and an investigation would take place internally in order to have a better understanding of medication errors in the future.

LEARNING ASSURANCE FRAMEWORK

The Committee received the Learning Assurance Framework (LAF) and an overview of the work that had been progressed within the LAF Group was highlighted. The Committee noted the progression and embedding of the Learning Assurance Group in the Trust Quality Governance System.

QUALITY DASHBOARD REPORT

The Committee received the Quality Dashboard, which now included the quarterly NED Audit of Complaints.

Quality issues for priority development:

- Further work is required to fully understand the performance relating to timely Care Programme Approach (CPA) reviews.
- The prevention, identification and management of all pressure ulcers remains a significant Trust priority
- The number of bed days for adult mental health inappropriate out of area placements has risen again in September. An analysis of this issue will be included in next month's dashboard.
- A number of quality concerns have been expressed concerning jointly commissioned services, e.g. Reablement and Telecare. Work is being undertaken to address these and will be presented in next month's dashboard. The Trust Board had been updated on the issues relating to Reablement Services and the work was felt to be progressing well.

Quality issues showing positive improvement:

- No healthcare associated Covid-19 infections attributable to the Trust's care for the fourth month in a row.
- The Trust's Level 3 Resuscitation Training program has been launched.

- Early Intervention in Psychosis has exceeded the required threshold for the implementation of care packages within two weeks of referral for the third consecutive month. This indicator will now be removed from Quality Dashboard, with ongoing reporting and monitoring via the Trust's Performance Dashboard.

The quarterly NED Audit of Complaints was presented within the Quality Dashboard for the first time. The Committee welcomed the format of the report and the assurance provided.

QUALITY ASSURANCE GROUP SUMMARY REPORT

The Committee received the Quality Assurance Group (QAG) summary report. The Quality Committee noted the contents of the summary report, acknowledging the huge amount of work undertaken at the QAG and the excellent level of attendance at the group – both in terms of numbers but also staff group and clinical representation. Significant assurance was provided via the QAG summary.

OTHER ITEMS RECEIVED AND DISCUSSED

The Committee also received the following reports for assurance and/or endorsement:

- The **Annual Infection Prevention and Control report 2019 – 2020** was endorsed and a good level assurance was received as to the systems and controls in place.
- The **Annual Resuscitation Report 2019 – 2020** was received and assurance provided regarding resuscitation, training, policies/procedures and audit.
- The **Research and Development Annual Report 2019 – 2020** was received and it was highlighted that that the Research and Development Team had consistently achieved targets and that funding had been increased due to this.
- James Willets, Theatre Manager and Severine Ryder, Theatre Endoscopy and Day Surgery Manager (Community Hospitals Tewkesbury and Stroud) were in attendance to provide a clinical presentation on Theatres.
- The Committee received the **Corporate Quality Risks** report, noting that there were 10 corporate risks meeting the criteria of a score of 12 or above. There was also 4 Covid related risks on the risk log specifically for Quality Committee oversight.
- The Committee received the **Quarterly Patient Safety Report Q2** and it was noted that the level of reporting was what was expected.
- The **Learning from Deaths Quarter 2 Report** was received and this would be received in full at Trust Board.
- The Committee received the **Guardian of Safe Working Hours Quarter 2 report** and this would also be received in full at the November Board meeting
- The Committee received and noted the **Medicines Optimisation Annual Report**

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary.

DATE OF NEXT MEETING	**7 January 2021**

AGENDA ITEM: 25/1120

AUDIT & ASSURANCE COMMITTEE SUMMARY REPORT

5 NOVEMBER 2020

COMMITTEE GOVERNANCE	• Committee Chair – Marcia Gallagher, NED • Attendance (membership) – 4 of 5 members present • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

INTERNAL AUDIT

The Committee received the internal audit progress report. Three reviews had been completed since the last meeting. The Committee approved the use of the contingency days within the internal audit plan in order to deliver additional reviews within year. The Committee considered progress with the implementation of internal audit actions, noting that 23 actions had been implemented and closed during the year and 2 were overdue.

Cyber Security in the context of the Covid-19 pandemic: The Committee received the report noting that it was an advisory report, and therefore did not have an overall risk rating. Implementation of the recommendations arising from the report would be tracked alongside other internal audit recommendations and progress reported to future meetings of the Committee. The Committee received an update on the phased roll out of multifactorial authentication and action in place to manage phishing attacks in the Trust.

Finance Governance: Report Classification: Low risk. 1 medium finding. 1 low finding. Following a letter Simon Stevens (sent out to all NHS bodies) a review was conducted on the Financial Governance arrangements and recording mechanisms relating to Covid claims. One medium risk was identified around formalising the waivers process with a recommendation for a unified process to be documented.

Corporate and Quality Governance: Report Classification: Low risk. 1 Low finding. The low risk was in relation to the Board Assurance Committee (BAC) and the limited number of executive attendance required. The Committee noted the positive outcome of the report which would be reported to the Board.

EXTERNAL AUDIT

The Committee received the progress report and technical update, highlighting the revision to value for money reporting arrangements and providing an update on IFRS16 implementation timescales and new requirements of the Group Accounting Manual (GAM).

COUNTER FRAUD, BRIBERY AND CORRUPTION

Counter Fraud continued to participate in staff induction sessions and Fraud Awareness Presentations including a session at the University of Gloucestershire to new students on the nursing programme.

A proactive exercise to review data provided by the Association of the British Pharmaceutical Industries (ABPI) on payments made to Health Care Professionals (doctors/nurses) would be carried out and this would commence in the next month.

The Committee received the final report on the Estates Appointment of Professional Consultants. The review had been conducted as part of the Counter Fraud Workplan for 2019/2020 and focussed on the arrangements in the appointment of professional consultants within the area of Estates.

The Committee congratulated Lee Sheridan, Local Counter Fraud Specialist on his nomination for Outstanding Investigator of the Year.

FINANCE COMPLIANCE REPORT

The Committee received the Finance Compliance report noting actions taken under delegated powers for the period 1 June 2020 – 30 September 2020. The report showed improved performance against the target of 'payments within 30 days' demonstrating performance close to or above the 95% target 7-day payments which had been set up as a result of Covid. In September 2020, the Trust paid 80% of invoices by value within 7 days for non-NHS Suppliers.

The Committee noted that there were no longer any outstanding invoices for Herefordshire. A review of the balance sheet overall was being carried out and this would include a review of debtors.

The Committee noted this report and expressed its thanks to the Trust finance team for the work undertaken.

CONFLICT OF INTEREST POLICY REVIEW

The Committee received the revised Conflict of Interest Policy for review, noting that the review had been undertaken in line with best practice and NHSI guidance. The areas which had been amended were highlighted within the report for the consideration of the Committee. Key stakeholders had been involved in the revision of the policy with input from Counter Fraud.

The Committee approved the policy on behalf of the Board subject to ratification at the JNCF on 11th November 2020.

CORPORATE RISK REPORT AND BOARD ASSURANCE FRAMEWORK

The Committee received the Corporate Risk Report and the Board Assurance Framework, noting the proposed changes in risk scores. It was noted that the Corporate Risks had all been considered by the relevant Governance Committee.

AUDIT COMMITTEE ANNUAL EFFECTIVENESS AND TERMS OF REFERENCE REVIEW

The Committee received the outcome of the Audit Committee Annual Effectiveness Review and the Terms of Reference Review. Responses received were largely positive and some actions had been agreed to strengthen the Committee's effectiveness.

There was one recommended change to the Committee's Terms of Reference to include the additional requirement of a member of the Committee having a *relevant financial qualification.* This recommended change would be presented to the Board for approval.

PROCESS FOR THE ANNUAL REVIEW OF THE EFFECTIVENESS OF INTERNAL AUDIT

The Committee received a paper setting out the process for the review of the effectiveness of the internal audit function. The paper proposed that the evaluation be based on feedback received from the Executive, Senior Managers and members of the Committee. The outcome of the evaluation would then be reported to the February meeting of the Committee. The Committee noted and endorsed the proposed approach.

EXTERNAL AUDITOR REAPPOINTMENT

The Committee considered the reappointment of the External Auditors, KPMG for a final year from 1 April 2021 until 31 March 2022. In considering the extension the Committee reviewed the outcome of the evaluation of performance of the external auditor and considered benchmarking data of external audit fees charged by other Trusts.

Based on the outcome of the evaluation and the benchmarking information considered, the Committee agreed the extension of the current contract for a final one-year term. This would be reported to the Council of Governors at its next meeting.

The Committee noted that the Trust would need to commence the tender for future external audit services in 2021.

ACTIONS REQUIRED BY THE BOARD
The Board is asked to:

- **Note** the contents of this summary.

DATE OF NEXT MEETING	11 February 2021

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 25/1120

REPORT TO: **TRUST BOARD, 25TH NOVEMBER 2020**

PRESENTED BY: Lavinia Rowsell, Head of Corporate Governance/Trust Secretary

AUTHOR: Lavinia Rowsell, Head of Corporate Governance/Trust Secretary

SUBJECT: **AUDIT AND ASSURANCE COMMITTEE TERMS OF REFERENCE REVIEW**

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

The purpose of this report is to:

Provide the Board with a proposed revision to the Audit and Assurance Committee terms of reference for approval.

Recommendations and decisions required

The Board is asked to:

- **approve** the proposed change to the Committee's terms of reference.

Executive summary

The terms of reference for the Committee have been reviewed against best practice and in view of the outcome of the recent evaluation processes. One amendment is proposed relating to an amendment to strengthen the requirement for financial expertise on the Committee to include a relevant financial qualification.

Risks associated with meeting the Trust's values

None

Corporate considerations	
Quality Implications	The Audit and Assurance Committee has a key role to play in driving quality improvements; particularly in terms of internal control and risk issues.
Resource Implications	None other than those identified in the report

Equality Implications	None other than those identified in the report

Where has this issue been discussed before?

Appendices:	Appendix 1: Terms of Reference

Report authorised by: Marcia Gallagher	**Title:** Chair, Audit and Assurance Committee

TERMS OF REFERENCE

AUDIT AND ASSURANCE COMMITTEE

1.	**Purpose**
1.1	The Audit and Assurance Committee will provide the Board of Gloucestershire Health and Care Servicews NHS Foundation Trust with an independent and objective review of its governance and assurance processes; including internal control, risk management, financial systems, financial information and compliance with laws, guidance and regulations governing the NHS.
2.	**Membership**
2.1	Three Non-Executive Directors as core members, one of whom will be appointed Chair. Any other Non-Executive Trust Board Member, (except the Chair) may attend the meetings and would contribute to the quorum. At least one member of the Committee shall have recent, relevant financial experience and a relevant financial qualification. The Chair of the Board shall not be a member of the Committee but may attend by invitation. Executive Directors shall not be members of the Committee but may be invited to attend. The Chief Executive shall not be a member of the Committee but will be invited to attend to discuss the Annual Report, Quality Report, Annual Accounts and the assurance process for the Annual Governance Statement **In attendance:** Director of Finance or deputy Local Counter Fraud Specialist at least twice a year Head of Corporate Governance or Deputy Internal Auditors (every meeting) External Auditors (minimum twice a year) At least once a year the Committee will meet privately with the external and internal auditors and the Local Counter Fraud Specialist, all of whom additionally have a right to direct access to the Chair of the Committee. The Local Counter Fraud Specialist will be entitled to attend every meeting of the Committee.
2.2	Other Officers or Directors of the Trusts may attend at the discretion of the Chair. In addition, up to two nominated Governors may observe the proceedings of the Committee in order to provide assurance to the Council of Governors and to assist in holding the Non-Executive Directors to account for the performance of the Board.
3.	**Quorum**
3.1	Three Members.
4.	**Reporting Arrangements**

4.1	The Audit and Assurance Committee will update each routine Board meeting on its activity, highlighting decisions made, issues being progressed and concerns requiring further consideration or decision by the Board.
4.2	The Committee will report to the Board annually on its work in support of the Annual Governance Statement.
4.3	The Committee will advise any key issues or concerns which require consideration by another of the Board's committees. The Chair will work with the Chairs of other Board Committees to ensure that where there are apparent overlaps in the work of the Committees, which will inevitably arise from time to time, every effort is made to ensure that duplication of work is avoided.
5.	**Powers**
5.1	The Trust's Standing Orders, Standing Financial Instructions, Scheme of Reservation and Scheme of Delegation shall apply to the Audit and Assurance Committee.
5.2	The Committee is authorised to obtain any external legal or other independent professional advice it considers necessary.
5.3	The Committee is authorised to establish sub-groups, to which it can delegate specific tasks or functions, whose activities it will monitor through the groups minutes or reports depending on the tasks or functions undertaken. The Committee will approve the terms or reference of the sub groups.
6	**Responsibilities**
6.1	<u>Governance, Risk Management and Internal Control</u> The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives. In particular, the Committee will review the adequacy of: • all risk and control related disclosure statements (in particular the Annual Governance Statement and, the Annual Report and the Quality Report), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board • the underlying assurance processes, including the Board Assurance Framework, that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements • the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification • the effectiveness of the arrangements in place by which staff may, in confidence, raise concerns, particularly the Freedom to Speak Up procedures • the policies and procedures for all work related to fraud and corruption • the systems to secure value for money • information governance processes • the Trust's insurance arrangements • the operation of the Board's Committees to ensure that the Trust's governance responsibilities can be achieved The Committee will maintain responsibility for the oversight of risk management across the Trust, oversee all risk management processes, including review of the Board Assurance Framework, the

	overarching Corporate Risk Register and other risks as determined by the risk stratification matrix to ensure their effectiveness. In carrying out this work the Committee will utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these functions. It will also seek reports and assurances from other committees, directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This work should provide assurance that Board Committees adequately assure the Board that risks are appropriately managed
6.2	Internal Audit The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by: • consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal, • review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework • consideration of the major findings of internal audit work (and management's response), and ensuring co-ordination between the Internal and External Auditors to optimise audit resources • ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation • annual review of the effectiveness of internal audit, including independence and objectivity
6.3	External Audit The Committee shall review the work and findings of the External Auditor and consider the implications and management's responses to their work. This will be achieved by: • consideration of the performance of the External Auditor, including consideration of independence and objectivity • discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensuring coordination, as appropriate, with other External Auditors in the local health economy • reviewing all External Audit reports, including agreement of the annual audit letter and any work carried outside the annual audit plan, together with the appropriateness of management responses. • Reviewing the External Auditor's review of the Quality Report, prior to approval and submission of the Quality Report to NHS Improvement The Committee will assist the Council of Governors to discharge its duties in respect of the appointment of the External Auditors.
6.4	Financial Reporting The Committee shall review the Annual Report and Financial Statements before submission to NHSI, focusing particularly on:

	• the wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee • changes in, and compliance with, accounting policies and practices • unadjusted mis-statements in the financial statements • major judgemental areas • significant adjustments resulting from the audit The Committee should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board. This will include: • recommending updates to the Trust's Standing Orders, Standing Financial Instructions, and Scheme of Delegation; monitoring compliance and approving any waivers • approving any schedules of losses and non HR special payments. • Review the schedule of debtor/creditor balances over 6 months old and over £5,000 or 2% of the aggregate amount, whichever is the greater.
6.5	Engagement Ensure effective on-going engagement and communication with all relevant internal and external stakeholders, including staff, service users, the public, Commissioners and other professional partners, as appropriate to the Committee's duties and remit.
7.	**Frequency and Review of Meetings**
7.1	The Committee will meet a minimum of five times per year
7.2	These Terms of Reference will be reviewed annually, with any change recommended to the Trust Board for approval following approval by the Audit & Risk Assurance Committee. This review will include a self-assessment of its effectiveness in discharging its responsibilities as set out.
8.	**Administration**
8.1	The Trust Secretary will ensure appropriate support is provided to the Committee.

Version:	**Date Approved:**	**Approved by:**
Version 1	6/11/19	Approved by Audit and Assurance Committee
Version 1	28/11/19	Approved by Trust Board
Version 2	05/11/20	Approved by Audit and Assurance Committee
Version 2	25/11/20	Approved by Trust Board (TBC)

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Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 26/1120

APPOINTMENTS AND TERMS OF SERVICE COMMITTEE SUMMARY REPORT

12 NOVEMBER 2020

COMMITTEE GOVERNANCE	• Committee Chair – Ingrid Barker, Trust Chair • Attendance (membership) – 7 of 8 members present • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

VOTING ARRANGEMENTS FOR EXECUTIVE DIRECTORS

The Committee fully supported the proposal that the Director of Strategy and Partnerships become a full voting member of the Board with immediate effect. Due to the need to maintain the correct balance of Executive and Non-Executive Directors on the Board, it had not be possible for the DoSP to have voting rights on appointment to the Board, but the recent changes in Board composition and NED appointments now allowed for this change which was in line with the Trust's constitution.

VSM PAY

The Committee received new guidance that had been issued from the DHSC setting out details of the VSM annual pay increase for 2020/21. The Committee noted this guidance and it was agreed that further work would take place on developing a recommendation for the Committee to consider in more detail at a future meeting. In line with this, the Director of HR&OD would develop an "in principle" policy to guide the Committee's thinking around VSM pay in future years.

CHIEF EXECUTIVE OBJECTIVES

The Committee received the final draft of the Chief Executive's objectives for 2020/21 for review. These had already been discussed by the Committee at previous meetings and any comments/amendments that had been suggested had been fed back to the Chief Executive for action. The Committee agreed the objectives, subject to some minor points of clarity which the Trust Chair would feed back to the Chief Executive.

COMMITTEE ANNUAL AGENDA CYCLE

A draft annual agenda cycle was presented to the Committee. The purpose of this was to ensure that the routine business of the Committee was appropriately scheduled throughout the year. The proposed work plan was agreed, with further discussions to take place with the Head of Corporate Governance and the Director of HR&OD to confirm exact timings and scheduling.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary.

DATE OF NEXT MEETING	17 March 2021

AGENDA ITEM: 27/1120

CHARITABLE FUNDS COMMITTEE SUMMARY REPORT

13 NOVEMBER 2020

COMMITTEE GOVERNANCE	• Committee Chair – Sumita Hutchison, NED • Attendance (membership) – 5 of 6 members present • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

The Committee noted the financial position for both Gloucestershire Health and Care (GHC) NHS Foundation Trust Charities Funds (formerly Gloucestershire Care Services NHS Trust Charities) and the NHS 2Gether Charities Funds at 30 September 2020 as follows:

- GHC Fund: the current value of the fund was £292k. Expenditure commitments, if completed, would result in a net fund balance of £190k across restricted and unrestricted funds.
- NHS 2Gether Fund: the current value of the fund was approximately £26k. It was noted that Charitable Funds for Herefordshire Mental Health Services had been transferred to Worcestershire Health and Care NHS Trust Charitable Funds. In addition, in light of the proposed closure of the New Highway charity, £34,238 had been transferred to the fund.

Updates on bids received for charitable funds and progressing bids were received for both Charities. The Committee considered the bid for £5,000 to support volunteering in physical health services for the forthcoming financial year noting that this would result in an overspend in the fund. The Committee agreed expenditure of spend of £2,500 for 6 months with a review of 2021/2022 of funding for volunteer services.

The Committee received an update on expenditure against the NHS Charities Together allocations and the next phase of grant applications, along with a summary of proposals currently being considered for the next stage of grants. All bids had been reviewed to ensure they met the conditions for funding. The trust had been successful in securing an additional £50k from the NHS Charities. The Committee considered the bids relating to health and wellbeing and highlighted the need to ensure sustainable funding sources going forward.

The Committee noted that an application had been made to the Charity Commission to merge the two Charities.

The Committee considered the next steps in developing a charitable funds strategy and work programme noting work that had been undertaken to date to strengthen the governance and processes around charitable funds activity. Further resources to support future funding raising activities relating to Forest of Dean would be a priority area for the strategy and a separate business case would need to be developed to support this.

The Committee approved, subject to audit the Annual Report and Accounts for both charitable funds.

ACTIONS REQUIRED BY THE BOARD
The Board is asked to:

- **Note** the contents of this summary.

DATE OF NEXT MEETING	**9 June 2021**

AGENDA ITEM: 28/1120

MENTAL HEALTH LEGISLATION SCRUTINY COMMITTEE SUMMARY REPORT

23 SEPTEMBER 2020

COMMITTEE GOVERNANCE	• Committee Chair – Jan Marriott, NED • Attendance (membership) – 100% • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

UPDATE FROM MENTAL HEALTH OPERATIONAL GROUP

The Committee received an update from the Mental Health Operational Group. Key issues highlighted which would continue to be taken forward by the Operational Group included:

- Section 136, the use of restraint and the ability of the police to remain present when patients are displaying low level challenging or low level behavioral disturbance.
- An update on Long Term Segregation in relation to Berkeley House
- Availability of statutory and mandatory training (due to Covid)

REPORTS OF ISSUES ARISING AT MHA TRIBUNALS AND HEARINGS

Issues arising at First Tier Tribunals

The Committee received a report providing assurance that the Trust was complying with the arrangements set out by the Tribunal Services. Tribunal panels were unable to meet due to Covid and social distancing measures, however, tribunals were being conducted via video conferencing calls with the Tribunal Service ensuring that a link to join the conference was sent out to all participants. The Committee was assured that if any issues were experienced with the video conference call, there was a fall back telephone service available for use.

Mental Health Act Managers' Hearing Issues

The Committee received a report which provided assurance that a robust process was in place if any Mental Health Act managers encountered issues which could affect their ability to make an informed decision or that may raise wider concern. A summary of three issues that had recently been raised was presented, with the Committee receiving assurance that these matters had been investigated and mitigating actions put in place.

The Committee received a revised Mental Health Act Managers' policy which had been amended to include guidance on the Coronavirus Pandemic. The changes were endorsed.

REVIEW OF LEGAL UPDATES

The Committee received a summary of the legal guidance received from NHS England for mental health services during the Coronavirus pandemic. The guidance had been shared with the Operational Group. The only changes to normal practice were how the hearings and tribunals were carried out, with them no longer being in person.

UPDATE ON AMHP COVER

Key points to note:

- AMHP Referrals for consideration of a Mental Health Act assessment in the 6 months between May and October have increased on average 45% compared to the same period in 2019
- 85% of these referrals were accepted for a MHA assessment (15% are diverted). No change compared to 2019.

- Assessments continue to be spread evenly between community assessments (patients home, supported accommodation, residential setting and custody suite), inpatients (WLH, CLC, GRH, CGH) and s136 assessments at the Maxwell Centre.
- Of the 854 MHA assessments completed between May and October only 42 were admitted informally immediately following MHA assessment (may later have been referred and detained). This accounts to only 4.9% of all admissions being informal during this period. Suggestion that this reflects the acuity of mental disorder seen during Covid/lockdown
- Increase in s136 activity - return to 2017 numbers when detentions were at their peak- theme of no contact by police prior to using powers of detention
- Increase in detentions following s136 assessment to 33% compared to 20% in 2019.

A paper had been presented at other forums asking for further support in order to maintain the on call system for AMHPs. There was an issue with there not being an operational policy in place to support how the on call AMHPs were paid. GHC's on call payment policy was only applicable to band 8s and above, whereas the AMHPs working within the hub were band 7s. It was noted that the issue had been raised with HR and suggested revisions to the on-call policy made.

COMPLEX CHILDREN AND YOUNG PEOPLE CASES AND USE OF MHA

This report provided an update to the Committee on the use of the Mental Health Act for Children and Young People under 18 within Gloucestershire from 1st September 2019 – 31st August 2020.

Issues had been identified regarding young people having been subjected to more than one assessment, with some patients being subjected to 9 separate assessments. In terms of outcomes; only a quarter had been detained under the Mental Health Act. This therefore demonstrates that the Mental Health Act was not necessarily applicable. There were no tier 4 beds available in Gloucestershire, and currently there were 7 young people in tier 4 beds out of county.

Work was underway in order to obtain an understanding of patients' journeys and experiences within the system.

WESSELY REPORT UPDATE

The Committee received a verbal update on the Wessley Report, noting that the work to address the recommendations had been delayed slightly due to Covid. However, a routine meeting was now in place with Trust and commissioning colleague to ensure focus, and a deep dive of BAME cases to understand service access and themes would be carried out. A focus on choice, and autonomy through the use of personalised care training and scoping/trial of peer workers roles in mental health teams would commence from Q4 onwards (subject to the impact of Covid).

MENTAL HEALTH ACT ACTIVITY 2012 - 2020

The Committee received the Mental Health Act Activity Report which highlighted trends and provided benchmarking data. There was an upwards trend in the use of some sections of the Mental Health Act, especially sections 2 and 3, although numbers had recently dipped. There had been an upwards trend of direct admissions on section, with a corresponding downwards trend of detentions after informal admission. It was also reported that there had been a disproportionately higher use of the Mental Health Act with people of BAME background and this also included CTOs. The numbers were, however, low and were spread across a number of different ethnic groups.

RE-APPOINTMENT OF MHA MANAGERS

The Committee noted the reappointment of two Mental Health Act Managers. Mental Health Act Managers were appointed for a term of 3 years, for a maximum period of 12 years. In the previous few months, 2 of the managers' appointments had ended. The managers had completed the required peer review process and it was noted that this was completed to a high standard. The Committee fully supported the reappointment of both managers for a further 3 years and would present this proposal for reappointment to the Board at its next meeting for endorsement.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary.
- **Endorse** the reappointment of 2 MHAMs *(Note: The Board endorsed these reappointments via a verbal report at its September meeting)*

DATE OF NEXT MEETING	**18 November 2020** (Verbal summary to be provided at the November Board)

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Gloucestershire Health and Care
NHS Foundation Trust

TRUST BOARD MEETING

PUBLIC SESSION
Wednesday 22 July 2020
10.00 – 12.00pm
To be held via Microsoft Teams

AGENDA

	Agenda Item	Title	Purpose		Presenter
Opening Business					
	01/0720	Apologies for absence and quorum	Note	Verbal	Chair
	02/0720	Declarations of interest	Note	Verbal	Chair
	03/0720	Draft Minutes of the meeting held on 20 May 2020	Approve	Paper	Chair
	04/0720	Matters arising and Action Log	Note	Paper	Chair
	05/0720	Questions from the Public *Questions need to be received in writing no later than 12 noon on 16 July*	Note	Verbal	Chair
Strategic Issues					
	06/0720	Report from the Chair	Note	Paper	Chair
	07/0720	Report from the Chief Executive and Executive Team	Note	Paper	CEO
	08/0720	System Wide Update	Note	Paper	DoSP
	09/0720	Board Assurance Framework	Note	Paper	HoCG
	10/0720	Update on Trust's Diversity work	Note	Paper	DoHR&OD
Performance and Patient Experience					
	11/0720	Covid-19 Recovery Programme Update	Note	Paper	Chief Executive
	12/0720	Performance Report	Note	Paper	DoF
	13/0720	Finance Report	Note	Paper	DoF
	14/0720	Quality Report	Note	Paper	DoNQ&T
	15/0720	Learning from Deaths Q4	Note	Paper	MD
Items to Information					
	16/0720	Board Assurance Committee - Covid	Note	Paper	Chair
	17/0720	Audit & Assurance Committee Summary (28 May and 17 June)	Note	Paper	Audit Chair
	18/0720	Resources Committee Summary (25 June)	Note	Paper	Resources Chair
	19/0720	Quality Committee Summary (1 July)	Note	Paper	Quality Chair

	Agenda Item	Title	Purpose		Presenter
	20/0720	Charitable Funds Committee Summary (3 July)	Note	Paper	CF Chair
	21/0720	Appointments and TOS Committee Summary (16 July)	Note	Verbal	Chair
	22/0720	Council of Governor Minutes (19 March)	Note	Paper	HoCG
	23/0720	Use of the Trust Seal – Q4 2019/20 and Q1 2020/21	Note	Paper	HoCG
Closing Business					
	24/0720	Any other business	Note	Verbal	Chair
	25/0720	Date of next meeting Weds 30 September – 10.00 – 12.00 Weds 25 November – 10.00 – 12.00	Note	Verbal	All

The AGM for the former Gloucestershire Care Services NHS Trust will take place immediately following the conclusion of the Board meeting.

BOARD MEETING
WEDNESDAY 20 MAY 2020
HELD VIA MS TEAMS

PRESENT:
Ingrid Barker, Trust Chair
Dr. Stephen Alvis, Associate Non-Executive Director
Sandra Betney, Director of Finance
Maria Bond, Non-Executive Director
Steve Brittan, Associate Non-Executive Director
John Campbell, Chief Operating Officer
Marcia Gallagher, Non-Executive Director
Helen Goodey, Director of Locality Development and Primary Care
Sumita Hutchison, Non-Executive Director
Jan Marriott, Non-Executive Director
Angela Potter, Director of Strategy and Partnerships
Paul Roberts, Chief Executive
Graham Russell, Non-Executive Director
Neil Savage, Director of HR & Organisational Development
Duncan Sutherland, Non-Executive Director
John Trevains, Director of Nursing, Therapies and Quality
Dr Amjad Uppal, Medical Director

IN ATTENDANCE:
Karen Bennett, Trust Governor
Katie Clark, Trust Governor
Said Hansdot, Trust Governor
June Hennell, Trust Governor
Anna Hilditch, Assistant Trust Secretary
Stephen McDonnell, Trust Governor
Bren McInerney, Member of the Public
Louise Moss, Deputy Head of Governance
Kate Nelmes, Head of Communications
Anneka Newman, Trust Governor
Sarah Nicholson, Trust Governor
Sonia Pearcey, Freedom to Speak Up Guardian (Item 7)
Lavinia Rowsell, Head of Corporate Governance and Trust Secretary
David Smith, Transition Director
Katherine Stratton, Trust Governor
Sian Thomas, Deputy Chief Operating Officer

1. WELCOME AND APOLOGIES

1.1 The Chair welcomed everyone to the meeting, with a special welcome to Steve Brittan who had been appointed as an Associate Non-Executive Director from 18 May 2020.

1.2 No apologies for the meeting had been received.

2. DECLARATIONS OF INTEREST

2.1 There were no new declarations of interest.

3. MINUTES OF THE MEETING HELD ON 22 APRIL 2020

3.1 The Board received the minutes from the previous meeting held on 22 April 2020. Steve Alvis suggested an amendment at 6.18 in relation to the Vulnerable People's Telephone service. He had raised a query regarding patients living in Gloucestershire but registered with an out of area GP practice, and the minute had recorded this the opposite way round.

3.2 Subject to this amendment the minutes were accepted as a true and accurate record of the meeting.

4. MATTERS ARISING AND ACTION LOG

4.1 The Board reviewed the action log and noted that all actions were now complete or included on the agenda.

4.2 Duncan Sutherland referred back to the Vulnerable People's Telephone service, noting that a target had been set of contacting 15k people. John Campbell advised that GHC had been supporting GP practices to make these calls and to date 6.5k calls had been made by the VPTS hub. It was hoped that all calls would be made by the end of June.

5. QUESTIONS FROM THE PUBLIC

5.1 No questions from the public had been received in advance of the meeting.

6. COVID19 TRUST RESPONSE - UPDATE

6.1 The purpose of this item was to provide assurance to the Board on the work the Trust had undertaken in responding to Covid and to highlight areas of good practice. Sian Thomas was in attendance to present this. Before commencing with the update, the Chair said that this report demonstrated an enormous amount of work and she wished to acknowledge the efforts of the Executive Team and Trust colleagues.

6.2 The item was broken down into 2 presentations; one focussing on the Trust's incident response and the second on Recovery Planning.

Incident Response

6.3 In terms of incident response, the Board noted that work on Covid commenced in early February, and the Trust implemented an Incident Control approach. Since that time, a formal programme structure has been put in place.

6.4 Some of the key things put in place to support this work included the allocation of RAG ratings to inpatient units to ensure that the Trust could continue to deliver quality services safely, developed new sickness absence apps and self-reporting tools for staff, carried out redeployment to clinical services, set up an effective stock management system and team to support this and further developed the Trust's reporting and business intelligence function. This development in reporting has enabled the Trust to closely monitor bed flow, activity, contact levels and referrals, which would be a key focus area as the Trust moves into the recovery phase.

6.5 Graham Russell asked whether the Trust held any Covid benchmark data with other Trusts. Sian Thomas advised that benchmarking for community trusts was relatively poor as the national focus tended to lean toward the acute trusts. However, the Trust did have a large amount of qualitative information coming in that would be reviewed.

Recovery Planning

6.6 The Board received the second presentation which set out the Trust's proposed approach to operational recovery during and post Covid. Paul Roberts advised that changing operational services to meet the demands of Covid had been challenging but the Trust had managed; however, the next phase of recovery would be complex and he assured the Board of the significant amount of work that was taking place to focus on this.

6.7 The presentation set out the work carried out to date, and the proposed workstreams, along with the key principles for recovery.

6.8 As part of the recovery process, teams would be asked to self-review their services and categorise these. Some services would propose to revert back to their pre-existing form; however, this work would also give services the opportunity to consider whether any of the changes made to manage Covid would be beneficial for the service moving forward, such as 7 day working or the use of digital communication. It would also be important when reinstating services to consider the "need" that the patient population has, for example supporting more people at home, and therefore gaining user, carer and staff input into the process would be key.

6.9 Jan Marriott highlighted the importance of co-production with service users and the public. She said that many people had found different ways to manage and cope during Covid so it would be important to draw on their views and feedback going forward. Angela Potter advised that a report was currently in production for presentation to the Executive Committee which set out the Trust's approach to patient, service user and carer involvement to support recovery and developing the future state. She said that work was still at an early stage but the importance of it was recognised.

6.10 Steve Alvis noted the national concern regarding suspected cancer investigations and asked about the recovery of endoscopy services. Sian Thomas advised that GHC was working closely with Gloucestershire Hospital's Trust to agree a joint recovery approach for these services.

6.11 Steve Brittan said that it was good to see the emphasis on "key enablers" such as digital and finance, which would help drive wider innovation. He suggested that training should also be highlighted as a key enabler, to help staff embrace new technologies and ways of working. Neil Savage advised that a Digital Working Group had been set up and said that he would welcome a further discussion outside the meeting.

6.12 Duncan Sutherland asked how the Trust was going to approach the review of lessons learned. Paul Roberts informed the Board that a Board workshop would be taking place in June focussing on the lessons learned, with individuals being invited to attend and speak to Board members about their specific experience and to enable time for the Board to reflect upon this. The Board noted that a formal lessons learned approach was being put in place, with a number of engagement activities planned including debrief sessions with staff, "Every Cloud" – a questionnaire for staff to complete and the issuing of posters for Trust sites inviting comment and feedback. Neil Savage added that a questionnaire was sent out to senior managers asking for their feedback on what had gone well, and what required improvement, and the collated responses to

this had been presented to the Executive Committee at the beginning of May. This included feedback on the redeployment process.

6.13 Ingrid Barker said that the Covid pandemic would only work to re-emphasise existing health inequalities, and it was therefore vital that work was done to address this and incorporate it into recovery planning going forward. Angela Potter advised that a mental health cell had been agreed as it was not felt that this area had received sufficient focus.

6.14 Said Hansdot, Trust Governor said that there had been concerns about the BAME community and he asked whether frontline BAME staff members had received the support that they required. Neil Savage said that there had been heightened concerns for BAME communities and the risk of contracting Covid, and GHC had written to all affected staff members and developed local risk assessment guidance, with the Trust's Working Well (Occupational Health) Team supporting people in doing this. The Trust has redeployed staff accordingly. He offered assurance that there were robust processes in place to manage this position. Amjad Uppal added that he had been in contact with his BAME medical colleagues and was closely monitoring any concerns that may arise.

7. FREEDOM TO SPEAK UP (FTSU) REPORT

7.1 The Board welcomed Sonia Pearcey, FTSU Guardian to the meeting to present the Freedom to Speak Up Report. The report provided assurance to the Trust Board that speaking up routes remained open for colleagues to speak up in these unprecedented times of Covid.

7.2 The Board noted that 18 concerns were raised in Quarter 4 2019-20. As of 13 May 2020, 12 colleagues had spoken up, including 1 from another NHS Trust, to the Freedom to Speak Up Guardian. Of the 11 concerns raised from colleagues within GHC, 8 were specifically related to Covid. Sonia Pearcey informed the Board that these concerns related to a lack of social distancing, misuse of PPE and anxiety around redeployment. She said that these were very similar to concerns raised nationally. Maria Bond noted the concern about social distancing and asked what the Trust was doing to address this. Neil Savage advised that a Task and Finish group had now been set up on release of the national guidance on safe work places. This group had multidisciplinary membership and would build on the work previously implemented on safer working.

7.3 In terms of promoting staff to Speak Up, the Board noted that a lot of work was taking place to encourage this, including promoting the service on social media and through global communications with staff. The FTSU Guardians in the South West region met fortnightly and Sonia Pearcey said that she had developed solid links with the Guardian at Gloucestershire Hospital's Trust.

7.4 Sumita Hutchison asked whether it was possible to breakdown the concerns received by staff group and ethnicity, as she was seeking assurance that all staff felt that they had equal opportunity and support to Speak Up. Sonia Pearcey reported that 3 of the 11 concerns raised in quarter 1 had been received from BAME staff members. The

Board agreed that it would be very helpful for overview and scrutiny if the report could include protected characteristics in future.

7.5 The Board noted that future papers would be presented 6 monthly and in a structured format to ensure compliance with the "Guidance for Boards on Freedom to Speak Up in NHS trusts and NHS foundation trusts". On behalf of the Board, Ingrid Barker expressed her thanks to Sonia Pearcey for providing assurance in this area and for the work carried out to encourage staff to feel confident in Speaking Up and promoting a positive Speak Up culture within the Trust.

8. PERFORMANCE DASHBOARD

8.1 Sandra Betney presented the combined Performance Dashboard to the Board for the period April 2020 (Month 1 2020/21). This report provided a high level view of key performance indicators (KPIs) in exception across the organisation.

8.2 As per last month's report, the Board noted that the organisation's response to Covid had adversely contributed to the available operational capacity to undertake routine performance monitoring processes for the period. Specifically this has had an impact across measures requiring validation or specific narrative feedback. Where possible, it has been highlighted within the indicator narrative where Covid may have specifically contributed to in-period data quality, narrative and/or performance.

8.3 The comprehensive list of the newly developed corporate and operational Covid reports were provided to the Executive in May 2020 and from this, the Executive agreed the specification for a weekly Covid monitoring dashboard for the Programme Management Board. This would be separate and in addition to the routine monthly corporate performance dashboard. A dashboard prototype had been drafted and shared with the Executive Team earlier this week. This could be updated with additional indicators going forward.

8.4 Following a review of the performance dashboard, indicator 3.11 was highlighted, IAPT Recovery Rate. It was noted that performance for April was uncharacteristically low, and feedback had been received that some clients were reluctant to move to telephone or video based interventions from face to face. The Board noted that patient feedback was being sought and received, and assurance was given that an individual assessment would always be carried out to ensure that the patient could receive the best approach for them.

9. FINANCE REPORT

9.1 The Trust submitted its draft Final Accounts by the revised deadline of the 11th May. External Audit are now reviewing the accounts. Final audited accounts will be submitted by 25th June.

9.2 The draft year end surplus for GHC was above plan at £2.724m before absorption accounting, and excluding impairments of £3.489m.

9.3 Block income payments are being made direct to the Trust from main commissioners based on income at month 9 for last year inflated by 2.8%, and not reduced by 1.1% efficiency savings.

9.4 All Trusts have to show a break even position at the month end by either accruing for an additional retrospective top up payment if their income is insufficient to cover their expenditure, or putting a negative retrospective top up payment if income exceeds expenditure. The Trust received a top up payment of £1.005m in April to cover an assumed shortfall in income to cover the expenditure run rate of last year (months 8-10). In order to balance to break even the Trust has removed this top up and assumed it will receive a top up payment of £0.090m.

9.5 The Cost Improvement Plan target for the Trust is £7.686m. The CIP removed at budget setting was £3.275m. During the interim Covid financial arrangements the Trust was not expected to deliver the 1.1% efficiency saving.

9.6 The Capital plan for 20/21 was set at £9.945m. Current spend as at the end of month 1 was £130k. It was noted that the ICS had a combined capital spend envelope of £31.287m which included GHC's full allocation of £9.945m.

9.7 Cash balance at the end of month 1 was £61.9m due to the Trust receiving both April and May's block contract payments in April.

9.8 The Board was pleased to note that despite challenging circumstances, GHC continued to hit its Public Sector Payment Policy (PSPP) target, with 92% of invoices paid within 10 days and 95% in 30 days.

9.9 The Board noted the month 1 financial position. Ingrid Barker expressed her thanks to the Director of Finance and her team for their work given the challenging circumstances.

10. QUALITY DASHBOARD REPORT

10.1 This report provided an overview of the Trust's quality activities for April 2020. It was noted that key data was now reported under the relevant CQC Domains – caring, safe, effective, responsive and well-led.

10.2 A series of Quality Priorities were agreed prior to the Covid outbreak. In the current climate, John Trevains advised that these priorities may no longer meet the needs the population of Gloucestershire which we serve. The Trust will, therefore, be reviewing the clinical and therapeutic needs of our patients, and the configuration of our services to support these needs over the coming months. The Board noted that this would, in turn, inform new quality indicators which will be launched at the appropriate juncture in 2020/21. Discussions with the CCG would be taking place with the aim of re-establishing these priorities going forward.

10.3 The organisation's response to Covid has adversely contributed to available staff capacity to undertake scheduled quality monitoring processes, with a range of Quality Directorate colleagues having been redeployed to prioritised frontline services and support roles. However, assurance was given that essential patient safety, incidents, quality and experience functions had continued to be closely monitored throughout. The Quality Assurance Group would resume virtually in May 2020 as the first step in recovery of business as usual quality governance arrangements. This will be followed by the Board Quality Committee recommencing in June 2020.

10.4 John Trevains advised that the Quality Dashboard would continue to include progress against the quality indicators for the Trust, as well as providing additional detail and assurance regarding areas identified within the Performance Report as being below target.

10.5 Maria Bond noted that GHC, and the NHS in general had received a huge volume of positive messages and compliments during the Covid pandemic and she asked whether the Trust was able to record all of these. John Trevains said that his team were working closely with Communication Team colleagues to triangulate this information and he agreed to provide the Board with a more detailed update in his next report.

ACTION: John Trevains to provide more detail in the next Quality Report on the work taking place to formally record all compliments received

10.6 Ingrid Barker said that she welcomed this report, as well as the Performance Dashboard report received earlier in the meeting. However, she said that the Trust needed to get smarter about what mattered and to agree smart metrics, aligned with strategic priorities. She asked colleagues to consider this as part of future report development.

11. ANY OTHER BUSINESS

11.1 The Board noted that the Trust was required to submit its Annual Provider License Declarations. It was proposed that delegated authority be given to the Audit and Assurance Committee to review and approve these in time for submission. The Board approved this delegation.

12. DATE OF NEXT MEETING

12.1 The next meeting would take place on Wednesday 22 July 2020.

Signed: …….. **Dated: ……**

Ingrid Barker (Chair)
Gloucestershire Health and Care NHS Foundation Trust

PUBLIC SESSION TRUST BOARD: Matters Arising Action Log – 22 July 2020

Key to RAG rating:

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

Meeting Date	Item	Action Description	Assigned to	Target Completion Date	Progress Update	Status
20 May 2020	10.5	John Trevains to provide more detail in the next Quality Report on the work taking place to formally record all compliments received	DoNQ&T	22 July 2020	Complete. Included in Board Quality Dashboard	

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Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 06

REPORT TO: Trust Board – 22 July 2020

PRESENTED BY: Ingrid Barker, Chair

AUTHOR: Ingrid Barker, Chair

SUBJECT: **REPORT FROM THE CHAIR**

If this report cannot be discussed at a public Board meeting, please explain why.	*Reasons for this may include:* *Patient / staff confidentiality, commercial sensitivity, financial sensitivity, purdah.*

This report is provided for:

Decision ☐ Endorsement ☐ Assurance ☑ Information ☑

The purpose of this report is to

To update the Board and members of the public on my activities and those of the Non-Executive Directors to demonstrate the processes we have in place to inform our scrutiny and challenge of the Executive and support effective Board working.

Recommendations and decisions required

The Board is asked to:

- **Note** the report and the assurance provided.

Executive summary

At our May Board it was agreed that we would broadly return to our usual governance arrangements and I am pleased to therefore provide an update on my and the Non-Executives activities from the end of March to mid-July.

I would also like to formally record mine and the Board's thanks to colleagues across the Trust who have made, and continue to make outstanding efforts to support our community during the pandemic and are now working to develop and put in place the "new normal" for our services, continue to meet the challenges of Covid-19 and ensure preparations are in place for what happens next. The tremendous efforts made are recognised and appreciated.

Risks associated with meeting the Trust's values

Corporate considerations	
Quality Implications	None identified
Resource Implications	None identified
Equality Implications	None identified

Where has this issue been discussed before?
This is a regular update report for the Trust Board.

Appendices:	**APPENDIX 1 -** Non-Executive Director – Summary of Activity - 26th March – 30th June

Report authorised by:	**Title:**
Ingrid Barker	Chair

CHAIR'S REPORT

1.0 INTRODUCTION AND PURPOSE

This report seeks to provide an update to the Board on the Chair and Non-Executive Directors activities in the following areas:

- Board developments
- Governor activities
- Working with our system partners
- Working with our colleagues
- National and regional meetings attended and any significant issues highlighted

2.0 BOARD

2.1 Non-Executive Director Update

Following a competitive interview process Steve Brittan joined the Trust on 18th May as an Associate Non-Executive Director. Steve has a career background in technology and innovation and has some unique experience, particularly in light of the opportunities and challenges presented by technology and digital working going forwards. His input will greatly help us in shaping the organisation, He lives in Gloucestershire and has been a partner at TecHorizons Ltd, a company established to identify, incubate and source investments into innovative UK Dual-Use Technology companies seeking growth capital since 2018. Before this he was the Chief Executive of the UK Defence Solutions Centre – an Innovation Centre comprised of a UK Government/Industry partnership to promote, develop and invest in UK technology. Between 2009 and 2014 he was a Technology and Innovation Consultant working with various clients to identify options/strategies to create new market entry points to create additional commercial value.

He previously spent eight years at QinetiQ Group Plc, as a Managing Director and Chief Operating Officer. The majority of Steve's early career was spent at Marconi Underwater Systems (1990-1998). In addition he was a Council Member of Cranfield University Advanced Manufacturing Group (from 2015-2020), and a Non-Executive Director of V-Auth Ltd (from 2013-2018); he is also a former Non-Executive Director of the Numerical Algorithms Group (2013-2016).

We welcome Steve to the Trust and look forward to his insights on how technology can be used to support new ways of working.

The Non-Executive Directors and I have met on a frequent basis during the pandemic with scheduled meetings taking place on 29th April, 6th May, 20th May, 17th June and 16th July. These meetings have been helpful check in sessions as well as enabling us to consider future plans.

I have also had regular individual meetings with the Non-Executive Directors.

My annual appraisal took place on 5th May with the process being led by the Trust's Senior Independent Director, Marcia Gallagher, informed by the latest guidance material from NHS England/ NHS Improvement.

Appraisals for all the Trust's Non-Executive Directors have taken place throughout April and May. The outcome was reported to the Nomination and Remuneration Committee on 9th June.

2.2 Board Updates:

Board Development

All meetings since March have been held via Microsoft Teams.

We continue to devote significant time to considering our Board ways of working and considering how we ensure that transformation remains central to how we work, whilst the necessary focus is maintained on ensuring clinical safety and colleagues' wellbeing.

Board meetings took place on 22nd April and 20th May with the focus on our Covid-19 response.

Board Assurance Committees have been held weekly to discuss matters relating to the pandemic and to ensure triangulation of information.

A Board development session was held on 24th June. A more detailed update on this is included in the CEO and Executive Team Report.

As the pace of work focussing on the pandemic has changed, so have our governance arrangements. The weekly Covid Board Assurance Committee meeting has now been stood down and normal Board committees resumed, albeit virtually and with more focussed agendas.

3.0 GOVERNOR UPDATES

I would like to place on record my thanks to Interim Lead Governor Simon Smith who has recently stood down from his role due to family circumstances. Simon has played a key part in ongoing work to develop the Council of Governors following the merger and governors much appreciated his contribution during this period of change.

I am pleased to announce that Dr. Faisal Khan has agreed to take on the role of Interim Lead Governor, with Mervyn Dawe as Deputy. I am grateful to them both for agreeing to take on these roles during the important 'review and refresh' period and look forward to working with them.

Following the retirement of the CCG nominee for the GHC Council of Governors (Dr. Lawrence Fielder), I am pleased to announce that Julie Clatworthy has been nominated for an interim period. Julie is the Clinical Member (Nurse) for the CCG

Governing Body and will bring a huge amount of clinical expertise and senior experience to the Council.

A Council of Governors meeting was held by Microsoft Teams on Weds 17th June where matters discussed included the Staff Survey outcomes, an update on the Annual Report and Accounts, plans for upcoming membership elections, as well as an update on the Trust provided by the Deputy Chief Executive.

Review and Refresh working group sessions have now been arranged commencing 7th July which will consider further how the Council of Governors will develop going forward.

Elections for seven public governor positions are now under way with posts to be filled in Gloucester, Cheltenham, the Forest of Dean, Cotswolds and All England and Wales constituencies. We hope to have our new governors in position by early September.

4.0 NATIONAL AND REGIONAL MEETINGS

I have attended the following virtual meetings from the end of March to date.

- NHS Providers Board on 6th May, 3rd June and 1st July where we discussed a number of important policy and national operational issues. I also attended three NHS Provider working group meetings during April - July.

- Two national meetings of the Community Network Chairs on 19th May and 9th June (which I chaired) and then a small follow up meeting to agree on next steps for the outputs from these sessions on 17th June.

- NHS Providers Chairs and CEOs meeting on 2nd July where matters discussed included a number of important policy and national operational issues. Board members have already been briefed by email on this session.

- I was invited to be part of the interview panel for the National Aspirant Chairs' programme on 8th July and will be following this through by acting as a mentor for one or two of the individuals selected as they progress through the programme.

- I joined one of a series of 'safe spaces' discussion groups for Chairs and Chief Executives organised by NHS Providers on 9th July regarding Race Inequality.

- Two NHS Confederation NHS Reset Webinars

Many of the meetings were inevitably Covid-19 dominated, but there was also consideration of future ways of working and discussions on how the NHS can take forward Race Equality with greater speed.

5.0 WORKING WITH OUR PARTNERS

I have continued my regular meetings with key stakeholders and partners where views on the working of the health and care system and the way we can mutually support each other are key issues for consideration. Highlights are as follows:

- Colleagues and members of the public on the Gloucestershire Royal Hospital site for the 'clap for Carers' event. I undertook a number of social media and other recordings as part of the NHS birthday celebrations.

- A meeting of the county's Health Overview and Scrutiny Committee is scheduled to be held on 14th July and a verbal update will be given at Board about this.

- I am a Trustee of Gloucestershire GP Education Trust (GGPET) and attended a meeting of its Board of Trustees on 16th July.

- I have recently been appointed as a Governor of the University of Gloucestershire Council and have attended several meetings. This link will assist with some of the workforce challenges faced by the Trust and the wider system, as well as developing research and other potential links between our two organisations. The Chair of Gloucestershire Hospitals NHSFT, Peter Lachecki, and I meet virtually on a weekly basis to discuss matters of mutual interest.

- The County's Health Chairs continue to meet where possible and met on 23rd June. The next meeting is scheduled for 14th July.

- I met with Chris Brierley, Deputy Police and Crime Commissioner on 2nd April.

- The Chief Operating Officer, John Campbell, and I met with the Police and Crime Commissioner and his Deputy on 29thApril to discuss mental health issues in the county.

- The ICS Board has continued to meet virtually and meetings were held on 21st May and 18th June where we discussed a number of important operational and strategic issues.

- I attended a meeting of the South West Regional Chairs on 2nd June where we discussed the challenges of Covid-19 and moving forward to a 'new normal'.

- Alongside the Director of Nursing, Therapies and Quality (John Trevains), I was pleased to welcome The Bishop of Gloucester, Rt. Revd. Rachel Treweek, on her visit to Wotton Lawn Hospital on Sunday 5th July, where she met colleagues and thanked them for their hard work during the Covid-19 outbreak. Later in the day, myself and the Chief Executive, Paul Roberts, joined a crowd of NHS.

6.0 WORKING WITH THE COMMUNITIES AND PEOPLE WE SERVE

On 30th June we had a virtual meeting with the Chairs of the county's Leagues of Friends where we were able to update them on the ongoing work within the Trust including updates on Covid. We are fortunate to have such a committed group of volunteers supporting our work.

The Chief Executive and I have been holding our regular annual meetings with the county's MPs to update them on Trust activities, including Covid. To date we have met with Mark Harper, Sir Geoffrey Clifton-Brown and Alex Chalk, with further meetings scheduled with the other MPs over the next few weeks.

7.0 ENGAGING WITH OUR TRUST COLLEAGUES

I carried out the Chief Executive's annual appraisal on 27th May, the outcome of which was reported to the Nomination and Remuneration Committee on 9th June.

The Senior Leadership Network meetings are currently being held virtually and I have attended meetings on 14th May and 11th June.

I had an introductory meeting on 11th June with Dr. Philip Fielding who has been appointed as Deputy Medical Director.

Sally King, lead officer for the Covid-19 Stock Management Team, invited me to join the team's weekly meeting on Thurs 11th June. It was very interesting to get an insight into the really important work this team is carrying out for the Trust.

I was invited to attend the Gloucester and Forest Assertive Outreach Team meeting on 23rdJune. I found this meeting extremely interesting and gave me a better understanding of the very complex work that this team is involved in.

I also continue to have a range of 1:1 sessions with Executive colleagues as part of my regular activities.

8.0 NED ACTIVITY

See Appendix 1 for the summary of the Non-Executive Directors activity for the period 27th March to 30th June.

9.0 CONCLUSION AND RECOMMENDATIONS

The Board is asked to **NOTE** the report and the assurance.

Appendix 1

Non-Executive Director – Summary of Activity - 26th March – 30th June
(Majority of meetings were held virtually by Microsoft Teams or Zoom)

NED Name	Meetings with Executives, Colleagues, External Partners	Governance meetings	Board membership meetings
Graham Russell	Ingrid Barker Marcia Gallagher Sandra Betney Sumita Hutchison	Audit & Assurance Committees Council of Governors ICS Board Resources Committee	ATOS/Remuneration Committee Board Assurance Committees Board Meetings Board Seminars/Development NEDs meetings Nomination & Remuneration Committee
Marcia Gallagher	Ingrid Barker Age UK "Listening Event" Amjad Uppal Angela Potter Graham Russell Helen Goodey Interview panel – 7th NED John Campbell Lavinia Rowsell Lead Governor Long-listing and short-listing for 7th NED Neil Savage NHSI Regional Director Paul Roberts Sandra Betney Senior Leadership Network Sumita Hutchison	Audit & Assurance Committee Council of Governors MHAM Hearing NHS Reset Webinar Procurement meeting	ATOS/Remuneration Committee Board Assurance Committees Board Meetings Board Seminars/Development NEDs meetings Nomination & Remuneration Committee

NED Name	Meetings with Executives, Colleagues, External Partners	Governance meetings	Board membership meetings
Jan Marriott	Ingrid Barker CCG Nurse Lay Member Charlotte Eley CCG Dominika Lipska-Rosecka Dr. Stephen Alvis Eddie O'Neil GHFT Clinical NED Governor candidates Governor meeting John Campbell John Trevains Sumita Hutchison Visit to City Farm Visit to Friendship Café Visit to GARAS	Audit of Complaints Council of Governors Good Governance Webinar Mental Health Act Managers Forum Mental Health Act Operational meeting MHLSC NHS Reset Webinar Quality Committee Resources Committee	ATOS/Remuneration Committee Board Meetings Board Assurance Committees Board Seminars/Development NEDs meetings
Maria Bond	Ingrid Barker Chair of Healthwatch Gloucestershire Covid-19 Stock Team meeting Governor meeting John Trevains Lavinia Rowsell NED phone call Senior Leadership Network	AAC Panel interviews Audit & Assurance Committees Cotswolds team virtual meeting Council of Governors Good Governance – role of quality committee post-Covid-19 Mental Health Act Managers Forum NHS Reset Webinar NHSP Effective Chairing (Birmingham) NTQ virtual meeting Quality Committee	ATOS/Remuneration Committee Board Assurance Committees Board Meetings Board Seminars/Development NEDs meetings

NED Name	Meetings with Executives, Colleagues, External Partners	Governance meetings	Board membership meetings
Sumita Hutchison	Ingrid Barker Allyson MacVean Dominika Lipska-Rosecka Eddie O'Neil Graham Russell Helen Goodey Jan Marriott Jan Marriott John Trevains Kate Nelmes Marcia Gallagher Neil Savage Prerana Isaar Sandra Betney Senior Leaders Network Visit to Friendship Café Visit to Southgate Moorings	Council of Governors Ethics Committees Quality Committee	ATOS/Remuneration Committee Board Assurance Committees Board Meetings Board Seminars/Development NEDs meetings
Duncan Sutherland	Ingrid Barker John Trevains Steve Brittan Sumita Hutchison		ATOS/Remuneration Committee Board Assurance Committees Board Meetings Board Seminars/Development NEDs meetings
Dr. Stephen Alvis	Ingrid Barker Amjad Uppal Angela Potter Jan Marriott John Campbell Paul Roberts Sandra Betney Neil Savage Lavinia Rowsell	Council of Governors Ethics Committees NHS Reset Webinar	ATOS/Remuneration Committee Board Assurance Committees Board Meetings Board Seminars/Development NEDs meetings

NED Name	Meetings with Executives, Colleagues, External Partners	Governance meetings	Board membership meetings
Steve Brittan **(appointed 18/5/20)**	Ingrid Barker Amjad Uppal Angela Potter Ben Iles Duncan Sutherland Gillian Steels Jan Marriott John Campbell John Trevains Lavinia Rowsell Lee Charlton Marcia Gallagher Maria Bond Neil Savage Paul Roberts Sandra Betney Sumita Hutchison	Audit & Assurance Committees Council of Governors Resources Committee	ATOS/Remuneration Committee Board Assurance Committees Board Meetings Board Seminars/Development NEDs meetings

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AGENDA ITEM: 07

REPORT TO: Trust Board – 22 July 2022

PRESENTED BY: Chief Executive Officer and Executive Team

AUTHOR: Paul Roberts, Chief Executive Officer

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

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

The purpose of this report is to

To update the Board and members of the public on my activities and those of the Executive Team.

Recommendations and decisions required

The Board is asked to **note** the report.

Executive summary

This has been an extraordinary time for GHC, for the NHS and the country as a whole. As we return to our more regular governance arrangements and the provision of the regular CEO and Team reports I, and the Team, are reflecting on the response to Covid-19 and to our ongoing actions to move to a new normal and these areas are considered within this report and the wider agenda.

The challenges of Covid-19 within 6 months of the creation of our new organisation were certainly not one of the risks that were considered during the process, although of course business continuity was a key area discussed. Despite this I am heartened to reflect on what this organisation, with its partners in the health and social care system, has achieved during this time. Colleagues have pulled together to support our community with no thought of what colour badges they were wearing last year, colleagues have taken on new responsibilities, we have reorganised at speed in all areas of the Trust: from governance through management, through services, front line or support and we have kept our eye on two key things: the health and wellbeing of our community and the health and wellbeing of each other.

This focus has enabled us to keep going through this challenging time and will help to ensure our resilience as we move forward to bring our services through to a new normal and to prepare for the future.

I would like to again put on record my sincere thanks to the entire Trust Team who have worked so determinedly and compassionately to support our community in this time when they themselves were faced with unknown. I am confident that this organisation will be able to respond to new challenges effectively.

This report also addresses our response to "Black Lives Matter" and strategic developments within the Trust.

Risks associated with meeting the Trust's values
None identified.

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

Where has this issue been discussed before?
n/a

Report authorised by:	**Title:**
Paul Roberts	Chief Executive Officer

CHIEF EXECUTIVE OFFICER AND EXECUTIVE TEAM REPORT

1.0 CHIEF EXECUTIVE ENGAGEMENT

Over the last three months a significant proportion of my time has been spent working on the Trust's response to the Covid-19 pandemic. The Trust's response, including its recovery programme, is covered in more detail in the Covid Recovery Report.

The Covid pandemic has restricted my ability to safely visit patient-facing services and meet colleagues delivering direct patient care. However, I, alongside a number of the Executive Team, have spent time undertaking hands-on roles to provide additional support during these difficult times. I have valued the opportunity to work as part of these teams and it has allowed me to witness first-hand the outstanding services that are being delivered. A wide range of redeployed colleagues across the organisation have been working tirelessly in different and often unknown roles, to ensure the continuity of essential services throughout the crisis.

I continue to be impressed and heartened by the professionalism and dedication of colleagues, both clinical and support, across the organisation as they work flexibly to support our preparations and ensure the delivery of high quality care.

I have continued to attend a range of meetings, including:

A **Board Development Seminar** was held on 24th June which provided an opportunity to reflect on the Trust's response to Covid-19, considering what has worked well, what could have been improved and how it will influence our agenda and approach to leadership of the Trust moving forward. A number of colleagues from different services were invited to share their experiences, which provided useful insight to inform learning and development. This session proved really helpful for developing Trust leadership and achieving our core value of always improving.

A **Board Assurance Committee-Covid** was formed with weekly meetings being held from 2nd April to 18th June. The purpose of the Committee was to provide regular updates to the Non-executive Directors for assurance on key aspects of the organisational response to the Covid-19 pandemic and to consider the impact of any exceptional measures being taken. The Committee membership included the Trust Chair, Non-executive Directors, Chief Executive Officer, Medical Director and the Director of Nursing, Therapies & Quality.

Senior Leadership Network meetings were held on 14th May and 11th June. Although it was not possible to hold the meetings in their usual format, virtual events were held to provide an opportunity for SLN members to hear key updates from Trust Executives and for them to ask questions or highlight any areas of concern. The sessions had a particular focus on the Trust's Covid response, with examples of how mental and physical health services have responded, and Staff Health and Wellbeing. One of the areas explored was Leadership Support Circles,

which are part of the National Health and Wellbeing response to Covid-19 to support the wellbeing of NHS colleagues.

I attended the **JNCF** meeting held on 8th July. As usual this was an effective meeting with attendees prepared to raise concerns and issues – again a demonstration of the open organisation we are determined to foster.

I attended the regular meetings of the **Medical Staffing Committee** on 1st May and 5th June and 3rd July and the **Local Medical Council** on 9th July, both via virtual forums.

1.1 ICS (Integrated Care System)

Our Trust plays an important role in the Gloucestershire system with colleagues working committedly to meet the needs of our community. I have regular meetings with the **CEO of Gloucestershire Hospitals NHS Foundation Trust (GHFT)** and the **Accountable Officer for Gloucestershire Clinical Commissioning Group (GCCG)** to keep abreast of any issues facing our partner organisations so that mutual help and support can be provided.

The **ICS Board** and **ICS Executive** meetings have also continued throughout this period, albeit virtually and with a condensed agenda focused on critical business. Resilience during this challenging period has been an issue of continuing focus, with regular meetings held with senior colleagues across the health system to ensure joined up working with system partners.

A system **Gold Health System Strategic Command CEOs** call has been in operation throughout the pandemic, as part of the **Gloucestershire ICS Covid-19 Response Programme** and GHC's level 4 business critical contingency plans. This call was held daily throughout the peak of the pandemic in order to stay aligned with the rapid pace of change but more recently has been reduced to three times a week. This forum has proved very useful in overseeing the system response to the Covid pandemic and in providing a regular liason point between senior leaders in the NHS system. The Gold system calls have been held in conjunction with various silver and bronze cell calls.

I have been involved in the weekly **Gloucestershire MP briefings**, chaired by Richard Graham, MP for Gloucester, involving CEOs of NHS organisations and senior County Council officers and Leaders. These have focussed solely on the latest developments in the management of the Covid-19 pandemic and, in particular providing updates on acute service issues, PPE, testing and public health updates.

1.2 National and Regional Meetings

There has been a plethora of national and regional meetings held virtually throughout the Covid-19 pandemic to support the valiant efforts of all the NHS Trusts in the region. Amongst others, these have included:

- MH/LDA (Mental Health/Learning Difficulties and Autism) Covid-19 Response Weekly webinar for Trust CEOs;

- SW Regional Chief Executive meetings, chaired by Elizabeth O'Mahony; and
- MH (Mental Health) CEO's meetings.

I attended the virtual **West of England Academic Health Science Network (AHSN) Board** meeting on 5th June. The main focus of the meeting was to review the AHSN support to the Covid-19 response to date and to discuss how best to support the NHS's response to Covid-19 over the weeks and months ahead.

I had a follow-up meeting with Natasha Swinscoe, Chief Executive Officer of AHSN, to discuss the particular challenges and priorities GHC are dealing with at present and are anticipating for the Recovery phase, with a view to seeing where the AHSN can continue to best support our organisation and staff, with a particular focus on mental health initiatives.

I attended the virtual **Chairs and Chief Executives Network** meeting on 2nd July, with a policy update from Chris Hopson - CEO NHS Providers, followed by a dialogue with Simon Stevens – NHS CEO and Amanda Pritchard – NHS Chief Operating Officer.

2.0 TRUST STRATEGY UPDATE

The Board approved its initial Strategic Framework at the Board meeting held in March 2020. Our vision for the organisation is ***Enabling People to live the best life they can - with you; for you*** and we agreed our four strategic aims as being:

Unfortunately Covid-19 activities have meant that we have not yet developed the next level of detail and granularity in understanding exactly what our strategic

priorities and objectives will be nor have we had the opportunity to share and obtain feedback on this framework with colleagues and stakeholders who worked with us in its development nor yet our Council of Governors.

It is therefore timely for us as a Board to start to develop the five year priorities and the success measures that will be our benchmarks for success and to re-engage and communicate more widely with our colleagues, patients, service users and stakeholders how our strategy will help take the organisation forward over the next five years.

A Board Development session is planned for late summer to continue to develop this work and we will also consider it alongside the Board Assurance Framework and our strategic risks. Additionally, we are starting to shape the underpinning work that will be needed for the enabling strategies for the organisation particularly in terms of the strategic Estates, Quality and our People strategies.

Further updates on this will be reported at future meetings.

3.0 TRUST DIVERSITY NETWORK

The Trust is in the process of establishing a new Diversity Network, particularly pertinent in light of the difficulties surrounding Covid-19 and the killing of George Floyd. Our challenge in GHC, as an organisation that was formed with an explicit objective of tackling inequality, is we must ensure our services, our leadership and our plans address race, discrimination and racism. Amongst other things, the aim of the network is to celebrate and value difference and contribute to improvements in our workplace.

The network will be developed with the close involvement of colleagues across the organisation and over the coming weeks we will be hosting a number of initial focus groups. The focus groups will engage with colleagues and inform the future shape and content of the network, with sessions for Black, Asian and Minority Ethnic colleagues (BAME), Lesbian, Gay, Bi-sexual, Trans and Queer (LGBTQ) colleagues, and those with a disability. The first of these focus groups took place on 23rd June with 26 colleagues attending, displaying strong and confident voices. There is also the option to complete an online survey for colleagues to share their views. It is hoped this network will also shape further work involving the wider Gloucestershire BAME community.

The Trust already has an established Women's network, which is chaired by our Finance Director and Deputy Chief Executive, Sandra Betney.

4.0 CUMBERLEDGE REPORT ON MEDICINES AND MEDICAL DEVICES REVIEW

The Trust will be looking at the recommendations of this report and any areas where we can build improvements in the way we operate. The review highlights the failure of the NHS to listen to concerns - the need to listen is a message we are building into the DNA of our Trust and continue to work on.
It is very saddening to hear Baroness Julia Cumberlege, Chair of the Independent Medicines and Medical Devices Safety Review, comment that:

"I have conducted many reviews and inquiries over the years, but I have never encountered anything like this; the intensity of suffering experienced by so many families, and the fact that they have endured it for decades. Much of this suffering was entirely avoidable, caused and compounded by failings in the health system itself.

"The first duty of any health system is to do no harm to those in its care; but I am sorry to say that in too many cases concerning Primodos, sodium valproate and pelvic mesh, our system has failed in its responsibilities. We met with people, more often than not women, whose worlds have been turned upside down, their whole lives, and often their children's lives, shaped by the pain, anguish and guilt they feel as the result of Primodos, sodium valproate or pelvic mesh. It has been a shocking and truly heart-rending experience. We owe it to the victims of these failings, and to thousands of future patients, to do better.

"That is why, having spent two years listening to these stories of acute suffering, "First Do No Harm" is an appropriate title and a necessary reminder not just to doctors but to the whole healthcare system. We are urging the system to do what it should have done years ago, to help those who have suffered and put in place the processes that will enable it to learn from past mistakes so that we spare other families from such anguish.

"The system's response – or lack of one – has added to the pain – both physical and mental - of those affected. The system and its leaders need to acknowledge what has gone so badly wrong. Our major recommendations, together with a number of actions for improvement we call for in our report, are wide ranging and radical. Given what we have witnessed, we are clear that is what is needed now."

The Executive will be reviewing the recommendations and considering areas where there are lessons for us within the health system.

The Review's major recommendations include:

- That the Government immediately issues a fulsome apology on behalf of the healthcare system to the families affected by Primodos, sodium valproate and pelvic mesh.
- That a Patient Safety Commissioner is appointed. This person would be the patients' port of call, listener and advocate, who holds the system to account, monitors trends, and demands action.

- Separate schemes should be set up for Hormone Pregnancy Tests, valproate and pelvic mesh to meet the cost of providing additional care and support to those who have experienced avoidable harm and are eligible to claim.
- A Redress Agency for those harmed by medicines and medical devices in future should be established.

- The establishment of two types of specialist centres, located regionally – for mesh, and separately for those affected by medications taken during pregnancy.

- The regulator of medicines and medical devices, the MHRA, needs to put patients at the heart of its activity, and to overhaul adverse event reporting and medical device regulation.

- That a central database should be created by collecting key details including the patient, the implanted device, and the surgeon.

- That the register of the General Medical Council (GMC) should be expanded to include a list of financial and non-pecuniary interests for all doctors, as well as doctors' clinical interests and specialisms.

- Finally, that the Government immediately sets up a task force to implement the Review's recommendations

Whilst many of these areas are outside the remit of this Trust it is important that the lessons highlighted are reviewed for application to the whole system.

5.0 HEREFORDSHIRE UPDATE

I am pleased to advise that despite the additional challenges of Covid-19, the transfer process has gone smoothly.

6.0 COVID-19 VIRUS & RECOVERY ACTIVITY

This is covered in detail within a separate item on the agenda.

7.0 CONCLUSION AND RECOMMENDATIONS

The Board is asked to **NOTE** the report and the assurance provided.

Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 08.1

REPORT TO: Trust Board – 22 July 2020

PRESENTED BY: Angela Potter, Director of Strategy & Partnerships

AUTHOR: Angela Potter, Director of Strategy & Partnerships
Emily Beardshall – Deputy ICS Programme Director

SUBJECT: **INTEGRATED CARE SYSTEM UPDATE**

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

The purpose of this report is to
This paper provides an update on the activities that are taking place across the Gloucestershire Integrated Care System (ICS) and confirms the publication of the Gloucestershire Long Term Plan.

Recommendations and decisions required

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

Executive Summary
The Sustainability and Transformation plan is now in its fourth year (from April 2020) and the ICS continues to play a key role in improving the quality of Health and Care by working in a more joined up way as a system.

The focus for the ICS since March 2020 has been a co-ordinated system wide response to the COVID-19 pandemic as a major incident which has been delivered through a bronze, silver and gold command structure, working in partnership with the Local Resilience Forum and co-ordinating the NHS response across partner organisations.

The cells at a bronze level have been wide ranging and have covered aspects such as personal protection and equipment delivery and supplies, capacity planning and scenario development along with extensive work to provide additional support to those most impacted by the COVID-19 pandemic.

The ICS work is now shifting towards focusing on Recovery and system restoration as we move into the next phase but also the system wide planning of any surge management alongside winter planning.

There is a focus on ensuring that we are using patient and public feedback plus information from services to help scope out how the health and wellbeing needs of the

Gloucestershire population will have changed as a result of the Covid-19 pandemic and the impact of the associated lock-down measures. We will need to continuously learn and adapt our service offer as we understand more about the impact that this has had on our populations.

The existing ICS programmes are currently reviewing their work programmes and continuing to work on and accelerate high priority areas. The report draws out the work of the following ICS Programmes;

The Enabling Active Communities (EAC) programme looks to build a new sense of personal responsibility and improved independence for health, supporting community capacity and working with the voluntary and community sector. Key priorities are aligned to the Health & Wellbeing Strategy and are split across the 4 main work streams: **supporting pathways, supporting people, supporting places and communities** and **supporting our workforce**. The projects within these work streams where able are continuing to run to previous plans but adapting their approach in light of Covid-19 restrictions e.g. moving to telephone/video conferencing rather than face-to-face.

The Clinical Programme Approach (CPA) ensures services work together to redesign the way care is delivered in Gloucestershire to provide the right care, in the right place, at the right time. During 2019/20 4 clinical programmes were identified to be moved forward more quickly. These are **Respiratory, Diabetes, Circulatory and Frailty & Dementia**. All work programmes are considering their current priorities and activities in light of COVID-19 and some are identifying activities that need to be accelerated in light of this.

The Fit For the Future programme work was temporarily put on hold due to COVID-19. A revised timeline has now been developed proposing that the programme now resumes with a proposed public consultation in the Autumn (subject to usual assurance and governance requirements).

Operational Planning has been also currently been paused and the Publication of the Gloucestershire Long Term Plan (LTP) has been delayed. Some of the work-streams within the LTP have been accelerated in particular around staffing, outpatient care, digital streams & sustainability.

It is worthy of note that system working has continued to work well and adapt during the incident response underpinned by good system relationships.

Risks associated with meeting the Trust's values

None.

Corporate considerations	
Quality Implications	There have been changes to previous programmes of work in light of COVID-19. This may impact on agreed timelines and delay some changes coming forward which may have

	an impact on the Trust's programme of change and service delivery and this ultimately may impact on the quality of care to our population.
Resource Implications	None specific to the Trust
Equality Implications	None specific to the Trust

Where has this issue been discussed before?
Regular report to Trust Board

Appendices:	None

Report authorised by: Angela Potter	**Title:** Director of Strategy & Partnerships

AGENDA ITEM 08.2

One Gloucestershire
Transforming Care, Transforming Communities

Gloucestershire Health Overview and Scrutiny Committee (HOSC)

July 2020

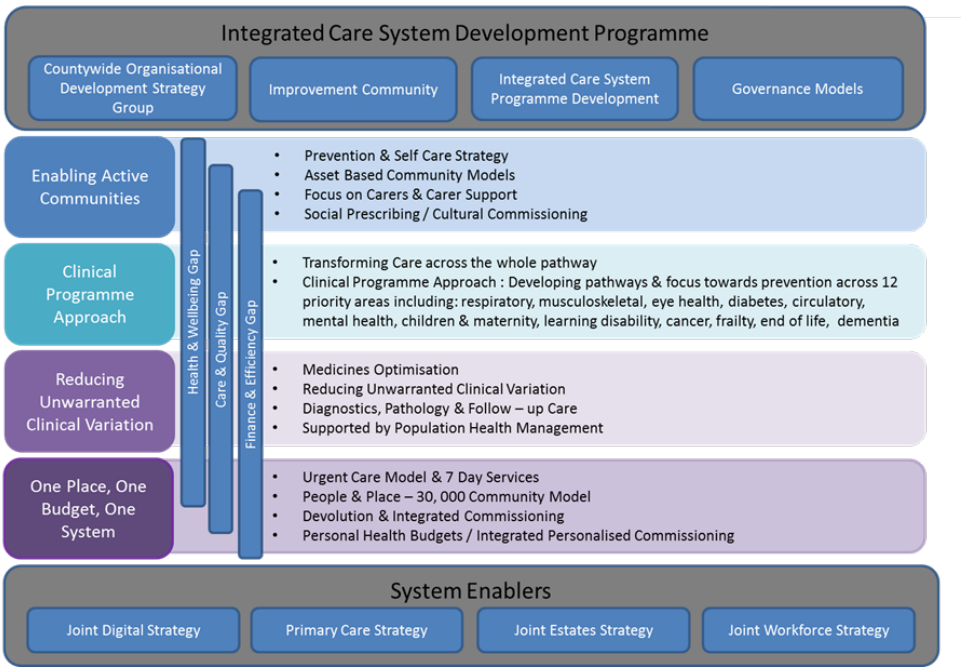
One Gloucestershire ICS Lead Report

1. Introduction

Since March 2020, the Health and Care system in Gloucestershire has been responding to the COVID-19 pandemic as a major incident. Our incident response has seen significant changes to the way health and social care is being delivered to our population. The following report provides an update to HOSC members on the work of key programme and projects across Gloucestershire's Integrated Care System (ICS) during this time.

Some of our programmes' focus has inevitably changed during the pandemic and certain activities have been accelerated or prioritised because of the COVID 19 response. During our 'recovery 'phase we will refocus and return to a new 'business as usual', restarting our programmes as appropriate and reprioritising in light of the new environment we are operating in.

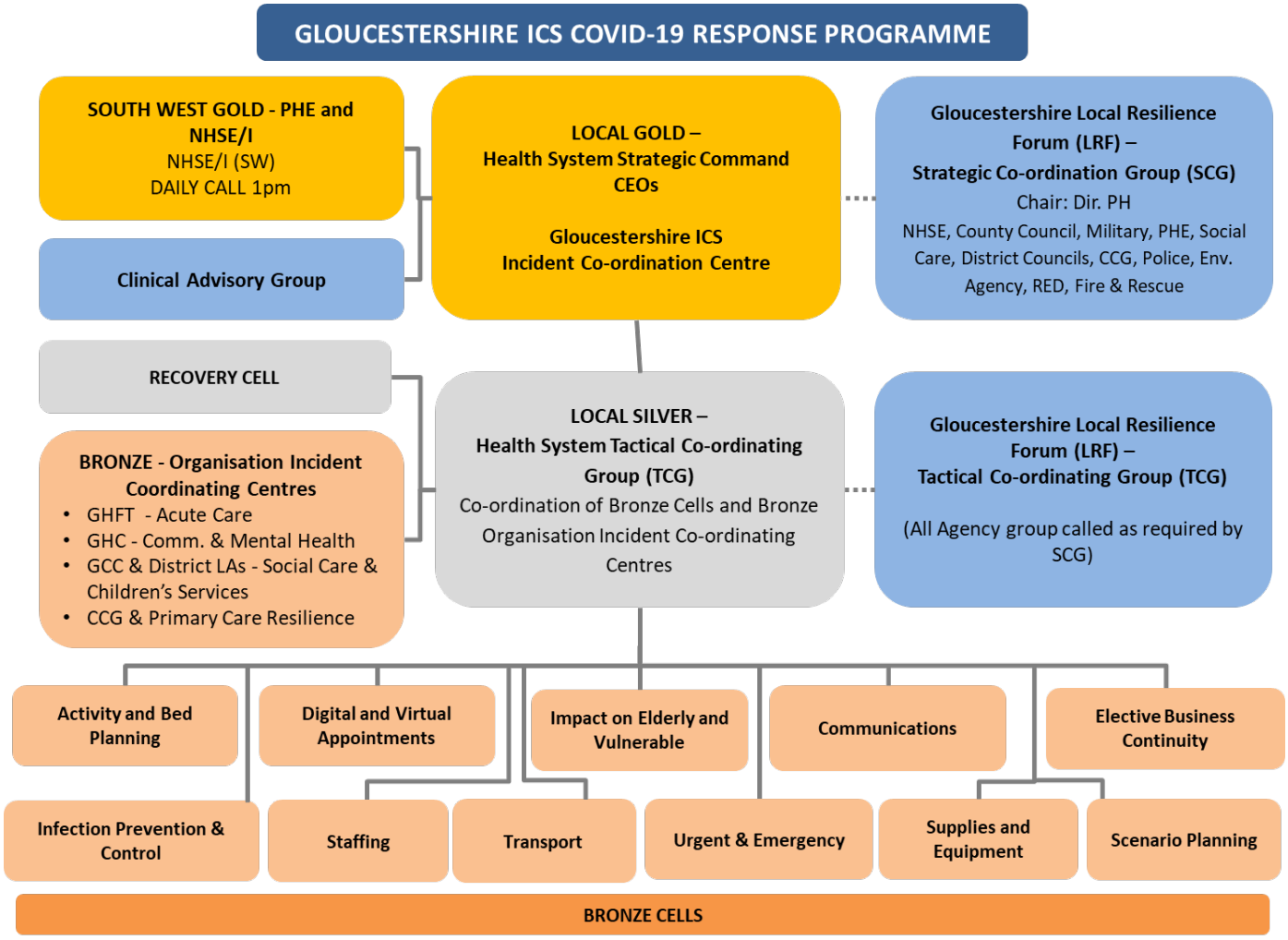
From April 2020 we moved into the fourth year of our Sustainability and Transformation plan. One of the roles of the ICS is to improve the quality of Health and Care by working in a more joined up way as a system. One 'silver lining' of the COVID-19 incident is that we have many new examples of excellent system working and delivery of best practice during the past few months, which the ICS have captured and intend to build on as we move forward.



Gloucestershire's ICS Plan on a page

Covid-19 Response

The incident response has been delivered through a bronze, silver and gold command structure, working in partnership with the Local Resilience Forum and co-ordinating the NHS response across partner organisations. The diagram below shows this operating structure, the bronze cells at the bottom representing co-ordinated county wide working on identified priorities. To give an example, there has been a focus on supporting care homes and the wider vulnerable population within two bronze cells: the Activity and Bed Planning cell and the Impact on Elderly and Vulnerable cell. Working together, these cells have developed a programme of extensive advice, education and support which has been offered to care home staff across the county regarding Infection Control and Prevention and the use of Personal Protective Equipment. A Primary Care led Care Home Enhanced Service has been further developed, with a virtual 'care home round' of residents needing clinical support introduced across the county as part of the incident response.



A further example of a bronze cell supporting system wide working is the way the Communications cell has involved all communications leads working together across the county to support and inform patients, staff and the public during the COVID 19 outbreak. Some examples of their work includes:

- Development of weekly county-wide system briefing, providing an overview of the incident response and plans for recovery and shared with key stakeholders such as local MPs.
- Weekly Staff update including a staff Wellbeing bulletin.
- "Every Name a Person – Lives Lost and Lived" campaign: https://www.onegloucestershire.net/every-name-a-person/
- Information for vulnerable and shielded residents delivered through the Gloucestershire Community Help Hub: https://www.gloucestershire.gov.uk/gloucestershires-community-help-hub/
- Gloucestershire Covid 19 Information hub- guiding patients and the public through some of the changes to the way local health services are being provided and keep them up to date on the latest local news and information: https://covid19.glos.nhs.uk/

A final example would be the excellent work of the Supplies and Equipment bronze cell to coordinate a system wide response to ensure that all partners have the required Personal Protective Equipment (PPE) to ensure that services have continued to be delivered safely in all care settings.

Focus on Impact on Elderly & Vulnerable Bronze Cell

The "Impact on the Elderly and Vulnerable" cell was established to support people across Gloucestershire who are most at risk from COVID 19 and the lockdown measures. One of the additional support services put in place was the Vulnerable People Support service. The support service is working with GP practices across the system to identify people who are clinically the most vulnerable to COVID-19. These include people with living with the following:

- Cancer
- Respiratory conditions
- Medication therapy e.g. immunosuppressant drugs
- Long term conditions / frailty

The Vulnerable People Support Service has set up a call centre function to contact these people, to offer shielding or social distancing guidance and to conduct a welfare check on behalf of their GP practice. The purpose of the call is to:

- Ensure people understand why they need to adopt measures including shielding, social distancing and hand-washing
- Complete a welfare assessment to check and find out if there is anything people need to ensure that they can stay as well as possible
- Take actions to address identified needs
- Provide reassurance that help is available
- Record outcomes of the assessment and all actions undertaken

Call line statistics include

- 117 staff from across the health and care system ha trained as call handlers and locality coordinators, working across three shifts every day
- Between 17th April and 4th June 2020, a total of 12,594 calls were made to 7,541 Shielded people. Of these 5,931 people had a completed welfare assessment.
- The team are now prioritising additional people who have been classed as being in the extremely vulnerable category. Between 5th and 22nd June 1,239 calls have been made and 1,001 welfare checks completed.

We have received positive feedback from GP surgeries. Comments included:

"A few [patients] have commented that they felt they were being valued by being rung"

"It was useful for patients who rarely see a GP and live on their own"

"Overall this has been a really useful service"

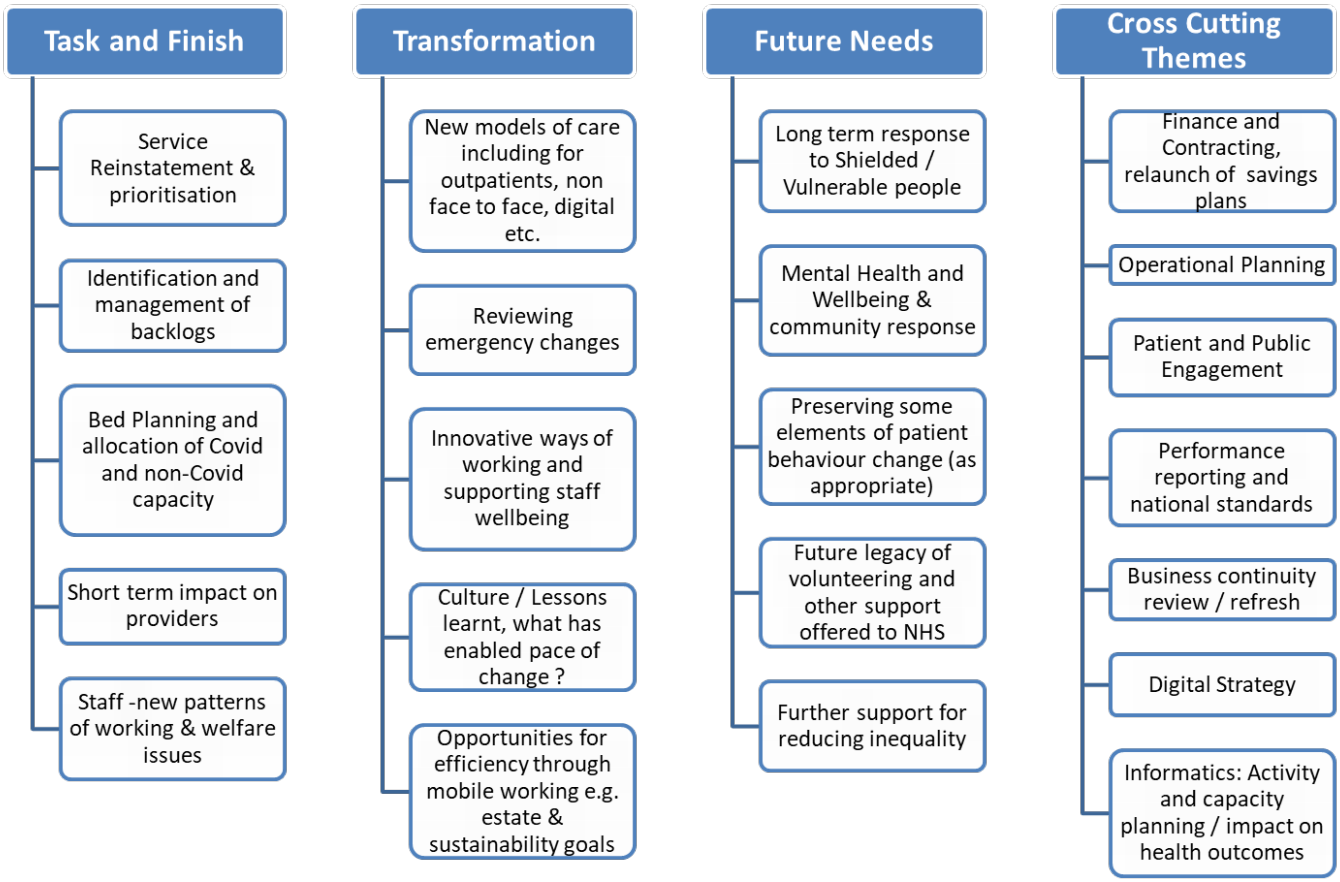
Covid-19 Recovery

As COVID -19 cases, both locally and nationally, have significantly declined the NHS has set out a recovery and restoration programme to describe how health and care services will start to return to some normality. There is recognition that services cannot return to previous operating models for a range of reasons:

- Loss of productivity due to increased need for infection control measures in all health and care services, which include but is not limited to extended use of PPE for staff and patients, additional requirements for cleaning between patients, social distancing measures limiting the use of services delivered to groups and access to facilities

- The ongoing additional support needed for people in the shielded and vulnerable categories, coupled with these services needing to be delivered through virtual means
- Increased levels of staff sickness absence due to COVID-19 and self-isolation requirements
- Preparation for anticipated increased winter pressures, including any potential second peak of COVID-19 and the potential for any peak to coincide with future seasonal flu peak (NHS must maintain state of readiness to respond)

Accepting that productivity has been severely compromised regarding the delivery of health and care services, the recovery programme is nonetheless looking at ways to reinstate services quickly that were adapted during the outbreak, whilst also looking at maximising the transformations that have come from new ways of working during the outbreak; for example extending the use of virtual means of conducting patient consultations. We are using patient and public feedback plus information from services to help scope how the health and wellbeing needs of the Gloucestershire population will have changed as a result of the Covid-19 pandemic and the impact of the associated lock-down measures. The diagram below shows the different strands of the recovery work that has begun within the Integrated Care System.



The existing ICS programmes are currently reviewing their work programmes and continuing to work on and accelerate high priority areas. The following sections outline the ongoing work programmes.

2. Enabling Active Communities

The Enabling Active Communities (EAC) programme looks to build a new sense of personal responsibility and improved independence for health, supporting community capacity and working with the voluntary and community sector.

The development of the Gloucestershire Prevention and Shared Care Plan, led by Public Health England, aims to improve health and wellbeing. It recognises that a more efficient approach to preventing ill health is very important. This will improve the health of the population and make an important contribution to the maintenance of sustainability in our ICS.

Key priorities are aligned to the Health & Wellbeing Strategy and are split across the 4 main work streams: **supporting pathways, supporting people, supporting places and communities** and **supporting our workforce**. The projects within these work streams where able are continuing to run to previous plans but adapting their approach in light of Covid-19 restrictions e.g. moving to telephone/video conferencing rather than face-to-face. Where projects are unable to continue contingency plans are being drawn up and new methods of delivery explored. Project teams are looking at how projects can support the response and recovery effort and are using the opportunity to continue planning work with a view to having well developed plans that can be enacted once restrictions are lifted.

Some projects have been prioritised to aid our recovery response. These include;

- Accelerate and widen the scope of the older adult's work stream in the *We Can Move* programme
- Accelerate roll out of Healthy Living with Type 2 diabetes App
- Increase publicising of *KiActiv* programme as it provides a remote, home based physical activity programme targeted at Long Term Conditions.

The programme intends to;

- Capitalise on and retain some of the voluntary and community response to the Covid 19 pandemic, incorporating this into the existing EAC community capacity building work.

- Provide greater offers of remote support using video conferencing
- Increase the use of digital technology
- Use communication tools to encourage and support people to continue to take responsibility for their own self-care and prevention beyond Covid 19.

3. Clinical Programme Approach

The Clinical Programme Approach has been adopted across our local health care system to make sure services work together to redesign the way care is delivered in Gloucestershire. By reorganising the way care is delivered and services that deliver this care we can make sure that people get the right care, in the right place, at the right time. During 2019/20 we identified 4 clinical programmes which will be moved forward more quickly. These are **Respiratory, Diabetes, Circulatory and Frailty & Dementia**.

The Clinical Programme Groups (CPGs) are all highlighting the impact of Covid-19 on the transformation programmes and Terms of Reference are being amended to agree ways of working through Covid 19 incident and recovery phases. Where projects are able they are continuing to run but adapting their approach in light of Covid-19 restrictions. Where projects are unable to continue contingency plans are being drawn up and new methods of delivery explored. There is also opportunity to fast track some work programme content (i.e. non face to face appointments). The Cancer, Diabetes and Respiratory Clinical Programme Groups have a high priority within the Covid 19 response given the impact to people with these conditions.

As the programme moves towards recovery priority areas include;

- Respiratory – Covid and Non Covid pathways
- Cancer (including implementation of Faecal Immunochemical Test - FIT)
- Frailty pathway
- End of Life Care
- Muscular Skeletal (MSK) Pathways

These areas have important links to;

- Mental Health pathways including social prescribing
- Diagnostics
- Use of remote technology including digital methods for advice and guidance between GPs and hospital clinicians.

These will sit alongside the existing CPG priority areas. All pathways are keen to build on the momentum of changes made to date, for example the use of virtual appointments and are looking

to prioritise patient and public involvement to inform substantiating or introducing new changes.

4. Reducing Clinical Variation

The Reducing Clinical Variation (RCV) programme looks to elevate key issues of clinical variation to ICS level. This will include having conversations with the public around some of the harder priority decisions we will need to make. This includes building on a different approach with primary care, promoting 'Choosing Wisely', thinking about how medicines can be used in a better way to reduce cost and waste, undertaking a review of diagnostic services and working to improve Outpatient services.

During the Covid 19 outbreak

- The Diagnostic Strategy development has been partially suspended.
- A regional home working image sharing solution has been proposed to be rolled out across the South West.
- Prescribing Support Team services are gradually returning to normal and work on developing local prescribing improvement schemes for 2020/21 has recommenced.
- The Outpatient Board is temporarily suspended along with associated work streams. However, a number of key elements of outpatient transformation are being accelerated as part of the Covid 19 response potentially allowing improvements to be sustained into the future.

Some projects have been prioritised to aid our recovery response. These include;

- End of life medications were prioritised during April, and during May we have seen priority work addressing the care home primary care requirements based on national guidance.
- 2 week wait (urgent) dermatology Referral Assessment Service (RAS) prioritised for implementation to support virtual review of patients who need rapid assessment.
- Plans for the development and implementation of 'Advice First' approach to referrals supporting more patients to be managed locally by their GP.
- 'Attend Anywhere' video consultations rolled out widely to avoid face to face appointments across many parts of our healthcare system.
- Telephone appointments rolled out more widely to avoid face to face appointments.
- Review of people on waiting lists for follow up appointments continued and accelerated in a number of specialities.

5. Fit For The Future

The Fit for the Future programme is concerned with how to make best use of our resources, facilities and beds in hospitals and in the community.

We want to improve arrangements for patients to access timely and senior clinical decision making about their treatment and ensure specialist support is accessed as soon as possible. We propose potentially changing the way some care and support is organised in Gloucestershire to meet changing demands, make best use of our staff, their skills and the money we have.

Regular updates on the Fit for the Future Programme have been shared with HOSC, describing how the programme aims to deliver an integrated urgent care system and hospital centres of excellence to ensure we realise the vision for care.

Due to Covid 19 the Fit For the Future programme work was initially on hold. A revised timeline has now been developed proposing that the programme now resumes with a proposed public consultation in the Autumn (subject to usual assurance and governance requirements). The HOSC Committee will receive full updates on these proposals as a separate report.

6. Enabling Programmes

Our vision for future Health and Social Care in Gloucestershire is supported by our enabling programmes. These are working to ensure that the ICS has the right capacity and capability to deliver on the clinical priorities. These have been identified as;

Joint IT Strategy: Local Digital Roadmap

All transformation work programmes have paused, except where objectives are aligned to supporting the COVID-19 Response. This has meant a concentration on supporting remote working and online access for patients. Activities that support remote working, digital information access and virtual consultation have been accelerated to meet the demands of the Covid 19 response.

Joint Workforce Strategy

The Workforce planning process and five year workforce plan has been paused. The Two leadership cohorts planned for April and May have been postponed until after the summer. The

July cohort is under review. HEE workforce development annual funding has been delayed and the process is to be reviewed. The System has seen some team redeployed to support the COVID 19 response and a concentration on the work of the Staffing bronze cell. The staffing cell has ensured that we taking steps to support our staff wellbeing and keep them as safe as possible during the Covid 19 response acting on national guidance and working across all partner organisations jointly with our staff.

Joint Estates Strategy

ICS wide joint work has been paused over past few months. There has been substantial redeployment and/ or focus of staff on immediate Covid 19 response operational matters including Bristol Nightingale and COVID hubs.

Primary Care Strategy

As a consequence of the pandemic Primary Care Networks (PCN) development has accelerated, with 15 PCNs now reconfirmed and in place across Gloucestershire. COVID/Resilience Hubs are now either operational (6 hubs) or on standby (2 hubs) to be operationalised as needed. Several hubs are now either being stood down into 'standby' or their models reviewed based on local demand. The hubs have been a catalyst for PCNs to come together to support their practices with the setting up of the hubs, in some areas this working together has incorporated multiple PCNs.

Home visiting services for PCN's are under development and home working for GPs and other practice staff who are self-isolating has been taking place. Practice requirements have increased under the Care Homes COVID Response, ahead of the national specification which is due to commence in Oct 2020. This includes virtual GP ward rounds.

The programme intends to;

- Continue use of telephone triage and video consultations.
- Use Microsoft Teams for meetings & wide spread uptake and use of technology and remote working
- Shielded patients work – plans to potentially use a similar telephone hub model to support High Intensity Users and Complex Care at Home projects in the future.

We have seen parts of the county work together extremely well and co-operatively. These newly forged relationships will benefit Gloucestershire patients and the ICS in the longer-term.

Developing the Primary Care Workforce

The CCG and the Gloucestershire Primary Care Training Hub continue to develop workforce

solutions to ensure that practices are supported over the recovery period. Solutions include:

- Following on from changes in government advice it is likely that face to face assessments will rise. Engagement with practices on workforce needs will continue to be assessed and supported.
- A primary care relevant volunteer toolkit has been developed and released to all practices in county. This is based on an ICS wide volunteer recruitment framework.
- An assessment of workforce and training programmes is taking place over the next few weeks to inform recovery planning for GP Practices and Primary Care Networks.
- There is a return to Non-Covid-19 work streams and projects to continue development for consideration within the 'new normal'.
- Exploring the implementation of a Virtual Learning Platform for use in Primary Care, to facilitate and deliver learning and development throughout the pandemic
- Engagement on workforce streams across the ICS continues to include joint bids on education facilitation in the future, and exploration of support for apprenticeships in primary care.

7. Integrated Care System Development

As a Wave 2 Integrated Care System we are working towards increased integration to improve health and wellbeing, we believe that by all working better together, in a more joined up way, and using the strengths of individuals, carers and local communities, we will transform the quality of care and support we provide to local people. The System Development work stream captures the work to develop the overarching ICS programme. The responsibilities of this programme are as follows:

- Provide Programme Direction to the Gloucestershire ICS
- Manage a Communications and Engagement approach on behalf of the ICS, including ensuring the Health and Social Care Act duties regarding significant services changes are met in relationship to the ICS
- Ensure the ICS has a robust resources plan in place that all ICS partners are signed up to and that is aligned to organisational level plans.
- To ensure that the ICS has clear governance and performance management in place to ensure the system can manage and oversee delivery.

Due to the Covid 19 the 2020/21 Operational Planning has been paused and the Publication of

the Gloucestershire Long Term Plan (LTP) has been delayed. Some of the work-streams within the LTP have been accelerated in particular around staffing, outpatient care, digital streams & sustainability.

Wider mechanisms for system working have continued to work well and adapt during the incident response underpinned by good system relationships.

8. Recommendations

This report is provided for information and HOSC Members are invited to note the contents.

Mary Hutton

ICS Lead, One Gloucestershire ICS

Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 09.1

REPORT TO: Trust Board – 22 July 2020

PRESENTED BY: Lavinia Rowsell, Head of Governance and Trust Secretary

AUTHOR: Lavinia Rowsell, Head of Governance and Trust Secretary

SUBJECT: **BOARD ASSURANCE FRAMEWORK AND CORPORATE RISKS**

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

The purpose of this report is to
To provide assurance to the Board on the management of risk. Along with the corporate risk register the BAF supports the creation of a culture which allows the organisation to anticipate and respond to adverse events, unwelcome trends and significant business and clinical opportunities. It helps to clarify what risks are likely to compromise the trust's strategic and operational objectives and assists the executive team in identifying where to make the most efficient use of their resources in order to improve the quality and safety of care.

Recommendations and decisions required

The Board is asked to:

- **receive** and **approve** the update BAF
- **note** the overarching risk profile (page 39)

Executive summary
The current Trust's Board Assurance Framework was considered and approved at the November 2019 meeting of the Board as an interim measure in advance of the finalisation of the GHC strategic framework. Due to the Covid-19 pandemic, the finalisation of the strategic framework has been delayed. A Board Seminar, scheduled for 15 September, will focus on finalising the strategy. The BAF and review of Risk Appetite will be considered as part of this session.

The BAF has been updated in consultation with members of the Executive. The corporate risks relating to each of the risk areas are highlighted in the paper and have been reviewed by the relevant governance oversight committee. The following key changes to the BAF since Board consideration in March 2020 are highlighted as follows:

Amendments made: All risks have been reviewed and actions/additional controls added where appropriate. Changes are highlighted in red text.

***Strategic risks removed this quarter*:** Risk 13 (*That the transfer of Herefordshire Services to Worcestershire health and Care NHS Trust impacts on our capacity to progress our strategic objectives before April 2020)* was removed from the register following the transfer of Herefordshire services.

***Strategic risk added in this quarter**:* Strategic Risk 00 relating to Covid-19 was added to the register following agreement at the March meeting of the Board and was further reviewed by the Board in April and May.

Movement in risk ratings since the last quarter: Overall, there has been little movement in risk ratings since the March meeting of the Board. The implementation of mitigating actions have been delayed due to resource being reallocated to support the Trust's response to Covid-19, however no concerns have been raised as a result of the delays that need to be brought to the attention of the Board. Updated timescales have been provided.

Risk 10: *There is a risk that the One Gloucestershire transformation plans become frustrated and impact on our individual Trust aims and objectives and the whole system plans*. Having considered this risk, it is the recommendation of Executive that the risk rating be reduced from 16 to 9. The rationale for reduction reflects the outcome of the urgent care in the community programme and the recommendation that urgent treatment centres will not be part of the MIIU model moving forward. Ongoing work will form part of any future trust wide transformation.

Risk 00: *That the impact of Covid-19 places the Trust's services under increased clinical and operational pressure which negatively influences patient care in terms of patient safety, wellbeing and mortality outcomes and limited access to services exacerbated by lower staffing levels.* Further to discussion at the May meeting of the Board, the risk working has been updated to better reflect the impact of Covid-19 on patients. The risk rating has been reduced from 20 (in May) to 16 to better reflect the position and impact of mitigating actions.

Risks associated with meeting the Trust's values

As set out in the paper.

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

Where has this issue been discussed before?
With individual risk owners and the Executive.

Appendices:	None

Report authorised by: Executive	**Title:**

BOARD ASSURANCE FRAMEWORK

The design of the Board Assurance Framework (BAF), adopts the NHS standard format and identifies risks to the delivery of the new Trust's strategic objectives and also to capture the controls and assurance in relation to strategic risks. Strategic risks are defined as those risks that, if realised, could affect the way in which the Trust exists or operates.

Strategic risks will be identified by Directors, and will be aligned to the Trust's strategic objectives. The nominated lead for each strategic risk will be responsible for identifying controls and sources of assurance to ensure that these controls operate effectively. Sources of Assurance are classified into type – Management, Board and External, reflecting the three lines of defense to enable the Board to understand how fully its assurance basis. Any gaps will be identified and action plans put in place to strengthen controls. Risks will be assigned to Board or Board committees for consideration at each meeting to provide appropriate visibility, monitoring and assurance.

The BAF will be fully reviewed by the Board three times a year, and the Audit and Assurance Committee three times a year and it will support the Chief Executive Officer in completing the Annual Governance Statement at the end of each financial year.

Strategic risks are those risks which could fundamentally affect the way in which the Trust operates, and that could have a detrimental effect on the Trust's achievement of its strategic objectives.

Corporate risks which relate to the Strategic Risks (12 or more), are detailed with their scores. The Corporate risks which are over 12 are reviewed by the Board committee which covers the related area.

1.1 **Risk Appetite** - The Board met in May and July 2019 to agree its risk appetite - a key element of its risk management process.

1.2 **The Risk Management Policy** has been put in place, as detailed within the agreed Board Memorandum – Financial Reporting Procedures.

1.3 **Strategic Objectives Development** - Recognising that the refining of the strategic objectives for the Gloucestershire Health and Care NHS Foundation Trust, is a process still being taken forward to enable an interim Board Assurance Framework to be put in place until the Board have their development and review session on it in June 2020, the strategic objectives from within the Strategic Intent, have been reduced to their core elements to provide a starting point which can then be used as a building block further down the process.

1.1 Strategic Risks: SUMMARY OF STRATEGIC RISKS

Trust strategic objectives	Strategic risks							
	Ref	Risk	RAG	Exec Lead	Assurance Body	Inherent Risk Score	Current Risk Score	Target Risk Score
All Strategic Objectives	**SR00**	That the impact of Covid-19 places the Trust's services under increased clinical and operational pressure which negatively influences patient care in terms of patient safety, wellbeing and mortality outcomes and limited access to services exacerbated by lower staffing levels.	**H** ↑	CEO/ DoNTQ	Board	25 5x5	**16** **4x4**	12 4x3
Strong System Leader and Partner	**SR1**	There is a risk that we fail to support and progress effective working within the health and care system and cannot fully achieve the benefits of integration targeted within the Strategic Intent for the merged Trust and meet the NHS Long Term plan.	**M** ↔	CEO/ DoSP	Board	12 3x4	**8** **2x4**	4 1x4
Strong System Leader and Partner	**SR2**	There is a risk that services are not sustainable and do not continue to improve and develop to meet needs.	**M** ↔	CEO/ DoSP	Board	12 3x4	**8** **2x4**	4 1x4
Outstanding Care	**SR3**	There is a risk that failure to: (i) meet consistent quality standards for care and support; (ii) address variability across quality standards; or (iii) reconcile conflicting quality standards or guidance, will result in poorer outcomes for patients/service user and carers and poorer patient safety and experience.	**M** ↔	DoNTQ	Quality Committee	12 3x4	**8** **2x4** **On Target**	8 2x4
Outstanding Care	**SR4**	There is a risk that the Trust does not maintain robust focus on either/or mental and physical health.	**M** ↔	CEO	Board	15 3x5	**10** **2x5**	5 1x5

Trust strategic objectives	Ref	Strategic risks Risk	RAG	Exec Lead	Assurance Body	Inherent Risk Score	Current Risk Score	Target Risk Score
Personalised Experience	**SR5**	There is a risk that we fail to keep service users and carers at the heart of what we do and do not deliver genuine co-production.	**M** ↔	DoNTQ	Quality Committee	12 3x4	**8** **2x4**	4 1x4
Engaged, Empowered and Skilled Workforce	**SR6**	There is a risk that we are unable to recruit and retain the workforce we need to meet our ambitions to: • provide outstanding, joined up care • maintain colleague well-being • minimise use of agency and bank staff	**H** ↔	Dir HR & OD	Resources Committee	16 4x4	**16** **4x4**	8 2x4
Engaged, Empowered and Skilled Workforce	**SR7**	There is a risk that we fail to establish a culture which: • engages and empowers colleagues engendering a sense of collective ownership • supports discretionary innovation	**M** ↔	Dir HR & OD	Resources Committee	16 4x4	**12** **3x4**	4 1x4
Innovation and Research Driven	**SR8**	There is risk that we don't enable colleagues to support Innovation and Research through appropriate funding, time and focus and strategic drivers.	**M** ↔	MD & DoSP	Quality Committee	9 3x3	**9** **3x3**	6 2x3
Innovation and Research Driven	**SR9**	There is a risk that we do not have in place structures and processes which enable colleagues to look beyond the organisation to identify leading edge practice to inform practice.	**M** ↔	~~DoNTQ~~ & MD	Quality Committee	9 3x3	**9** **3x3**	6 2x3
Best Value	**SR10**	There is a risk that the One Gloucestershire transformation plans become frustrated and impact on our individual Trust aims and objectives and the whole system plans.	**M** ↑	CEO	Board	16 4x4	**9** **3x3**	8 2x4

Trust strategic objectives	Ref	Strategic risks Risk	RAG	Exec Lead	Assurance Body	Inherent Risk Score	Current Risk Score	Target Risk Score
Best Value	**SR11**	There is a risk we **do not** maintain robust internal controls (Including financial) and governance systems; resulting in potential financial and organisational instability.	**M** ⟷	Dir Finance	Resources Committee Audit & Assurance Committee	12 3x4	**8** **2x4**	4 1x4
Best Value	**SR12**	There is a risk we do not achieve our individual organisations financial sustainability and contribute to whole system sustainability.	**M** ⟷	Dir Finance	Resources Committee	12 3x4	**8** **2x4**	6 2x3

Strategic Objective:		ALL STRATEGIC OBJECTIVES
Risk Ref:	**Latest Rating and Direction of Travel**	**Risk Description**
SR00	↑	That the impact of Covid-19 places the Trust's services under increased clinical and operational pressure which negatively influences patient care in terms of patient safety, wellbeing and mortality outcomes and limited access to services exacerbated by lower staffing levels.

Type	Quality			**Executive Lead**	Director of Nursing	Med Director
Risk Rating	**Likelihood**	**Impact**	**Total**	**Assurance Committee**	Board	
Inherent (without controls being applied) Risk Score	5	5	25	**Date Identified**	Feb 2020	
Previous Meeting Risk Score	4	5	20	**Date of Review**	June 2020	
Current Risk Score	**4**	**4**	**16**	**Date Next Review**	Ongoing	
Tolerable (Target) Score	4	3	12	**Date to Achieve Target**	March 2021	

Key 2020 Deliverables	**Relevant Key Performance Indicators**
Continued compliance with national guidance and requirements i.e. Covid secure environments, Public Health England personal protective equipment guidance, BAME guidance and high standards of infection control, all to maintain safety and wellbeing of patients , carers and staff . Ongoing staff support and wellbeing measures to care for staff and maintain effectiveness.	

Key Controls To Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
Business continuity planning and emergency response plans in place	Executive briefings. Board Assurance Committee.	Management		Regular Exec/Board briefings/	Completed	Sian Thomas	Programme management approach adapted to longer term incident management.

Key Controls To Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
Recovery programme established with Exec work-stream leads	Weekly executive briefings.	Management		Recovery programme structure in place.		Sian Thomas	Programme Structure in place reporting to Exec. Recovery plans in place for all services. Future state programme plan developed with system partners.
Engagement in local/regional/national NHS emergency guidance and protocols	Feedback from ICS/discussion with system partners to Executive.	Management	Guidance from centre on specific issues.	Continued engagement with system and wider NHS partners.	Ongoing	Executive	Demand and capacity systems for essential services in place and monitored. Trust contributing to national work on PPE supply.
Protocols for maintaining infection prevention and control in workplaces established for the protection of patients and staff	Executive. Quality Committee/QAG.	Management	Covid secure environments across trust.	Implementation of government guidelines. Infection prevention and control board assurance framework reviewed by QAG in July.	Ongoing	Sian Thomas	Joint working with ICS partners. Regular review of PPE guidance. GHC stock management team established. Additional PPE storage secured. IP&C assurance framework in place. Covid secure environmental toolkit rolled out. Serology programme completed.

Key Controls To Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
Maintenance of safe staffing levels	Progress reports to Executive.	Management			Ongoing	DoHR&OD/ Sian Thomas	Health and Wellbeing offer in place to support all staff. Annual Leave is encouraged and carry over has been extended and approved.
Key workforce policies and HR guidance on remote working, sickness reporting	Weekly executive discussion. Communication through internal Comms structure.	Management		HR guidance/ policies regularly updated in line with national policy developments	Ongoing	DoHR&OD	Sickness and isolation reporting in place. Home working risk assessments in place.
Risk assessments for all at risk staff	Management and Board.	Management and Board		Risk assessments for all at risk staff. Covid Secure environment project.			All at risk staff contacted. Additional support including OH and FTSU in place. Covid- secure environment toolkit developed. As of 08/07/20 – 89% of BAME colleagues have had a risk assessment. Roll out of returning sheilders toolkit risk assessment and guidance.

Key Controls To Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
Sufficient PPE to ensure Workforce remains safe and to reduce spread of the Virus	Monthly progress reports to business continuity team and Executive.	Management		Centralised stock management team Monitoring and standard operating procedure as per national guidance	Ongoing	Sian Thomas	Regular monitoring of central guidance. Stock management team in place.
Links to Risk Register							
Risk 264 (Impact on GHC)/ **Risk 282** (Staff Health & Well-being)/ **Risk 285** (Impact on Staff)/ **Risk 265** (PPE)/ **Risk 281** (Equipment) **/ Risk 278 / 279** (Litigation)/ **Risk 291** (Fraud)							

Strategic Objective:		STRONG SYSTEM LEADER AND PARTNER
Risk Ref:	**Latest Rating and Direction of Travel**	**Risk Description**
SR1	⟷	There is a risk that we fail to support and progress effective working within the health and care system and cannot fully achieve the benefits of integration targeted within the Strategic Intent for the merged Trust and meet the NHS Long Term plan.

Type	Quality			**Executive Lead**	Director of Nursing	Med Director
Risk Rating	**Likelihood**	**Impact**	**Total**	**Assurance Committee**	Quality Committee	
Inherent (without controls being applied) Risk Score	3	4	12	**Date Identified**	Nov 2019	
Previous Meeting Risk Score	2	4	8	**Date of Review**	June 2020	
Current Risk Score	**2**	**4**	**8**	**Date Next Review**	September 2020	
Tolerable (Target) Score	1	4	4	**Date to Achieve Target**	March 2021	

Key 2020 Deliverables	**Relevant Key Performance Indicators**
Overall 5 Year Trust Strategy developed.	

Key Controls To Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
CEO & Chair members of the Integrated Care System – engaged in all processes, regular meeting structure in place. Attendance levels and partner engagement strong	Reports to Board on ICS work, priorities & action plans. Two way communication processes in place.	Board	ICS Governance requires further development.	ICS Memorandum of Understanding, including delegation & ways of working.	June 2020	ICS Chair	Strong engagement/ attendance at ICS meetings by Chair/Exec. ICS MoU currently under review with input from the DoS&P
Director of Locality and Primary Care Post – Joint post with Clinical Commissioning Group which has embedded ongoing partnership working with Primary Care, which is supporting	Reports to Board (attendance at Board by Director of Locality and Primary Care to ensure issues reviewed through this lens on ongoing basis.	Board	ILP activity has been suspended during COVID and needs to be re-instigated in a safe and timely manner.	Active engagement with all system partners as ILPs recommence activities.	~~June 2020~~ Sept 2020	Director of Locality and PC/ Director of S&P	Deputy MD ad CD now in post. Place' considered a key element for the delivery of strategy and will be considered further in the emerging

Key Controls To Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
effective cross system working							priorities around health outcomes.
Executive membership & leadership of key ICS Groups, Local Medical Committee, Primary Care Networks. Attendance levels and partner engagement strong	Feedback from Groups to Executive.	Management	Executive capacity during COVID pandemic has meant lack of time to engage.	Up-skilling next layer of management team.	~~June 2020~~ March 2021	CEO	Development planning ongoing.
Effective Engagement in the Primary Care Networks (PCN). Meetings with Clinical Directors	Reports to Board & Executive.	Board	Capacity to personalise support and take forward actions from PCN.	Development of roles below directors to enhance capacity. Development processes planned.	Sept 2020	CEO	Development planning ongoing. CEO meetings and regional presentations to Clinical Directors.
Long Term Plan integrated into strategic planning work	Strategic Intent & approved Merger documentation.	External – NHSE/I	Awaiting guidance on finalisation of 20/21 plans which were delayed due to COVID19.	Executive to consider any short and long term implications.	~~March 2020~~ Sept 2020	CEO	ICS Long Term Plan submitted. Alignment process to Trust objectives and plans has taken place and is first draft.
Links to Risk Register							

Strategic Objective:		STRONG SYSTEM LEADER AND PARTNER
Risk Ref:	**Latest Rating and Direction of Travel**	**Risk Description**
SR2	⟷	There is a risk that services are not sustainable and do not continue to improve and develop to meet needs.

Type	Quality			**Executive Lead**	Director of Nursing	Med Director
Risk Rating	**Likelihood**	**Impact**	**Total**	**Assurance Committee**	Quality Committee	
Inherent (without controls being applied) Risk Score	3	4	12	**Date Identified**	Nov 2019	
Previous Meeting Risk Score	2	4	8	**Date of Review**	June 2020	
Current Risk Score	**2**	**4**	**8**	**Date Next Review**	September 2020	
Tolerable (Target) Score	1	4	4	**Date to Achieve Target**	March 2021	

Key 2020 Deliverables	**Relevant Key Performance Indicators**
ICS Strategy Implemented taking forward One Gloucestershire proposals.	

Key Controls To Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
ICS Board ensures focus is on sustainability across the Gloucestershire health sector. GHC Chair and CEO fully engaged in ICS Board and ICS Development to ensure forward looking agenda	Reports to Board. Non-Executive Director Sessions. Executive meetings with counterparts.	Board and management.	Sustainable Development management plan to be developed for the Trust that joins up across the wider ICS system.		Sept 2020	DoSP	Best Value Board Development session completed. Fit for the Future consultation process due to commence September 2020.
Fit for the Future Engagement – publication and engagement programme developed collectively with staff from across the Healthcare system delivering	Board involvement in Fit for the Future Engagement.	Board	Council of Governors to reflect the wider Trust need to be appointed and developed.	Governors Review and Refresh Programme.	Sept 2020	DoSP	Governor 'review and refresh' to report in ~~April~~ September. Full involvement in the Fit for the Future Solutions Appraisal workshop.

Key Controls To Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
Co-production central to Trust's operation and this is being built into ways of working and ways of reviewing practice	Development work of Director of Strategy and Partnerships and Chief Operating Officer.	Management	Clear approach to co-production and people participation not in place.	People Participation Committee to be established.	~~April 2020~~ Sept 2020	DoSP	Discussions commenced on People Participation agenda.
Gloucestershire Health Finance Directors meet regularly to ensure up to date understanding of the financial position across the local Health economy	Reports to Executive and Board Management Accounts.	Management and Board				DoF	ICS Financial updates given as part of Board Reports.
Executive involvement in development of key pathways within ICS	Reports to Board.	Management & Board				DoSP	DoSP attending New Models of Care Board and Fit for the Future programme to ensure alignment with key work programmes.

Links to Risk Register
Risk 1002 (Operational Resilience)/ **Risk 291** (Fraud)/ **Risk 293** (Software replacement)

Strategic Objective:		OUTSTANDING CARE
Risk Ref:	**Latest Rating and Direction of Travel**	**Risk Description**
SR3	⟷	There is a risk that failure to: (i) meet consistent quality standards for care and support; (ii) address variability across quality standards; or (iii) reconcile conflicting quality standards or guidance, will result in poorer outcomes for patients/service user and carers and poorer patient safety and experience.

Type	Quality			**Executive Lead**	Director of Nursing	Med Director
Risk Rating	**Likelihood**	**Impact**	**Total**	**Assurance Committee**	Quality Committee	
Inherent (without controls being applied) Risk Score	3	4	12	**Date Identified**	Nov 2019	
Previous Meeting Risk Score	2	4	8	**Date of Review**	June 2020	
Current Risk Score	**2**	**4**	**8**	**Date Next Review**	Sept 2020	
Tolerable (Target) Score	2	4	8	**Date to Achieve Target**	Ongoing	

Key 2020 Deliverables	**Relevant Key Performance Indicators**
Quality Strategy in place with Performance Measures.	

Key Controls To Manage Risk	**Assurance on Controls**	**Type of Assurance**	**Gaps in Controls**	**Key Actions To Address**	**Target to Complete**	**Action Owner**	**Action Update**
Patient Safety Controls: Clinical Risk Management Processes, Risk Management Strategy & Policy, Patient Safety Team processes. (for example – medication management – including Annual Report, Never Event and Serious Incidents Requiring Investigation & Never Event monitoring & learning, Mortality Review processes)	Reports to Quality Committee and sub Committees. Internal audit on Governance.	Management & Board	Quality Committee frequency of meeting and combined quality report not yet in place.	During transition phase Quality Committee will meet on a monthly basis and separate Quality Reports will continue for at least 6 months to ensure breadth of focus.	Ongoing	DoNTQ	Quality Committee arrangements established and functioning well. Board consideration of Quality Reports at each meeting. Positive outcome of internal audit on governance.

Key Controls To Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
Patient experience controls (including compliments, complaints and learnings identified, communicated, embedded and confirmed through audit and review)	Reports to Quality Committee Reports to Executive.	Management and Board	Experts by Experience not embedded within community services.	Experts by Experience actions to be embedded.	~~July 2020~~ Oct 2020	DoNTQ	Progress delayed due to Covid. Expert by Experience on Quality Committee. To extend to sub-groups.
Co-production actions – Better care together engagement events & related clinical and operational review to reflect feedback	Reports to Quality Committee Reports to Executive.	Management and Board	Co-production to be further developed across the combined Trust.	Co-production further developed and embedded across Trust.	Oct 2020	DoSP	Activities have been suspended during COVID and need to be reconsidered in light of new ways of delivery via social distanced approaches.
Workforce Controls – safe staffing processes and ways of working – defined and reported on within Quality reporting processes	Reports to Resources Committee and Quality Committee. Reports to Executive.	Management and Board	Staff turnover and staff sickness which may lead to increased use of agency staff that have less knowledge of Trust processes and procedures.	Staff recruitment and Retention actions.	Ongoing	Dir HR & OD DoNTQ	Use of practices such as Safety huddles to update staff within working day. Use of GHC Bank and Master Vendor Contract to ensure greater consistency of staffing. Agency Management Group.
Freedom to Speak Up and Whistleblowing processes fully embedded across Trust	Reports to Board (covering processes, volumes, types of issues, resolution practices, benchmarking & good practice guidance and internal audit report.	Board		Internal Audit and action plan	March 2020	DoNTQ	New policy in place. Incorporated Guardian in senior team. Board development session in April (session delayed due to Covid).

Links to Risk Register
Risk 253 (consultant capacity)/ **Risk 562** (pressure ulcers)/ **Risk 609 (**staff retention)/ **Risk 116** (Agency management)/ **Risk 173 (**workforce)/ **Risk 258** (workforce)/ **Risk 6** (Serious incidents)

Strategic Objective:		OUTSTANDING CARE
Risk Ref:	**Latest Rating and Direction of Travel**	**Risk Description**
SR4	⟷	There is a risk that the Trust does not maintain robust focus on either/or mental and physical health.

Type	Quality			**Executive Lead**	Director of Nursing	Med Director
Risk Rating	**Likelihood**	**Impact**	**Total**	**Assurance Committee**	Quality Committee	
Inherent (without controls being applied) Risk Score	3	5	15	**Date Identified**	Nov 2019	
Previous Meeting Risk Score	2	5	10	**Date of Review**	June 2020	
Current Risk Score	**2**	**5**	**10**	**Date Next Review**	Sept 2020	
Tolerable (Target) Score	1	5	5	**Date to Achieve Target**	Nov 2020	

Key 2020 Deliverables	**Relevant Key Performance Indicators**
Quality Strategy in place with Performance Measures.	

Key Controls To Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
Patient Safety Controls: Clinical Risk Management Processes, Risk Management Strategy & Policy, Patient Safety Team processes. (For example – medication management – includes Annual Report, Never Event and Serious Incidents Requiring Investigation & Never Event monitoring & learning, Mortality Review processes)	Reports to Quality Committee and sub Committees. Reports to Executive.	Management & Board	Quality Committee frequency of meeting and combined quality report not yet in place.	During transition phase Quality Committee will meet on a monthly basis and separate Quality Reports will continue for at least the first 6 months to ensure focus continues across the breadth of the new Trust's services.	Ongoing	Director of Nursing, Therapies & Quality	Meetings embedded. Reporting process to Board defined. All sub-groups and work-plan in place. Agendas for Quality Committee and subgroups demonstrate good balance of mental/physical care. Positive outcome of internal audit on governance.

Key Controls To Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
Patient Safety Controls: Clinical Risk Management Processes, Risk Management Strategy & Policy, Patient Safety Team processes. (For example – medication management – includes Annual Report, Never Event and Serious Incidents Requiring Investigation & Never Event monitoring & learning, Mortality Review processes)	Reports to Quality Committee and sub Committees. Reports to Executive.	Management & Board	Quality Committee frequency of meeting and combined quality report not yet in place.	During transition phase Quality Committee will meet on a monthly basis and separate Quality Reports will continue for at least the first 6 months to ensure focus continues across the breadth of the new Trust's services.	Ongoing	Director of Nursing, Therapies & Quality	Meetings embedded. Reporting process to Board defined. All sub-groups and work-plan in place. Agendas for Quality Committee and subgroups demonstrate good balance of mental/physical care. Positive outcome of internal audit on governance.
Key Controls To Manage Risk	**Assurance on Controls**	**Type of Assurance**	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
Management Structure developed through merger process ensures focus on mental and physical health, whilst not acting as a barrier to integration	Management Structure	Management	Medical Strategy	To develop Medical Strategy	Nov 2020	Medical Director	Key appointments made in physical and mental health. Structure in place.
Co-production and engagement activities with carers, service users and staff reflect the need to ensure integration is not achieved at the expense of necessary specialism and that all relevant groupings are appropriately engaged	Co-production and engagement methodology.	Management	Quality Framework	To develop Quality Framework	Nov 2020	DoNQT	Draft strategy to March Board. Experts by Experience on Quality Comm. Looking to extend to sub-comms. Quality Framework delayed due to Covid but deadline to be achieved.

Key Controls To Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
Patient Safety Controls: Clinical Risk Management Processes, Risk Management Strategy & Policy, Patient Safety Team processes. (For example – medication management – includes Annual Report, Never Event and Serious Incidents Requiring Investigation & Never Event monitoring & learning, Mortality Review processes)	Reports to Quality Committee and sub Committees. Reports to Executive.	Management & Board	Quality Committee frequency of meeting and combined quality report not yet in place.	During transition phase Quality Committee will meet on a monthly basis and separate Quality Reports will continue for at least the first 6 months to ensure focus continues across the breadth of the new Trust's services.	Ongoing	Director of Nursing, Therapies & Quality	Meetings embedded. Reporting process to Board defined. All sub-groups and work-plan in place. Agendas for Quality Committee and subgroups demonstrate good balance of mental/physical care. Positive outcome of internal audit on governance.
Board composition reflects the need to ensure the history and legacy of each precursor Trust is maintained and that the Board has the skills to challenge to enforce appropriate focus on both areas of activity	Board appointment process and Development processes. Associate Non-Executive Director in place for transition period.	Board NHSE/I	Service User feedback process does not currently review against commitment to physical & mental health for early indications.	To be incorporated in review process as the systems are integrated.	Dec 2020	DoNQT	Service User feedback regularly reported to Quality Committee and considered by Executive – ongoing. Board development sessions/seminars in place.
Medical Committee and Staff Forum provide feedback mechanism from colleagues across the Trust, with different specialisms and foci, to ensure focus is maintained.	Reports to Executive Staff Engagement	Management	Membership for Trust may not currently reflect spectrum of service users.	Focus on Membership with aim balance of service users across the Trust's provision.	Sept 2020	CEO	Governance mechanism in place - Senior Leadership Network, Team Talk and creation of bi-monthly Senior Leadership Team business meetings. Governor Review and Refresh.

Key Controls To Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
Patient Safety Controls: Clinical Risk Management Processes, Risk Management Strategy & Policy, Patient Safety Team processes. (For example – medication management – includes Annual Report, Never Event and Serious Incidents Requiring Investigation & Never Event monitoring & learning, Mortality Review processes)	Reports to Quality Committee and sub Committees. Reports to Executive.	Management & Board	Quality Committee frequency of meeting and combined quality report not yet in place.	During transition phase Quality Committee will meet on a monthly basis and separate Quality Reports will continue for at least the first 6 months to ensure focus continues across the breadth of the new Trust's services.	Ongoing	Director of Nursing, Therapies & Quality	Meetings embedded. Reporting process to Board defined. All sub-groups and work-plan in place. Agendas for Quality Committee and subgroups demonstrate good balance of mental/physical care. Positive outcome of internal audit on governance.
Reporting frameworks from 2021 demonstrate equity of physical and mental health assurance	Governors, Resources Committee	Management Board	Central guidance issued w/c. 31/01		May 2020		Completed. New quality dashboard.
Links to Risk Register							
Risk 112 (IAPT)/ **Risk 31** (data quality)/ **Risk 121** (Record Compliance)/ **Risk 247** (workforce)							

Strategic Objective:		PERSONALISED EXPERIENCE
Risk Ref:	**Latest Rating and Direction of Travel**	**Risk Description**
SR5	⟷	There is a risk that we fail to keep service users and carers at the heart of what we do and do not deliver genuine co-production.

Type	Strategic			**Executive Lead**	Chief Operating Officer	Med Director
Risk Rating	**Likelihood**	**Impact**	**Total**	**Assurance Committee**	Quality Committee	
Inherent (without controls being applied) Risk Score	3	4	12	**Date Identified**	November 2019	
Previous Meeting Risk Score	2	4	8	**Date of Review**	June 2020	
Current Risk Score	**2**	**4**	**8**	**Date Next Review**	Sept 2020	
Tolerable (Target) Score	1	4	4	**Date to Achieve Target**	November 2020	

Key 2020 Deliverables	**Relevant Key Performance Indicators**
Co-production Methodology embedded across Trust.	

Key Controls To Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
Patient Safety Controls: Clinical Risk Management Processes, Risk Management Strategy & Policy, Patient Safety Team processes. (for example – medication management – including Annual Report, Never Event and Serious Incidents Requiring Investigation & Never Event monitoring & learning, Mortality Review processes)	Reports to Quality Committee and sub Committees.	Management & Board	Quality Committee frequency of meeting and combined quality report not yet in place.	Quality Committee to meet monthly. Separate Quality Reports to continue for first 6 months to ensure focus across breadth of Trust's services.	Ongoing	DoNTQ	Five meetings held to date. Reporting process to Board now defined. Agendas for Quality Committee and subgroups demonstrate good balance of mental/physical care. Positive outcome of internal audit on governance.

Key Controls To Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
Co-production and engagement activities with carers, service users and staff reflect the need to ensure integration is not achieved at the expense of necessary specialism and that all relevant groupings are appropriately engaged	Co-production and engagement methodology	Management	Quality Framework	To develop Quality Framework	Nov 2020	DoSP	Strategy development delayed due to Covid. On target to develop quality framework by due date. 2 key management posts advertised, Clinical Director/Deputy Medical Director.
Patient experience controls (including compliments, complaints and learnings identified)	Reports to Quality Committee.	Management	Experts by Experience not embedded within community services.	Experts by Experience actions to be embedded.	July 2020	DoNTQ	Better Care Together engagement programme ongoing. Patient experience report to the Quality Committee. DoSP focus on co-production and extension of Experts by Experience for physical health.
Links to Risk Register							
RISK 559 (Mental Capacity Act)							

Strategic Objective:		ENGAGED, EMPOWERED AND SKILLED WORKFORCE
Risk Ref:	**Latest Rating and Direction of Travel**	**Risk Description**
SR6	⟷	There is a risk that we are unable to recruit and retain the workforce we need to meet our ambitions to: • provide outstanding, joined up care • maintain colleague well-being • minimise use of agency and bank staff

Type	Workforce			**Executive Lead**	Director of HR
Risk Rating	**Likelihood**	**Impact**	**Total**	**Assurance Committee**	Resources Committee
Inherent (without controls being applied) Risk Score	4	4	16	**Date Identified**	Inherited risk from 2g and GCS
Previous Meeting Risk Score	4	4	16	**Date of Review**	June 2020
Current Risk Score	**4**	**4**	**16**	**Date Next Review**	Sept 2020
Tolerable (Target) Score	2	4	8	**Date to Achieve Target**	Sept 2020 – Trust led activities, **BUT** it is recognised that the national context is a significant driver in ensuring impact.

Key 2020 Deliverables	**Relevant Key Performance Indicators**
Workforce Plan in place.	

Key Controls To Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
Workforce planning processes. (Integrated within business planning process to ensure impact considered across the range of staffing types and levels)	Reports to Resources Committee and Executive and ICS LWAB.) Workforce planning and narrative submissions.	Board	National approach to NHS pension limits impacts on recruitment & retention.	Key staff being trained in workforce planning via HEE. Lobbying at national level with NHS Providers and NHS Employers.	Ongoing	Dir. HR & OD	Workforce planning presentation included in annual planning workshop. Additional 2 staff have successfully completed university workforce planning qualification. Phase 3 of ICS workforce plan & narrative recommencing in August 2020.

Key Controls To Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
Implementation of the Interim People Plan	Reports to Resources Committee.	Board	Lack of integrated workforce planning data.	Promotion of system approach to workforce planning, including shared career pathways.	March 2021	Dir. HR & OD	People plan delayed due to Covid. Workforce systems projects underway. Legacy ESRs now integrated with further work related to Finance Ledger on-going. ICS LWAB, Workforce & OD steering groups delivering system implementation of interim People Plan.
Skills Mix Reviews	Reports to Chief Operating Officer & Executive.	Management			Ongoing	Dir. HR & OD	Skills mixes carried out. Reviews requested with all turnover New reviews in NTQ & S & P Directorates (Q2).
Monitoring of Agency Use & Vacancies	Reports to Executive, Agency and Bank Management & Resources Committee.	Management & Board		Refocused Agency and Bank Management Group with 3 additional workstream task and finish groups.	Ongoing	COO and Dir. HR & OD	Sustainable Workforce strategy - January 2020 Board. Refocussed Agency and Bank Management group and work streams with action plans & fortnightly meetings. End to end process review of recruitment re-commenced with PMO support end Q1. Fast Track. Recruitment weekly reporting commenced

Key Controls To Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
							Q1.
Safe Staffing Reports	Reports to Quality Committee and Executive.	Board	Trust doesn't commission all training.	Completion of Staff workforce planning training and programme of workforce planning workshops with support from HEE.	July 2020	DNQ&T	Safe Staffing reporting in place. University of Gloucestershire RGN, RMN, & new LD nursing programmes well subscribed to for September intake.
Recruitment & Retention Plans and actions	Reports to Resources Committee.	Board	Limited Resources for promoting Trust jobs and enabling innovative approaches to recruitment & retention.	Recruitment Action Plan and New recruitment strategy & action plan – ensuring best use of funds available.	December 2019 March 2020	Dir. HR & OD	Additional Recruitment & Retention lead post commenced Q4 2019/20. Future State Programme dedicated Recruitment & Retention work stream commenced June 2020. Fast Track Recruitment processes put in place for COVID during Q1 – adoption for longer term processes being progressed.
Career pathway developments	Reports to Executive.	Management	Legacy succession planning and talent management processes from former GCS and 2G.		~~March 2020~~ Oct/Sept 2020	Dir. HR & OD	Planned succession planning & talent management approach delayed due to COVID. ICS Apprenticeship Hub being created & hosted by GHC. ICS agreed NA, ACP & HEE workforce transformation funding,

Key Controls To Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
							programmes & reporting in place. Process for 2020/21 HEE funding & programme recommenced in June after COVID delay with review of existing programme through ICS in July and August 2020.
Partnership arrangements with academic organisations	Reports to Resources Committee.	Board			Ongoing	Dir. HR & OD	Regular Glous Strategic Workforce Development Partnership Board with ICS colleagues – delayed due to Covid. Continuing to work with UoW on 3 Counties Medical School & scoping medical & post grad options with UoG.
Vacancy Monitoring	Reports to Resources Committee.	Board			April 2020 Sept 2020	COO and Dir. HR & OD	Director level sign off. New vacancy BI plan being developed reporting to Agency and Bank Management Group Demonstration of TRACK end-to-end recruitment software package & business case in draft.
Agency and Bank Management	Reports to Executive.	Management	Workstreams have 6/9 month				Refocussed Agency & Bank Management

Key Controls To Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
			lead in time for many actions.				Group action plan & reporting in place.
Flexible working, retire and return options	Reports to Executive and JNCF.	Management	Related business intelligence harmonisation.	Review 2019 Staff Survey opportunities for flexible working patterns scores and feedback and develop response.	March 2020	Dir. HR & OD	BI under being progressed. Additional flexible retire & return options rolled out. Further refresh of these, informed by COVID learning experiences to be undertaken.
Co-production of opportunities, working patterns etc. with staff	Staff Friends and Family Test and staff survey.	External		Review 2019 Staff Survey "Staff Engagement" and "Ability to contribute to improvements" scores and feedback, develop response.	March 2020	Dir. HR & OD	Delayed due to Covid – Focus groups, Staff Forum & Your Voice surveys recommenced in June. E-rostering project will recommence in July and will provide further co-production opportunities through 2020/21.
Links to Risk Register							
Risk 48 (workforce and culture)/ **Risk 609 (**staff retention)/ **Risk 173** (workforce – recruitment)/ **Risks 989/962/258** (recruitment, nursing)/ **Risk 116** (Agency management)							

Strategic Objective:		**ENGAGED, EMPOWERED AND SKILLED WORKFORCE**
Risk Ref:	**Latest Rating and Direction of Travel**	**Risk Description**
SR7	⟷	There is a risk that we fail to establish a culture which:

		• engages and empowers colleagues engendering a sense of collective ownership • supports discretionary innovation

Type	Strategic			**Executive Lead**	Director of HR & OD
Risk Rating	**Likelihood**	**Impact**	**Total**	**Assurance Committee**	Quality Committee
Inherent (without controls being applied) Risk Score	4	4	16	**Date Identified**	Nov 2019
Previous Meeting Risk Score	3	4	12	**Date of Review**	June 2020
Current Risk Score	**3**	**4**	**12**	**Date Next Review**	September 2020
Tolerable (Target) Score	1	4	4	**Date to Achieve Target**	September 2020

Key 2020 Deliverables	**Relevant Key Performance Indicators**
Implementation of the Interim People Plan.	

Key Controls To Manage Risk	**Assurance on Controls**	**Type of Assurance**	**Gaps in Controls**	**Key Actions To Address**	**Target to Complete**	**Action Owner**	**Action Update**
Values developed through co-production	Reports to Board.	Board	Strategic Objectives to be fully developed	Strategic Objectives to be developed using co-production principles	June 2020	CEO	Board Development session delayed due to Covid. Cascading process developed. Used widely in branding & comms. Integration of values into workforce policies processes e.g. appraisal, performance, staff awards, disciplinary.
Interim People Plan	Reports to Resources Committee.	Board	Full implementation of Plan	Communication & implementation through future "Best People" Strategy. Respond to new national People Plan	Sept 2020	Director of HR & OD	Development and agreement of "Best People" strategy and actions. Regular updates to Resources Committee in place. Final national People Plan now expected to be published in July /

Key Controls To Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
				once releases			August 2020.
Better Care together engagement processes	Reports to Board.	Board	Implementation outcomes of Better Care together.	Outcomes to be built into strategies	Sept 2020	Director of Strategy & Partnerships	Ongoing Better Care Together Programme in place.
Heads of Professional Knowledge Network in place	Reports to Director of Nursing.	Management					
Research Knowledge Partnership in place	Reports to Executive.	Management					
Freedom to Speak Up Guardian & supporting processes	Reports to Board (covering processes, volumes, types of issues, resolution practices, benchmarking & good practice guidance.)	Board				Director of Nursing, Quality and Therapies.	New Freedom to Speak Up Policy agreed with staff side & published. Work in Confidence anonymous platform for raising issues & engaging relaunched. Regular global comms & Board reports in place.
Colleague Communication & Engagement activities	Reports to Executive	Management			March 2020	Director of HR & OD	Regular review of colleague communications. "You said, we did" comms with colleagues, new monthly survey and quarterly Staff FFT surveys. Paul's Open Door. Staff Hub on intranet. Staff focus Groups for BAME, LGBTQ & Disabled Staff. New Staff Diversity Network commencing July

Key Controls To Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
							2020. New Executive visit process scoped but delayed due to Covid.
Staff Surveys	Reports to Resources Committee and Board.	Board		2019 Staff Survey outcomes from former GCS and 2G due February 2020 – to be used to develop plan.	June 2020	Director of HR & OD	Your Voice monthly surveys and Staff FFTs paused due to COVID. Your Voice recommencing. Additional surveys on health, charitable funds and BAME risk assessments run.
Links to Risk Register							

Strategic Objective:		INNOVATION AND RESEARCH DRIVEN
Risk Ref:	**Latest Rating and Direction of Travel**	**Risk Description**
SR8		There is risk that we do not enable colleagues to support Innovation and Research through appropriate: funding, time and focus and strategic drivers

Type	Quality	**Executive Lead**	Medical Director	DoSP

Risk Rating	**Likelihood**	**Impact**	**Total**	**Assurance Committee**	Quality Committee
Inherent (without controls being applied) Risk Score	3	3	9	**Date Identified**	Nov 2019
Previous Meeting Risk Score	3	3	9	**Date of Review**	June 2020
Current Risk Score	**3**	**3**	**9**	**Date Next Review**	Sept 2020
Tolerable (Target) Score	2	3	6	**Date to Achieve Target**	Feb 2021

Key 2020 Deliverables	**Relevant Key Performance Indicators**
Research Strategy in place with Performance Measures.	

Key Controls To Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
Research Actions & Activities	Reports to Quality Committee.	Board	Research Strategy in development	Put in place Research Strat.	March 2021	Medical Director	Reviewing current strategy to align with organisations research vision. Progress delayed due to Covid. Research team structure in place. Time in consultant job-plans for research.
Annual Research Conference	Reports to Executive.	Management	Conference proposal	To be developed	March 2021	CEO	Timing of conference under consideration.
Learnings from Incidents, Complaints and	Reports to Quality Committee.	Board	Clinical Strategy	Develop clinical safety strategy	March 2021	MD	Assurance reports provided to the quality

Key Controls To Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
compliments							committee and Board (mortality review and SI reports)
Good Practice Identification & Follow Up process	CQC working group	Management	Quality Framework	To be developed	March 2021	Director of Quality	To be developed to align with new strategy
Training & Development Activities	Reports to Executive	Management	Training and development strategy	To be developed	March 2021	Medical Director	To be included in research strategy.
Quality Improvement Unit activities	Reports to Executive	Management	QI Strategy and Transformation plan	To be developed	Dec 2020	DoSP	Associate Director of QI and Transformation appointed and team structure approved
Better Care together activities	Reports to Board	Management	Plan for 2020/2021	To be developed	Sept 2020	DoSP	Activities have been suspended during COVID and need to be reconsidered in light of new ways of delivery via social distanced approaches
Links to Risk Register							

Strategic Objective:		INNOVATION & RESEARCH DRIVEN
Risk Ref:	**Latest Rating and Direction of Travel**	**Risk Description**
SR9	⟷	There is a risk that we do not have in place structures and processes which enable colleagues to look beyond the organisation to identify leading edge practice to inform practice.

Type	Quality	**Executive Lead**	Director of Nursing	Med Director

Risk Rating	**Likelihood**	**Impact**	**Total**	**Assurance Committee**	Quality Committee
Inherent (without controls being applied) Risk Score	3	3	9	**Date Identified**	Nov 2019
Previous Meeting Risk Score	3	3	9	**Date of Review**	June 2020
Current Risk Score	**3**	**3**	**9**	**Date Next Review**	Sept 2020
Tolerable (Target) Score	2	3	6	**Date to Achieve Target**	Jan 2021

Key 2020 Deliverables	**Relevant Key Performance Indicators**
Research Strategy in place with Performance Measures.	

Key Controls To Manage Risk	**Assurance on Controls**	**Type of Assurance**	**Gaps in Controls**	**Key Actions To Address**	**Target to Complete**	**Action Owner**	**Action Update**
Research Actions & Activities	Reports to Quality Committee	Board	Research Strategy in development	Put in place Research Strategy	March 2021	Medical Director	Reviewing current strategy to align with organisations research vision. Progress delayed due to Covid.
Annual Research Conference	Reports to Executive	Management	Conference proposal	To be developed	March 2021	CEO	Timing of conference under consideration.
Learnings from Incidents, Complaints and compliments	Reports to Quality Committee	Board	Clinical Strategy	To be developed	March 2021	DoNTQ	Lessons learned reports within patient experience / safety team portfolios
Good Practice Identification & Follow Up process	Improving care working group	Management	Quality Framework	To be developed	March 2021	DoNTQ	To be developed to align with new strategy
Training & Development Activities	Reports to Executive and Board Committees	Management and Board					
Quality Improvement Unit activities	Reports to Executive	Management					To be included in research strategy.

Links to Risk Register

Strategic Objective:		BEST VALUE
Risk Ref:	**Latest Rating and Direction of Travel**	**Risk Description**
SR10	↑	There is a risk that the One Gloucestershire transformation plans become frustrated and impact on our individual Trust aims and objectives and the whole system plans.

Type	Strategic			**Executive Lead**	CEO
Risk Rating	**Likelihood**	**Impact**	**Total**	**Assurance Committee**	Board
Inherent (without controls being applied) Risk Score	3	4	12	**Date Identified**	Nov 2019
Previous Meeting Risk Score	3	4	12	**Date of Review**	June 2019
Current Risk Score	**3**	**3**	**9**	**Date Next Review**	March 2021
Tolerable (Target) Score	2	4	8	**Date to Achieve Target**	September 2021

Key 2020 Deliverables	**Update**
One Gloucestershire Engagement complete and clear road map in place.	

Key Controls To Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
Fit for the Future Engagement Plan in place	Report to Board.	Board	Original timeline revised. Due to go to HOSC on 14 July.	Impact of updated timeline to be considered against other key strategic activities, e.g. hospitals in Forest of Dean	~~June 2020~~ July 2020	Dir Strat & Partnerships	Work is ongoing to confirm on-going inter-relationships with the timelines with the FFTF work.
Ongoing ICS Updates to ICS Board & Board	Reports to Board to support scrutiny, challenge & openness in working.	External & Board			June 2020	Dir Strat & Partnerships	System update standing item on Board agenda.
Development of Trust wide strategic priorities and transformation programmes needs to be completed	Board Development & clinical service delivery.	Board	Strategic transformation programme needs to be finalised as	Executive and Board development sessions planned for	Oct 2020	Dir Strat & Partnerships	Links to Future State work programme developed with use of ODF as key governance route

Key Controls To Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
			strategy develops.	August/Sept			
Clinical Programme Groups developing transformation proposals	Clinical and service leads engaged fully engaged in groups.	Management			Sept 2020	Chief Operating Officer	Focus on respiratory and cardiac pathways as a result of post COVID patient needs.
Links to Risk Register							

Strategic Objective:		BEST VALUE
Risk Ref:	**Latest Rating and Direction of Travel**	**Risk Description**
SR11	⟷	There is a risk we do not maintain robust internal controls (Including financial) and governance systems; resulting in potential financial and organisational instability.

Type	Strategic			**Executive Lead**	CEO
Risk Rating	**Likelihood**	**Impact**	**Total**	**Assurance Committee**	Board
Inherent (without controls being applied) Risk Score	3	4	12	**Date Identified**	Nov 2019
Previous Meeting Risk Score	2	4	8	**Date of Review**	June 2020
Current Risk Score	**2**	**4**	**8**	**Date Next Review**	September 2020
Tolerable (Target) Score	1	4	4	**Date to Achieve Target**	December 2020

Key 2020 Deliverables	**Update**
Budget and CIP targets to be achieved.	

Key Controls To Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
Clinical and corporate governance arrangements enable controls to be effectively managed	The Board Committee structure provides assurance on all corresponding controls to the Trust Board. Management Groups report exceptions to Committees.	Board	Combined Quality Reporting development is ongoing.	Integrated Quality Report to be developed.	July 2020	Director of Nursing, Therapies and Quality	Development ongoing.
Committee / reporting structures enable controls to be monitored and reviewed	Grant Thornton Reporting Accountant Opinion. GCS and GHC External Audit Opinion. Head of Internal Audit Opinion 2019/20.	External					GCS and GCS External Audit - clean opinion 2019/2020.

Key Controls To Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
Internal and external audit and plans provides additional scrutiny.	Combined Internal Audit Plan Agreed Reports by Internal & External Audit to Audit Committee. Internal Audit follow up actions report.	External					
The Trust's Standing Orders, Standing Financial Instructions, Scheme of Reservation and Scheme of Delegation in place.	Based on best practice. Approved by Audit Committee. Regularly reviewed for omissions.	Management and Board	Assurance on compliance.	Internal Compliance Review to be undertaken.	~~March 2020~~ Sept 2020		Compliance Review delayed by COVID.
Robust governance framework to ensure continual monitoring and reporting with clear escalation.	Reports to Board and Executive.	Management and Board	Full range of Strategies not yet in place.	Strategies to be developed & put in place.	~~Sept 2020~~ Dec 2020	Director of Strategies & Partnerships (with Board)	Strategies delayed by COVID.
Links to Risk Register							
Risk 116 (Agency usage), **Risk 1002** (operational resilience)/ **Risk 294 (**CIP)							

Strategic Objective:		BEST VALUE
Risk Ref:	**Latest Rating and Direction of Travel**	**Risk Description**
SR12	⟺	There is a risk we do not achieve our individual organisation's financial sustainability and contribute to whole system sustainability

Type	Financial			**Executive Lead**	Dir Finance
Risk Rating	**Likelihood**	**Impact**	**Total**	**Assurance Committee**	Board
Inherent (without controls being applied) Risk Score	3	4	12	**Date Identified**	Nov 2019
Previous Meeting Risk Score	2	4	8	**Date of Review**	June 2020
Current Risk Score	**2**	**4**	**8**	**Date Next Review**	Sept 2020
Tolerable (Target) Score	2	3	6	**Date to Achieve Target**	Dec 2020

Key 2020 Deliverables	**Update**
Budget and CIP targets to be achieved.	

Key Controls To Manage Risk	Assurance on Controls	Type of Assurance	Gaps in Controls	Key Actions To Address	Target to Complete	Action Owner	Action Update
Financial Management	Board Reports and mid-Year Review. Budget Setting. CIP workshops completed. CIP targets 20/21 issued.	Board	Identification of 20/21 CIPS.	Planned Challenge Schemes Planned.	Sept 2020	Director of Finance	Efficiency CIP delivered. Differential CIP identified and mostly delivered. CIP target revised due to COVID.
Financial reporting	Board Reports & Resources Committee Reports.	Board	Finance systems in integration.	Finance system integration processes to be completed.	~~April 2020~~ Sept 2020	Director of Finance	Integration process delayed due to COVID, on revised Plan.
Agency Management Group	Reports to Resources Committee. Sustainable staffing paper to Board.	Board	Comprehensive plan to reduce agency reliance.	Trajectory for improvement	~~June~~ Oct 2020	Chief Operating Officer	COVID delayed trajectory, October plan for major improvements in HCA agency spend.
ICS Financial Plan Monitoring	Board Report.	Board					

Links to Risk Register
Risk 294 (CIP), **Risk 973 (**Medical devices)/ **Risk 116** (Agency usage)

RISK MATRIX AND RISK PROFILE (July 2020)

Likelihood	IMPACT				
	1	2	3	4	5
5	(LOW)	(MEDIUM)	(HIGH)	(CATASTROPHIC)	(CATASTROPHIC)
4	(LOW)	(MEDIUM)	(MEDIUM) **T-SR00**	(HIGH) **C-SR6 / C-SR00**	(CATASTROPHIC)
3	(LOW)	(MEDIUM)	(MEDIUM) **C-SR8 / C-SR9 / C-SR10**	(MEDIUM) **C-SR7**	(HIGH)
2	(LOW)	(LOW)	(MEDIUM) **T-SR8 / T-SR9/ T-SR12**	(MEDIUM) **C-SR1/ C-SR2/ C-SR5 / C-SR11/ C-SR12** **C-SR3 – T-SR3** **T-SR6/ T-SR10**	(MEDIUM) **C-SR4**
1	(LOW)	(LOW)	(LOW)	(LOW) **T-SR1/ T- SR2/ T-SR5/ T-SR7/ T-SR11**	(LOW) **T-SR4**

Impact Score x Likelihood Score = Risk Rating

DEFINITIONS

The overall risk ratings below are calculated as the product of the Probability and the Severity.

LEVEL	INJURY / HARM	SERVICE DELIVERY	FINANCIAL / LITIGATION	REPUTATION / PUBLICITY
5 CATASTROPHIC	Fatality, multiple fatalities or large number injured or affected.	Complete breakdown of critical service/ 'Significant under-performance' against key targets.	Losses; claims/damages; criminal prosecution, over-spending; resourcing shortfall: >£1M.	National adverse publicity/reputation irreparably damaged.
4 Major (HIGH)	Fatality, multiple serious injuries/major permanent loss of function/increased length of stay or level of care >15 days.	Intermittent failures of a critical service/'under-performance against key targets'.	£501K - £1M	Adverse national publicity.
3 Moderate (MEDIUM)	Semi-permanent harm (1 month-1 year). Increased length of stay / level of care 8-15 days, >1 month's absence from work.	Failure of support services/under-performance against other key targets'.	£51K - £500K	>3 days local media publicity.
2 Minor (LOW)	Short-term injury (<1 month). Increased length of stay or level of care <7 days, 3 days-1 month absence for staff.	Service Disruption.	£11K - £50K	<3 days local media publicity.
1 (Insignificant)	No harm. Injury resulting in <3 days' absence from work for staff.	No service disruption.	<£10K	

LIKELIHOOD SCORE		
Level		
5	Almost certain	Will occur frequently given existing controls.
4	Likely	Will probably occur given existing controls.
3	Possible	Could occur given existing controls.
2	Unlikely	Not expected to occur given existing controls.
1	Rare	Not expected to occur, except for in exceptional circumstances, given existing controls.

AGENDA ITEM: 10

REPORT TO: Trust Board – July 2020

PRESENTED BY: Neil Savage, Director of HR & Organisation Development

AUTHOR: Neil Savage, Director of HR & Organisation Development

SUBJECT: **UPDATE ON TRUST'S DIVERSITY WORK**

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

The purpose of this report is to

The purpose of this report is to provide an update on the Trust's work to promote and progress diversity at work within a workforce context. It also presents a recommendation for the key strategic focus areas for progressing improvement moving forwards.

Recommendations and decisions required

The Board of Directors is asked to:

- **Note** the update
- Debate and **approve** the recommended strategic focus areas
- **Note** that tackling race and other health and employment inequalities will require sustained commitment, with engaged leadership and stronger working relationships with ICS partner and wider community organisations.

Executive summary

The report provides a summary update on the Trust's progress with the following diversity, equality and inclusion workforce work streams:

- BAME COVID Risk Assessments
- Reciprocal Mentoring
- Diversity Network
- Recruitment Advertising
- Leadership Development Programme
- Equality Training
- WRES and WDES
- PHE
- Board Development
- ICS approach

Finally, the report makes a recommendation for the key strategic focus areas for progressing improvement moving forwards.

Risks associated with meeting the Trust's values
Failure to achieve a fair organisational culture which celebrates and promotes diversity, equality and inclusions will mean the Trust will be unable to live its agreed values of: working together | always improving | respectful and kind | making a difference

Corporate considerations	
Quality Implications	The Trust cannot provide high quality services to patients, services users and carers, or a high quality workplace without a diverse, inclusive workforce which is well trained and supported in equality matters. The work streams outlined in the report aim to ensure a better enabled workforce which will be motivated, supported and well managed to deliver high quality care and workplace experiences in innovative ways. There is strong & conclusive correlation between diversity, inclusion & equality practices & culture, and high performance & quality.
Resource Implications	The work streams are resourced via existing departmental budgets, and from a training perspective by the additional £100k OD / Leadership Development budget the Board approved for this year. Additional actions not yet determined will need to be costed as required, for example, the long term approach to delivering on the detail of the PHE 7 recommendations.
Equality Implications	As a Public Sector organisations, the Trust has a statutory duty in the exercising of its functions, to have due regard to the need to: 1. Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act. 2. Advance equality of opportunity between people who share a protected characteristic and those who do not. 3. Foster good relations between people who share a protected characteristic and those who do not. 4. Equality and diversity issues have been taken into account in the initial stages of developing the new organisation's strategy and will be reflected in the implementation of the strategy.

Where has this issue been discussed before?
Previous Board and Board Committee discussions on WRES, WDES, COVID, Staff Survey and in a "Leadership for a Diverse and Transformational Organisation" paper.

Explanation of acronyms used:	ICS	Integrated Care System
	OD	Organisation Development
	LGBTQ	Lesbian, Gay, Bi-sexual, Trans & Queer
	BAME	Black & Minority Ethnic
	PHE	Public Health England
	WRES	Workforce Race Equality Standard
	WDES	Workforce Disability Equality Standard
	GIRFT	Getting It Right First Time
	ESR	Electronic Staff Record

Appendices:	None.

Report authorised by: Neil Savage	**Title:** Director of HR and OD

Update on Trust's Diversity Work

1.0 BAME COVID RISK ASSESSMENT

At the end of April, Sir Simon Stevens, the Chief Executive of the NHS, wrote to all NHS Trusts asking that they implement risk assessment relating to COVID-19 for all BAME staff. This followed on from the earlier implementation of the risk assessments for colleagues with underlying / long term conditions, those who were 70 or over and pregnant staff. At the same time he commissioned a national review of the COVID related risks and experiences of BAME colleagues by PHE.

No national template or guidance was provided to support this process, so the Trust's Working Well Occupational Health Services worked with HR, Nursing, Operations and Infection Control **colleagues to produce a risk assessment tool and guidance** to deliver this requirement. Subsequently, the Faculty of Occupational Medicine produced guidance and the Trust's assessment guidance was further updated.

The CEO subsequently wrote out to all senior managers in the Trust in the first week of May detailing the new requirement, reminding colleagues of **additional support, including Occupational Health and Freedom to Speak Up processes**. The new risk assessment tool and guidance was shared. At the same time, the Director of HR and OD wrote to all colleagues identified as BAME on the Trust's ESR informing them of the requirement and outlining the addition support. Support was provided to line managers from Working Well in the completion of the assessment and any resulting adjustments.

In May and early July 2020, the Director of HR and OD led a task and finish group to create a **COVID Secure Environment toolkit**. Two senior leaders, Andy Telford and Cheryl Haswell, were then seconded to implement the toolkit. Having focussed on priority clinical workplaces, they are now supporting the Trust's other workplaces.

An audit process has set up to capture the completion of the BAME risk assessments. As of 8th July, out of over 300 substantive BAME employees and over 100 BAME bank workers, 89% of these colleagues have had a COVID assessment with the outstanding 11% consisting of staff who are on long term sick leave, stuck overseas and unable yet to return to the UK or for other known reasons such as not currently working on the bank. The outstanding assessment are being overseen by Working Well and the Director of HR and OD and his PA, and the Trust fully expects to be compliant in line with the national expectation that 100% of BAME staff are assessed by the end of July 2020 (excluding those on long term sick leave). A **confidential Smart Survey** is also open for BAME colleagues to report on their personal experiences of the risk assessment so as the Trust doesn't solely rely on

management returns. A further verbal update will be provided at the Board meeting on additional progress.

The Trust's current focus also includes rolling out this month the returning **shielders' toolkit risk assessment and guidance** (underlying conditions and 70 or overs – 191 staff) and a newly required process for all males and all White Europeans who are 60 or over.

2.0 LEADERSHIP DEVELOPMENT PROGRAMMES

The Trust has secured expressions of interest from potential partners to work with the OD team to provide the **three new Leadership Development Programmes for Entrance, Middle and Senior Manager level training**. The team is meeting with these providers shortly with a view to commencing these new programmes in Quarter 3. **Positive action will be taken to encourage applications from BAME colleagues to join these programmes.**

A core element of the three new development programmes' content will be inclusion, equality and diversity. Similarly, there will be core people management training provided with Just Culture and Civility content – another core improver of social justice. The Trust disciplinary and resolution (aka grievance) policies have already been updated to include core principles of "Just Culture", and the Medical Director and Director of HR & OD are currently consulting with the BMA through the Local Negotiating Committee on associated revisions to the local Maintaining High Professional Standards in the NHS policy.

In a recent article published in July 2020 by Shilpa Ross, researcher at the King's Fund, she determines that enabling improved access for BAME colleagues to development training and career progression (e.g. through development programmes) means that colleagues could have improved opportunities while also feeling that their organisations were becoming more inclusive and fairer. This and findings from other similar research emphasise the importance of ensuring diversity, inclusion and equality in the Trust's leadership development offers going forwards.

3.0 RECIPROCAL MENTORING PROGRAMME

In partnership with the NHS National Leadership Academy the Trust launched its "Reciprocal Mentoring Inclusion Programme" pilot in November 2019. Circa 35 colleagues, including a number of Board members, are involved in the programme.

Reciprocal mentoring involves two people jointly working together, one partner is a senior leader/Executive Director and the other a more junior colleague.
Colleagues meet regularly their reciprocal mentor and work together in a constructive manner to explore insights into behaviours and understand and breakdown any bias that may exist. In order to ensure that there is systemic

change this is planned to take place over a period of 12 – 18 months, although COVID, has introduced a temporary hiatus of 3 – 4 months.
The programme aims to build a mutually beneficial understanding and insight into the difficulties and barriers colleagues from under-represented groups may face. There are opportunities to explore how our senior leaders can learn and adapt their leadership approach to ensure they are more inclusive and appreciative of the diversity of our workforce.

Reciprocal mentoring has benefits for the both the organisation and individual and is known to have a significant impact on changing mind-sets and influencing real cultural transformation.

The programme is informed by significant research from Australia, India, USA and the UK that supports the positive and lasting impact of reciprocal mentoring.
The Trust is fortunate to have the support of the National Leadership Academy who have developed a programme specifically for the NHS which they are piloting here in Gloucestershire.

Following a pause in the programme due to the COVID pandemic and lockdown, the programme has been reinitiated in June 2020 and Linda Gabaldoni, Head of Leadership and OD is working with the Leadership Academy on alternative virtual programme options and content going forward.

4.0 NEW DIVERSITY NETWORK

The Trust's new **Diversity Network** is planned to launch at the end of this month, having been informed by three virtual staff focus groups and the successful experiences of other organisations.

Circa 60 Trust colleagues contributed to the virtual **focus groups** which discussed the experiences of BAME, LGBTQ and Disabled colleagues working in the Trust. The most supported option going forwards was for the Trust to have an overarching Diversity Network supported by 3 sub-networks for BAME, LGBTQ and Disabled colleagues.

The purpose of the Network will be to provide a forum for differences to be celebrated, for good and bad practices and experiences to be shared, for priorities to be identified and overseen, and importantly, a forum where involvement, consultation and engagement can be improved.

Again, the recent research from the King's Fund determined that putting measures in place to make it safer to talk about race (e.g. staff networks and psychologically safe routes for raising concerns) meant colleagues can feel that their organisations are becoming more inclusive and fairer.

A number of senior colleagues will support the Network including Paul Roberts (CEO), Amjad Uppal (Medical Director), Sumita Hutchison (NED), Steve Brittan (NED), Neil Savage (Director of HR & OD), Ruth Thomas (

Associate Director of OD, Learning and Development), Linda Gabaldoni (Head of Leadership and OD), Sonia Pearcey (Freedom To Speak Up Guardian) and Firoza Shaikh (HR & OD Engagement Manager).

5.0 RECRUITMENT ADVERTISING

Alongside our use of the processes and requirements associated with our **Disability Confident Leader, Age Positive and Stonewall Diversity Champion kite mark** status and standards, we are engaging with local community groups about what additional ways we can use these groups to better communicate and encourage a wider diversity of applications, particularly for more senior roles where we know we are under-represented.

The Trust has implemented a policy of taking **positive action** for **Band 7, 8 and 9** vacancies. As part of this, job adverts now include the wording:

"We are keen to develop a more representative diversity of our senior staff and particularly encourage applications from those individuals with protected characteristics -- in particular from BAME, LGBTQ and disabled candidates."

We will review the impact of this via our recruitment data over the coming months. To improve the quality and depth of recruitment data, the Executive will be considering a business case shortly for a new recruitment software package.

Further positive actions will be considered subject to the Board's consideration and support of the recommendations.

It is also worth noting that a new "race equality mark" which would be given to trusts demonstrating they are furthering the careers of ethnic minority staff is being considered by NHS England.

6.0 EQUALITY TRAINING

The Trust's Equality, Diversity and Human Rights Training compliance is presently 97.16%.

The Trust currently provides equality and diversity training to all new staff through the corporate induction process and an Equality, Diversity and Human Rights e-learning package for existing staff.

The OD, learning and development team are currently review this as part of the wider review of statutory and mandatory training with a view to making recommendations to the Executive Committee in Quarter 3 for our future approach going forwards.

7.0 WRES AND WDES

The Trust has a WRES and WDES action plan which was reported previously to the Resources Committee.

NHS England has just commenced the 2020 WRES and WDES annual data collection process. The local and national progress and benchmarking reports are expected at the end of 2020 / early 2021. This will be the first time that the new Trust will have combined data to consider and inform actions. The reports and action plan updates will be submitted to the Resources Committee and reported to the Board later in 2020.

7.1 Taking the **WRES**, looks at a number of key indicators such as:

- Relative likelihood of White staff being appointed from shortlisting compared to BME staff
- Relative likelihood of BME staff entering the formal disciplinary process compared to White staff
- Relative likelihood of White staff accessing non-mandatory training/CPD compared to BME staff
- % of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
- % of staff experiencing harassment, bullying or abuse from staff in last 12 months
- % staff believing that trust provides equal opportunities for career progression or promotion
- % staff personally experienced discrimination at work from Manager/team leader or other colleague

The WRES data confirmed that in most cases BAME colleagues have a worse experience than White colleagues. However, in the 2019 Staff Survey related questions, mental health and learning disabilities colleagues rated the Trust above average in all the metrics, while physical health colleagues rated the Trust above average on 50% of them.

7.2 Taking the **WDES**, reports on the following:

- % of staff in Agenda for Change pay bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce.
- Relative likelihood of Disabled staff compared to non-disabled staff being appointed from shortlisting across all posts.
- Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.
- % of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse

- % of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.
- % of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.
- % of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.
- % of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.
- The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.

In the previous year's legacy trusts' WDES reports mental health and learning disabilities colleagues rated the Trust above average in 6 out of the 9 metrics, while physical health colleagues rated the Trust below average on all 9 metrics. The WDES data also confirmed that in many cases colleagues with a disability have a worse experience than colleagues without a disability.

As a result of a Board decision following consideration of a paper on **Learning Lesson To Improve People Practices**, the Resources Committee will be receiving reports on a quarterly basis of performance, disciplinary and grievance cases analysed by protected characteristics from August 2020 onwards.

8.0 PHE RAPID REVIEW

In April 2020, the Chief Medical Officer asked PHE to investigate disparities in risk and outcomes of COVID-19. This rapid review, 'Disparities in the risk and outcomes of COVID-19' has now been published. This report confirms that the impact of COVID-19 has replicated existing health inequalities, and in some cases, increased them.

To support this work PHE engaged more than 4,000 people who represent the views of Black, Asian and Minority Ethnic (BAME) communities, to gather insights into factors that may be influencing the impact of COVID-19 on these groups and to find potential solutions. This work also included a rapid literature review conducted with the National Institute for Health Research (NIHR).

The Rapid Review has made 7 recommendations for the NHS and individual organisations. These are summarised below:

- Mandate comprehensive and quality **ethnicity data collection and recording** as part of routine NHS and social care data collection systems.

- Support **community participatory research**, in which researchers and community stakeholders engage as equal partners in all steps of the research process.
- **Improve access, experiences and outcomes** of NHS, local government and Integrated Care Systems commissioned services by BAME communities.
- Accelerate the development of **culturally competent occupational risk assessment tools** that can be employed in a variety of occupational settings and used to reduce the risk of an employee's exposure to and acquisition of COVID-19.
- **Fund, develop and implement culturally competent COVID-19 education and prevention campaigns**, working in partnership with local BAME and faith communities to reinforce individual and household risk reduction strategies; rebuild trust with and uptake of routine clinical services; reinforce messages on early identification, testing and diagnosis; and prepare communities to take full advantage of interventions including contact tracing, antibody testing and ultimately vaccine availability.
- **Accelerate efforts to target culturally competent health promotion and disease prevention programmes for non-communicable diseases** promoting healthy weight, physical activity, smoking cessation, mental wellbeing and effective management of chronic conditions including diabetes, hypertension and asthma.
- **Ensure that COVID-19 recovery strategies actively reduce inequalities** caused by the wider determinants of health to create long term sustainable change. Fully funded, sustained and meaningful approaches to tackling ethnic inequalities must be prioritised.

A Trust project group has been set up to review and take these recommendations forwards internally, whilst further work is need to understand how the local ICS system tackles the recommendations collectively.

9.0 BOARD DEVELOPMENT

A Board Development seminar on Diversity is being planned for later in 2020/21 with external expert facilitation. The aim of this is to provide colleagues with an update on the Board's statutory duties and examples of good practice from across the globe on key diversity matters in an employment and care provision context.

10.0 ICS APPROACH

On behalf of Mary Hutton and Deborah Lee, Paul Roberts is exploring options with local community leaders via the Community Advocacy Group for Trust and wider **ICS involvement in a community-based reciprocal mentoring scheme**.

The HR and OD directorate is also sharing and providing support to GHT on the Reciprocal Mentoring, while GHT will in return shortly be providing GHC colleagues with access to its Stepping Up BAME development programme currently in planning stage.

11.0 RECOMMENDATIONS FOR KEY STRATEGIC FOCUS AREAS

Professor Partha Kar's recent article in the Health Service Journal urges the NHS and its organisations to make fundamental changes to their approaches towards promoting racial equality within care systems. He is currently the National Specialty Advisor, Diabetes with NHS England and also the co-lead of Diabetes GIRFT with NHS Improvement from his review; he recommends the following four key actions most likely to effectively tackle racism in the longer term:

1. **DATA. Ditch the term BAME and collect data based on ethnicity properly.** A simple lumping of a conglomeration of a range of ethnicities into one homogenous category doesn't work. People of colour, whether Black or Asian, come from a range of backgrounds that need a different focus. They aren't one homogenous group. Trusts should look at the deprivation index and differences between those from Bangladesh, Pakistan and India, for example, and take action accordingly.

   Given the recommendations from the PHE report, this is clearly an important area to focus on and progress within the Trust.

2. **POSITIVE ACTION - Introduce an NHS version of the Rooney Rule** – to those who say positive discrimination is not allowed under the Equality Act 2010, he advises that they read up on the difference between "positive discrimination" and "positive action".

   He suggests that it may be possible to insist that at least one non-white person is interviewed for every role (the "Rooney rule"), arguing that if the England and Wales Cricket Board can do it, so can the NHS. Given that the Trust regularly has no applicant from a BAME ethnicity for some roles, this could occasionally be challenging. At the same time he suggests that the NHS should pay homage to one of the greatest pioneers of racial equality in healthcare. As we have the Nightingale hospitals in the midst of the pandemic – he asks "what about a Seacole Stipulation?" – named after the great British-Jamaican nurse Mary Seacole from the time of the Crimean War.

   Some Trusts have put into place the need to have BAME representation and/ or wider protected characteristic colleagues on every interview panel. Given evidence of the good impact positive action can make on improving diverse representation in organisations, it is recommended that the Trust urgently considers further positive actions it can take going forwards.

3. **DATA - Transparency of Data.** Professor Kar recommends that there should be a national body which not only monitors adherence to the new requirements but imposes penalties on organisations if they don't do what the "Seacole Stipulation" says and makes it public which provider or commissioner organisation is complying or not.

   He argues that in the diabetes world, that's exactly what the NHS did when it wanted to make sure access to new technology was uniform and not dependent on individual clinical commissioning group whims. While there was plenty of resistance, the final outcome was widespread adherence.

   While this is a recommendation which would need national development and implementation, the Board may wish to consider whether it would be supportive of such an approach, and, if so, to then use its collective and individual members' influence to that end.

4. **LEADERSHIP - Accountability of leadership.** Finally, Professor Kar, suggests that those leading such a national body should also be accountable for change. There would need to be "defined measures of success, which if they are not met should mean those leaders making way for the next willing group." The Board, could again consider whether or not it supports this on a national basis, and also how similar principles could be applied to defined success measures for patient experience and access, workforce experience and associated data and information requirements and measures.

12.0 RECOMMENDATIONS AND DECISIONS REQUIRED

The Board of Directors is asked to:

- **Note** the update provided in this report
- **Debate and approve** the recommended strategic focus areas from Professor Kar's article, and,
- **Note** that tackling race and other health and employment inequalities will require sustained commitment, with locally engaged leadership and stronger partner and community allyship.

with you, for you

NHS
Gloucestershire Health and Care
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Equality & Diversity Matters – Data Slide Deck

Slides 2 - 5 BAME
Slides 6 – 14 Disability
Slides 15 to 18 LGBTQ

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

1. BAME Facts – the UK

Employment

- **Unemployment** rates are significantly higher for ethnic minorities at 12.9% compared with 6.3% for White people
- Black workers with **degrees** earn 23.1% less on average than Whites
- Lower % of ethnic minorities (8.8%) worked as **managers, directors & senior officials**, compared with White people (10.7%) - this was particularly true for African or Caribbean or Black people (5.7%) & those of mixed ethnicity (7.2%)
- Black **A-level school leavers** get paid 14.3 % less than White peers

Education

- Just 6% of Black school leavers attended a **Russell Group university**, compared with 12% of mixed & Asian school leavers % 11% of White school leavers
- Black Caribbean & Mixed White/Black Caribbean children have rates of **permanent exclusion** 3 times of the pupil population as whole

2. BAME Facts – the UK

Health and care

- Black African female **mortality rate** 4 is times higher than White women
- There is a significant disproportionate number of ethnic minorities detained under **mental health legislation** in hospitals
- Black African women 7 times more likely to be **detained** than White British women
- Gypsies, Travellers & Roma found to suffer **poorer mental health** than rest of UK population & more likely to suffer from **anxiety/depression**

Living standards

- Pakistani or Bangladeshi & Black adults are more likely to live in **substandard accommodation** than White people
- 30.9% Pakistani or Bangladeshi people live in **overcrowded accommodation**, while 26.8% for Black people & 8.3% for White people
- 35.7% of BAME people are more likely to live in **poverty** compared with 17.2% of White people

3. BAME - Facts – the NHS

Nationally within the NHS in England:-

- White applicants were **1.46 times** more likely to be **appointed from shortlisting** compared to BAME applicants
- Relative likelihood of BAME staff **entering the formal disciplinary process** compared to white staff was **1.22**
- Relative likelihood of white staff **accessing non–mandatory training and continuous professional development** compared to BAME staff was **1.15**
- Only 8.4% of **board members** in NHS trusts were from a BAME background – despite circa 14% of the population of England being Black, Asian, Mixed, Chinese or other non-White ethnicity
- In 2014, two-fifths of all NHS trusts in London had ZERO BAME board members. As at 2019, all London trusts had at least one BAME board member

4. BAME - Facts – GHC

Gloucestershire Health and Care
NHS Foundation Trust

1.Less likely to be appointed from a shortlist to a job. White people were 1.4 (2G) & 1.6 (GCS) times more likely to be appointed
2.Less likely to be promoted/supported in career development. Staff believing promotion/career development opportunities are fair were 88% (GCS) & 85% (2g) compared to BAME staff at 68.4% (GCS) & 76% (2G)
3.Likelihood of being bullied by patients, relatives & public. Staff were 4% > to be bullied if white (GCS) & 6% > if you are BAME(2G).
4.More likely to be bullied by staff. Staff were 4% > to be bullied if you were BAME (GCS) and 9% > to be bullied if you were white (2G).
5.More likely to personally experience discrimination from manager / team leader. Nationally, 15% BAME staff report discrimination over 6% white colleagues. Locally, BAME staff are 7% (GCS) & 2% (2G) more likely.
6. Likelihood of being disciplined. Nationally BAME 1.22 times > to be disciplined than white staff. In GHC BAME staff were < than white colleagues to be disciplined - 0.78 (GCS) & 0.81 (2G).

5. Disability - Facts – the UK

June 2019

- 7.7 million people with disabilities are in UK employment aged between 16-64
- 52.6% of working age people with disabilities were in employment, compared to 81.5% for working age people without disabilities.
- Unemployment rate, the percentage for people with disabilities was over twice the percentage for those without; 7.3% vs 3.4%
- 43.3% working age people with disabilities are economically inactive (neither in employment or actively looking for work), compared to 15.6% of non-disabled
- An employment rate for people with disabilities that is 28.9 % lower than that of non-disabled people
- People with disabilities earned a median average of £10.63 an hour, compared with £12.11 an hour for those without

6. Disability – Facts – the NHS

2019 NHS Workforce Disability Equality Scheme (WDES)

Metric 1 – Workforce representation

Overall, 3.6% of the non-clinical & 2.9% of the clinical workforce (excluding medical & dental staff) had declared a disability through the NHS Electronic Staff Record

For medical & dental staff, 1.94% of trainee grades, 1.2% of non-consultants career grade & 0.8% of consultants had declared a disability

Metric 2 – Recruitment

People with disabilities are less likely to be appointed. Non-disabled job applicants are 1.23 times more likely to be appointed from shortlisting compared to applicants with a disability

7. Disability - Facts – the NHS

2019 NHS WDES

Metric 3 – Capability

People with disabilities are 1.1 times more likely to go through formal capability processes on the basis of performance compared to those without

Metric 4 – Harassment, bullying & abuse

People with disabilities are more likely to experience harassment, bullying & abuse than those without
People with disabilities are 7% points more likely to be harassed from patients (33.8% vs 26.8%), 6.8 % points more likely from managers (19.8% vs 13.0%) & 8.7 % points more likely from colleagues (26.8% vs 18.1%) compared to those without a disability

8. Disability - Facts – the NHS

2019 NHS WDES

Metric 5 – Career progression

People with disabilities are 7.4 % points less likely to believe that their trust provides equal opportunities for career progression or promotion, compared to those without a disability (75.3% vs. 82.7%)

Metric 6 – Presenteeism

People with disabilities are 9 % points more likely, compared to those without a disability to be pressured to come into work despite not feeling well enough to perform their duties (32.0% vs. 23.0%)

9. Disability - Facts – the NHS

2019 NHS WDES

Metric 7 – Feeling valued

People with disabilities are 10.7 % points less likely to say that they feel their organisation valued their work when compared to those without (37.2% vs. 47.9%).

Metric 8 – Workplace adjustments

72.4% of people with disabilities felt that their NHS employer had made adequate adjustments to enable them to carry out their work.

10. Disability - Facts – the NHS

2019 NHS WDES

Metric 9 – Disabled staff engagement

People with disabilities are less likely to feel engaged with the NHS Staff Survey, with an engagement score of 6.6, compared to 7 for those without a disability

Metric 10 – Board representation

Overall 2.1% of NHS board members had a disability; 1 % point lower than the percentage of people with disabilities in the wider workforce

11. Disability - Facts – GHC

Gloucestershire Health and Care
NHS Foundation Trust

2019 NHS WDES

Q1 - % of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months? 35.5% (GCS) against a national benchmark average of 29.7%, compared with 23.4% (GCS) of non-disabled staff against a non-disabled national average of 22.4%.26.5% (2G) against a national benchmark average of 37.1%, compared with 25.4% (2G) of non-disabled staff against a non-disabled national average of 30.7%.

Q2 - % of staff experiencing harassment, bullying or abuse from manager in last 12 months? 17.7% (GCS) against a national benchmark average of 14.6%, compared with 7.6% (GCS) of non-disabled staff against a non-disabled national average of 7.5%.
17% (2G) against a national benchmark average of 16.6%, compared with 9% (2G) of non-disabled staff against a non-disabled national average of 9.9%.

Q3 - % of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months? 23.3% (GCS) against a national benchmark average of 22.3%, compared with 14.6% (GCS) of non-disabled staff against a non-disabled national average of 12%.
17.9% (2G) against a national benchmark average of 23%, compared with 13.2% (2G) of non-disabled staff against a non-disabled national average of 13.6%.

Q4 - % of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it? 51.3% (GCS) against a national benchmark average of 54.6%, compared with 52.4% (GCS) of non-disabled staff against a non-disabled national average of 57.4%.
50% (2G) against a national benchmark average of 58.2%, compared with 49.7% (2G) of non-disabled staff against a non-disabled national average of 59.9%.

12. Disability - Facts – GHC

Gloucestershire Health and Care
NHS Foundation Trust

2019 NHS WDES

Q5 - % of staff who believe that Trust provides equal opportunities for career progression or promotion? 80.7% (GCS) against a national benchmark average of 85.2%, compared with 89.5% (GCS) of non-disabled staff against a non-disabled national average of 90.6%.
75.5% (2G) against a national benchmark average of 79.3%, compared with 86.6% (2G) of non-disabled staff against a non-disabled national average of 86.6%.
Q6 - % of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties? 26.7% (GCS) compared with a national benchmark average of 26%, compared with 19.3% (GCS) of non-disabled staff against a non-disabled national average of 16.6%
22% (2G) against a national benchmark average of 22.3%, compared with 19.8% (2G) of non-disabled staff against a non-disabled national average of 14.3%
Q7 - % of staff with a disability satisfied with the extent to which Trust values their work? 34.9% (GCS) compared with a national benchmark average of 41.8%, compared with 46.8% (GCS) of non-disabled staff against a non-disabled national average of 53.5%
42.4% (2G) against a national benchmark average of 41.7%, compared with 53.8% (2G) of non-disabled staff against a non-disabled national average of 53.5%
Q8 - Has your employer made adequate adjustment(s) to enable you to carry out your work? 75.5% (GCS) against a national benchmark average of 76.0%. 80.6% (2G) against a national benchmark average of 77.1%

13. Disability - Facts – GHC

Gloucestershire Health and Care
NHS Foundation Trust

2019 NHS WDES

Q9 - Staff engagement score. 6.8 (GCS) compared with a national benchmark average of 6.9 compared with 7.2 (GCS) of non-disabled staff against a non-disabled national average of 7.4.
6.9 (2G) compared with a national benchmark average of 6.7 compared with 7.3 (2G of non-disabled staff against a non-disabled national average of 7.2
Q10 - On what grounds have you experienced discrimination? – Disability. 9.7% (GCS) against a national benchmark average of 11.7%.
6.7% (2G) against a national benchmark average of 9.7%
Q11- Do you have any physical or mental health conditions, disabilities or illnesses that have lasted or are expected to last for 12 months or more? 20.1% (GCS) against a national benchmark average of 20.4%.
24.9% (2G) against a national benchmark average of 24.2%

14. LGBTQ - Facts – the UK

Latest UK Government Survey (2017)

Although respondents were generally positive about UK's record on LGBTQ rights, findings suggest there is significantly more work to do:

- LGBTQ respondents are **less satisfied with their life** than the general UK population (satisfaction 6.5 on average out of 10 compared with 7.7)
- Trans respondents had particularly low scores (around 5.4 out of 10)
- >2/3rds of LGBTQ respondents said they had avoided holding hands with a same-sex partner for **fear of a negative reaction** from others
- At least 2/5 respondents had experienced an incident because they were LGBT, such as **verbal harassment or physical violence**, in the 12 months preceding the survey
- More than 9/10 of the most serious **incidents went unreported**, often because respondents thought **"it happens all the time"**
- 2% of respondents had undergone conversion/reparative therapy in an attempt to "cure" them of being LGBT, & a further 5% had been offered it
- 24% accessed **mental health services** in 12 months preceding survey

15. LGBTQ - Facts – the UK

Latest STONEWALL Survey

From 2018's "**LGBT in Britain - Work Report**"

- Almost 1/5 **LGBT staff (18%) have been the target of negative comments or conduct from work colleagues** in the last year because they're LGBT
- 1/8 trans people (12%) have been **physically attacked** by customers or colleagues in the last year because of being trans
- 1/10 BAME LGBT staff (10 per cent) have similarly been **physically attacked because of sexual orientation and/or gender identity**, compared to 3% white LGBT staff
- Almost 1/5 LGBT people (18%) who were looking for work said they were **discriminated against** because of sexual orientation and/or gender identity while trying to get a job in the last year

16.LGBTQ - some Facts – the UK

From "**LGBT in Britain - Work Report**" continued:-

- 1/8 BAME LGBT employees (12%) have **lost a job** in the last year because of being LGBT, compared to 4% white LGBT staff
- Almost 2/5 bi people (38%) **aren't out to anyone at work** about their sexual orientation
- More than 1/3rd of LGBT staff (35%) have **hidden or disguised** that they are LGBT at work in the last year because they were **afraid of discrimination**
- 1/8 lesbian, gay and bi people (12%) **wouldn't feel confident reporting any homophobic or biphobic bullying to employer**. 1/5 trans people (21%) **wouldn't report transphobic bullying** in the workplace
- Almost 1/3rd of non-binary people (31%) and 1/5 trans people (18%) **don't feel able to wear work attire representing their gender expression**

17.LGBTQ - Facts – the NHS & Health

The NHS

- LGBT people **provide circa £6bn funding** annually to the NHS
- Over 100,000 LGBT staff **work for the NHS** in England
- From **2G's** Staff Survey - 1.3% gay men, 1.7% lesbians, 1.6% bi & 0.7% other, 10% prefer not to say, & **GCS** Staff Survey 1% gay men, 1.2% lesbians, 0.9% bi, 0.2% other, 5.4% prefer not to say

Health

- 3% of gay and bisexual men attempted to **take their life** in 2013, compared to just 0.4 % men in general
- More than 4/5 trans young people have **self-harmed** at some point compared to 1/10 young people in general
- Gay & bisexual men are less likely to eat **5 portions of fruit & vegetables** a day than the general population
- Lesbian & bisexual women have higher risks of **obesity and cardiovascular disease** than straight women
- Bisexual women are 4 X as likely to **have long-term mental health** problems as straight women

There is no debate

If you are Black, Disabled or LGBTQ in the UK or in the NHS, at best you have a poorer experience than White able-bodied heterosexual people. At worst, you will be discriminated against and treated less favourably.

Sources:

WDES & WRES, NHS 2019
Staff Survey, NHS 2019
“LGBT in Britain - Work Report” – Stonewall, 2018
“Race Report” – Equality & Human Rights Commission, Dec 2018
“National LGBT Survey: Summary report” February 2019

Gloucestershire Health and Care
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AGENDA ITEM: 11.1

REPORT TO: Trust Board – 22 July 2020

PRESENTED BY: Paul Roberts, Chief Executive and
Sian Thomas, Deputy Chief Operating Officer

AUTHOR: Sian Thomas, Deputy Chief Operating Officer

SUBJECT: **COVID PROGRAMME RECOVERY UPDATE**

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

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

The purpose of this report is to

Provide assurance to the Board on the work the Trust has undertaken in responding to Covid and present an update on the Recovery Planning work.

Recommendations and decisions required

The Board is asked to:

- **Note** the update and work to date

Executive summary

This item provides an overview of the work carried out to manage the Covid pandemic, including an update on recovery planning, celebrating our success and the proposed next steps.

Risks associated with meeting the Trust's values

A Covid specific risk register is being maintained, with the key strategic risk(s) raised on the corporate risk register.

Corporate considerations	
Quality Implications	Maintaining quality care has been at the forefront out our response to Covid.
Resource Implications	Our Covid response has required the redeployment of significant numbers of staff. Some equipment and facilities spend has been required, this has been attributed to a specific budget code.
Equality Implications	Ensuring incident management responses do not disproportionately affect certain groups has been a key principle of our work.

Where has this issue been discussed before?
Weekly discussions held at Executive Team Meeting

Appendices:	Appendix 1 - GHC Covid Recovery and Update

Report authorised by: Sian Thomas	**Title:** Deputy Chief Operating Officer

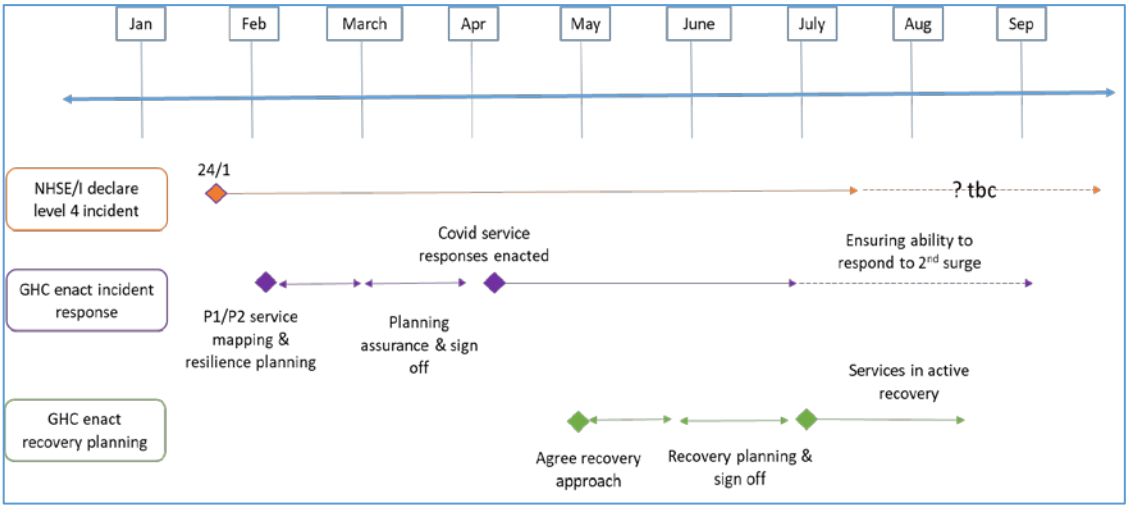
AGENDA ITEM: 11.2

COVID PROGRAMME RECOVERY UPDATE

1.0 OVERVIEW

The NHS has been in a Level 4 Incident since the end of January. During the last 6 months the Trust has moved from a business as usual approach, to enacting emergency measures in response to Covid (defined nationally as phase 1) and on to recovery planning and mobilisation (defined nationally as phase 2). Figure 1 below provides a high level timeline.

Figure 1 – High level Covid timeline

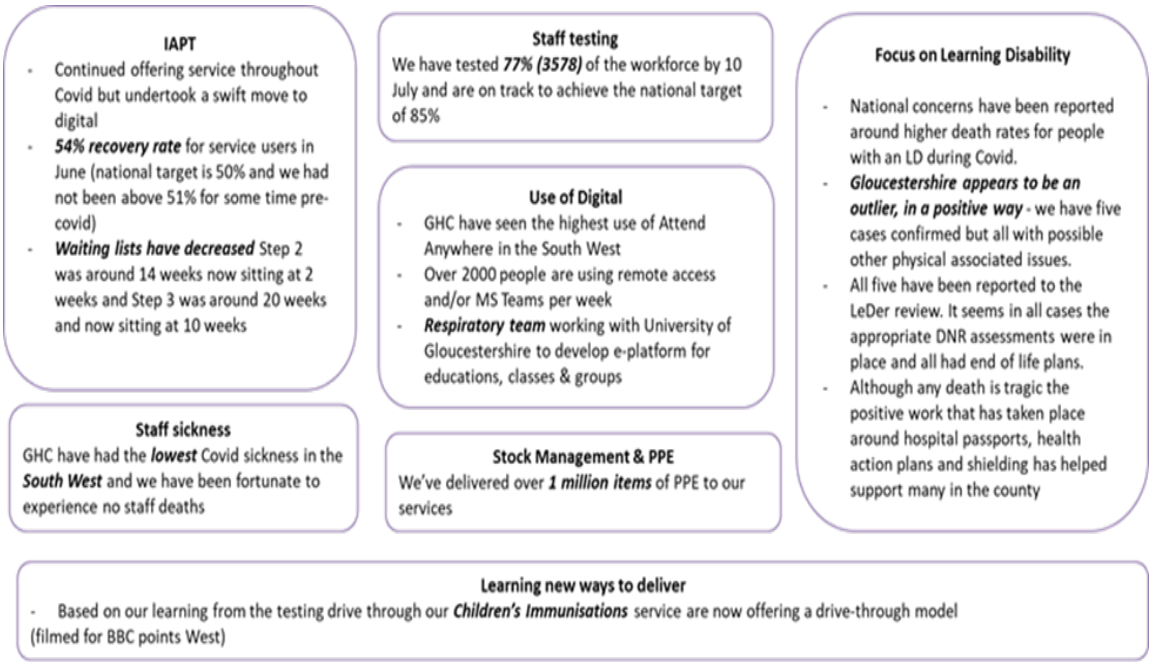


As well as being in 'Active Recovery' the Trust and the wider NHS is planning its response to a second surge, alongside normal winter planning, and a national direction to move into Phase 3. While we await a national letter outlining the requirements of phase 3 it is nominally referred to as 'Ongoing Covid Management and NHS Open for Business'.

2.0 CELEBRATING OUR SUCCESS

Since the declaration of the level 4 incident the Trust has undertaken a level of transformation, alongside ensuring resilience, that we need to ensure are recognised and celebrated. A few highlights are detailed below in figure 2. Learning the lessons from these successes is also important to enable us to maintain and replicate where appropriate.

Figure 2 – Celebrating our success



3.0 RECOVERY

We have now completed all initial recovery planning and the majority of services are in 'active recovery'. This means they are either fully open to all normal referrals or are on a phased plan to open to all normal referrals. It is important to remember that active recovery does not mean a service is functioning exactly as it did pre-Covid, for example we will continue to offer a blended digital / F2F approach across teams, based on Covid learning and where clinically indicated for high risk groups for Covid e.g. patients with an eating disorder. Key headlines from this process can be found in figure 2 and a more detailed picture in Appendix 1.

As well as a significant amount of work in overseeing our normal services the Trust enhanced a number of services and provided a number of systems offers, detailed below in figure 3. These have been well received by system partners and we are exploring the options to continue a number of these offers.

Figure 3 – Headlines from recovery planning

GHC runs 91 different services	• Some of these services operate from multiple sites with multiple teams e.g. mental health inpatients is registered as one service • These services run from around 60 buildings e.g. Pullman Place in central Gloucester
44% of our services were open to all referrals throughout Covid	This includes : • Rapid Response • Crisis • All of our bed based facilities.
Only 11% of our services were fully closed	This includes : • Macmillan cancer rehab • Endoscopy department • ADHD/ASC assessment
As of Monday 6 July 76% of our services are open to all normal referrals and only 3% remain closed	The closed services include: • Endoscopy – plan in place to open by end of July • Community Hospital outpatients – plan in place to open through July & August • Self Management service – largely run by volunteers with group based activity we continue to explore our opening plans

Figure 4 – Additional service offers

Service enhancements	New service offers
Increase in hours of the IV Team enabling offering more complex regimes to facilitate discharge and prevent admission. Community Equipment service going from a Monday to Friday service to a 7-day service. Providing timely advice and access to complex equipment for staff supporting patients. Stroke rehab beds increasing from 14 to 20 to enable GHFT to manage bed flow and support high quality rehab through Covid Community Therapy services going from a Monday to Friday service to a 7-day service. Supporting the Winfield and Nuffield model plus admission prevention.	Running the patient testing home visiting and drive-thru service for Covid. Running the staff testing (PCR) service for all health partners. Setting up 'hot hubs' for primary care to enable physical separation of Covid estate from non-Covid. Running the countywide urgent care dental hub. Providing triage and treatment for all patients with urgent need. Offering a priority access service to IAPT for GHC staff.

4.0 NEXT STEPS

As we move into phase 3 it is critical we ensure the resilience of our services through any further Covid surges, while ensuring we have learned from our response during phase 1 and 2.

Work is underway to review the Covid programme structure and incident management drumbeat; as well as developing the investment cases for our medium term Covid testing and stock management approach.

We are actively looking at our ongoing use of digital, having seen the Trust have the highest utilisation of Attend Anywhere in the South West, and how that links into our home working strategy.

Finally we are undertaking planning, modelling and workshops to look at potential second surge scenarios; both as a standalone organisation and within the wider ICS.

with you, for you

Gloucestershire Health and Care NHS Foundation Trust – Covid and Recovery update (as of 6 July)

Covid state	Number of services	Recovery state	Plan to re-open/Comments
Open to all normal referrals	**40**	40 remain open to all referrals	All remain open but some recovery actions e.g. equipment services return to 5/7 from 7/7
Reduced service offer: reduced sites/hours but delivering normal care	**1** - MIIU	1 - remains in Covid state	Seeking extension to 30/09 through July HOSC
Reduced service offer: urgent/complex referrals only	**33**	**24 open to all referrals 9 remain with reduced access**	
		OT (ICT)	Phased re-opening through July/August
		Physio (ICT)	Phased re-opening through July/August
		Lymph	Remain with access focusing on urgent/complex while significant estate challenges resolved
		AOT	Reopen 1/8
		Recovery	Reopen 1/8
		Older Persons Mental Health (CMHT)	Reopen 1/8
		Complex Psychological Interventions (CPI)	Reopen 1/9
		Community LD team (CLDT)	Reopen 14/8
		Podiatry (core)	Reopens 13/7
Reduced service offer: accepting referrals, triage & advice but not care delivery	**2**	**1 open 1 remains in Covid state**	
	Cardiac Rehab	Remains offering triage & advice	Working with University of Glos to develop online platform to deliver rehab classes & groups
	Pulmonary rehab	Open	
Closed to new referrals but supported priority patients on the existing caseload	**1** – Complex care at Home	1 - Open	Staff redeployed during Covid to support Vulnerable People's Hub and District Nursing
Closed and alternative service put in place	**4**	**3 open 1 remains in Covid state**	
	Dental – high street	Partially Open	In line with NHSE and national dental guidance all routine care was ceased. GHC established the sole countywide urgent care hub and to triage and treat patients. We continue to provide a countywide hub, from the start of July 11 high street practices have opened.
	Dental – OOHs	Partially Open	
	Dental special care	Partially Open	
	Complex Leg	Still in Covid state	Delivered through integration with district nursing via home care. Returning to clinics by end of July
Full closure	**10**	**3 open, 4 partially open, 3 remain closed**	
	Community hospital – Outpatients	Remains closed	Working with GHFT to plan phased re-opening based on clinical priority
	Community Hospital – Theatre	Partially open	Cirencester open (6/7/20) Tewkesbury open (3/8/20) Stroud open (mid-August date tbc)
	Community Hospital – Endoscopy	Remains closed	Cirencester open (20/7) Stroud open (27/7)
	Macmillan cancer rehab	Open	Significant digital delivery due to potential vulnerability of client group
	Self-Management	Remains closed	Plan to be agreed. Small service with 2 staff that relies on volunteers with lived experience to run groups/classes
	MSK APS	Partially open	The plan is to address the backlog of held patients: first those waiting to be referred on (i.e. had an identified pathway when the service was closed) and then the follow up lists (expected approx 6 weeks). Opening to new urgent - 13/7 Opening to all referrals - TBC by ortho pathway
	ASC/ADHD	Partially open	Team working through current waiting list. Re-opens to new referrals 1/09/20
	Memory Assessment	Partially open	Team working through current waiting list, significant work to identify digital opportunities and balance risk to client group of exposure to increased Covid risk. Re-opens to new referrals 1/09/20
	Children's Immunisations (apart from BCG)	Open	NA
	CAHMS Interagency Team	Open	NA

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AGENDA ITEM: 12.1

REPORT TO: Trust Board – 22 July 2020

PRESENTED BY: Sandra Betney, Director of Finance

AUTHOR: Chris Woon, Associate Director of Business Intelligence

SUBJECT: **Combined Performance Dashboard June 2020 (Month 3)**

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

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

The purpose of this report is to
This performance dashboard report provides a high level view of key performance indicators (KPIs) in exception across the organisation.

To offer reader clarity, the visualisation is separated into the following reporting sections;

- Mental Health National Requirements (NHS Improvement & DoH)
- Mental Health Local Contract Gloucestershire (including Social Care)
- Physical Health National Requirements
- Physical Health Local Requirements

Performance covers the period to the end of June (month 3 of the 2020/21 contract period). This report aligns to the organisational response to Covid-19 and associated recovery of services. Although data validation and associated indicator narrative has improved, it is still not as comprehensive as we intend it to be. We continue to discuss how this can be improved with operational and corporate stakeholders and this is overseen though the Business Intelligence Management Group (BIMG).

Where possible, it has been highlighted within the indicator narrative where Covid-19 may have specifically contributed to in-period data quality, narrative and/ or performance.

Where performance is not compliant, operational service leads are prioritising appropriately to address issues. A Covid-19 Recovery and Future State Programme will schedule recovery trajectories, more fully account for 2020/21 performance indicators in exception and provide legacy Service Recovery Action Plans (SRAP) updates.

Recommendations and decisions required

The Resources Committee are asked to:

- Note the aligned Performance Dashboard Report for June 2020/21.
- Acknowledge the impact of Covid-19 (management and recovery) on our performance; namely the reduced service delivery across some teams and the diminished operational capacity to undertake full data validation or provide comprehensive narrative to explain *all* indicators in exception.
- Note the report as a **significant level of assurance** that our contract and regulatory performance measures are being met or that appropriate service recovery action plans are being developed to address areas requiring improvement - in line with the C19 Recovery & Future State Programme.

Executive summary

The Committee's attention is requested to review the 13 key **mental health** key performance thresholds listed in the dashboard (with associated narrative) that were not met for June 2020. It is of note that all indicators have been in exception previously within the last 12 months. It is further noted there are an addition 4 mental health indicators outside threshold but are within normal, expected variation or have a confirmed data quality issue that is administrative only and is being resolved.

In addition your attention is drawn to the 18 key **physical health** performance thresholds listed in the dashboard (with associated narrative) that were not met for April 2020. It is of note that all indicators have been in exception previously within the last 12 months. It is further noted there are an addition 20 physical health indicators outside threshold but are within normal, expected variation, have a proxy threshold or have a confirmed data quality issue that is administrative only and is being resolved.

Risks associated with meeting the Trust's values

Where appropriate and in response to significant and wide reaching performance issues (such as Eating Disorders, Podiatry, IAPT, Children's or Wheelchair Services); operational services have Service Recovery Action Plans (SRAP) in place which outlines appropriate risk and mitigation.

Corporate considerations	
Quality Implications	The information provided in this report can be an indicator into the quality of care patients and service users receive. Where services are not meeting performance thresholds this may also indicate an impact on the quality of the service/ care provided.
Resource Implications	The Business Intelligence Service provides the support to operational services to ensure the robust review of performance data and co-ordination of the combined

	performance dashboard and its narrative.
Equality Implications	Equality information is monitored within BI reporting.

Where has this issue been discussed before?	BIMG 16/07/2020

Appendices:	None

Report authorised by: Sandra Betney	**Title:** Director of Finance

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Performance Dashboard Report & BI Update

Aligned for the period to the end June 2020 (month 3)

This performance dashboard provides a high level view of key performance indicators (KPIs) *in exception* across the organisation for the period. Highlighted indicators are underperforming against their threshold or are outside normal variational control limits that warrant senior oversight. If an indicator in exception is due to a confirmed data quality issue that is being resolved this will be considered in any escalation decision. A full list of all indicators are available within the dynamic version of this Tableau report.

Where performance is not compliant, operational service leads are prioritising appropriately to address issues. Additionally, a Covid-19 Recovery and Future State Programme will schedule service specific recovery trajectories, more fully account for 2020/21 performance indicators in exception and where appropriate, provide legacy Service Recovery Action Plans (SRAP) updates.

In spite of unplanned Covid-19 BI demands and increasing recovery activity, Business Intelligence services have continued to deliver key infrastructure development tasks to date and ensured the continuity of business critical reports during the pandemic. The following tasks have been completed since the last update;

- The development of business critical operational performance reports within Tableau
- Establishment of the new, organisationally aligned system hierarchy and cost centres within the data warehouse, including initial report production and data validation processing of Incident (Datix), Workforce (ESR) and Finance (Integra) data.
- Continued Covid reporting development (such as Track&Trace) and finalisation of C19 Exec Dashboard
- SPC upper and lower limit calculations for MH services

The following tasks continue to be 'in the development pipeline';

- Dashboard visualisation capability further developed to include; threshold figures in place of variances, benchmarking observation, SRAP alerts and data quality alerts (Q2 2020/21).
- C19 Programme Management Board Dashboard
- Commissioner led local contractual key performance indicator review
- Internal service specification review
- Server capacity, infrastructure evaluation and development (Q3 2019/20).
- Existing data source adjustments (to support data quality monitoring and historic activity) in new environment (Q4 2020/21).
- Data source replication (prioritisation for ESR, Integra and Datix) (Q4 2020, dependant on GL and ESR progress)
- Key financial reporting to support the new General Ledger (GL) (Sept 2020/21).
- Final legacy GCS reports migrated to Tableau (Q2 2020/21)
- Complete data sources replication for complimentary systems (Q3 2020/21)
- Supplementary system sources brought into BI reporting (Datix, Service Experience, Q4 2020/21)
- Integrated Business Intelligence Performance Dashboard (Q4 2020/21) for Board/ Resources Committee (incorporating full BI stack).
- Birtie decommissioning (Q4 2020/21)

PLEASE NOTE THAT THE DELIVERY OF THIS BI DEVELOPMENT TIMETABLE CONTINUES TO BE RESPONSIVE TO THE DEMANDS ON CURRENT CORPORATE/ OPERATIONAL BAU & ADHOC (e.g. C19) REPORTING.

Performance Dashboard: *Mental Health - National Requirements (NHS Improvements & DOH)*

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Mental Health - National Requirements Gloucestershire

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

1.04: CPA Approach – Formal review within 12 months
This indicator is non-compliant for June at 87.2% (123 non-compliant records) against a 95% threshold with the majority of cases within the Recovery Service (59), EI service (22) and AOT Service (18).

The EI service has been concentrating on Priority 1 clients as part of **Covid planning** and as part of recovery planning will be seeking to return to compliance by the end of July 2020.

There has been a lack of Adult Community service response to clarify why this indicator is in exception for its services; however it is likely that there may have been reduced data quality checking for this period due to the focus towards **Covid-19 priorities**. The Recovery service was identified as a priority 2 service and staff identified for redeployment.

Performance Dashboard: *Mental Health - Local Contract (Including Social Care) Gloucestershire*

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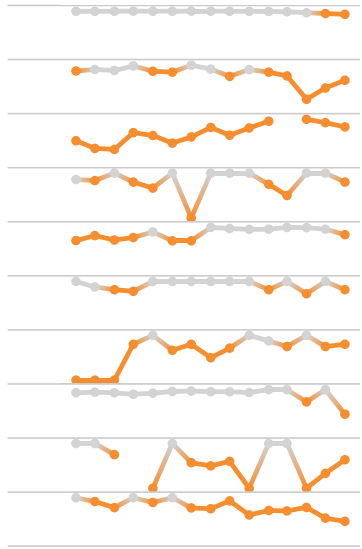
NHS Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

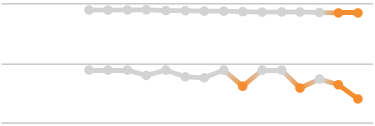
Mental Health - Local Contract Gloucestershire

		June	YTD
3.07	CPA Review - 95% of those on CPA to be reviewed within 1 month (Review within 13 months)	92.3% 2.7%	94.0% -1.0%
3.12	IAPT access rate: Access to psychological therapies for adults should be improved	78.4% -21.6%	58.5% -41.5%
3.25	% of CYP entering partnership (treatment) in CYPS have pre and post treatment outcomes and measures recorded	48.4% -51.6%	55.1% -44.9%
3.26	Patients with Dementia have weight assessments on admission	80.0% -5.0%	90.9% 5.9%
3.27	Patients with Dementia have weight assessments at weekly intervals	84.1% -0.9%	92.5% 7.5%
3.28	Patients with Dementia have weight assessments near discharge	83.3% -1.7%	86.6% 1.6%
3.29	Patients with Dementia have delirium screening on admission	80.0% -5.0%	81.8% 3.2%
3.33	CPI: Assessment to Treatment within 16 weeks	50.0% -40.0%	71.4% -18.6%
3.37	Adolescent Eating Disorders - Urgent referral to NICE treatment start within 1 week	63.6% -31.4%	53.3% -41.7%
3.40	Eating Disorders - Wait time for adult psychological interventions will be 16 weeks	52.1% -42.9%	67.9% -27.1%



Mental Health - Social Care Gloucestershire

		June	YTD
4.05	% of WA & OP service users on the caseload who have a carer, who have been offered a carer's assessment	89.7% -0.3%	92.6% 2.6%
4.12	Ensure that reviews of new short or long term packages take place within 12 weeks of commencement	46.4% -33.6%	78.9% -1.1%



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

3.07: CPA Review: 95% of those on CPA to be reviewed within 1 month (Review within 13 months)
Performance for June is at 92.3% against a 95% threshold. This indicator is a subset of 1.04 and of those non-compliant records above there were 73 where the CPA review is not recorded as having taken place within 13 months. Of those, 35 were with the Recovery service, 13 with the EI service and 11 with the AOT service.

The EI service has been concentrating on Priority 1 clients as part of **Covid planning** and as part of recovery planning will be seeking to return to compliance by the end of July 2020.

There has been a lack of Adult Community service response to clarify why this indicator is in exception for its services; however it is likely that there may have been reduced data quality checking for this period due to the focus towards **Covid-19 priorities**. The Recovery service was identified as a priority 2 service and staff identified for redeployment.

3.12: IAPT Access rate
This indicator is below plan for June but access has increased to approximately 80% of demand pre-lockdown; this is in line with other IAPT services in the region.

3.25: CYPs entering partnership have pre and post treatment outcomes and measures recorded
Performance has fallen in June due to virtual working through the **Covid** period and delays experienced in receiving outcome forms through the postal system. A review is taking place to look at methods available for completing forms during the pandemic period.

Although June performance is lower than anticipated, the average across the 1st quarter is above the CQUIN 1st quarter expected performance.

3.26: Patients with Dementia have weight assessments on admission (1 non-compliant case)
3.27: Patients with Dementia have weight assessments at weekly intervals (10 non-compliant cases)
3.28: Patients with Dementia have weight assessments near discharge (1 non-compliant case)
3.29: Patients with Dementia have delirium screening on admission (1 non-compliant case)

Commentary for 3.26, 3.27, 3.28 and 3.29
Ensuring that patients' safety from risk of COVID was priority, as staff concentrated their time on reviewing safe zoning. Wards were staffed with redeployed staff who may not have understood the relevance of recording the exact date and time that weighing or screening took place. The records have been reviewed by the service and assurance given that non-compliance is due to recording errors.

3.33: CPI Assessment to Treatment within 16 weeks
There was 1 non-compliant case in June. The patient was assessed by the service but due to the service being inactive during the COVID pandemic treatment could not be offered within the required 16 week period. The client was under the care of the recovery service during this period.

3.37: Adolescent Eating Disorders: Urgent referral to NICE treatment within 1 week
There were an unprecedented number of urgent cases starting treatment this month, the monthly average is 3, however, during June there were 11 cases, 4 of which did not start treatment within the required 7 days.

For two of these cases treatment started on day 8 due to delays in receiving more information for the triage process. One client was an inpatient at time of referral and treatment started when clinically appropriate on day 14. The remaining case is due to data quality and the service will arrange for the record to be corrected on the clinical system.

3.40: Eating Disorders: Wait time for Adult psychological interventions will be 16 weeks
There were 11 non-compliant cases in June. The longer waiting times for these clients are due to the wait for CBT or IPT (Interpersonal Therapy) treatment which generally has a longer waiting time than for other treatments. However, one client's commenced day-treatment which is not yet recorded on the clinical system and therefore does not capture that treatment has started. The Business Intelligence service is working with the Clinical Systems Team and the Eating Disorders Service to progress this.

The service has recognised that more can be done to improve process and waiting list management tools are being better utilised further trajectory modelling will be used to inform new threshold targets for these indicators for 20/21 and to look at reducing CBT and IPT waiting times.

4.05: % of WA & OP service users on the caseload who have a care who have been offered a carer's assessment
Performance has fallen just below the required 90% for June with 170 service users reported with carers who have not been offered a carer's assessment. The majority of cases are within the Older People services (OP Community Services: 49, Managing Memory Together: 46), Recovery Service (33) and EI service (19).

The EI service has been concentrating on Priority 1 clients as part of Covid planning and as part of recovery planning will be seeking to return to compliance by the end of July 2020.

There has been a lack of Adult Community service response to clarify why this indicator is in exception or their services, however it is likely that there may have been reduced data quality checking for this period due to the focus towards Covid-19 priorities. The Recovery service was identified as a priority 2 service and staff identified for redeployment.

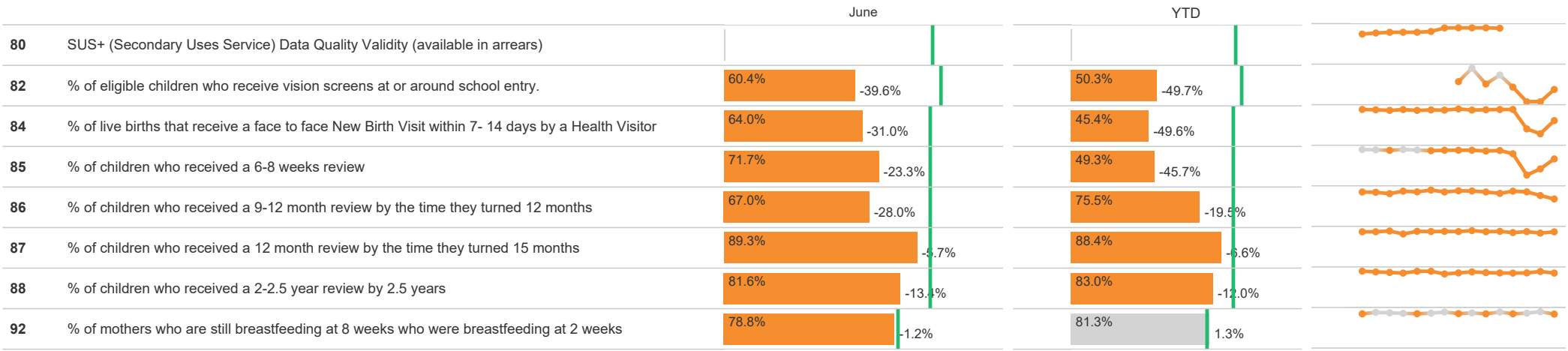
4.12: Ensure that reviews of new short or long-term packages take place within 12 weeks of commencement
There are 15 non-compliant cases for June. Initial communication with the service has shown that 8 of these have been corrected on the clinical system after the data freeze date and performance is now at 67%. The service has been asked to comment on the remaining June cases and also the outstanding May cases which have not yet been addressed.

Performance Dashboard: *Physical Health - National Requirements Gloucestershire*

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Physical Health - National Requirements Gloucestershire



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

80: SUS+ (Secondary Uses Service) Data Quality Validity (available in arrears)
The latest data for comparative reports from NHS Digital are not available until after July 2020. The last reported position from February 2020 is under threshold (88.9% against a target of 96.3%). This is due to data quality coding issues within Emergency Care and Admitted Patient Care (datasets) which are being reviewed.

82: Proportion of eligible children who receive vision screens at or around school entry
The Vision Screening Programme was stopped due to **Covid** resulting in the cumulative position being behind trajectory.

The service is working towards a catch up programme for the Vision Screening programme in September 2020. This will be for children who will be in Year 1 in September who were not screened in the academic year 2019-20 when they would have been in Reception year. This is dependent on schools reopening as planned in September. It is also dependent on schools allowing school nurses to visit. However, informal enquiries with primary schools have so far been positive.

84: Percentage of live births that receive a face to face NBV (New Birth Visit) within 7- 14 days by a Health Visitor
The target (95%) was not achieved in June 2020 (64.0%). 273 out of 426 visits were completed within the timeframe. The significant reduction in performance is as a result of **Covid** outbreak with visits cancelled by patients. All families of children in this cohort received an offer of a visit.

85: Percentage of children who received a 6-8 weeks review
The target (95%) was not achieved in June 2020 (71.7%). 328 out of 457 reviews were completed within the timeframe. The significant reduction in performance as a result of **Covid** outbreak . In recent weeks, parents who had declined a home visit for the NBV have been more receptive to seeing a HV in the home when the baby is 6 weeks old, leading to an increase in contacts in June. All families of children in this cohort received an offer of a visit.

86: Percentage of children who received a 9-12 month review by the time they turned 12 months.
The target (95%) was missed in June 2020 (67.0%). 346 out of 516 reviews were completed within the timeframe. The reduction in performance is related to **Covid** with visits cancelled by patients . All families of children in this cohort received an offer of a visit.

During May, all parents were contacted by phone or via Attend Anywhere (AA). If they agreed to having their developmental assessment via phone or AA this was completed. For those parents that requested a Face to Face, their name has been recorded on a waiting list to be contacted. Also, if a parent did not answer the phone or respond to message, these families will also receive an invite via post later in the year inviting them for a developmental review.

87: Percentage of children who received a 12 month review by the time they turned 15 months.
The target (95%) was missed in June 2020 (89.3%). 438 out of 490 reviews were completed within the timeframe and is consistent with previous months. All families of children in this cohort received an offer of a visit.

During May, all parents were contacted by phone or via Attend Anywhere (AA). If they agreed to having their developmental assessment via phone or AA this was completed. For those parents that requested a Face to Face, their name has been recorded on a waiting list to be contacted. Also, if a parent did not answer the phone or respond to message, these families will also receive an invite via post later in the year inviting them for a developmental review.

88: Percentage of children who received a 2-2.5 year review by 2.5 years.
The target (95%) was missed in June 2020 (81.6%). 450 out of 551 reviews were completed within the timeframe and is consistent with previous months.

During May, all parents were contacted by phone or via Attend Anywhere (AA). If they agreed to having their developmental assessment via phone or AA this was completed. For those parents that requested a Face to Face, their name has been recorded on a waiting list to be contacted. Also, if a parent did not answer the phone or respond to message, these families will also receive an invite via post later in the year inviting them for a developmental review.

Additional commentary for 83, 84, 85, 86, 87 and 88
Health Visitors are currently working to a partial suspension plan due to the current **Covid** pandemic. There have been 25% of Health Visitors redeployed to the District Nursing service or the Community Hospitals to support the pandemic. There has been number of redeployed staff that have now been repatriated to the HV service with all HVs to be back from the 27th July and the student health visitors from 10th August. The level of safeguarding referrals has over doubled leading to HVs prioritising safeguarding and NBVs support to the most vulnerable.

The service is now actively recruiting to Health Visitor, Public Health Nurses and Student Health Visitor vacancies, to allow the service to reach its optimum trajectory of staff in order to support the current service suspension plan, the recovery plan and moving forward into the future.

There is also a centralised contact number for the HV teams in each locality and a duty HV to respond to increased volume of calls that the service is receiving due to parents being anxious and worried about **Covid**, general feeding and parenting questions that would have been asked at a Baby Hub but these have currently ceased.

The service has also been focusing on the increased levels of safeguarding referrals to ensure vulnerable children are adequately supported during this period. As the lockdown is being gradually eased and more staff are coming out of redeployment, it is expected that activity will increase again and figures will improve.

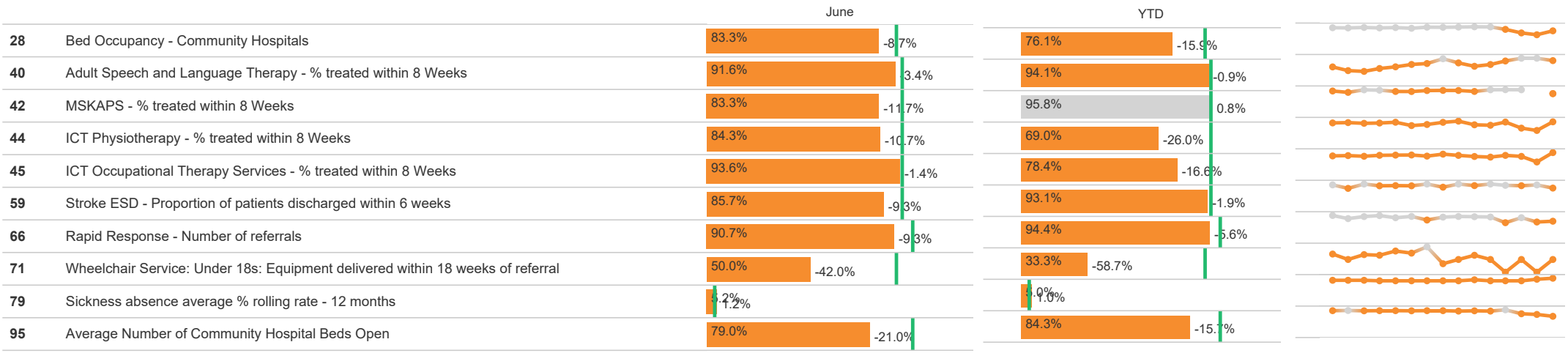
92: % of mothers who are still breastfeeding at 8 weeks who were breastfeeding at 2 weeks
70 mothers out of 331 did not continue to breastfeed from 2 week to 8 weeks.

Staff have been returning from **Covid** redeployment and a backlog of exceptions are yet to be fully investigated. These exceptions are being investigated throughout the month as April and May have now been completed and are compliant against threshold.

Performance Dashboard: *Physical Health - Local Requirements Gloucestershire*

KPI Breakdown

Physical Health - Local Requirements Gloucestershire



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

28: Bed Occupancy - Community Hospitals
Bed Occupancy in Community Hospitals has shown a continued reduction and is now below SPC chart lower control limit based on 2018/19 activity. Performance in June was 83.3%, which is below the threshold of 92%. This is mainly due to reduced demand for Community Hospital beds in the wake of the **<u>Covid</u>** outbreak.

The colour coding of the beds (red, amber, green) which requires matching of incoming patients' **<u>Covid</u>** status to available beds has also impacted on how community hospital beds are allocated.

40: Adult Speech and Language Therapy - % treated within 8 weeks
91.7% of patients were seen within 8 weeks compared to the target of 95% in June 2020. 1 patient out of 12 was seen outside of 8 weeks.

Specific therapy skills were required for this patient, who was waiting for a video consultation with the appropriate member of the team.

42. MSKAPS Service- % treated within 8 weeks
In June 2020 83.3% of recorded patients were seen within 8 weeks compared to the target of 95%. However this was only 1 patient out of 6 patients being seen outside of 8 weeks.

This activity reduction was because the MSKAPS service has been closed since the end of March due to **<u>Covid</u>**. A backlog of 415 patients awaiting their first appointment will have breached the 8 week RTT measure which is outside of the services control. The service are proposing a suspension of this measure until the back log is cleared, but as a substitute will be closely monitoring internally the longest waits and urgent referrals to ensure they are being prioritised.

44: ICT Physiotherapy - % treated within 8 Weeks
In June 84.3% of patients were seen within 8 weeks compared to target of 95%. 28 out of 179 patients were seen outside of 8 weeks. However the number of patients seen and treated is significantly lower than usual as a direct result of the **<u>Covid</u>** outbreak. In 2019/20 the average was 359 per month.

45: ICT Occupational Therapy Services - % treated within 8 Weeks
In June 93.6% of patients were seen within 8 weeks compared to target of 95%. 13 out of 204 patients were seen outside of 8 weeks. However the number of patients seen and treated is significantly lower than usual as a direct result of the **<u>Covid</u>** outbreak. In 2019/20 average was 436 per month.

Additionally there were a small number of data quality issues that had not been rectified in time this month, this would have contributed to the service meeting the 95% target.

Additional Comments for 44 & 45
The ICT Covid response has placed a greater proportion than normal of the therapy resources into the referral centres to facilitate early response and as often as possible rapid resolution of cases referred to the ICTs. This activity currently falls outside the indicator due to existing definitions and methodology. When the work carried out by Physiotherapists within the ICT referral centres is included, the % of patients seen in less than 8 weeks in June is 96.4% which would show the threshold as being met.

59: Stroke ESD – Proportion of patients discharged within 6 weeks
85.7% of patients were discharged within 6 weeks compared to a target of 95%. 3 out of 21 patients were discharged after 6 weeks

Covid has limited accessibility of services to refer on to while extending the normal waiting times for the Stroke ESD service.

66: Rapid Response Number of referrals
276 referrals were received by the Rapid response team in June, below the target of 304. The main reasons for reduction in referrals is around change in GP service delivery model and the Covid outbreak affecting the number of patients presenting at the emergency departments for urgent care. It is thought that patients shielding from **Covid** have had reduced exposure to some of the usual infections seen by Rapid Response.

71: Wheelchair Service: Under 18s: Equipment delivered within 18 weeks of referral
Target continues to be missed. 2 out of 4 patients who had equipment delivered in June were provided with this outside of 18 weeks of referral. The service recognises that there are performance and data quality issues, which are actively being addressed through its Service Recovery Action Plan. Work to address performance reporting has resumed now the service has commenced the recovery process following the **Covid** response."

79: Sickness absence average % rolling rate - 12 months
This measure has shown an increase from 5.0% in May to 5.2% in June. The figures now reflect GHC figures as a whole (i.e. ex-GCS and ex-2G staff figures). Performance in subsequent months is expected to be impacted by **Covid** out-break however GHC have had the lowest rate of sickness in the South West over the period.

95: Average Number of Community Hospital Beds Open
The average number of beds open in Community Hospitals in June was 156 (compared to usual bed stock of 196 beds) and is below SPC Chart lower control limits. This is directly impacted by the **Covid** outbreak. See also indicator 28.

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AGENDA ITEM: 13.1

REPORT TO: Trust Board – 22nd July 2020

PRESENTED BY: Sandra Betney, Director of Finance

AUTHOR: Stephen Andrews, Deputy Director of Finance

SUBJECT: **FINANCE REPORT FOR PERIOD ENDING 30th June 2020**

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

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

The purpose of this report is to
Provide an update of the financial position of the Trust.

Recommendations and decisions required

- The Board to **note** the month 3 position
- Approve the use of Merger savings to fund the development of the Strategies & Partnership Directorate

Executive summary

- There is a Covid interim financial framework for the NHS in place for April to July. It is expected that this will be extended until September but no formal guidance has been received at present.
- The Trust's position at month 3 is break even. All Trusts are required to show a break even position by NHSI.
- To reach a break even position the Trust has requested a retrospective top-up of £726k for Apr- June. £556k of this has been approved by NHSI for April to May.
- To support the transformation agenda the Trust is proposing to invest £414k of merger savings in the Strategy and Partnerships directorate.
- The cash balance at month 3 is £64.426m.
- Capital expenditure is £0.301m at month 3. The Trust has a capital plan for 20/21 of £9.945m.
- The revised recurring Cost Improvement Plan (CIP) target for the merged Trust is £4.722m and the amount delivered to date is £3.302m.

• The Trust has put in place monitoring arrangements for all Covid related costs.

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

Corporate considerations	
Quality Implications	
Resource Implications	
Equality Implications	

Where has this issue been discussed before?

Appendices:	Appendix 1 - Finance Report

Report authorised by:	**Title:**
Sandra Betney	Director of Finance

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NHS
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NHS Foundation Trust

AGENDA ITEM 13.2

Finance Report Month 3

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Gloucestershire Health & Care Overview

Gloucestershire Health and Care
NHS Foundation Trust

- There is a Covid interim financial framework for the NHS in place for April to July. Guidance about months 5-12 has not yet been published but it is expected soon. It is likely that the interim arrangements will be extended until September.
- NHSI monitoring of the Trust's performance is measured against income and expenditure run rates for months 8-10 from 19/20 uplifted by 2.8%.
- Block income payments are being made direct to the Trust from main commissioners based on income at month 9 for last year inflated by 2.8% and not reduced by 1.1% efficiency savings.
- All Trusts have to show a break even position at the month end by accruing for an additional or reduction in retrospective top up payments.
- The Trust has been notified it will receive £556k of retrospective top up funding relating to April and May, and has calculated it requires a further £170k for June in order to break even. This will bring the total retrospective top up payments to £0.726m for the first three months of the financial year.
- The Trust has assumed a £750k reduction in Income from Gloucestershire Hospitals NHSFT as they are not using Theatres, Endoscopy or Outpatients during the pandemic.

Gloucestershire Health & Care Overview 2

Gloucestershire Health and Care
NHS Foundation Trust

- The following tables in this report compare month 3 actuals against Trust budgets.
- The Trust has seen a c. £400k reduction in NCA income as Trusts have been instructed not to invoice.
- The Trust has recorded adjusted Covid related expenditure of £1.22m for April to June.
- The Trust has seen reduced expenditure in a number of areas including agency and bank costs, mileage, training, room hire and some clinical costs.
- The adjusted recurrent Cost Improvement Plan target for the Trust is £4.722m. The CIP removed so far is £3.302m.
- The non recurrent CIP target was £2.2m. £1.6m is no longer required due to changes in the financial regime caused by Covid.
- Capital plan for 20/21 was approved at £9.945m. Spend as at the end of month 3 is £301k. The ICS has a combined capital spend envelope of £31.287m which includes our £9.945m.
- Cash balance at the end of month 3 is £64.4m due to the Trust receiving July's block contract payment in June.
- In order to strengthen the capacity of the Strategy and Partnerships directorate and support the transformation agenda that formed an integral part of the merger business case it is proposed to utilise merger savings of £414k to support the creation of 5 new posts and increase the non pay budget to enable the Trust to invest more in QI and Better Together Events.

Gloucestershire Health & Care Bridge Analysis

Gloucestershire Health and Care
NHS Foundation Trust

- The Trust has done some high level bridge analysis reconciling the interim NHSI plan for 20/21 to the Trust's actual costs at month 3. The key highlights of this analysis are ;
- The NHSI plan overstates the Trust income
- There are large variations due to the NHSI plan being calculated on last years income and expenditure position. The plan includes income and expenditure that will either not occur in 20/21 e.g merger costs, or will be significantly lower than plan e.g depreciation following MEA valuation at year end, or will be higher than the plan in 20/21 e.g Community Care costs rising.
- Reductions in costs have occurred in 20/21 in certain teams due to changes in service delivery during Covid, leading to costs being lower than the plan but has also incurred significant Covid costs which are not included in the plan.
- The Trust has seen a reduction in some income streams, eg GHFT and private providers no longer hiring Theatres or Endoscopy suites, reduced income from some providers, and lower Education funding

GHC Income and Expenditure

Gloucestershire Health and Care
NHS Foundation Trust

The performance at Month 3 is above the planned deficit of £0.282m at break even in line with NHSI policy. The Trust has requested £726k of true-ups over three months.

	GHC	GHC Month 3			
Statement of comprehensive income £000	2019/20	2020/21			
	Actual	NHS I Interim plan	Budget	Actual	Variance
Operating income from patient care activities	187,601	57,567	52,266	54,020	1,754
Other operating income exc PSF	9,642	2,475	2,268	1,551	(717)
True up income		0	0	726	726
Provider sustainability fund (PSF) income	2,042	0	0	0	0
Employee expenses	(142,521)	(40,509)	(40,404)	(40,972)	(568)
Operating expenses excluding employee expenses	(55,456)	(15,468)	(13,410)	(14,438)	(1,028)
PDC dividends payable/refundable	(2,351)	(993)	(1,005)	(930)	75
Other gains / losses	222	15	3	11	8
Surplus/(deficit) before impairments & transfers	**(821)**	**3,087**	**(282)**	**(32)**	**250**
impairments	3,489	0	0	0	0
Remove capital donations/grants I&E impact	56	0	0	32	32
Surplus/(deficit) inc PSF	**2,724**	**3,087**	**(282)**	**0**	**282**

Note . The variance compares ‘Budget’ against ‘Actual’

GHC Balance Sheet

Gloucestershire Health and Care
NHS Foundation Trust

STATEMENT OF FINANCIAL POSITION (all figures £000)		GHC 2019/20	GHC Month 3 2020/21 Year to Date		
		Actual	Budget	Actual	Variance
Non-current assets	Intangible assets	2,023	2,283	1,583	(700)
	Property, plant and equipment: other	115,916	121,248	112,602	(8,646)
	Total non-current assets	**117,939**	**123,531**	**114,185**	**(9,346)**
Current assets	Inventories	288	245	283	38
	NHS receivables	11,017	8,456	5,753	(2,703)
	Non-NHS receivables	8,973	5,723	13,715	7,992
	Cash and cash equivalents:	26,619	28,469	64,427	35,958
	Property held for sale	0	500	0	(500)
	Total current assets	**46,897**	**43,393**	**84,177**	**40,784**
Current liabilities	Trade and other payables: capital	(2,143)	(1,784)	(628)	1,156
	Trade and other payables: non-capital	(5,580)	(10,551)	(8,163)	2,388
	Borrowings	(76)	(104)	(164)	(60)
	Provisions	(371)	(604)	(369)	235
	Other liabilities: deferred income including contract liabilities	(16,655)	(1,482)	(41,441)	(39,959)
	Total current liabilities	**(24,825)**	**(14,525)**	**(50,765)**	**(36,240)**
Non-current liabilities	Borrowings	(1,773)	(8,338)	(1,403)	6,935
	Provisions	(3,491)	(451)	(3,883)	(3,432)
	Total net assets employed	**134,747**	**143,610**	**142,311**	**(1,299)**
Taxpayers Equity	Public dividend capital	127,526	125,181	125,751	570
	Revaluation reserve	6,566	7,098	7,204	106
	Other reserves	(1,241)	(1,241)	(1,241)	(0)
	Income and expenditure reserve	1,896	12,572	10,597	(1,975)
	Total taxpayers' and others' equity	**134,747**	**143,610**	**142,311**	**(1,299)**

Note. £35m deferred income. July income received in June

Cash Flow Summary

Gloucestershire Health and Care
NHS Foundation Trust

Statement of Cash Flow £000	YEAR END 19/20		ACTUAL YTD 20/21	
Cash and cash equivalents at start of period		**33,553**		**37,720**
Cash flows from operating activities				
Operating surplus/(deficit)	1,308		333	
Add back: Depreciation on donated assets	0		32	
Adjusted Operating surplus/(deficit) per I&E	**1,308**		**365**	
Add back: Depreciation on owned assets	4,944		1,534	
Add back: Impairment	3,489		0	
(Increase)/Decrease in inventories	(38)		0	
(Increase)/Decrease in trade & other receivables	(3,516)		5,843	
Increase/(Decrease) in provisions	2,485		9	
Increase/(Decrease) in trade and other payables	2,580		18,507	
Increase/(Decrease) in other liabilities	(863)		1,519	
Net cash generated from / (used in) operations		**10,389**		**27,777**
Cash flows from investing activities				
Interest received	206		11	
Purchase of property, plant and equipment	(4,835)		(987)	
Sale of Property	560		0	
Net cash generated used in investing activities		**(4,069)**		**(976)**
Cash flows from financing activities				
PDC Dividend Received	570		0	
PDC Dividend (Paid)	(2,565)		0	
Finance Lease Rental Payments	(158)		(94)	
		(2,153)		**(94)**
Cash and cash equivalents at end of period		**37,720**		**64,426**

Gloucestershire Health & Care Covid

Gloucestershire Health and Care NHS Foundation Trust

- The Trust has established monitoring arrangements for the capture of all Covid related costs. New cost centres and monitoring arrangements for capturing costs have been established.
- We have strengthened financial governance arrangements. SFI's have been reviewed and senior managers have been written to reminding them of their key responsibilities and delegated limits
- A review of the Procurement to Pay process has been undertaken to ensure the systems to ensure payments to suppliers continue. As a consequence the introduction of the new Finance ledger has been deferred until September.
- No Covid related capital costs were identified in 19/20. Covid related capital costs will be incurred in 20/21 and a request to proceed has been put forward for national sign-off.
- Covid related revenue costs of £1,220k have been identified for April to June 2020, a reduction from the £1,472k in May due to clarification of the guidance on Sick pay at full pay.

For period up to and including 30/06/2020 (M1 - M3)	Pay	Non Pay	
Expand NHS Workforce - Medical / Nursing / AHPs / Healthcare Scientists / Other	160,266.00		Doctors, Nurse trainees, some admin / mgt
Sick pay at full pay (all staff types)	28,636.00		Clarification of guidance, now only extra cost rather than full cost
COVID-19 virus testing (NHS laboratories)	34,100.00	11,213.00	Swabbing team, Serology testing and EJC canopy
Remote management of patients		39,708.00	Includes 50% of Data charges
Support for stay at home models		829.00	
Plans to release bed capacity		23,855.00	GIS hire, recode of stores from month 1
Existing workforce additional shifts	65,106.00		Substantive workforce additional hours minus swabbing team
Decontamination		81,693.00	Includes portacabin showers, clinell supplies, cleaning etc
Backfill for higher sickness absence	579,717.00		Bank and agency cost, includes extra Adult Community costs as advised by CH
Remote working for non patient activites		39,976.00	Teamview, headsets plus 50% data
National procurement areas		135,714.00	Increase from M2 is vizors and increased accomodation
Other		19,129.00	Uniforms, signage, printing
	867,825.00	352,117.00	1,219,942.00

Capital – Five year Plan

Gloucestershire Health and Care
NHS Foundation Trust

Capital 5 year Plan	Original Plan	Revised Plan	Actuals to date	Plan	Plan	Plan	Plan	
£000s	2020/21	2020/21	2020/21	2021/22	2022/23	2023/24	2024/25	Total
Land and Buildings								
Buildings	4,259	3,057	224	3,202	4,500	7,500	1,000	19,259
Backlog Maintenance	1,393	1,322	50	1,371	1,050	1,050	250	5,043
Urgent Care	475	200	0	275		0		475
Covid	0	0	0	0				0
Medical Equipment	1,220	1,191	23	1,059	1,030	1,030	3,330	7,640
IT								
IT Device and software upgrade	600	1,270	0	0	600	600	600	3,070
IT Infrastructure	1,498	2,705	0	132	1,400	1,300	1,300	6,837
Sub Total	**9,445**	**9,745**	**297**	**6,039**	**8,580**	**11,480**	**6,480**	**42,324**
Forest of Dean	500	200	4	6,500	5,700		0	12,404
Total	**9,945**	**9,945**	**301**	**12,539**	**14,280**	**11,480**	**6,480**	**54,728**
Disposals				(3,260)		(1,500)		(4,760)
Donation						**(5,000)**		(5,000)
	9,945	**9,945**	**301**	**9,279**	**14,280**	**4,980**	**6,480**	**44,968**

Capital – Returns

Gloucestershire Health and Care
NHS Foundation Trust

During the last few months there have been a significant number of Capital returns that the Trust has had to complete. For information these include;

Covid Capital – March 20, assessed but nil return.
Covid Capital - April return with £137k claimed for Charlton Lane and Dilke works – awaiting confirmation of funding

ICS Capacity return – South West Capacity Planning – Can additional capacity be created - submitted 7th July as a joint ICS return.

Covid Phase 2 returns – 'Optimising Existing Capacity' – bids for switching on services within existing capacity - due 15th July as a Trust bid but after ICS review.

Mental Health Investment for Spending review – to help inform the government Mental Health Capital spending review for next 5 years. Submitted 19th June

Dormitories – bid for funds to eradicate Mental Health inpatient dormitory facilities - Nil submission

Risks

Gloucestershire Health and Care
NHS Foundation Trust

Risks to delivery of the 2020/21 position are as set out below:

Gloucestershire Health & Care Risks	20/21 Risks	Made up of: Recurring	Made up of: Non Recurring	Likelihood
			0	
Challenge Scheme CIPs	1,034	1,034	0	Likely
Unidentified Differential CIP schemes	386	386	0	Possible
Delivering non recurring savings	613	0	613	Possible
Interim finance might lead to loss of ability to deliver agreed developments	3,791	0	3,791	Likely
	5,824	**1,420**	**4,404**	

Gloucestershire Health and Care
NHS Foundation Trust

Single Operating Framework Ratings

Current FT Financial Risk Rating - Single Oversight Framework
Use Of Resource

Finance and use of resources rating Metric	Audited PY 31/03/2020 Year ending	Plan 31/03/2021 Year ending	Actual 30/06/2020 YTD	Forecast 31/03/2021 Year ending
Capital service cover rating	1	1	1	1
Liquidity rating	1	1	1	1
I&E margin rating	1	1	1	1
I&E margin: distance from financial plan	1	1	1	1
Agency rating	4	1	1	2
Risk ratings after overrides	3	1	1	1

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AGENDA ITEM: 14.1

REPORT TO: Trust Board - 22 July 2020

PRESENTED BY: John Trevains, Director of Nursing, Therapies & Quality

AUTHOR: John Trevains, Director of Nursing, Therapies & Quality

SUBJECT: **Quality Dashboard – June 2020**

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

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

The purpose of this report is to
To provide the Gloucestershire Health and Care NHS Foundation Trust Board with a summary assurance update on progress and achievement of quality priorities and indicators across Physical, Mental Health and Learning Disability Services.

Recommendations and decisions required
The Board is asked to:

- **Discuss, Note** and **Receive** the June 2020 Quality Dashboard

Executive summary
This report provides an overview of the Trust's quality activities for June 2020. This report will be produced monthly for Board, Quality Committee and Operational Governance Forum for information and assurance.

Quality issues for priority development

- A noted increase in all grades of acquired pressure ulcers across services, plans are in place to address this.
- The Trust quality ambition to deliver enhanced team learning events for embedding learning following serious incidents is behind plan for 2020/21. This is due to Covid-19 disruption, plans are in place to resolve in Quarter 2.

Quality issues showing positive improvement

- A continued reduction in Covid-19 related deaths across all services
- Significant improvement seen for people accessing Occupational Therapy and

Physiotherapy within agreed timescales
- A reduction in the number of people falling and experiencing harm within an inpatient setting

Are Our Services Caring?
Good assurance is available gained through complaints, concerns and compliments demonstrating that the voice of patients and carers continues to be heard, valued and remains central to our core business. The new Datix Patient Experience Model provides a more dynamic facility to capture patient feedback Trust wide.

Are Our Services Safe?
The Board will note that there is a continued but gradual increase in the overall numbers of reported patient safety incidents; this is to be expected as services begin to return to usual activity. The total number of reported incidents continues to be monitored by the patient safety team and where appropriate take action to understand and address any potential under reporting. The board will note that the number and grade of acquired pressure ulcers is increasing, assurance can be given that demonstrates that this is recognised, understood an improvement action is being taken to address the issues.

Are Our Services Effective?
Bed occupancy in our inpatient services has seen an expected increase as the services across the Gloucestershire system begin to return to business as usual. However, occupancy levels will continue to reflect the need to ensure a Covid-19 safe environment is achieved within inpatient areas to protect our patients and staff. The impact of this can be evidenced through the decreased mortality rate and corresponding increase in successful patient discharges. It is heartening to report that a further 21 patients were discharged from inpatient services having recovered from the Covid-19.

It is encouraging to note that many of our KPI's are now on an upward trajectory as we continue to move forward with our recovery plans, including those relating to IAPT.

Are Our Services Responsive?
The Board is asked to note the ongoing improvement within waiting times as services continue to re-establish themselves. The risk stratified approach taken by teams when reviewing patient's remains in place ensuring that those who are in most need are seen first. Recovery work is being conducted utilising quality improvement approaches to address historical waiting list challenges. Childhood Immunisations have recommenced and are being delivered within the Covid-19 testing facility at Edward Jenner Court alongside external visits and clinics.

Are our Services Well Led?
Mandatory training remained paused during June. Plans are in place to recover the training position. Face to face training, or close contact training such as PMVA/PBM will remain the most challenging to re-establish but plans are in place to mitigate related risks. In recognition of the psychological and emotional impact of the Covid-19 pandemic upon colleagues, face to face direct support led by the Trust psychology team has commenced. Refreshed focused is being applied to restarting staff engagement meetings such as the senior leadership forum and delivering Team Talk via digital mediums. The Trust communications team continue to proactively communicate clinical, operational and strategic information to Trust colleagues.

Risks associated with meeting the Trust's values
Specific initiatives that are not being achieved are highlighted in the Dashboard.

Corporate considerations	
Quality Implications	By the setting and monitoring of quality targets, the quality of the service we provide will improve
Resource Implications	Improving and maintaining quality is core trust business.
Equality Implications	No issues identified within this report

Where has this issue been discussed before?
Trust Board on a monthly basis.

Appendices:	See attached dashboard

Report authorised by:	**Title:**
John Trevains	Director of Nursing, Therapies & Quality

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Quality Dashboard 2020/21

Physical, Mental Health & Learning Disability Services

Data covering June 2020

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Executive Summary

Gloucestershire Health and Care
NHS Foundation Trust

This Quality Dashboard reports quality focussed performance, activity and developments regarding key quality measures and priorities for 2020/21 and highlights data and performance by exception. This data includes national and local contractual requirements. With regard to defined contractual or nationally-mandated quality related KPIs, the dashboard is only reporting on indicators not met. Certain data sets contained within this report are also reported via the Trust Resources committee, they are included in this quality report where it has been identified as having an impact on quality matters. Feedback on the content of this report is most welcome and should be directed to John Trevains Director of Nursing, Therapies & Quality.

Are Our Services Caring?
Despite there having been a national 'pause' on the NHS Complaints Procedure until 1st July we have continued to proactively link with patients, carers and members of the public to ensure that their voice is heard, valued and remains central to our core business. Our feedback survey work, including the Friends and Family Test which was suspended between April – June resumed from 1 July 2020 but through online and digital media only following infection prevention and control advice regarding paper surveys. Operational services have been provided with links to share with patients and carers in order to receive feedback data. From 1st July 2020, we anticipate a gradual increase in feedback via operational services as progress with their recovery whilst acknowledging that certain services were previously receiving the majority of their feedback via paper copies of surveys.

Are Our Services Safe?
Reported serious incidents remain within historical norms, as expected we are seeing a gradual rise in the overall numbers of reported patient safety incidents but the volume remains below the combined monthly average across the two historical Trusts in 2019/20 (Gloucestershire). Whilst there has been a recovery in the total number of incidents reported, we may be continuing to see staff prioritising the reporting of moderate or severe incidents and reporting fewer no or low incidents due to ongoing Covid-19 related pressures; safer lower priority services have remained closed in June, with higher priority services that were still open being those more likely to see moderate or severe incidents and this could be influencing the data. The patient safety team are monitoring levels of incident reporting closely. There continues to be a more enhanced focus for the review of reported pressure ulcers across all services and this will remain a key patient safety priority going forward. Work has been conducted though out June to provide strong assurance on Infection Control effectiveness in line with national guidance.

Are Our Services Effective?
Whilst bed occupancy in our inpatient services remains lower than usual, essential in terms of ensuring a Covid -19 safe environment, as expected it is beginning to increase as the system responds to patient need. The impact of lower occupancy can be evidenced through the decreased mortality rate and sustained successful patient discharges. It is encouraging to note that many of our KPI's are now on an upward trajectory, and those which have been failing to regularly meet their KPI's, such as IAPT, are either now compliant or moving towards required performance. The Trust quality has maintained close working relationships with Care Quality Commission and NHSE/I regional offices with regard to quality reporting and the Trust continues to receive positive feedback from these agencies.

Are Our Services Responsive?
Referral to treatment times have been significantly affected by Covid-19. There continues to be encouraging signs that waiting times are reducing, notably within podiatry and also within paediatric physiotherapy and occupational therapy services which have both sustained compliance above their respective thresholds. Recovery work is being conducted utilising quality improvement approaches to address historical waiting list challenges as currently paused services , such as Autism and Memory Assessment Services begin to restart. ICT therapy teams continue to apply a risk stratified approach to stepping up their services in order to ensure that those who are in most need are responded to within an appropriate timeframe and by the most relevant therapist. Across community occupational therapy and physiotherapy there has been a significant improvement towards achieving their targets. Immunisation programmes have recommenced and are being delivered within the Covid-19 testing facility at Edward Jenner Court alongside external clinics.

Are our Services Well Led?.
Mandatory training remained paused during June. Plans are in place to recover the training position, noting that online training can continue with minimal impact. Face to face training, or close contact training such as PMVA/PBM will remain the most effected and take the longest time to recover, plans are in place to mitigate related risks. In recognition of the psychological and emotional impact of the Covid-19 pandemic upon the workforce, a range of tools and routes of support continue to be developed, alongside promotion of face to face direct support led by the Trust psychology team. Refreshed focused is being applied to restarting staff engagement meetings such as the senior leadership forum and delivering Team Talk via digital mediums. The Trust communications team continue to proactively communicate clinical, operational and strategic information to Trust colleagues.

Quality Dashboard

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COVID-19 (Whole Trust data, reporting nationally mandated Covid focussed safety and activity information)

No		Reporting Level	Threshold	2019/20 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2020/21 YTD	R A	Exception Report?	Benchmarking Report
1	No of Patient Deaths reported to CPNS	N-R			30	7	1										38			N/A
2	Total number of deaths reported as C-19 related	L-R			55	14	2										71			
3	No of Patients tested at least once	N-R			202	234	259										695			N/A
4	No of Patients tested C-19 positive or were admitted already positive	N-R			120	65	6										191			N/A
5	No of Patients discharged from hospital post C-19	N-R			33	60	21										114			N/A
6	Community onset (Positive specimen <2 days after admission to the Trust)	N-R					0										0			N/A
7	Hospital onset (nosocomial) indeterminate healthcare associated (Positive specimen date 3-7 days after admission to the Trust)	N-R					0										0			N/A
8	Hospital onset (nosocomial) probable healthcare associated (Positive specimen 8-14 days after admission to the Trust)	N-R					0										0			N/A
9	Hospital onset (nosocomial) Definite healthcare associated (Positive specimen date 15 or more days after admission to the Trust	N-R					0										0			N/A
10	No of Staff Tested	N-R			276	521	104										901			N/A
11	No of Staff with confirmed C-19	L-R			85	38	0										93			N/A
12	No of Staff Self-Isolating	L-R			597	174	63													N/A
13	No Staff returning to work post Self-Isolating.	L-R			333	118	25													N/A

Additional Information

Patient Reporting

The table above shows that the number of patient deaths reported as Covid-19 related has declined significantly since April 2020.

The age range for deaths meeting the criteria for CPNS reporting during April and May was 73-98 years. During June 2020, the age range for these deaths was 70 to 98 years.

The total number of patient deaths reported as Covid-19 related is shown by hospital site / community team in the graph opposite.

Patient Testing

It is encouraging that there was a 91% decrease in the number of patients testing positive when compared to May 2020 with an 11% increase in patients being tested at least once

Staff Testing

Staff testing is well established with the numbers of staff tests stated above. However, this number reflects the number of tests undertaken within the Trust and others that have been reported to us, but will not include those undertaken elsewhere unless the staff member has advised the Trust of this. Numbers of staff testing positive reduced to zero for the month of June, Numbers of staff self isolating decreased by 64% from the May 2020 figure. Staff accessing serology testing appointments with minor symptoms are swabbed and these numbers are included above. Wide spread Trust serology testing will continue until Monday 20th July, it will then be delivered within standard routes .

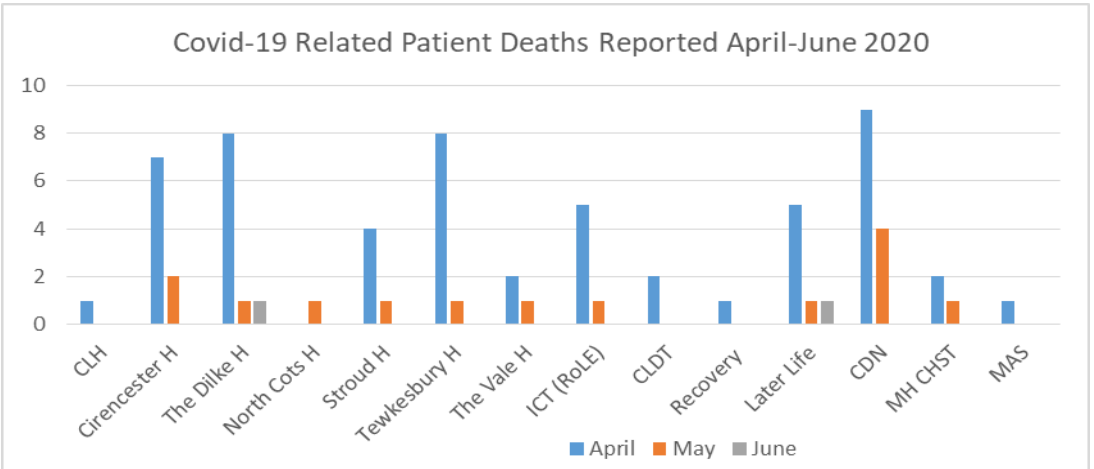
Infection Prevention and Control - COVID 19

The Trust is now required to report any healthcare associated acquired COVID-19 infections (nosocomial infections) attributable to our care.

A root cause analysis is required for each infection which is coordinated by the Infection Prevention & Control Team (IPC), discussed at the Trust's Infection Control Team meeting, and ICS Bronze System (IPC) Cell.

Any learning will be disseminated at system level, and within the Trust any learning assurance will be overseen by the Infection Prevention & Control Group and its forums and reported to the Quality Committee and ICS Cell.

There have been no nosocomial infections to report during June.



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COVID – 19 - KEEPING STAFF SAFE – (Are services well led)

PPE

There are no current concerns regarding stock levels of PPE items. Where the Trust has previously had lower levels of certain items good assurance is available that demonstrates a high level of stock and future supply. The Trust PPE stock team continue to provide high levels of assurance on PPE logistical management and our responsiveness to urgent requests for PPE mutual aid to other organisations or product quality checks that are received through national routes. The stock management team are moving operations to new premises to reduce operational impact on headquarters as we continue to enact our Trust wide recovery plans in July.

The Trust is positively engaged with regional and national conversations on PPE innovation and additional assurance on national supply chains. We have participated with NHSE national team seeking good practice for PPE emergency measures regarding equipment substitution preparedness.

Since the Secretary of State's announcement and subsequent guidance on the use of masks for NHS colleagues and face coverings for visitors, there has been a significant distribution of level 2 masks to patient areas for all colleagues and for visitors who do not attend with their own face covering.

Fit-testing

The Deputy Director of Nursing, Therapies and Quality wrote to Matrons and Service Directors on 29/05/20 to advise that all colleagues who may be involved/ or nearby a resuscitation event involving airway management (i.e. all inpatient services and a small number of community teams) would be required to be fit-tested for FFP3 masks within the next 6 months as a contingency measure . There are approximately 1300 staff who will require to be fit tested. Latest reports states that 542 staff have been fit tested and the Trust has now trained 90 fit testing specialists. As an additional safety measure all our inpatient and urgent care areas have specialist respirator equipment to use in these events and are not reliant on FFP3 masks for first responders.

Following correspondence from NHSE/I, the Trust has volunteered to trial fit-testing with the Cardinal FFP3 mask. It represents a significant amount of additional stock the Trust can access for the medium to longer term.

Due to the decision to expand the Trust's fit-testing strategy, additional testing kits were required. We were unable to order these centrally and so a mutual aid request was made to system partners and through the escalation process, this was successful and additional supplies were received in June.

Quality Dashboard

NHS
Gloucestershire Health and Care
NHS Foundation Trust

CQC DOMAIN - ARE SERVICES CARING? (Patient & Carer Experience)

No		Reporting Level	Threshold	2019/20 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2020/21 YTD	R / A / G	Exception Report?	Benchmarking Report
	Friends and Family Test Response Rate	N - T	15%		Suspended															
	% of respondents indicating 'extremely likely' or 'likely' to recommend service	N - R	95%	88%	Suspended															
	Number of Compliments	L - R		2,938	228	58	166										452			
	Number of Complaints	N - R		117	5	6	1										12			
	Number of Concerns	L - R		620	33	29	46										108			

Additional information

Combined figures for both physical and mental health services are shown.

Recent activity

- One complaint was received in June 2020 which is a 90% reduction from the monthly average during 2019/20 (n=approx. 10 complaints per month in 2019/20).
- Numbers of compliments received this month are about 32% below the average number of compliments per month over the last year (n=approx. 245 compliments per month in 2019/20). However the new Datix Patient Experience Model is scheduled for launch in July and this will have the facility for all services to log compliments directly; this functionality is currently only available to physical health services.
- Although there has been a 59% increase in the number of concerns raised compared to the previous month, this number remains close to the monthly average of concerns received during 2019/20 (n=approx. 52 concerns per month in 2019/20).

Summary of current Patient and Carer Experience Team (PCET) processes during Covid-19:

- The PCET continue to review all new complaints, concerns and enquiries on a weekly basis during a conference call.
- All new complainants receive a Covid-19 Acknowledgement Letter explaining why we are experiencing significant delays in responding to complaints.
- All new complaints are assessed for the need for any urgent action to be taken e.g. potential issues relating to patient safety or a death relating to the current Covid-19 pandemic.
- Complainants are kept informed of the progress of their complaint (i.e. If it is on hold or being investigated) and this is in line with current national guidelines relating to the Covid 19 (coronavirus) pandemic
- For complaints that have been investigated and the investigation report has been received by the PCET, the normal process for drafting, reviewing and approving FRLs is followed and complainants are regularly updated on progress.
- The PALS (Patient Advice and Liaison Service) team within PCET continue to provide support and advice to patients, their families and colleagues regarding issues raised and respond to queries as required including the support of resolution at a local level.
- The Friends and Family Test survey re-commenced on 1st July 2020.

National

NHSE indicated that providers could 'pause' the Complaints Process from 26th March 2020 in response to the pandemic. The pause ended on 1st July 2020

You said / We did:

Wife of patient made contact via Facebook messenger as they would like to know when the ADHD service will resume as they require support. *Clinical Nurse Specialist, ADHD Service contacted the patient and advise given around their medication and reassurance given that the patient will be contacted again as soon the ADHD Service reopens.*

Patient feels they are being detained unlawfully. *The patient's concerns were addressed by the ward team and advocacy. Patient's concerns relate to her legal status and treatment plan which cannot be altered at present.*

ABBEY WARD, WOTTON LAWN: While there I found a lot of support, good, kind, gentle people good resources that aid in recovery. Very good place to meet new people to get better. Things I needed to help me recover, friendly people, thank you for all the aid and time.

CIRENCESTER HOSPITAL: It is not easy for everyone in the current situation and we really appreciated your thoughtfulness in your care of dad and last Friday when you made it possible for us to see him before he passed away. That meant so much to both of us.

*In-month threshold (i.e. March)

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Quality Dashboard

Gloucestershire Health and Care
NHS Foundation Trust

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

		Reporting Level	Threshold	2019/20 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2020/21 YTD	R / A / G	Exception Report?	Benchmarking Report
	Number of Never Events	N - T	0	1	0	0	0													N/A
	Number of Serious Incidents Requiring Investigation (SIRI)	N - R		49	4	3	3													N/A
	Number of Serious Incidents Requiring Investigation (SIRI) where Medication errors caused serious harm	N - R		0	0	0	0													N/A
	Number of Serious Incidents Requiring Investigation (SIRI) regarding falls lead to fractures	N - R		6	0	1	0													N/A
	Number of Serious Incidents Requiring Investigation (SIRI) regarding pressure ulcers	N - R		5	0	0	1													N/A
	Number of Serious Incidents Requiring Investigation (SIRI) regarding suspected suicides	N - R		18	2	0	0													N/A
	Number of Serious Incidents Requiring Investigation (SIRI) regarding self harm or attempted suicide	N - R		6	3	1	1													N/A
	Number of Serious Incidents Requiring Investigation (SIRI) regarding mental health homicides	N - R		1	0	0	0													N/A
	Total number of Patient Safety Incidents reported	L - R		12,109	690	866	1001													N/A
	% incidents resulting in low or no harm	L - R		94.71%	90.50%	92.50%	93.11%													N/A
	% incidents resulting in moderate harm, severe harm or death	L - R		5.29%	9.50%	7.50%	6.89%													N/A
	% falls incidents resulting in moderate, severe harm or death	L - R		2.24%	0.96%	3.13%	2.04%													N/A
	% medication errors resulting in moderate, severe harm or death	L - R		0.61%	6.06%	0.00%	0.00%													N/A
	Embedding Learning meetings taking place to review the outputs of completed SIRI reports and consider practice implications.	L - R		N/A	0	0	0													N/A

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ARE SERVICES SAFE ? – ADDITIONAL NARRATIVE INFORMATION

3 SIRIs were reported in June, one fall with associated fracture, one attempted suicide, and one incident where a person died following a fall within inpatient services. All SIRIs have an allocated investigating officer to produce the preliminary investigation. SIRI review meetings are routinely held using MS Teams and good progress is being made to address the work that was paused during the Covid-19 pandemic, including the delivery of final reports and learning summaries to Trust teams an external stakeholders and regulators.

Due to Covid-19 disruption (quality team clinicians redeployed to frontline services and reduction in face to face workshops) no enhanced "embedding learning" meetings have been able to take place in quarter 1, this is planned to restart during quarter 2 via digital routes. The patient safety forum in which individual teams review the output of completed serious incident investigations and consider practice implications has been maintained throughout Q1.

- The percentage of moderate, severe and death patient safety incidents reported in June (6.89%) fell for the third month in a row. The patient safety team are monitoring levels of incident reporting closely in light of potential Covid disruption influencing reporting levels.

- The total number of patient safety incidents reported in June (1001) rose for the third month in a row and marks a return to the monthly average reporting levels seen across the two Trusts in 2019/20 (Gloucestershire only – Pre Covid) of 1009 patient safety incidents a month.

- Percentage of falls resulting in moderate or severe harm fell in June (2.04%) compared with May (3.13%) and is close to the combined historical average for 2019/20 (2.24%)

- No medication errors resulting in moderate or severe harm were reported in June 2020, continuing this positive trend .

- The Patient Safety Team review and sign off all incidents graded as moderate and above, taking investigative action where indicated and coordinating Duty of Candour responses in conjunction with the Patient & Carer Experience Team.

- To note there was an amendment to the previously reported April 2020 figures (690 from 695 total incidents) due to some incidents subsequently being identified as duplicates on review through data quality checks. This did not substantially change the percentages reported against different levels of harm or result in any change to the data related to medication incidents or falls for April.

- Regarding Trust Patient safety developments. The Nursing, Therapies & Quality directorate are developing and deliver a programme for improvement based on the 'Civility Saves Lives' approach Civility Saves Lives is a grass roots campaign aimed at raising awareness of the impact of incivility on team and individual performance, in order to improve patient safety. https://www.civilitysaveslives.com

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

CQC DOMAIN - ARE SERVICES SAFE? Physical Health Focus

		Reporting Level	Threshold	2019/20 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2020/21 YTD	RAG	Exception Report?	Benchmarking Report
	VTE Risk Assessment - % of inpatients with assessment completed	N - T	95%	97.3%	94.6%	93.4%	96.2%										94.7%	A		
	Safety Thermometer - % Harm Free	N - R L - C	95%	93.2%	N/A	N/A	N/A										N/A	N/A		
	Safety Thermometer - % Harm Free (New Harms only)	L - I	98%	97.8%	N/A	N/A	N/A										N/A	N/A		
	Total number of Acquired pressure ulcers	L - R	61	784	62	76	82										138	R		
	Total number of grades 1 & 2 Acquired pressure ulcers	L - R	56	737	54	68	70										122	R		
	Number of grade 3 Acquired pressure ulcers	L - R	0	46	4	6	8										18	R		
	Number of grade 4 Acquired pressure ulcers	L - R	0	8	4	2	4										6	R		

Additional information

Safety Thermometer

Reporting remains suspended due to Covid-19 . This is in agreement with commissioners and will be reviewed within the contractual Clinical Quality Review meetings.

Pressure Ulcers

Although the number of grade 3 pressure ulcers reported in June remains within SPC chart control limits, the number recorded is rising. Quality and Safety Team investigative panel meetings are taking place in relation to the grade 4 pressure ulcers. Work continues within the Nursing, Quality and Therapies directorate in order to develop a refreshed approach to the pressure ulcer improvement work. This will sit within the wider context of a revised wound care strategy across physical health, mental health and learning disability services. Good progress has been made since the return of the clinical pathway lead to their substantive post following their secondment to Community Nursing as part of the Covid-19 response. It is expected that a detailed focus of the pressure ulcer and wider wound care work will be available to Quality Committee in September.

VTE Risk Assessment

VTE Risk Assessment - % of inpatients with assessment completed in Community Hospitals has now met the 95% target in June (96.2%) which is an encouraging sign of ongoing recovery and supports the evidence that previous underperformance was a data quality issue.

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Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

CQC DOMAIN - ARE SERVICES EFFECTIVE- (Whole Trust data)

		Reporting Level	Threshold	2019/20 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2020/21 YTD	RAG	Exception Report?	DQ Rating	Benchmarking Report
Community Hospitals																					
	Bed Occupancy - Community Hospitals	L - C	92%	94.4%	76.1%	69.8%	83.3%										76.4%	A		A	90.4%
Mental Health Services																					
	Early Intervention in psychosis EIP: people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral	N - T	50%	69%	0%	40.0%	33.3%										20.0%				
	Ensure that cardio-metabolic assessment & treatment for people with psychosis is delivered routinely in the following service areas:																				
	Inpatient Wards	N - T	90%	80%																	
	GRiP	N - T	90%	85%																	
	Community	N - T	75%	78%																	
	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	N - T	50%	50.1%	37.5%	44.4%	54.5%										41.0%				
	Admissions to adult facilities of patients under 16 years old.	N - R		2	0	0	0														
	Inappropriate out-of area placements for adult mental health services	N - R	average bed days	19	30	31	30														
Children's Services - Immunisations				2019/20 Academic Year	Academic Year 2019/20					Academic Year 2020/21											
	HPV Immunisation coverage for girls aged 12/13 years old (1st Immunisation)	N - T	85%*	89.5%	79.7%	Programme commences January 2021											79.7%	R		G	
Childrens Services - National Childhod Measurement Programme				2019/20 Academic Year	Academic Year 2019/20					Academic Year 2020/21											
	Percentage of children in Reception Year with height and weight recorded	N - T	70%*	97.7%	66.4%	68.0%	67.9%			Programme commences in November 2020							66.4%	R		G	
	Percentage of children in Year 6 with									Programme											

Additional Information

Bed Occupancy
Bed Occupancy in Community Hospitals has increased by 19% this month following a number of months with a significantly reduced percentage in order to safely manage patients within the first wave of the Covid 19 response. Colleagues within operations are closely monitoring bed occupancy levels in order to ensure that care can be delivered safely and effectively within a Covid 19 secure environment.

Mental Health
IAPT recovery rates have increased by 33% this month and have achieved the threshold required. However, the Early Intervention in Psychosis (EIP) service remains below the threshold, and indicates a reducing trend. It is anticipated that as Recovery Plans gain traction these will continue to improve. The EIP service has been deliberately focussing on Priority 1 clients as part of Covid-19 crisis delivery and as part of recovery planning will be seeking to return to compliance by the end of July 2020. Covid-19 has disrupted IAPT targets nationally and will reduce expectations for national Q1 reporting ,although it is pleasing to note that for June the threshold has been achieved.

Children's Services
These reported programmes were paused due to the Covid-19 outbreak and the Trusts response to the crisis. However, in July the immunisation teams have started to work as part of the Covid-19 testing facility with the remit of recommencing HPV Immunisation and recovery is underway.

The HPV Immunisation programme was been paused due to the initial Covid-19 outbreak. The cumulative position is now behind the internal trajectory (79.7% compared to trajectory 85%). The service has now reopened albeit in a limited capacity in order to facilitate the completion of outstanding HPV 1 and 2 doses for the 2019/20 academic year.

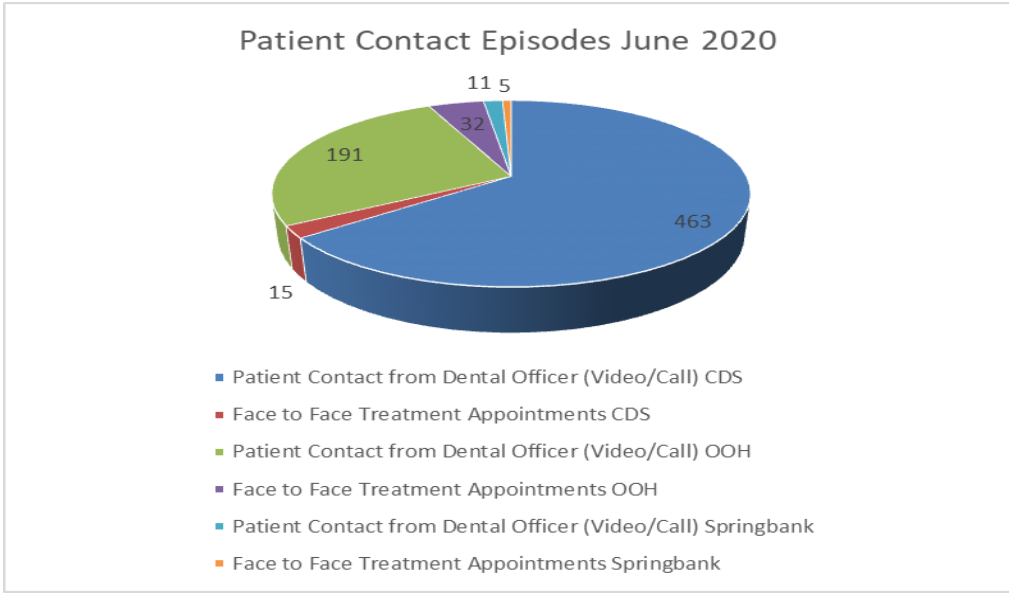
CQC DOMAIN - ARE SERVICES EFFECTIVE

Focus on Dental Services

Due to Covid-19 all face to face dental treatments were stopped due to the high risk of transmission of the virus via aerosol generated procedures (AGP's).
To provide a point of contact and pain relief advice to patients experiencing problems dental officers were given access to 'attend anywhere' so that if necessary patients could have a consultation via video and given advice and/or a prescription if needed.
As these activities do not generate urgent dental appointments (UDA) activity has been measured by units of activity in the different areas of patient contact the service has had.

In June the service was able to provide UDA's to the cohort of special care patients who had received remote advice and prescribing but who were still experiencing problems. As the majority of patients have complex medical histories and specific additional needs each person who is presenting as needing a face to face appointment is carefully risk assessed to make sure patient and staff safety is the priority consideration. This activity is currently delivered within Southgate Moorings and St Paul's clinic. Our outlying clinics are single surgery clinics so under the current guidance would not be suitable for treating patients therefore all patients are brought into the two main clinics.

The Community Dental Service was also required to provide urgent face to face care for patients on referral from general dental practitioners for the whole of Gloucestershire at the beginning of the pandemic. As the only urgent dental care centre (UDC) available, demand for appointments was significantly high for the first 4 weeks until further UDC's were opened.
Springbank Dental Clinic which is the general dental service branch of the Trusts dental services re-commenced face to face treatments for registered patients on 29th June.



Total number of calls received into service (CDS/OOH/SPCA/Springbank) - 1606

FOCUS ON DENTAL SERVICES– ADDITIONAL NARRATIVE INFORMATION

Risks

The high risk of transmission Covid-19 within the dental environment was clearly evidenced and consideration has had to be given to patient selection for treatment in hubs. Each case was risk assessed and if at all possible any dental problems are being managed remotely. Clinics are well prepared and following standard operating procedures for carrying out procedures using full PPE including FFP3 masks, visors and gowns.

Assurance

During the initial Covid-19 outbreak all patients requiring urgent care were either video or telephone triaged by two clinicians to assess both the need to bring them into the clinic and also if their medical history would compromise them and increase their risk should they be potentially exposed to Covid-19. The team were and continue to be supported by senior management in relation to additional training.

The clinical team have received training in 'doffing and donning' of PPE and have been fit tested for their FFP3 masks; were trained on the decontamination of the surgery environment following procedures, and staffing was also rotated to ensure that viral load was kept at a minimum. Service recovery plans have been developed which includes a timeline for returning to normal provision but this will be guided by Public Health England information and recommendations.

St Pauls dental clinic was re-configured to meet the requirements to see patients face to face and stocked with appropriate PPE. Procedures were put in place for supporting patients through the new process. The portal for referrals was opened and the most urgent patients were contacted, clinically assessed via telephone/video and appointments were made. This service was also provided by the out of hours team and became a 7 day service.

The team have remained positive and have striven to provide the best service they could under very challenging circumstances. The team sickness rate has been below average and staff have worked additional hours to accommodate any activities that have needed to be undertaken to maintain a safe environment. In addition they have provided fit testing for over 80 dental professionals across Gloucestershire in order to increase the number of Dental hubs available for patients in the county.

The clinic at Southgate Moorings has been re-organised to be an area where special care patients can be seen for emergency care who would be considered high risk – for example patients who have been shielding or patients who would require extra time in order to make reasonable adjustments to meet their individual needs.

FOCUS ON CHILDRENS COMPLEX CARE TEAM

The Children's Complex Care team support children with life-limiting and complex health conditions in their own homes including respite care for families.

The impact of Covid-19 has caused increased anxiety and vulnerability for these children and families in relation to the potential risk of acquiring the virus from staff visiting the home. Some families have been reluctant to receive support and respite from the team resulting in increased feelings of isolation, carer stress and tiredness. The team deployed an enhanced level communication with each family during Covid-19 to undertake clinical review and provide emotional support.

Risk reduction mechanisms were applied to home visits and care packages to minimise spread of Covid-19 whilst continuing to provide planned care. The team provided additional support to those who were challenged by national PPE and social distancing guidance enabling family life to continue as usual.

External care agencies involved in providing direct care to those on the caseload were supported with accessing adequate supplies of PPE and GHC infection prevention and control training resources were made available to those colleagues. Regular case management calls were undertaken with commissioners and providers throughout the outbreak.

FOCUS ON BERKLEY HOUSE – LEARNING DISABILITY SERVICES

Throughout the Covid-19 pandemic colleagues at Berkley House have continued to provide high quality compassionate care to individuals. Excellent practice with regards to Infection prevention and control was observed preventing spread following a positive test result. Staff continued to prioritise individuals wellbeing needs with good community access within social distancing measures.

Following on from last years CQC national team visit, as part of a countrywide programme to review Learning Disability inpatient services where restrictive practices are employed, there have been further external visits under the DHSC programme of enhanced care and treatment reviews earlier this year. A range of feedback was received from these visits , positive practice was identified and also areas of learning related to ongoing clarity required regarding definitions of long term segregation and it's management in complex care settings. The Trust have been active involved in development on this issue with CQC and NHSE colleagues in recent years. Positively CQC have offer to work closely with the Trust in additional refinement to local policy in line with developing national guidance for this specific matter in similar care settings.

Subsequent collaborative planned review work with NHSE, CQC and DHSC has been disrupted by Covid-19. However, the Trust has made good progress with the support of the regional NHSE Transforming Care Lead in engaging with these national agencies to further discuss feedback and findings prior to developing refreshed plans. Supporting individuals to transfer to new placements that can be considered more homely remains a priority. The NHSE regional lead for transforming care is working with local commissioners to understand challenges within the local social care market which are preventing some individuals from being able to move quickly to a new living environment. The Trust is engaged with commissioners in this planning and options have been developed but will take time to be achieved.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

CQC DOMAIN - ARE SERVICES RESPONSIVE?

Physical Health Services

Minor Injury and Illness Units

		Reporting Level	Threshold	2019/20 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2020/21 YTD	RAG	Exception Report?	Benchmarking Report Feb Figure
	Time to initial assessment for patients arriving by ambulance (95th percentile)	N - T	<15 m	00:14	00:17	00:11	00.13										00:13	R		
Referral to Treatment																				
	Podiatry - % treated within 8 Weeks	L - C	95%	73.6%	92.9%	97.2	100%										96.7%	A		
	ICT Physiotherapy - % treated within 8 Weeks	L - C	95%	79.8%	65.1%	57.9%	84.4%										69.1%	R		
	ICT Occupational Therapy Services - % treated within 8 Weeks	L - C	95%	83.5%	79.4%	62.5%	93.6%										78.5%	R		
	Paediatric Speech and Language Therapy - % treated within 8 Weeks	L - C	95%	88.5%	60.2%	68.8%	95.3%										74.8%	R		
	Paediatric Physiotherapy - % treated within 8 Weeks	L - C	95%	84.5%	72.2%	98.8%	95.2%										88.7%	R		
	Paediatric Occupational Therapy - % treated within 8 Weeks	L - C	95%	95.4%	92.9%	97.2%	96.2%										95.4 %	A		
	Single Point of Clinical Access (SPCA) Calls Offered (received)	L - R	3,279	35939	1787	1731	1774										5292	R		
Mental Health Services																				
	CPA Review within 12 Months	N - T	95%	96.9%	86.9%	86.7%	87.2%										87.5%	R		
	Admissions to hospital gate kept by CRHTT	N - T	95%	100.0%	96.8%	94.8%	100%										98.9%			

Additional information

The temporary closure of the Vale, Dilke & Tewkesbury MIIUs in response to the Covid-19 outbreak initially impacted upon initial assessment times. However an improved picture is now evident. In line with other urgent care services across the system MIIU's are expected to see an increase in attendances following the relaxation of lockdown measures- this is being closely monitored to ensure the units are able to respond safely and appropriately to patient need.

Referral to treatment times have been impacted upon directly by the Trusts response to Covid-19. As we enter the Recovery phase these KPI's will be revisited. It is reassuring that the Podiatry KPI has recovered and been maintained as have the paediatric physiotherapy, speech and language therapy, and occupational therapy treatment targets. During recovery planning, services have been reviewing traditional models of service delivery and implementing new and innovative ways of working in order to respond safely to COVID-19 whilst maximising service effectiveness and efficiency. ICT therapy teams continue to apply a risk stratified approach to stepping up their services in order to ensure that those who are in most need are seen first. As is evident both Occupational Therapy and Physiotherapy services have significantly improved their performance within the month of June.

Whilst a slight increase in performance is noted CPA reviews remain challenging to achieved in light of the need for minimal face to face contacts and social distancing. It is anticipated that this indicator will remain challenging to achieve whilst recovery plans are embedded.

May was the first month that CRHTT gatekeeping admissions has fallen below target (due to Covid-19 disruption) and it is positive to note that this has now recovered in June.

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Quality Dashboard

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Additional KPIs Physical Health

		Reporting Level	Threshold	2019/20 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2020/21 YTD	RAG	Exception Report?	Benchmarking Report Feb Figure
	Proportion of eligible children who receive vision screens at or around school entry.		70%*	N/A	60.4%	60.4%	60.4%										60.4%	R		
	Number of Antenatal visits carried out		92	944	46	42	35										60.4%			
	Percentage of live births that receive a face to face NBV (New Birth Visit) within 7- 14 days by a Health Visitor		95%	91.5%	42.9%	30.6%	58.7%										44.1%	R		
	Percentage of children who received a 6-8 weeks review.		95%	94.1%	12.2%	44.4%	71.8%										49.1%	R		
	Percentage of children who received a 9-12 month review by the time they turned 12 months.		95%	84.8%	80.3%	75.2%	67.1%										75.4%	A		
	Percentage of children who received a 12 month review by the time they turned 15 months.		95%	90.2%	89.4%	86.2%	89.2%										88.3%	A		
	Percentage of children who received a 2-2.5 year review by 2.5 years.		95%	83.5%	81.9%	85.3%	81.7%										83.0%	A		
	Percentage of infants being totally or partially breastfed at 6-8wks(breastfeeding prevalence).		58%	54.9%	56.7%	56.2%	58.2%										57%	A		
	Chlamydia Screening of Gloucestershire residents aged 15-24 via the Chlamydia Screening Service (minimum positivity rate)		3108	1929	895	676	844										2415			
	Number of Positive Screens		169	1329	53	40	50										143	R		
	Average Number of Community Hospital Beds Open		196	195.4	173.3	168.8	155.8										173.5	R		
	Average Number of Community Hospital Beds Closed		0	1.1	19.2	27.2	40.2										29.9	R		

Additional Information

The National Childhood Measurement Programme continues to be paused due to the Covid-19 outbreak. The cumulative position is now behind the internal trajectories .Public Health England (PHE) does not expect that local authorities will resume NCMP measurements for the current school year, even when schools reopen as planned for some year groups. For the 2019/20 school year, there will therefore not be an expectation that local authorities meet the minimum participation rates (as set out in the NCMP operational guidance 2019) in the data they submit to NHS Digital by Wednesday 5th August 2020.

*In-month threshold (i.e. March)

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

RAG Key: R – Red, A – Amber, G - Green

CQC DOMAIN - ARE SERVICES WELL LED?

		Reporting Level	Threshold	2019/20 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2020/21 YTD	RAG	Exception Report?	Benchmarking Report
	Staff Friends and Family Test - Percentage of staff who would recommend the Trust as a place of work	N - R L - T	61%																	
	Staff Friends and Family Test - Percentage of staff who would recommend the Trust as a place to receive treatment	N - R L - T	67%																	
	Mandatory Training	L - I	90%	89.14%	88.8%	88.7%														
	% of Staff with completed Personal Development Reviews (Appraisal)	L - I	90%	80.38%	72.7%	69.9%	65.4%													
	Sickness absence average % rolling rate - 12 months	L - I	<4%	4.72%	4.9%	5.0%	5.2%													
	SUS+ (Secondary Uses Service) Data Quality Validity - Available in arrears	N-R	96.30%																	

Additional information

Mandatory training, appraisal and absence

Mandatory training remained paused during June. Plans are in place to recover the training position, noting that online training can continue with minimal impact. Face to face training, or close contact training such as PMVA/PBM will remain the most effected and take the longest time to recover, plans are in place to mitigate related risks. Once training fully recommences staff will be able to access training that is showing as 'out of date'. However it is likely that full recovery will take time due to the backlog of staff needing training and limits on service areas to release staff along with capacity of training places.

Appraisal compliance continues to fall although as staff return from redeployment an improvement is expected and will be monitored. Team leaders have received support to complete appraisals to return to required compliance .

Sickness/absence rose to 5.2% compared to the 2019/20 out turn data.

Facilitating new ways of leading

In recognition of the challenges and varying experiences that staff and teams have encountered, part of the recovery planning has given consideration to emotional and psychological impacts, alongside the practical task-based work. It is clear that some clinical areas have been more affected than others and these will be explored in detail to understand fully the reasons behind this.

Through collaborative working, a suite of tools together with associated training has been developed including:

1.Facilitation skills training to support effective meetings.

2.Support with planning or co-facilitating team meetings.

3. Additional resources/toolkit which can be downloaded from the intranet for the purpose of individual reflection, in one to one sessions and with teams.

Staff Health and Wellbeing

In recognition of the psychological and emotional impact of the Covid-19 pandemic upon the workforce, a range of tools and routes of support continue to be developed, alongside promotion of face to face direct support led by the Trust psychology team. Refreshed focused is being applied to restarting staff engagement meetings such as the senior leadership forum and delivering Team Talk via digital mediums. The Trust communications team continue to proactively communicate clinical, operational and strategic information to Trust colleagues.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

CQC DOMAIN - ARE SERVICES WELL LED?

Safe Staffing Mental Health Inpatient – June 2020

	Code 1		Code 2		Code 3		Code 4		Code 5	
Ward Name	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions
Dean	32.5	4	0	0	0	0	0	0	0	0
Abbey	310	41	0	0	0	0	0	0	0	0
Priory	385	47	0	0	0	0	0	0	0	0
Kingsholm	0	0	0	0	0	0	0	0	0	0
Montpellier	55	7	15	2	0	0	0	0	0	0
Greyfriars	55	59	0	0	0	0	0	0	0	0
Willow	105	14	0	0	0	0	0	0	0	0
Chestnut	22.5	3	0	0	0	0	0	0	0	0
Mulberry	0	0	0	0	0	0	0	0	0	0
Laurel	0	0	0	0	0	0	0	0	0	0
Honeybourne	0	0	0	0	0	0	0	0	0	0
Berkeley House	0	0	0	0	0	0	0	0	0	0
Total In Hours/Exceptions	1383.0	160	7.5	1	0	0	0	0	0	0

Definitions of Exceptions;

Code 1 =	Min staff numbers met – skill mix non-compliant but met needs of patients
Code 2 =	Min staff numbers not complaint but met needs of patients e.g. low bed occupancy , patients on leave
Code 3 =	Min staff numbers met – skill mix non-compliant and did not meet needs of patients
Code 4 =	Min staff numbers not compliant did not meet needs of patients
Code 5=	Other

MENTAL HEALTH & LD						
Ward	**Average Fill Rate**	**In-Post**	**Bank**	**Agency**	**Vacancies**	**Sickness**
Berkeley House	104.75%	78.90%	18.56%	7.29%	21.10%	3.00%
Honeybourne Unit	106.39%	95.80%	10.37%	0.22%	4.20%	10.32%
Laurel House	102.78%	89.30%	13.48%	0.00%	10.70%	7.10%
Abbey Ward	111.72%	57.70%	14.32%	39.70%	42.30%	7.50%
Dean Ward	123.22%	84.10%	22.45%	16.67%	15.90%	
Kingsholm Ward	134.67%	91.60%	31.23%	11.84%	8.40%	
Priory Ward	114.00%	72.70%	15.98%	25.32%	27.30%	
PICU Greyfriars Ward	131.53%	88.60%	32.20%	10.73%	11.40%	
Chestnut Ward	108.15%	96.60%	11.55%	0.00%	3.40%	6.84%
Mulberry Ward	124.50%	92.00%	32.50%	0.00%	8.00%	
Willow Ward	108.63%	90.00%	17.10%	1.53%	10.00%	
Totals	**115.49%**	**85.20%**	**22.90%**	**7.39%**	**14.80%**	**6.95%**

Mental Health & LD Inpatient

There are mitigations to note in reference to the gaps in the in-post percentages:

- Wotton Lawn is currently running at 25 WTE vacancies. There is a cohort of 8 newly qualified nursing staff joining Wotton Lawn in September 2020. Therefore, the net vacancy rate for Wotton Lawn will be 17 WTE. Charlton Lane is currently running at 2 WTE vacancies. There is a cohort o f3 newly qualified nursing staff joining Charlton Lane in September 2020. Therefore, the net vacancy rate for Charlton Lane will be 1 WTE. This is a positive development and reflects recruitment work undertook earlier this year with student nurses. However further attention is required to maintain required staffing in these areas
- There are currently 6 x 12wk agency contracts in place in Wotton Lawn. A further 4 x 12wk agency contracts are being developed.
- An agency Guaranteed Volume Contract is in place in Wotton Lawn delivering 28 shifts per week. Work is currently underway to increase this contract by 100% at Wotton Lawn to meet current demand. An equivalent guaranteed volume contract is being developed to include Charlton Lane and work is underway to establish demand. This contract promotes improved continuity care service as these staff undertake RiO and clinical risk raining so can undertake the full clinical role including nurse in charge.

CQC DOMAIN - ARE SERVICES WELL LED?

Safe Staffing Physical Health – June 2020

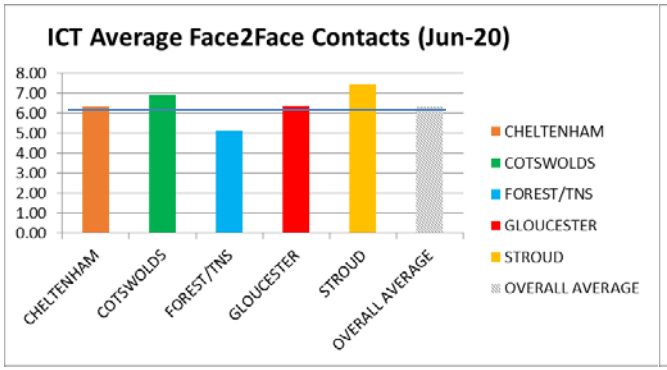
Physical Health

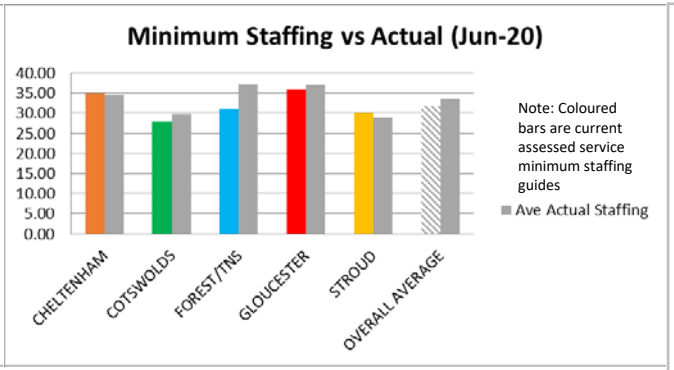
The Trust is working to homogenise safe staffing reporting methods across the new organisation. This development work has been delayed by Covid-19. However the Trust is able to report good levels of staffing maintained in inpatient areas sets against agreed safe staffing levels and no exceptions have been reported in June. The table below shows fill rates in June 2020. A detailed piece of work will be undertaken to enable the reporting of physical health exceptions as currently delivered in MH/LD services.

PHYSICAL HEALTH						
Ward	**Average Fill Rate**	**In-Post (RGN & HCA)**	**Bank**	**Agency**	**Vacancies**	**Sickness**
Coln (Cirencester)	88.95%	80.70%	6.24%	2.01%	19.30%	6.16%
Windrush (Cirencester)	98.40%	75.20%	19.76%	3.44%	24.80%	
Jubilee (Stroud)	98.20%	76.90%	16.84%	4.46%	23.10%	7.27%
Cashes Green (Stroud)	91.02%	87.60%	3.31%	0.11%	12.40%	
Tewkesbury	117.07%	92.90%	22.27%	1.90%	7.10%	6.77%
North Cotswolds	88.11%	95.50%	0%	0%	4.50%	8.73%
The Dilke	107.06%	87.40%	17.53%	2.13%	12.60%	6.39%
Lydney	94.64%	88.10%	4.84%	1.70%	11.90%	5.51%
Vale	96.20%	83.60%	10.62%	1.98%	16.40%	3.77%
Totals	**97.74%**	**85.40%**	**10.55%**	**1.79%**	**14.60%**	**6.37%**

CQC DOMAIN - ARE SERVICES WELL LED?

Effective Staffing Review - June 2020 – Development data providing focus on ICT (District Nursing teams) activity and staffing levels





- Face to face contacts was the regular method of contact prior to Covid-19. Phone contact is now more utilised with service users which is not included in these figures.
- Actual staff levels include the additional extra staff who were redeployed during Covid-19 thereby inflating recorded number of actual staff.
- The average number of redeployed staff per working day = 26. Currently the 'actual' number of staff is 167.88 average per day in total, against a minimum number of 165.
- Post Covid-19, the 'actual' staffing would therefore return to 141.88 – well below the minimum.
- The average vacancy rate for ICT = 14.8% for June 2020 (this equates to 41.07 WTE).

Note: Good progress has been made on ICT D/N recruitment through June 2020 – A more detailed analysis of this will be included in the next iteration of this report

with you, for you

Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 15

REPORT TO: Trust Board – 22 July 2020

PRESENTED BY: Dr Amjad Uppal, Clinical Director

AUTHOR: Zoë Lewis, Patient Safety Administrator

SUBJECT: **2019/20 QUARTER 4 LEARNING FROM DEATHS**

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

The purpose of the report is to

Inform the Board of the mortality review process and outcomes during 2019/20 quarter 4. It is a regulatory requirement for all NHS Trusts to identify, report, investigate and learn from deaths of patients in their care, as set out in the National Quality Board *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*, published March 2017.

Recommendations and decisions required

The Board is asked to **note** the contents of this mortality review report which covers Quarter 4 of 2019/20

Executive summary

The Board is asked to note that this is the second quarter of the merged organisation and as such, this Learning From Deaths paper includes data concerning both the deaths of mental health and physical health patients.

For the period 1 January to 31 March 2020, 165 mental health patient deaths and 32 physical health patient deaths were reported, a total of 197 patient deaths. At the time of reporting, 0 deaths representing 0.0% of the 197 patient deaths are judged to be more likely than not to have been due to problems in the care provided by the Trust.

The Board is asked to note the learning presented here from mortality review of both physical and mental health patient deaths during 2019/20 Q1-4.

Risks associated with meeting the Trust's values
None

Corporate considerations	
Quality Implications	Required by National Guidance to support system learning
Resource Implications	Significant time commitment from clinical and administrative staff
Equality Implications	None

Where has this issue been discussed before?
Quality Assurance Group.

Appendices:	None.

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

LEARNING FROM DEATHS 2019-20 Q4 REPORT

1.0 INTRODUCTION AND OVERVIEW

The Board is asked to note that this is the second quarter of the merged organisation and as such, this is the second joint Learning From Deaths paper which includes data concerning both the deaths of mental health and physical health patients.

For physical health patients, inpatient only deaths are reported. For mental health patients (including LD), both inpatient and community deaths are reported.

All data contained in this paper is correct as of 14 April 2020.

2.0 MENTAL HEALTH PATIENTS (INCLUDING LD)

2.1 During 2009-2020 Q1-Q4, 789 Gloucester Health and Care NHS Foundation Trust (the Trust) patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 221 in the first quarter;
- 200 in the second quarter;
- 203 in the third quarter;
- 165 in the fourth quarter.

2.2 By 14 April 2020, 36 case record reviews and 17 investigations have been carried out in relation to the 789 deaths included in 2.1.

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:

- 28 in the first quarter;
- 14 in the second quarter;
- 10 in the third quarter;
- 1 in the fourth quarter.

2.3 0 representing 0.0% of the patient deaths during the reporting period are judged more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of:

- 0 representing 0.0% for the first quarter;
- 0 representing 0.0% for the second quarter;
- 0 representing 0.0% for the third quarter;
- 0 representing 0.0% for the fourth quarter.

These numbers have been estimated using Structured Judgement Review (SJR). For deaths of mental health patients, the RCPsych Mortality Review Tool 2019 is employed. For deaths of LD patients, a similar Trust-developed SJR tool is utilised which pre-dates the RCPsych tool. This approach has been maintained to allow consistency with the Learning Disabilities Premature Mortality Review (LeDeR) programme. All case record reviews are discussed at a Mortality Review Group meeting chaired by Clinical Directors. For any deaths meeting Serious Incident or Clinical Incident criteria, a Comprehensive Investigation is carried out.

2.4 The Trust has identified:

- In some cases, escalation plans for informal inpatients taking leave had not been clearly discussed and agreed with the patient or clearly recorded on RiO, (the Trust's electronic records system).
- Communication with patients' GPs was not always as up to date as expected in terms of informing with regards to informing of: disengaged patients; patients who had been discharged from community teams; changes to patient's risk assessments and care plans; and patients who had been accepted onto a community team caseload, including being allocated a care coordinator.
- During a case of an unexpected death of a formal mental health inpatient, CPR was not instigated as quickly as per Trust policy.
- In some cases, the recording of Risk on RiO was not consistent with Trust policy.
- In one case, following discharge of a patient from an independent, out of area, acute mental health inpatient unit, there was an absence of an appropriately agreed discharge plan, which impacted on the range and timelines of a follow-up service in order to support the patient and reduce the risk of them ending their life.
- In one case, the Trust found that there was patient confusion with regards to the time of an appointment with the Older People's Community Mental Health Team. The Trust considered that the confusion may have been negated if the patient had received an automatically generated SMS message confirming the appointment time.
- Following an investigation, the Trust noted that staff had not informed a patient as to their entitlement to an assessment under the Social Care Act 2012.
- In one case, the Trust noted gaps in the induction of a recently recruited Consultant Psychiatrist and of a Bank nurse who had not recently worked with the Crisis and Home Treatment Team.
- In some cases, the Trust found a delay in prescribing End of Life medication during out of hours, due to junior doctors on call not being familiar with patients or not feeling confident to prescribe.
- Following review of mental health inpatient deaths, the Trust found that in some cases the cause of death had not been recorded on the electronic records system.

- Following review of several End of Life mental health inpatients suffering with dementia, it would seem there is some anecdotal evidence to suggest that dementia patients require higher doses of End of Life medications than currently stated in the BNF and consequently often advice from Palliative Care needs to be sought in order to make patients comfortable.

2.5 In response to the above learning points, the Trust has:

- Put measures in place to ensure that, with regard to informal mental health patients, prior to leave being taken, staff must agree with the patient and document on a case by case basis, what the expected return to the ward time is, and in the event of a patient being late, at what time contact with them/their family will be attempted and escalation process initiated.
- Put measures in place to ensure that GPs are informed if their patient disengages from a community team and Trust community colleagues have been reminded to inform GPs if their patient is accepted onto a community team caseload, if their patient is allocated a care coordinator, changes to care plans and if their patient is discharged from the team, to include re-referral routes where services are not offered following discharge.

- With regards to resuscitation, The Trust has:

  i. instigated an urgent review of the Observations Policy to consider the need to provide additional direction with regards to physical wellbeing and mental health observations;

  ii. instigated an urgent review of resuscitation training to clarify that causation should be used in identifying Signs of Life Extinct

  iii. sought urgent assurance from Medacs agency that all staff employed by them will be aware of the need for commencing CPR in accordance with standard resuscitation guidance.

- Colleagues have been reminded that Risk Assessments should be updated following patient contact with A&E and that reported risk of use of a firearm must be clearly documented in the RiO Risk Assessment and Management Plan.
- The Trust is considering re-establishing a preferred provider relationship for mental health inpatient and acute care services.
- The Trust is considering whether letters or SMS messages should be routinely used to inform and remind patients of appointments that have been booked or rearranged.
- The Trust has put measures in place to ensure that patients are informed that they have the legal right to have their social care needs assessed under the Social Care Act 2012, plus ongoing delivery of training to ensure on-call support is delivered.

- The Trust has put measures in place to ensure that Bank staff receive an adequate procedural briefing. The Trust is also reviewing preliminary information with regards to risk management, received by a doctor upon starting a new position with the Trust.
- The Trust has put measures in place to ensure that, where indicated, End of Life medication will be written up by responsible consultant beforehand with a clear plan outlined on RiO, so that only approval to begin End of Life medication is sought from a junior medic on call.
- The Trust has put measures in place to ensure that death certifications issued by the Trust should be uploaded to the electronic records system.
- The Trust is looking into the possibility of an audit of doses of End of Life medications in conjunction with Palliative Care. The Trust is further investigating whether medication doses for End of Life patients suffering from dementia could be addressed using a standard operating procedure (SOP) and whether scripts could be checked against the SOP by the junior doctor (if applicable) and the nurse in charge.

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

The case record review and investigation figures given above do not include current ongoing reviews and investigations.

2.6 As a Trust, we are committed to the National Quality Boards (2017) Learning from Deaths guidance. The Trust ensures that it seeks to actively learn and implement changes in practice identified from reviews of death. The Trust is a an active supporter of the Learning Disabilities Premature Mortality Review programme (LeDeR) in Gloucestershire and Herefordshire

All our staff are required to notify, using the Datix system, the deaths of all Trust patients. This comprises anyone open to a Trust caseload at the time of their death and who dies within 30 days of receiving care from GHC. Deaths recorded on Datix are collated for discussion at the Mortality Review Group meetings chaired by the lead Clinical Directors. All deaths of patients with a learning disability will be also reported through the appropriate LeDeR process, and deaths of people under the age of 18 will be reported through the current child death reporting methodology.

Learning From Death continues to provide vital guidance. As a Trust, we are fully committed to recognising the need to improve services following learning from events both nationally and locally such as Gosport, Mid Staffordshire and the LeDeR programme, alongside our own local serious incidents investigation process.

From 1January 2017 up until 6 April 2020 in Gloucestershire, 153 LeDeR referrals had been received (Table 1.), 120 have had an initial review

completed (78% review completed) and 26 are open (7 remain unable to be allocated due to reviewer capacity).

Table 1 - Status of LeDeR reviews in Gloucestershire to 6th April 2020

	Closed	Open	On hold	Grand Total	% completed
2017	45	0	1	46	**98%**
2018	49	0	0	49	**100%**
2019	26	15	5	46	**57%**
2020	0	11	1	12	**0%**
Grand Total	**120**	**26**	**7**	**153**	**78%**

The Trust awaits the end of the 2019-20 Q4 reporting period for the 2019-20 LeDeR annual report containing learning themes. Learning themes identified by the end of the 2018-19 reporting period:

- Communications and support to access primary care Learning Disability Annual Health Checks.
- Reasonable adjustments made to access to mainstream healthy lifestyles preventative services e.g. smoking cessation, weight management and eating well.
- Suitable reasonable adjustments being put in place in mainstream health services is inconsistent particularly around meeting communication needs.
- Utilisation and documentation of the Mental Capacity Act by mainstream health services is inconsistent.
- Treatment escalation practices particularly in relation to end of life protocols for those individuals who are considered to be frail.

2.7 By 14 April 2020, 19 case record reviews and 6 investigations completed after 31 March 2019 related to deaths which took place before the start of the reporting period.

0 representing 0.0% 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 SJR. For deaths of mental health patients, the RCPsych Mortality Review Tool 2019 is employed. For deaths of LD patients a similar Trust-developed SJR tool is utilised which pre-dates the RCPsych tool, which has been maintained to allow consistent approach with the LeDeR programme. All case record reviews are discussed at a mortality

review meeting chaired by Clinical Directors. For any deaths meeting Serious Incident or Clinical Incident criteria, a Comprehensive Investigation is carried out.

0 representing 0.0% of the patient deaths during 2018-2019 are judged to be more likely than not to have been due to problems in the care provided to the patient.

3.0 PHYSICAL HEALTH PATIENTS

3.1 During 2019-2020 Q1-Q4, 168 Gloucester Health and Care NHS Foundation Trust (the Trust) patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 34 in the first quarter;
- 61 in the second quarter;
- 41 in the third quarter;
- 32 in the fourth quarter.

3.2 By 14 April 2020, 15 case record reviews and 0 investigations have been carried out in relation to the 168 deaths included in 3.1.

In 0 cases 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:

- 2 in the first quarter;
- 5 in the second quarter;
- 8 in the third quarter;
- 0 the fourth quarter.

3.3 0 representing 0.0% of the patient deaths during the reporting period are judged more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of:

- 0 representing 0.0% for the first quarter;
- 0 representing 0.0% for the second quarter;
- 0 representing 0.0% for the third quarter;
- 0 representing 0.0% for the fourth quarter.

These numbers have been estimated using a Structured Judgement Review (SJR) tool developed by the Trust to robustly assess the standard of care provided to patients that die during an inpatient stay at a community hospital. Cases are discussed at a Mortality Review meetings attended by the Trust's Deputy Medical Director / Clinical Director and the County Medical Examiner.

3.4 The Trust has identified:

- a common theme across all community hospitals whereby a significant proportion of patients admitted for rehabilitation have since been identified as being for end of life care soon after their admission;
- that in some cases, patients' causes of death could discussed with the County Medical Examiner before being formally certified;
- that some medics considered the guidelines as to the circumstances when a form 100A should be completed following a patient death to be unclear.

3.5 In response to the above learning points, the Trust has:

- set up the Joint Patient Safety Group with GHNHSFT, which has quarterly meetings, where issues around admissions and transfers between Trusts can be taken for discussion. The Trust will continue to invite SWAST to Physical Health Mortality Review meetings;
- reminded medical staff at the appropriate community hospitals that cause of death can be discussed with the Medical Examiner;
- discussed with the Medical Examiner who has agreed to draw up new guidance regarding when a 100A form should be completed.

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

3.6 As a Trust, we are committed to the National Quality Boards (2017) Learning from Deaths guidance. The Trust ensures that it seeks to actively learn and implement changes in practice identified from reviews of death. The Trust is an active supporter of the Learning Disabilities Premature Mortality Review programme (LeDeR) in Gloucestershire.

All our staff are required to notify, using the MIDAS system for the reporting year 2019-2020, the deaths of all patients who die whilst receiving inpatient care. Deaths recorded on MIDAS are collated for discussion at Physical Health Mortality Review Group meetings chaired by the Head of Clinical Governance and Compliance and attended by the Medical Examiner. All deaths of patients with a learning disability will be also reported through the appropriate LeDeR process, and deaths of people under the age of 18 will be reported through the current child death reporting methodology.

3.7 In order to align systems and processes as one merged organisation, and to facilitate learning and data collection, from 1st April 2020, deaths of inpatients will be reported using the Datix incident reporting system.

AGENDA ITEM: 16

BOARD ASSURANCE COMMITTEE – COVID SUMMARY REPORT

Held 28 May, 4 June, 11 June & 18 June 2020

COMMITTEE GOVERNANCE	**Committee Chair** – Ingrid Barker, Trust Board Chair **Attendance (membership)** – 90.9 % / 100% **Quorate** – Yes

Purpose and duration of the Committee

In light of the Covid-19 pandemic, a Board Assurance Committee-Covid was established for the purpose of assurance during these exceptional times. The Committee provided a mechanism through which Non-executive Directors could receive information for the purpose of assurance on key aspects of the organisational response to the Covid-19 pandemic and consider the impact of any exceptional measures being taken.

Since the last meeting of the Board on 20th May, the Committee convened on a weekly basis on 28th May, 4th June, 11th June, and 18th June. There was no meeting on 21st May.

The Committee was closed on 23rd June 2020 as it is no longer required. The Committee can be re-instated at any time, if required.

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION – 14 MAY 2020

Key Issues Discussed:

The CEO provided the weekly update from the Covid task force and urgent issues, including:

- Progress and recovery;
- Mental Health & Learning Disabilities;
- Covid Testing;
- Dental Services;
- PPE; and
- Governance arrangements.

Helen Goodey was invited to the meeting and provided an update on issues in Primary Care and changes that had been made to address the pandemic situation.

A query was raised over health inequalities and whether the Trust had a strategy in place to address concerns. The issue is being taken to the July Trust Board meeting.

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION – 28 MAY 2020

Key Issues Discussed:

The CEO provided the weekly update from the Covid task force and urgent issues, including**:**

- Test and Trace service;
- Serology testing (to be added to the Ethics Committee agenda);
- National shielding for vulnerable staff;

- Inpatient facilities (including the Covid secure environment work); and
- Recovery programme.

The Covid-19 Workforce Response Update report was presented to the Committee. It was confirmed that the Trust is sending letters to colleagues to assess the need for a summer holiday provision and will be exploring options with education authorities and local schools.

The CEO provided an update on system national issues, including the intention to keep the MIIU closures in place for a further three months. The ICS is in active debate regarding the process for reinstating the longer-term changes discussed at the Fit for the Future Board.

An update on how Covid is impacting on homeless people in terms of physical and mental health to be added to a future agenda item.

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION – 4 JUNE 2020

Key Issues Discussed:

The CEO provided the weekly update from the Covid task force and urgent issues, including:

- Covid secure environment;
- Recovery process;
- Serology testing;
- Test and trace; and
- PPE.

The CEO provided an update on infection rates and bed occupancy rates. The Trust needs to remain vigilant of a potential second spike. There is a national early warning system in place.

A discussion was had surrounding workforce equality issues, including a letter issued by Prerana Issar / Dido Harding (NHSI) which contains urgent issues for the Trust to consider.

An update was provided by the Ethics Committee, covering the decision not to implement a system-wide ethical framework at present.

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION – 11 JUNE 2020

Key Issues Discussed:

The CEO provided the weekly update from the Covid task force and urgent issues, including:

- Serology testing;
- Face mask / face coverings;
- Recovery programme;
- MIIUs (4 open/3 closed and new booking system);
- Young people's mental health issues; and
- Support for BAME colleagues (new task and finish group).

An update was provided on system national issues. The Government is expecting a large bid from the NHS for investment to cope with the post-Covid world, to include both capital and revenue. There will be opportunity to influence this work at regional level, Executives to be engaged in the work. Diagnostics will require significant investment. There will be a need to explore new ways of integrating mental and physical health care at a local level.

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION – 18 JUNE 2020

Key Issues Discussed:

The Acing CEO provided a weekly update from Covid task force and urgent issues, including:

- PPE;
- Face mask / face coverings implementation;
- Serology testing;
- Test and trace;
- Covid secure implementation;
- BAME (PHE guidance); and
- Recovery (including demand on services).

An update was provided on system national issues. The system is coordinating their approach to recovery so organisations don't provide onward referrals to services which aren't yet in recovery.

A national finance announcement was made last night regarding the second half of the financial year. They have confirmed the expectation is for break-even, assuming there is no second peak, although there will be a different financial framework.

A discussion was had surrounding Matt Hancock's announcement on the Covid vaccine, currently in its testing phase.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary.
- **Note** that the Committee was closed as of 23rd June 2020.

DATE OF NEXT MEETING	The Committee was closed as of 23rd June 2020.

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 17.1

AUDIT AND ASSURANCE COMMITTEE SUMMARY REPORT

28 MAY 2020

COMMITTEE GOVERNANCE	• Committee Chair – Marcia Gallagher, Non-Executive Director • Attendance (membership) – 57.1% • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

EXTERNAL AUDIT

The Committee was informed that an unqualified audit opinion was expected from the external audit of the Trust's accounts. It was reported that there had been good engagement with the audit from the GHC Finance Team. It was acknowledged that the audit had been more challenging as the Trust was still operating off two finance ledgers.

INTERNAL AUDIT

Internal Audit Reports

The Committee received the following Internal Audit reports:

- Business Continuity Management Draft:
- Cost Improvement Programme (CIP) Phase 2
- Corporate Governance
- Finance Systems Review
- Information Governance Review
- Estates and Facilities
- Performance Management
- Staff Complaints and Speaking Up
- Statutory and mandatory Training Review

The majority of the reports were classified as either a low or medium risk. The Estates and Facilities internal report was classified as a high risk; and the Committee received assurance on the actions and mitigation in place to address the recommendations.

Draft Internal Audit Annual Report and Head of Internal Audit Opinion

The Committee received the draft Internal Audit Annual report. The report reflected internal audit activity undertaken for the 2gether Trust from 1st April 2019 – 30th September 2019 and the merged Trust GHC from 1st October 2019 – 31st March 2020.

The Committee noted the Head of Internal Audit's Opinion *of* ***Generally satisfactory with some improvements required****.*

The Committee noted that there were some overdue actions from previous internal audits. Assurance was received that these were being followed up and the final number of outstanding actions would be reflected in the annual report.

Draft Internal Audit Plan 2020/21

The Committee considered the Draft Internal Audit Plan for 2020-2021. It was noted that given the current situation with Covid19, the plan for the year was not fixed and would be reviewed regularly

during the year. An internal audit on cyber security was planned for Q1. The Committee considered the report and noted that a full audit plan would be submitted to the Committee in June.

DRAFT ANNUAL REPORT AND ACCOUNTS - GHC

The Committee received the draft Annual Report and Annual Governance Statement and agreed a number of minor changes to be taken forward in relation to the content of the report. Changes included clarifications relating to the number of compliments received by the Trust over the period under review, complaint data and the inclusion of additional information regarding the Trust's sustainability work.

The Committee considered the Annual Accounts noting that the timetable for the completion of accounts had been extended due to the Covid-19 pandemic and that the scope of the audit had changed to exclude the quality accounts. It was noted that the accounts were currently being reviewed by the External Auditor so may be subject to changes before final approval

DRAFT QUALITY REPORT

The Committee received the draft Quality Report. It was noted that due to the impact of Covid, there was no longer the requirement for a quality report to be included in the Annual Report, and NHS Foundation Trusts were encouraged to include the additional quality report content in their quality account. In addition, assurance work on quality accounts and reports was suspended and were not subject to external audit.

UPDATE ON ANNUAL REPORT AND ACCOUNTS - GCS

The Committee received an update on the arrangements for finalising the part year Annual Report and Accounts for Gloucestershire Care Services NHS Trust. Since the last meeting of the Committee, minor adjustments had been made and the External Auditors were checking whether reference needed to be made to Covid-19. It was noted that the GCS AGM would be scheduled in due course.

PROVIDER LICENCE SELF CERTIFICATION APPROVALS

The Committee considered the self-certificate compliance with the NHS provider licence (which includes compliance with the Health and Social Care legislation and having regard to the NHS Constitution), and NHS governance requirements. It was noted this had been delegated to the Committee by the Board in May for review. It was confirmed the process was in line with the processes put in place in 2019 when the requirements were put in place. The views of Governors had been sought and three response had been received which supported the proposed declaration.

The Committee confirmed the GC6 self-certification for the required submission at the end of May. The Committee confirmed the process for the second submission (FT4) as required at the end of June 2020.

COUNTER FRAUD, BRIBERY AND CORRUPTION

The Committee noted the Progress report and received updates on ongoing investigations.
The Committee endorsed the proposed work plan for 2020/21.

POLICIES REPORT

The Committee received a paper summarising progress with the integration of Trust policies following the merger. It was noted that a number of recent internal audits had highlighted the issue of policy integration within their findings.
The Committee was informed that of a total of 224 policies; the review of 132 was now complete with 77 outstanding and 15 policies discarded/superseded. A plan was in place to complete the review of all outstanding policies within three months.

FINANCIAL COMPLIANCE REPORT

The Committee received the finance compliance report for the period of 1 January 2020 - 31 March 2020. The Committee noted the losses and special payments made during the period. There had been two waivers of Standing Financial Instructions. The Chair confirmed that she had been kept informed of issues as they arose
The Committee also received an update on the outstanding debtors.

ACTIONS REQUIRED BY THE BOARD
The Board is asked to:

- **Note** the contents of this summary.

DATE OF NEXT MEETING	**17 June 2020**

AGENDA ITEM: 17.2

AUDIT AND ASSURANCE COMMITTEE SUMMARY REPORT

17 JUNE 2020

COMMITTEE GOVERNANCE	• Committee Chair – Marcia Gallagher, Non-Executive director • Attendance (membership) – 57.1% • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

INTERNAL REPORT

The Committee received the final Internal Audit Annual report for 2019/2020.
A '*generally satisfactory with some improvements required*' opinion was received.

FINAL ACCOUNTS AND CERTIFICATES

The Committee received the final Accounts and Certificates for 2019/2020 for Gloucestershire Health and Care NHS Foundation Trust. The Director of Finance confirmed that there had been no significant changes to the accounts since their consideration at the last meeting of the Committee.
The Committee approved the 2019/2020 Annual Accounts for Gloucestershire Health and Care NHS Foundation Trust on behalf of the Board.
The Committee approved the signing of:

- The Statutory Accounts (including the statement of financial position and foreword to the accounts).
- TAC Summarisation Schedule Certificate (NHS Improvement's Accounts) (TACs)
- Letter of Representation.

ANNUAL REPORT 2019/20

The Committee received the Annual Report 2019/20 for Gloucestershire Health and Care NHS Foundation Trust which had been finalised following its consideration by the Committee at its meeting on 28 May. It had been subject to external audit and no issues remained outstanding from the audit.
The following was approved by the Committee:

- Signing off of the Report and Accounts by the Chief Executive and Finance Director
- Submission of the Report and Accounts to NHSE/I
- The Annual Report and Accounts to be submitted to be laid before parliament.

EXTERNAL AUDIT REVIEW OF THE ANNUAL REPORT AND ACCOUNTS – 2019/20

The Committee received the External Audit review of the Annual Report and Accounts 2019/20. The External Auditors took the Committee through their report which confirmed they were not required to provide assurance over the quality report, and confirmed that their audit opinion and conclusions were:

- Financial Statements – Unqualified
- Value for Money –- Adequate arrangements

QUALITY REPORT

The Quality Report was received by the Committee. The report had been shared with key stakeholders and there were no major changes to report.
The Committee discussed the benefits of submitting the report to meet the extended December deadline for submitting in July. It was agreed that the report should be finalised and published as soon as possible, with the inclusion of additional stakeholder responses if received. The Committee

approved and agreed the publication of the Quality Report.

STANDING FINANCIAL INSTRUCTIONS AND SCHEME OF DELEGATION

The Committee received and approved proposed amendments to the Standing Financial Instructions and Scheme of Delegation.

RISK REVIEW

The Committee received a report which set out a proposed work-plan to implement the recommendations arising from the internal audit on risk management, considered by the Committee at its meeting in February.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary.

DATE OF NEXT MEETING	**06 August 2020**

AGENDA ITEM: 18

RESOURCES COMMITTEE SUMMARY REPORT

25 JUNE 2020

COMMITTEE GOVERNANCE	• Committee Chair – Graham Russell, Non-Executive Director • Attendance (membership) – 75% • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

FINANCE REPORT – MONTH 2

The Committee received the Finance Report for month 2. The report showed performance at month 2 above the planned deficit of £0.188m at break even in line with NHSI policy. Confirmation on the top-up requested by the Trust of £556k had not yet been received.

The report included the breakdown of Covid expenditure and it was noted that not all expenditure was additional financial cost (i.e. sick pay). The report showed a cumulative position of months 1 and 2 of £1.47m.

The target for 20/21 was to achieve a break even position, not a surplus.

PERFORMANCE REPORT – MONTH 2

The Committee received the Performance Report which highlighted 10 mental health and 31 physical health high level performance indicators in exception at month 2. It was noted that many indicators continued to lack data quality validation and narrative due to the reduced Covid related capacity.

All indicators had been in exception previously within 12 months, with the exception of % of WA and OP service users on the caseload who have been offered a carer's assessment (mental health) and % of infants for whom breastfeeding status is recorded at 6-8wk check (physical health). It was explained the mental health indicator was believed to be a data quality issue. The physical health indicator was due to breast feeding groups being closed at the beginning of the Covid lockdown. The Committee was informed that in regards to the breast feeding indicator; the Trust had exceeded the health visiting required and received assurance that all new families had continued to be offered face to face visits with health visitors. Some families had declined due to Covid related anxieties. In instances where the families had declined, video appointments were offered where available. Assurance was provided that babies that had not been seen since birth would be seen within 6 months.

FOREST OF DEAN BUSINESS CASE UPDATE

The Committee received an update on the Forest of Dean Business Case. It was agreed that an Extraordinary Resources Committee would take place to focus on this in more detail. A separate update would be presented to the July private session Board meeting.

BUSINESS DEVELOPMENT REPORT

The Committee received the Business Development report, which highlighted that the breakdown of the Mental Health Investment Standard had been agreed with the CCG.

RISK REGISTER AND ASSIGNED BOARD ASSURANCE FRAMEWORK RISKS

The Committee received the Risk Register and it was noted that the actions reflected the internal

audit received from PwC.

The Committee was informed that a work plan was now in place which would focus on the implementation of the audit recommendations received. The format of the risk register would also be reviewed.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary.

DATE OF NEXT MEETING	**28 JULY 2020 (Extraordinary meeting of the Resources Committee)**

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 19

QUALITY COMMITTEE SUMMARY REPORT

01 JULY 2020

COMMITTEE GOVERNANCE	• Committee Chair – Maria Bond, Non-Executive director • Attendance (membership) – 83.3% • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

SERIOUS INCIDENTS REQUIRING INVESTIGATION (SIRI) UPDATE

The Committee received the SIRI update. It was reported that there had been 7 SIRIs recorded during April and May 2020. Of the 7 reported, 6 related to mental health services. The Committee noted this report, and the planned developments within the Patient Safety team.

MEDICAL STAFFING

The Medical Director provided a verbal update on Medical Staffing; informing the Committee that the Trust had been successful in making three new consultant appointments. It was reported that there were further vacancies open.

QUALITY DASHBOARD REPORT

The Committee received the Quality Dashboard Report up to May 2020. The proposed 2020/21 Trust quality priorities agreed prior to the Covid-19 outbreak will be reviewed during July/August 2020 to consider if they remain appropriate and if not, a suite of new quality priorities will be drafted.

Good assurance is available that demonstrates that despite there being a national 'pause' on the NHS Complaints Procedure, the Trust has continued to ensure that we hear and respond to patients, carers and members of the public concerns. All complaints, concerns and compliments continue to be recorded and where required an immediate response has taken place. The Trust is well placed to resume full activity when the national complaints 'pause' ceases from 1 July 2020; the Parliamentary Health Service Ombudsman will also resume activity from the same date.

An increase in the overall numbers of reported patient safety incidents was highlighted; however, this was expected as services begin to return to usual activity. The total number of reported incidents will continue to be monitored by the patient safety team and where appropriate take action to understand and address any potential under reporting.

Mandatory training has remained paused during May, and plans are underway to recover the training position, noting that online training can continue with minimal impact. Face to face training, or close contact training such as PMVA/PBM will remain the most impacted and take the longest time to recover.

Work was underway to link with the Service leads of the historically less reported services, such as Dental and Sexual Health, in order to develop quality monitoring, narrative and assurance. The Committee would receive focussed reports on Sexual Health and Homeless healthcare services at its next meeting.

The Committee welcomed the Quality Dashboard report and the assurances provided.

TRUST QUALITY REPORT

The Committee received the Trust Quality Report and was informed that the report had been received and signed off by the Audit and Assurance Committee.

ANNUAL AGENDA WORK PLAN AND PARKING LOT

The Committee received the Committee Annual Agenda Work Plan and the Parking Lot. It was explained that the Parking Lot had been created to log all agenda items that had been deferred or reassigned due to Covid pressures and guidance received. This provided assurance that nothing had been lost. The work plan was currently being reviewed and it was proposed that a definitive version would be presented at the next Committee meeting.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary.

DATE OF NEXT MEETING	**11 August 2020**

CHARITABLE FUNDS COMMITTEE SUMMARY REPORT

03 JULY 2020

COMMITTEE GOVERNANCE	• Committee Chair – Sumita Hutchison, Non-Executive Director • Attendance (membership) – insert 66.6% • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

NHS CHARITIES TOGETHER

The Committee was informed the Trust was contacted in April 2020 and asked if as a provider of NHS services with a registered NHS Charity, would like to become a member of NHS Charities Together for a fee of £1,5k per annum for the next two years. The fee would be deducted from the initial grant allocation of £35k. The Director of Strategy and Partnerships informed the Committee that the decision was taken to the Executive Committee. The Executive supported the decision to move forward with the membership application. This was completed in May 2020.

The Committee received the *NHS Charities Together and support during the Covid Pandemic* report which detailed the different stages and the distribution of the funds from NHS Charities Together.

The Committee noted that to date a total of £67k has been received from NHS Charities Together and of this 2 requests which had been prioritised:

- Water bottles (one per employee) – £7.1k (inc VAT)
- Subscription for Nightingale Trust for tailored support for registered and unregistered nurses - £5k

The Committee was informed that there was £55k remaining to be allocated. The proposals for the allocation of the remaining amount were:

- Additional counselling support in the Occupational Health team for 3 days a week at a band 7/8 for a period of 6 months.
- A covid art/photo mindfulness and reflection programme.
- NHS Elect management and leadership recovery and post covid 12 month support offer.

The Committee received confirmation of the requirement to inform NHS Charities Together what the first allocation of funding would be spent on in order to be eligible to bid for a further grant of £50k.

The Committee approved the submission of a bid for the £50k grant ahead of the submission deadline of 31st July 2020 and the areas of priority put forward to be contained within this application.

It was noted that the total amount requested exceeded the total monies available from NHS Charities Together, even if the next grant application is successful therefore utilisation of existing funds will be used as necessary

RESTRUCTURE OF LEGACY ORGANISATIONS CHARITIES

The Committee was informed that Lyn Radford had requested copies of the governing documents from charitable commissions in order to progress the merging of the two legacy charities 2gether and GCS. Once the documents were received, the process of merging the legacy charities into one would be progressed further.

The former bank account for GCS would be closed and merged with the 2gether account.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary.

DATE OF NEXT MEETING	**05 November 2020**

AGENDA ITEM: 22

DRAFT MINUTES
GLOUCESTERSHIRE HEALTH AND CARE NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS MEETING
Thursday, 19th March 2020

Via Teleconference

PRESENT: Graham Russell (Chair)

Vic Godding	Miles Goodwin	June Hennell	Stephen McDonnell
Katie Clark	Bren McInerney	Anneka Newman	Sarah Nicholson
Brian Robinson	Anne Roberts	David Summers	Jo Smith

IN ATTENDANCE: Steve Alvis, Non-Executive Director
Gordon Benson, Associate Director of Clinical Governance (part)
Maria Bond, Non-Executive Director
Marcia Gallagher, Non-Executive Director
Anna Hilditch, Assistant Trust Secretary
Sumita Hutchison, Non-Executive Director
Marianne Julebin, Trust Secretariat
Jan Marriot, Non-Executive Director
Paul Roberts, Chief Executive (Item 1-2)
Lavinia Rowsell, Head of Corporate Governance

1.0 WELCOMES AND APOLOGIES

1.1 Apologies were received from Ingrid Barker, Mervyn Dawe, Said Hansdot, Cherry Newton, Jenny Hincks, Karen Bennett, Alison Feher, Faisal Khan, Nic Matthews, Katherine Stratton, Simon Smith and Lawrence Fielder.

1.2 The Chair opened the meeting with thanks to all for giving their time during this unprecedented time. As a result of the current situation with Covid-19, the agenda for the meeting had been reviewed and all non-urgent items deferred to allow time for the Governors to receive an update report from the Chief Executive.

1.3 The Chair welcomed and introduced three newly-elected Governors: Cllr Brian Robinson (GCC, Appointed), Katherine Stratton (Staff) and Sarah Nicholson (Staff).

2.0 CHIEF EXECUTIVE'S REPORT (Agenda Item 11)

2.1 Coronavirus update

Paul Roberts' report focused on the coronavirus health crisis which was driving the work of the Trust at present. Public Health England was co-ordinating the response on behalf of the NHS. Managing the pandemic has seen increased numbers in A&E and huge demand on services across the system. GHC had been one of the first Trusts to set up community, home and drive-through testing. However, tests are in short supply internationally and all Trusts are operating at a relatively low level of testing.

Sian Thomas, Deputy Chief Operating Officer had been appointed to co-ordinate the management of the incident for the Trust. There were daily briefings within the Trust, with GHT, the CCG, primary and social care colleagues, the ambulance services and other statutory services and this network of coordination was replicated at regional and national level.

PR reported that with a historically high vacancy rate, staffing pressures were a major concern across the organisation, especially in community nursing. At the meeting date, 178 staff were in self-isolation and staff testing was not yet available. There were ongoing discussions at a national level regarding this as well concerns regarding the availability of personal protective equipment (PPE).

PR continued that in order for the Trust to appropriate respond the pandemic and support the wider system, some of its current services would need to cease in their current form. The Trust leadership team was reviewing and prioritising all services, identifying those which could
be put on hold either to free up capacity or staff for a short period, while ensuring that appropriate arrangements were made for vulnerable patients.

2.2 Herefordshire Update

PR reported that Herefordshire services transfer to Worcestershire Health and Care at the end of the month would proceed as planned. Arrangements for coronavirus around staffing, isolation and equipment for Herefordshire had mirrored those for Gloucestershire and teams there were already working closely with the community service teams at Wye Valley and Worcestershire Health and Care.

2.3 Corporate Governance

PR advised that the leadership team had been developing work-from-home arrangements or redeployment of roles for corporate services staff in order to support clinical services. Non-urgent business was being stood down with Lavinia Rowsell (LR) reviewing all governance requirements. This would include the forward plan for Governor activities. In light of national guidance, all Governor's meetings would need to take place virtually for the time being,

BM conveyed thanks on behalf of Governors for the phenomenal work of the leadership team and staff across the in responding to the pandemic and requested that staff wellbeing be top priority during this difficult period. PR reported that health and wellbeing support programmes had been extended

for all colleagues.

PR thanked the Governors for their contribution and understanding and left the meeting. David Summers raised the question whether Herefordshire Officers had been notified that the transfer of services was going ahead. The Chair advised that PR had left the meeting and that the question would be put to him to answer outside the meeting. *[Post meeting note: Trust Secretary confirmed that all stakeholders were aware of the position in relation to the transfer of services]*

3.0 FORMAL BUSINESS

3.1 The Chair reiterated the apologies received from Simon Smith, Interim Lead Governor and Ingrid Barker, Chair of the Board.

3.2 In terms of the minutes from the previous meeting, the Chair advised that written comments and an update had been received from Bren McInerney (BM). These included a typographical amendment to the minutes to include a correction to the name of the University of Gloucestershire. Subject to the correction, the minutes of the Council meeting held on 21st January 2020 were agreed as a correct record.

4.0 MATTERS ARISING AND ACTION POINTS

4.1 LR confirmed that all actions from the previous meeting were either complete, on-going or included on this meeting's Agenda.

4.2 Feedback from the meeting evaluation form was noted.

5.0 CHAIR'S REPORT

5.1 The Chair's Report was taken as read. GR advised that Sue Mead, interim Non-Executive Director had stepped down. Governors expressed thanks for her excellent contribution over the years. BM requested that the Lead Governor write to Sue Mead on behalf of Governors.

6.0 MEMBERSHIP UPDATE

6.1 LR congratulated the three new Governors on their election and appointment. LR advised that the remaining elections would be held as soon as possible, given the current circumstances.

6.2 LR requested that Governors approve the termination of Craig Pryce's term as Governor on the basis of his failure to meet the attendance and communication requirements set out in the Constitution. APPROVED.

7.0 NOMINATION AND REMUNERATION COMMITTEE

7.1 LR referred to Paper E which provided updates on the recruitment of the 7th NED and the Chair's and NEDS' appraisal processes. As the pre-meet was

cancelled, LR together with Marcia Gallagher (MG) would find another way to communicate with Governors to move this process forward. Vic Godding (VG) advised that he could now only attend meetings virtually. LR agreed that it was likely all meetings would be held virtually until further notice.

ACTION: LR and MG to contact Governors regarding Chair's and NEDS' appraisal process.

8.0 PROPOSED CHANGES TO THE CONSTITUTION

8.1 LR highlighted minor changes to the Constitution arising from the merger and transfer of Herefordshire services. Anne Roberts (AR) queried whether some of the wording in the Constitution needed to be updated. LR agreed to review the document. AR also queried how Herefordshire Governors would be replaced. LR responded that this point would fall within the Review and Refresh working group which would set the framework and structure of the Council of Governors for the new Trust.

8.2 June Hennell (JH) questioned whether all Governors had complied with article 14.3.1 and returned their Code of Conduct forms. LR confirmed that this was an annual requirement, that the Secretariat kept a log of responses and non-respondents were chased.

9.0 REVIEW AND REFRESH UPDATE

9.1 LR spoke to the recommendations in Paper H which provided an update on the training and development plans for the Council of Governors as well as looking at practices and structures comparable at other Trusts. It was proposed that the Review and Refresh work be taken forward through two working groups of the Council of Governors focussing on membership and governance with meetings conducted via. LR asked that any Governors who wish to participate in a working group contact her directly. This was AGREED.

10.0 ANNUAL QUALITY REPORT

10.1 The Chair introduced Gordon Benson (GB) to speak on behalf of John Trevains, Director of Nursing, Therapies and Quality and advised that any Quality Indicators contained in the report could substantially change given the current situation. GB asked Governors to note the progress made in the Quarter 3 Report appended to Paper H. Governors NOTED the progress and ENDORSED the proposed quality priorities for 2020/21.

10.2 Governors were asked to choose a local indicator that they would like to be subject to audit. LR conducted a poll of Governors and the majority vote from Governors was for Indicator 5 from the Mental Health list – Information on who to contact outside of office hours in a crisis. GB thanked Governors and left the meeting.

INFORMATION TO NOTE

12.1 **Council of Governor Visits**

BM provided feedback on the visit to Quedgeley Children's Hub. Both BM and GR praised the fantastic multi-disciplinary team which provided case studies of the many vulnerable families they help.

12.2 **Feedback from Governor Observers**

VG sat on the Quality Committee as an Observer and reported that the Committee and its Chair did an excellent job under much pressure and time constraints. JH endorsed VG's praise.

MG reported that the Audit Committee of 13th February did not have any Observers. This was **NOTED**.

ANY OTHER BUSINESS

13. **Formal thanks to Herefordshire Governors**

The Chair thanked Herefordshire Governors for their contribution and dedication over the years. VG and GM added their personal thanks to Miles Goodwin, Cherry Newton, David Summers and Jade Brooks. Marianne Julebin conveyed that a goodbye to all Governors and a message of best wishes messages had been received from Cherry Newton. GR thanked and praised the Herefordshire governors for their contribution over the years.

14. **Dates of next meeting**

LR reported that meetings will go ahead either via teleconference or video conference to ensure as many participants as possible can attend. The March Board meeting was now to be held in private.

Board Committees will be pared back now and we are working with Chairs of the Committees to determine best practice during the current situation.

The Chair ended the meeting by thanking all who had participated.

Council of Governors

Main Meeting Action Points

Item	Action	Lead	Progress
19 March 2020 Main meeting			
7	Contact Governors regarding Chair's and NEDS' appraisal process.	LR / MG	Completed
9	Governors to put their names forward to Lavinia Rowsell to participate in two Review & Refresh Working Groups	Governors	On Agenda

AGENDA ITEM: 23

REPORT TO: **TRUST BOARD – 22 July 2020**

PRESENTED BY: Lavinia Rowsell – Head of Corporate Governance and Trust Secretary

AUTHOR: Louise Moss – Deputy Head of Corporate Governance

SUBJECT: **USE OF THE TRUST SEAL – Q4 2019/20 AND Q1 2020/21**

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

The purpose of this report is to:

To provide information to the Trust Board on the use of the Trust Seal, as required by the Trust's Standing Orders, reference section 7.3.

Recommendations and decisions required

The Board is asked to note the use of the Trust seal for the reporting period 1 January – 30 June 2020.

Executive summary

The Trust's Standing Orders require that use of the Trust's Seal be reported to the Trust Board at regular intervals. The common Seal of the Trust is primarily used to seal legal documents such as transfers of land, lease agreements. The seal has been used 9 times since the last report to the Board in January 2020.

Risks associated with meeting the Trust's values

All actions have been taken in accordance with the Trust Board's Scheme of Delegation and no inherent risks are to be reported to the Trust Board in the application of the Corporate Seal.

Corporate considerations	
Quality Implications	Nil
Resource Implications	Nil
Equality Implications	Nil

Where has this issue been discussed before?
Audit and Risk Assurance Committee – June 2020

Appendices:	Appendix 1: Register of Seals

Report authorised by: Lavinia Rowsell	**Title:** Head of Corporate Governance and Trust Secretary

Register of Seals January 2020 – June 2020

APPENDIX 1

Seal No.	Date of Sealing	Document Description	Document Signatory (1)	Document Signatory (2)	Attested by	Attested Date
02/2020	04.02.20	Grant of Application: Supplement Deed for the Acquisition of GCS and 2gether (signed by E O'Mahony, RD of South West NHS England and NHS Improvement	Sandra Betney Director of Finance	Paul Roberts Chief Executive Officer	Simon Crews Interim Trust Secretary	04.02.20
03/2020	27.02.20	Invista Lease	Paul Roberts Chief Executive Officer	Sandra Betney Director of Finance	Lavinia Rowsell, Trust Secretary	27.02.20
04/2020	02.03.20	Lease extension relating to **Unit D, 178 Widemarsh Street, Hereford, HR4 9HN** Between – David John Lively, Rosalind Lively and Russell James Lively and GHCNHSFT	Sandra Betney, Director of Finance	Colin Merker, MD Herefordshire	Lavinia Rowsell, Trust Secretary	02.03.20
05/2020	26.03.20	TR1 – Title No if the Property: **HE13612** **Rose Cottage, Belle Orchard, Ledbury, HR8 1DD** Transferee: Worcestershire Health and Care NHS Trust Transferor: GCSNHST	Paul Roberts Chief Executive Officer	John Trevains Director of Nursing, Therapies and Quality	Louise Moss Deputy Head of Corporate Governance	26.03.20
06/2020	26.03.20	TR1 – Title No of the Property: **HE13615** **62 Etnam Street, Leominster, HR6 8AQ** Transferee: Worcestershire Health and Care NHS Trust Transferor: GCSNHST	Paul Roberts Chief Executive Officer	John Trevains Director of Nursing, Therapies and Quality	Louise Moss Deputy Head of Corporate Governance	26.03.20
07/2020	26.03.20	TR1 – Title No of the Property: **HE13611** **Knoll, Gloucester Road, Ross-on-Wye, HR9 5NA** Transferee: Worcestershire Health and Care NHS Trust Transferor: GCSNHST	Paul Roberts Chief Executive Officer	John Trevains Director of Nursing, Therapies and Quality	Louise Moss Deputy Head of Corporate Governance	26.03.20

Seal No.	Date of Sealing	Document Description	Document Signatory (1)	Document Signatory (2)	Attested by	Attested Date
08/2020	26.03.20	TR1 – Title No of the Property: **HW28100** **25 and 27a St Owen Street, Hereford, HR1 2JB** Transferee: Worcestershire Health and Care NHS Trust Transferor: GCSNHST	Paul Roberts Chief Executive Officer	John Trevains Director of Nursing, Therapies and Quality	Louise Moss Deputy Head of Corporate Governance	26.03.20
09/2020	26.03.20	TR5 – Transfer of portfolio of titles (whole or part) Title No. HW11632 - **36 Stonebow Rd, Hereford** Title No. HW38870 – **38,42, 42a, 44, 44a, 46, 48, 50 Stonebow Road Hereford** Title No. HE14398 – **The Stonebow Unit** Title No. HW11238 – **40 Stonebow Road, Hereford** Transferee: Worcestershire Health and Care NHS Trust Transferor: GCSNHST	Paul Roberts Chief Executive Officer	John Trevains Director of Nursing, Therapies and Quality	Louise Moss Deputy Head of Corporate Governance	26.03.20
10/2020	26.03.20	Deed of Assignment of leasehold property Unit D: **178 Widemarsh Street, Hereford, HR4 9HN** Between GHCNHSFT and Worcestershire Health and Care NHS Trust	Paul Roberts Chief Executive Officer	John Trevains Director of Nursing, Therapies and Quality	Louise Moss Deputy Head of Corporate Governance	26.03.20

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NHS
Gloucestershire Health and Care
NHS Foundation Trust

TRUST BOARD
PUBLIC
Wednesday, 20 May 2020
9.30 – 10.30am
To be held via Microsoft Teams

AGENDA

	Agenda Item	Title	Purpose		Presenter
Opening Business					
	01/0520	Apologies for absence and quorum	Note	Verbal	Chair
	02/0520	Declarations of interest	Note	Verbal	Chair
	03/0520	Draft Minutes of the meeting held on 22 April 2020	Approve	Paper	Chair
	04/0520	Matters arising and Action Log	Note	Paper	Chair
	05/0520	Questions from the Public *Questions need to be received in writing no later than 12 noon on 19 May*	Note	Verbal	Chair
Covid19 Business					
	06/0520	COVID-19 programme update and issues to report	Note	Paper	Chief Executive/ Dep. COO
Performance And Patient Experience					
	07/0520	Performance Report	Note	Paper	Director of Finance
	08/0520	Finance Report	Note	Paper	Director of Finance
	09/0520	Quality Report	Note	Paper	Director of NQ&T
	10/0520	Freedom to Speak Up Report	Note	Paper	FTSU Guardian
Closing Business					
	11/0520	Any other business	Note	Verbal	Chair
	12/0520	Date of next meeting Weds 24 June – 10.00 – 12.00 Weds 22 July – 10.00 – 12.00	Note	Verbal	All

AGENDA ITEM 03

UNCONFIRMED MINUTES
Trust Board
MEETING IN PUBLIC
Held on Wednesday, 22 April 2020 via Microsoft Teams

PRESENT:
Ingrid Barker, Trust Chair
Dr Stephen Alvis, Associate Non-Executive Director
Sandra Betney, Director of Finance
Maria Bond, Non-Executive Director
John Campbell, Chief Operating Officer
Marcia Gallagher, Non-Executive Director
Sumita Hutchison, Non-Executive Director
Jan Marriott, Non-Executive Director
Angela Potter, Director of Strategy and Partnerships
Paul Roberts, Chief Executive
Graham Russell, Non-Executive Director
Neil Savage, Director of HR & Organisational Development
Duncan Sutherland, Non-Executive Director
John Trevains, Director of Nursing, Therapies and Quality
Dr Amjad Uppal, Medical Director

APOLOGIES:
Helen Goodey, Director of Locality Development and Primary Care
Jane Melton, Director of Therapies
Lavinia Rowsell, Head of Governance and Trust Secretary

IN ATTENDANCE:
Anna Hilditch, Assistant Trust Secretary
Claire Kenny, Board, Committee & Membership Officer
Bren McInerney, Trust Governor
Louise Moss, Deputy Head of Governance
Kate Nelmes, Head of Communications
Brian Robinson, Trust Governor
David Smith, Transition Director
Katherine Stratton, Cheltenham Community Manager
Sian Thomas, Deputy Chief Operating Officer

1.0 APOLOGIES AND CHAIRS WELCOME

1.1 The Chair welcomed everyone to the meeting. Apologies for the meeting had been received from Jane Melton, for what would have been her final Board meeting with the Trust. The Chair expressed her thanks and appreciation to Jane for all of her work carried out with 2gether and subsequently GHC. Jane had worked tirelessly in raising the profile both locally and nationally of Allied

Health Professionals and research. The Chief Executive advised that a Board dinner would be arranged once it was possible to do so, to say farewell to Jane. The Board noted that following her departure, Jane Melton would be continuing in her role as Gloucestershire ICS Lead for AHPs and was also acting as the Regional AHP Lead during the Coronavirus pandemic.

2.0 DECLARATIONS OF INTEREST

2.1 There were no new declarations of interest.

3.0 MINUTES OF THE MEETING HELD ON 25 MARCH 2020

3.1 It was noted that Brian Robinson, Trust Governor had been in attendance at the last meeting. The attendance list would be revised accordingly. Subject to this amendment, the minutes of the Board meeting held on 25 March 2020 were accepted as a true and accurate record of the meeting.

4.0 MATTERS ARISING AND ACTION LOG

4.1 The Board reviewed the action log and noted that all actions were now complete or included on the agenda. There were no further matters arising.

5.0 QUESTIONS FROM THE PUBLIC

5.1 No questions from the public had been received in advance of the meeting.

6.0 COVID19 TRUST RESPONSE - UPDATE

6.1 The purpose of this report was to provide assurance to the Board on the work the Trust has undertaken in responding to Covid and to highlight areas of good practice. Sian Thomas was in attendance to present this report. Before commencing with the update, the Chair said that this report demonstrated an enormous amount of work and she wished to acknowledge the efforts of the Executive Team and Trust staff. She said that the Trust was is a positive, stable position because of the efficiency and effort put in.

6.2 In terms of Governance, it was noted that the Trust has a clear incident management framework in place that includes the daily running of an Incident Control Room. Typical incidents tend to last days or weeks therefore in recognition of the length of this incident the Trust has also established a programme approach which will enable a broader and more longitudinal co-ordination of our organisation-wide management in response to Covid-19. The Chief Executive advised that the Recovery and Future State element of the programme would look to address how normal service would be resumed, as well as reviewing how to compensate for those services that haven't been provided and the learning from all of this.

6.3 The Board noted that the Trust was at the forefront of business continuity planning and our Priority 1 and Priority 2 service classifications have been shared nationally. This enabled us to have early plans for how we would safely cease, reduce or maintain service delivery. These plans have been fully and effectively implemented enabling us to continue to deliver high quality care. The service changes remain under constant review to ensure they continue to deliver what our patients, system partners and the public need from their health services during Covid-19.

6.4 Graham Russell asked whether the Trust was operating at maximum capacity. Sian Thomas advised that there was good capacity across all services at present, noting that it was a similar picture across the country with attendances at minor injury units having reduced. Currently the Rapid Response team and the District Nursing services were seeing the highest demand and the Trust had been successful in redeploying staff into these services to address this. John Trevains said that the NHS both locally and nationally had done well to ensure there was sufficient capacity, having been able to learn from other countries. It was a testament to quick and early planning. He advised however that there was a need to be mindful of ongoing staff absence rates (currently 20-30%).

6.5 Brian Robinson noted the plans to introduce additional telephone support and contact with patients, and he queried whether the Trust had considered groups who may struggle with this form of contact. Sian Thomas said that this was an additional form of contact and all patients would receive an assessment first and face to face contact would continue to be used if necessary.

6.6 Jan Marriott congratulated the Trust's Crisis and Home Treatment Teams for the work they had been carrying out to prevent the need for people to be admitted to hospital. Board members agreed that this had been a fantastic achievement.

6.7 In relation to stock and PPE, the Board noted that there is a regular review of national guidance in relation to the type of PPE required for each clinical setting and situation, ensuring teams are aware of the PPE equipment they should be using, thereby minimising the risk to colleagues. As a large rural Trust we have put in place a centrally co-ordinated stock management and distribution team to ensure teams across the county have access to the PPE and equipment they need to deliver safe care. We monitor stock levels daily and have a 7-day a week response service to rapidly distribute stock if issues emerge. We highlight stock and PPE issue through the appropriate national and regional escalation routes, and have put in place local supply relationships to help ensure we do not run out of essentials.

6.8 John Trevains informed the Board that for staff on the front line this was a very frightening time. The Trust had introduced PPE Champions located at each of the main clinical sites to talk to staff and help demonstrate how to use PPE

correctly. A lot of time had been invested in ensuring that staff felt safe and supported, with management walk arounds, pastoral care and informal communication. John Trevains said that he felt well assured that there was a good level of support available to all staff who needed it and any concerns that had been raised had been addressed promptly.

6.9 The Trust designed and implemented an app for staff to self-report Covid related illness. This has allowed us to have a clear view on the impact of this absence both on colleagues and on service delivery. We are now seeing more colleagues return from illness than new daily reports of illness. Where individual colleagues have unfortunately been more affected by the illness the Trust has offered support to them, their families and their teams.

6.10 Supporting the physical and mental wellbeing of colleagues throughout this period is of paramount importance. A range of offers have been put in place including access to self-help material, online support and telephone based psychological support for staff from the Trust's IAPT team. Home working has been enabled through the roll out of additional equipment, Microsoft teams and an increase in network capacity. Neil Savage said that the Trust's occupational health service, Working Well, had received 800 contacts from staff and help and support has been offered. David Smith added that staff had been given information about financial support organisations, and a weekly message went out to all staff on access to staff accommodation. It was noted that 18 colleagues had taken up accommodation to date.

6.11 The Trust is running the countywide staff testing service on behalf of GHFT, Primary Care, Pharmacy and Social Care. The service is currently a drive through model based at Edward Jenner Court but this is likely to expand to a second site and a domiciliary service for care homes as testing requirements increase. Sian Thomas advised that there were currently no capacity issues in terms of testing.

Vulnerable People Telephone Service

6.12 The purpose of this report was to brief the Trust Board on the establishment of a Vulnerable People Telephone Support Service, being run in conjunction with Gloucestershire CCG, during the Covid19 crisis.

6.13 The Government have contacted over 900,000 people nationally that are deemed to be clinically at highest risk of adverse outcome if they contract coronavirus. These people have been told to self-isolate for a period of 12 weeks and are referred to as the 'shielded group'. To support GP Practices in making contact with those defined as most vulnerable, the Trust in collaboration with Gloucestershire CCG have established a Vulnerable People Telephone Support Service.

6.14 The new Service which commenced operation on the 15th April 2020 provides two key functions:

- To provide a welfare check to all patients registered with a GP practice identified as vulnerable in the context of Covid-19
- To provide advice and guidance to staff members regarding support for people who are vulnerable within their families (initially just GHC with a view to expanding across the ICS).

6.15 John Campbell reported that 45 GP practices had signed up for support and approximately 15,000 calls were expected to be made (89 had been made so far). Interpreting services were available to assist in contacting all groups. The Board noted that any mental health or Learning disability concerns would continue to be supported by the Primary MH Teams.

6.16 Graham Russell asked whether people had the ability to call into the service if they wanted help or advice. It was noted that currently this was just a call out service so incoming calls were not received.

6.17 Sumita Hutchison noted the impact of Covid19 on people from black and minority ethnic communities (BAME) and asked whether the training that call centre staff received focussed on the cultural aspects of the different communities. Current national guidance focussed purely on identifying those who were medically/clinically vulnerable; however, John Campbell said that work was underway to identify further vulnerable groups within the overarching "vulnerable" title, alongside GP practices, which would include the BAME community and ensure that these groups were signposted and had access to the relevant community support groups that would be available to assist. Training for this was included for all staff. Paul Roberts advised that Bren McInerney had raised a question prior to the meeting about the vulnerable people programme and recovery more generally, and how the Trust was honouring its aim to tackle and focus on inequalities. It was agreed that this had been addressed by the discussion just held.

6.18 Steve Alvis asked how this service would work for those vulnerable people living in Gloucestershire but registered with an out of county GP practice, and vice versa. John Campbell said that more work was needed to link this in and to see how this could be managed.

6.19 Marcia Gallagher asked about expected response times if any issues were flagged following calls to vulnerable patients. John Campbell advised that daily updates would be provided back to GP practices; however, if an urgent health or wellbeing issue was identified this would be actioned immediately.

6.20 The Board noted this report, and welcomed the development.

GHC Services Update

6.21 The Board received this report which provided an update on GHC Services enhanced due to Covid19.

6.22 Jan Marriott made reference to learning disability services and those families who were struggling with challenging behaviour during lockdown. John Campbell advised that the LDISS & IHOT teams were not doing the usual intensive work but were providing staffing back up for other teams including Berkeley House inpatients. He added that following a legal challenge that the lockdown rules discriminated more against people with additional needs, changes have been made to the rules for people with specific health conditions, including people with learning disabilities and autism, including the ability to go out for exercise more than once a day. CLDT Teams have written a letter for people to carry with them that they can share and has the CLDT details included.

6.23 The Board noted the update in relation to the volunteering programme. Neil Savage advised that the volunteering programme and how this would be developed and utilised in the future would be considered by the workforce stream of the post Covid recovery reset project.

6.24 The Board noted this update, acknowledging the huge amount of work being carried out by Trust staff to accommodate changes in services at such a challenging time.

7.0 TERMS OF REFERENCE: BOARD ASSURANCE COMMITTEE (COVID)

7.1 The purpose of this item was to provide the Board with the proposed terms of reference for the Board Assurance Committee (Covid) to ensure clarity on decision making and delegated authority.

7.2 The Terms of Reference were approved.

8.0 TERMS OF REFERENCE: ETHICS COMMITTEE

8.1 The purpose of this item was to provide the Board with the proposed terms of reference for the Ethics Committee to ensure clarity on decision making and delegated authority.

8.2 Recognising that difficult decisions will need to be made in light of the Covid19 pandemic, it was proposed that an ethics committee be established. The Group will lead in addressing complex ethical issues that may arise from the Trust's response and plans put in place to respond to the Covid19 pandemic and ensure that all decisions are made in accordance with the law and official guidance issued and applicable at the time, while meeting statutory duties and professional responsibilities.

8.3 The Board welcomed the establishment of this Committee and the Terms of Reference were approved.

9.0 FINANCE REPORT

9.1 The Board received the Finance Report for month 12. The Director of Finance advised that this was the draft month 12 position as due to the pandemic, the timetable for completion of the final position and accounts had been extended.

9.2 The month 12 position was a surplus of £2.987m excluding impairments, which was slightly better than the planned surplus. This position included £666k of additional income received from the Department of Health and Social Care.

9.3 The cash balance at month 12 was £37.8m which was £4.1m above the plan. Capital expenditure was £6.613m at year end, which is in line with the revised forecast submitted to NHS Improvement in February.

9.4 The Board noted that monitoring arrangements for all Covid related costs had now been put in place. No Covid related capital costs have been identified in 2019/20. Covid related revenue costs of £309k have been identified in 19/20 and a breakdown of those costs was presented to the Board. The Trust has had confirmation from NHS E that all these costs will be funded. The Board was asked to note that during this time, the contracting regime has been suspended. The Trust will receive cash payments based on last years' run rate.

9.5 The Director of Finance asked the Board to note the potential risks to delivery of the 2020/21 position, in particular non-recurring CIPs. She advised that this would be a complex position for the next few month.

9.6 Herefordshire services transferred to Worcestershire Health & Care Trust on the 1st April 2020. Settlement has been reached with Herefordshire CCG on the final year end position to ensure there are no disputes.

9.7 The Board noted the draft month 12 financial position. Ingrid Barker expressed her thanks to the Director of Finance and her team for their work as this was an excellent outcome given the challenging circumstances.

10.0 PERFORMANCE REPORT

10.1 Sandra Betney presented the combined Performance Report for March 2020 to the Board. The report provided a high level view of key performance indicators in exception across the organisation; however, the Board was asked to note that the organisational response to Covid-19 had adversely contributed to available operational capacity to undertake routine performance monitoring processes for the period. Specifically this has had an impact across measures requiring validation or specific narrative feedback. Where possible, was

highlighted within the indicator where Covid-19 may have specifically contributed to in-period data quality and performance.

10.2 Sandra Betney advised that in light of the fact that services were not operating as usual (due to service reconfiguration, reduced governance monitoring and limited capacity to validate data quality) it was anticipated that an alternative performance dashboard would be presented at the next meeting.

10.3 The Board noted the combined Performance Dashboard Report for March 2020, and acknowledged the challenges being faced currently in receiving validated service data.

11.0 QUALITY REPORT

11.1 This report provided an end of year overview of the Trust's quality activities for 2019/20. John Trevains advised that the report combined information from the two Trusts', prior to merger, reporting systems into a single format for the Board. A new reporting format is being designed for quality reporting for the 2020/21 contractual year, however, the Board was asked to note that there had been some disruption to the quality schedule development due to Covid-19.

11.2 The organisation's response to Covid-19 has adversely contributed to available staff capacity to undertake scheduled quality monitoring processes. This has had an impact across measures requiring audit, validation or specific narrative feedback. Alongside this, some Q4 quality improvement activity was restricted or unable to be delivered.

11.3 With regard to CQUINs, the Trust has now received official notification that due to the pressure being put upon services by Covid19 there is no longer an expectation to report upon Q4 CQUIN achievements via the National Portal and that Commissioners are being advised to take a pragmatic approach to payment of the initiatives during this time. As a Trust we have met the expectations of all the initiatives for this financial year so are expecting full payment.

11.4 Due to services not operating as usual, from April 2020 a revised Quality Summary report will be produced inclusive of specific Covid-19 quality related information.

11.5 Marcia Gallagher raised an issue about Out of County placements and how the Trust was monitoring OOC patients during the Covid pandemic. John Trevains agreed to pick this up as an action to provide more detail.

ACTION: Update to be provided offering the Board assurance on the management of out of county placements during the Covid19 pandemic

12.0 ANY OTHER BUSINESS

12.1 There was no other business.

13.0 DATE OF NEXT MEETING

13.1 The next meeting would take place on Wednesday 20 May 2020.

Signed: …….. **Dated: ……**

Ingrid Barker (Chair)
Gloucestershire Health and Care NHS Foundation Trust

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AGENDA ITEM: 04

PUBLIC SESSION TRUST BOARD: Matters Arising Action Log – 20 May 2020

Key to RAG rating:

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

Meeting Date	Item	Action Description	Assigned to	Target Completion Date	Progress Update	Status
22 Apr 2020	11.5	Update to be provided offering the Board assurance on the management of out of county placements during the Covid19 pandemic	DoNQ&T	20 May 2020	Our Mental Health Individual Case Management Team lead reports that all out of county hospital placements are receiving weekly contact. The Team Lead is also attending all MDTs virtually as agreed with each unit, this includes prompts and questions re family contact. For residential/social care placements, individual care coordinators have responsibility to maintain contact, and operational colleagues are currently seeking additional assurance on this matter to ensure it is being consistently achieved through the C19 crisis.	

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AGENDA ITEM: 06

REPORT TO: **Trust Board – 20 May 2020**

PRESENTED BY: **Paul Roberts, Chief Executive and Sian Thomas, Deputy Chief Operating Officer**

AUTHOR: **Sian Thomas, Deputy Chief Operating Officer**

SUBJECT: **Covid Programme Update and Issues to Report**

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

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

The purpose of this report is to

Provide assurance to the Board on the work the Trust has undertaken in responding to Covid and to highlight areas of good practice.

Recommendations and decisions required

The Board is asked to:

- Note the update and work to date

Executive summary

This item provides an update on the Trust's Covid Incident Management process, and the proposed approach to operational recovery during and post Covid.

Risks associated with meeting the Trust's values

A Covid specific risk register is being maintained, with the key strategic risk(s) raised on the corporate risk register.

Corporate considerations	
Quality Implications	Maintaining quality care has been at the forefront out our response to Covid.

Resource Implications	Our Covid response has required the redeployment of significant numbers of staff. Some equipment and facilities spend has been required, this has been attributed to a specific budget code.
Equality Implications	Ensuring incident management responses do not disproportionately affect certain groups has been a key principle of our work.

Where has this issue been discussed before?
Weekly discussions held at Executive Team Meeting and Covid Committee

Appendices:	NA

Report authorised by: **Sian Thomas**	**Title:** **Deputy Chief Operating Officer**

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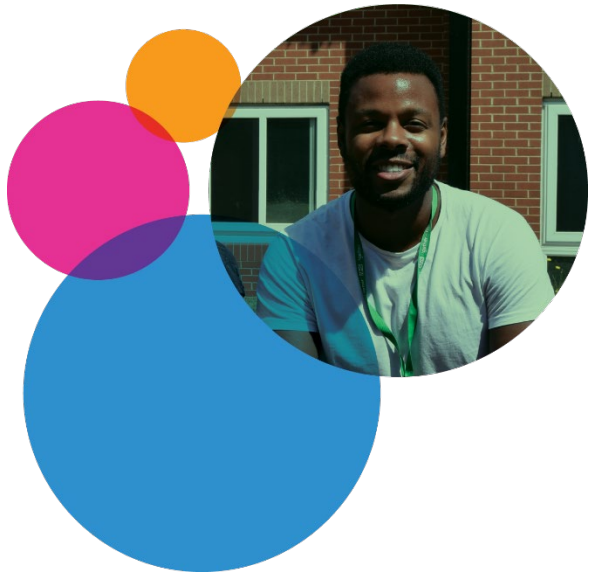
NHS Foundation Trust



Covid Incident Management

progress update

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

Gloucestershire Health and Care
NHS Foundation Trust

When in all started……

Early February (pre-incident phase) Joint work undertaken by clinical, operational & corporate to identify
P1 & P2 services & functions

Mid-February (phase 2) Trust enacts incident management plans & establishes Incident Control Centre

End March/April (phase 3) Running redesigned services while also continuing to have an ICC

Mid April/May (phase 4) Starting to plan for incident recovery while maintain ICC and ability to respond to further Covid peaks

February				March					April			
03-Feb	10-Feb	17-Feb	24-Feb	02-Mar	09-Mar	16-Mar	23-Mar	30-Mar	06-Apr	13-Apr	20-Apr	27-Apr
Pre-incident												
	Phase 1											
				Phase 2								
									Phase 3			
											Phase 4	
May				**June**					**July**			
04-May	11-May	18-May	25-May	01-Jun	08-Jun	15-Jun	22-Jun	29-Jun	06-Jul	13-Jul	20-Jul	27-Jul
Phase 3												
Phase 4												

So what have we done ?

Supported primary care with 'hot hubs'

Ran countywide patient testing service

Gave staff priority access to IAPT

Set up RAG areas in all inpatient sites

Roll out of Attend Anywhere

Intranet site, videos, blogs, daily comms

Increased number of stroke rehab beds

Running countywide staff testing service

Built staff absence app

Increased 7/7 management cover

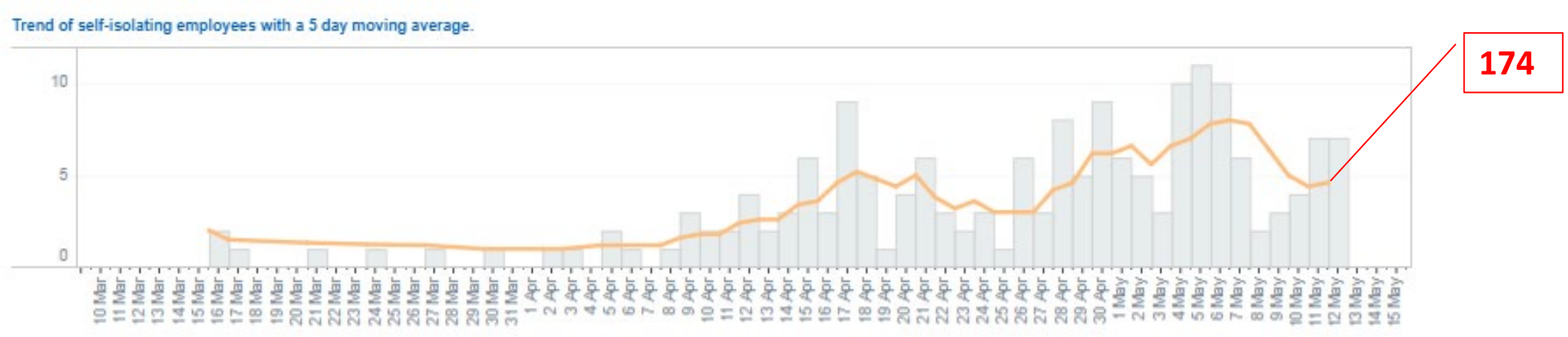
Set up a stock management team

Moved a number of services to 7/7

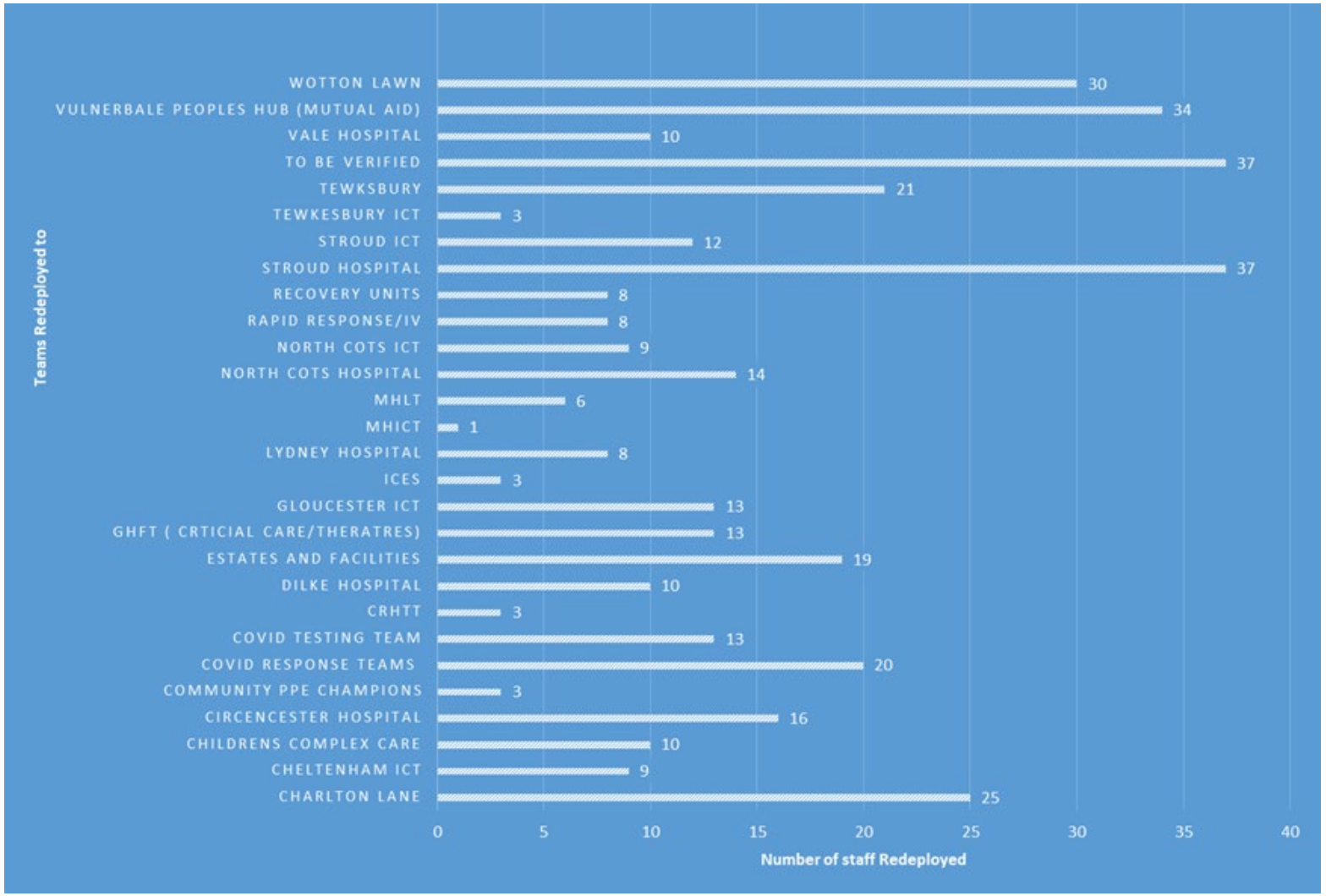
Accommodation offer

Staff absence - highlights

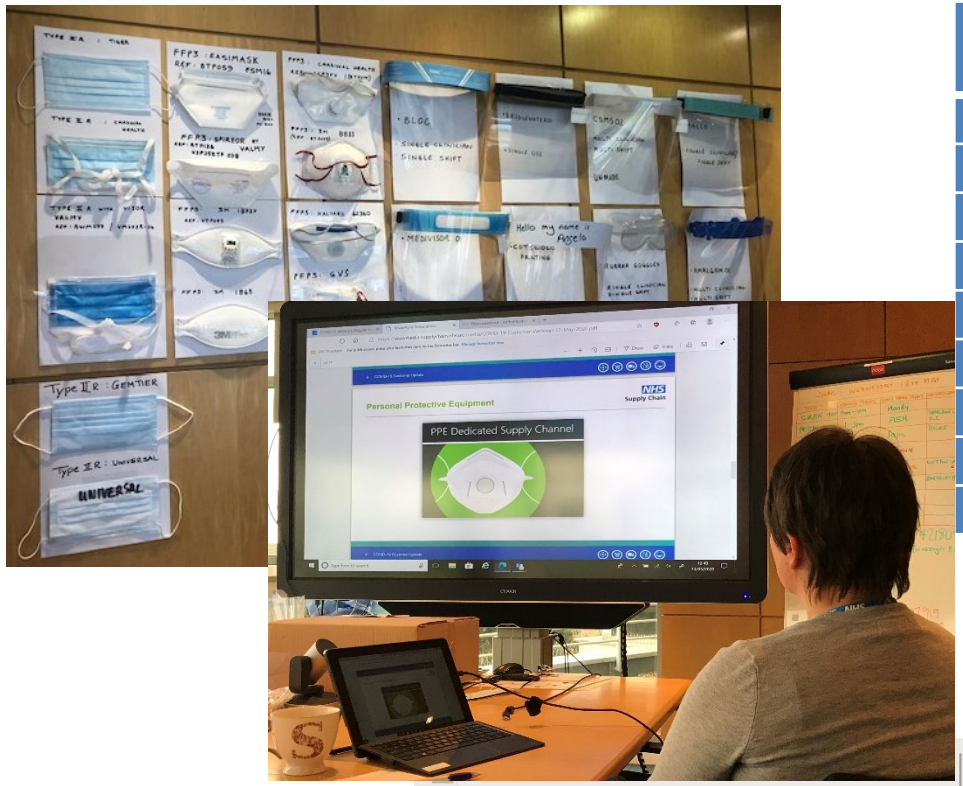
Gloucestershire Health and Care
NHS Foundation Trust



Staff redeployment - highlights



Stock management - highlights



PPE TYPE	Rate of use per week	Current stock	Remaining weeks (based on no new stock)
Goggles	5196	7474	1
Visor	7176	11474	2
Wipe	57085	147400	3
Gloves	82268	214155	3
Apron	40832	134960	3
Mask Type2R	54996	218617	4
Goggle Frame	1133	7116	6
Mask FFP3	2790	28129	10
Gown	152	1952	13

	AY	AZ	BA	BB	BC	BD	BE	BF	BG	BH	BI	BJ	BK	BL	BM	BN	BO
1	Pulman Place			16-Apr			17-Apr			20-Apr			21-Apr			22-Apr			23-Apr	
2	Type	Product		Start	In	Total	Start	In	Total	Start	In	Total	Start	In	Total	Start	In	Total	Start	In
3	Mask TYPE2R	Valmy - Blue Face Mask w/ Face Shield		10		10	10		10	10		10	10		10	10		10	10	
4	Mask TYPE2R	TYPE2R Medical Face Mask - Type 2		21500	300	21800	21850		21850	20550		20550	20400		20400	19750	1200	20950	20550	
5	Mask FFP3	Easimask FFP3 Mask				0			0			0			0			0		
6	Mask FFP3	Valmy Spireor FFP3 Mask				0			0			0			0			0		
7	Mask FFP3	Cardinal Health FFP3 Mask				0			0			0			0			0		

Gloucestershire Health and Care
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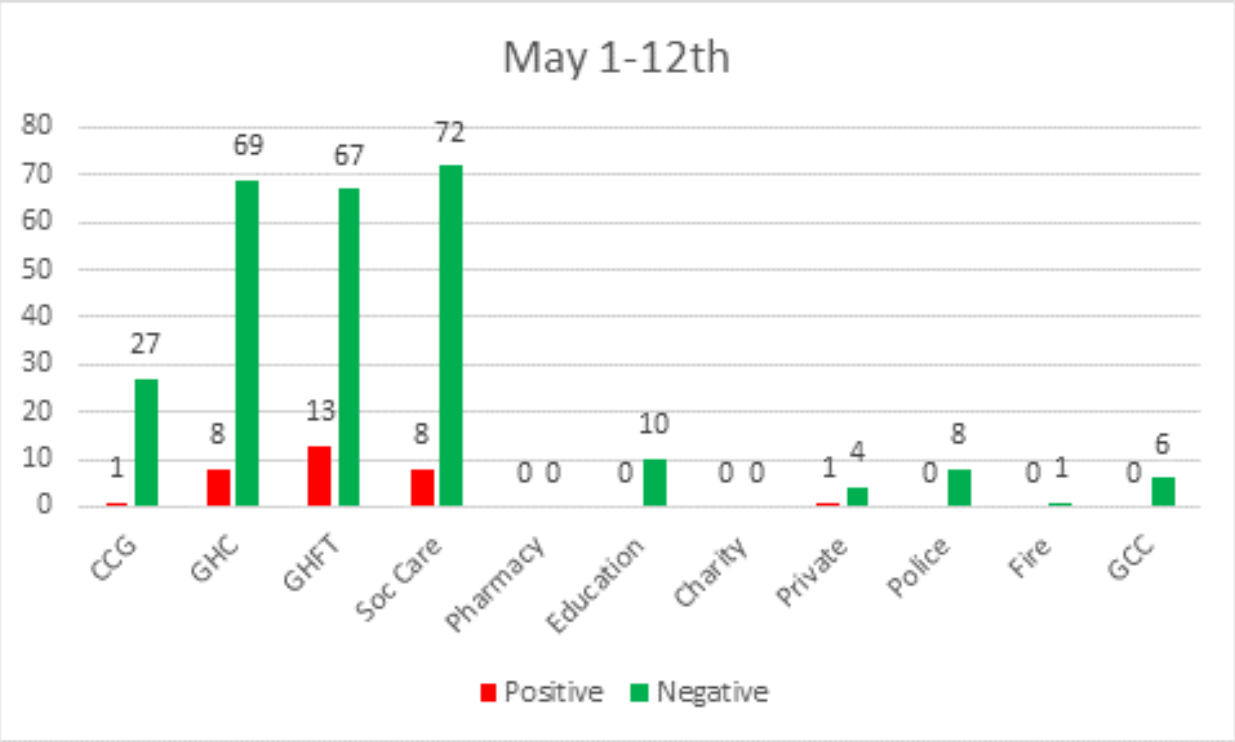
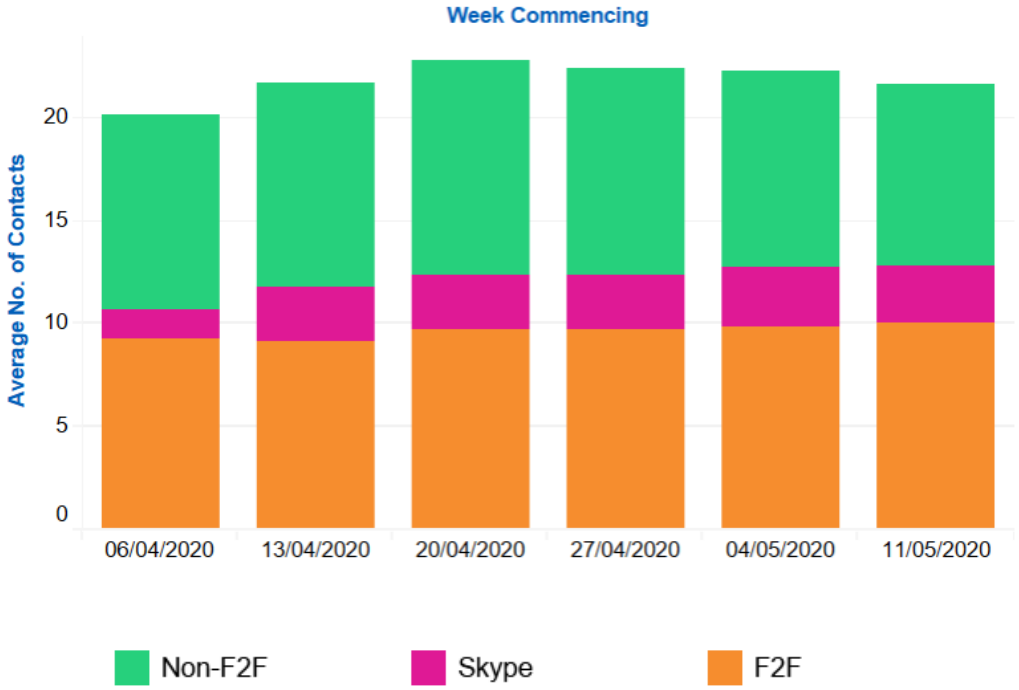
Staff testing - highlights



	GHFT	GHC	CCG	Soc Care	Charity	Pharm	Educ	Charity	Private	Police	Fire	GCC	TOTAL
April	433	276	85	139	1	16	11	1	4	0	0	0	966
May	83	80	29	83	0	0	10	0	5	8	1	6	305

Reporting & BI - highlights

Gloucestershire Health and Care NHS Foundation Trust



Service	referrals between 16-03-2019 and 13-04-2019	referrals between 16-03-2020 and 13-04-2020	% Difference from 2019
Bone Health	197	74	-62.4
Cardiac Rehab	126	95	-24.6
Rapid Response	298	287	-3.7

Bed flow

F2F vs nF2F

Demand & Capacity

Referral rates

Mortality

Service	Referrals between 16-03-2019 and 13-04-2019	Referrals between 16-03-2020 and 13-04-2020	% Difference from 2019
Child & Adolescent Mh Service	315	138	-56.19%
Community Learning Disabilities Service	39	13	-66.67%
Criminal Justice Liaison Service	108	25	-76.85%
Crisis Resolution & Home Treatment	174	99	-43.10%

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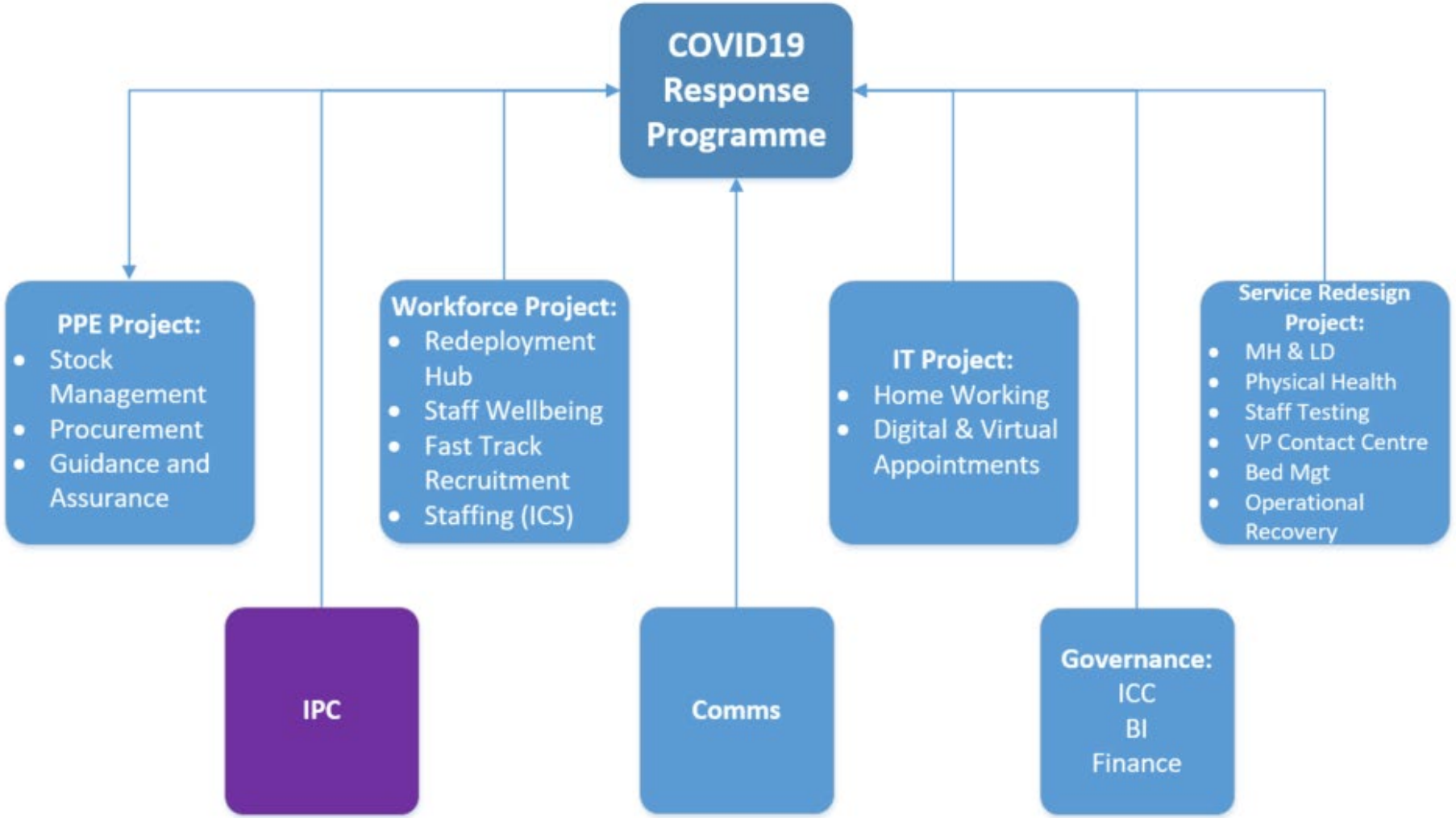
Covid Programme



Next steps

- Learning lessons
- Recovery planning
  - Staff engagement
- Maintaining our ability to respond to a second surge
- Future state
  - Patient & carer engagement

Thank you

We recognise your leadership, support and hard work through this exceptional time

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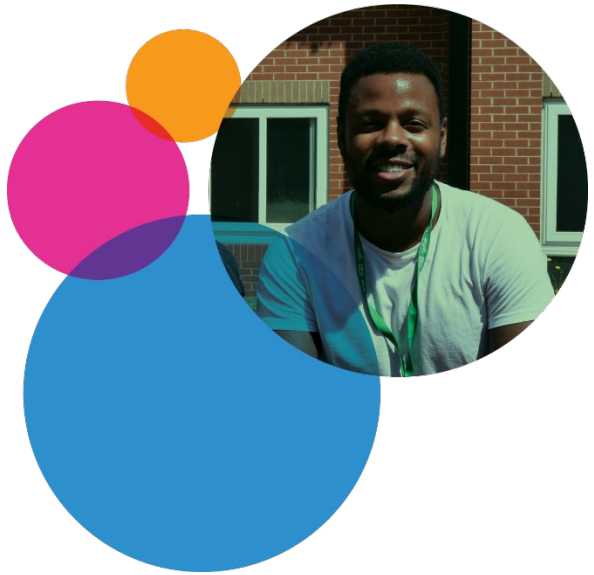


Operational recovery during and post Covid

Proposed approach

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

National context

National recovery cells

- UEC and Elective (incl cancer)
- Maternity
- Critical care & specialist commissioning
- Out of acute hospital Cell
  - Primary Care
  - Community Services
  - Mental Health and Learning
  - Disability/ Autism services
  - Screening and Immunisations
- Information and Digital Cell

Local context

- Internal recovery programmes in each organisation – we are directly linked to GHFT
- ICS wide recovery programme
  - Task & finish (operational recovery, meeting every Tuesday)
  - Transformation & future state (meeting every Friday)
  - Cross cutting themes (e.g. digital & finance)
  - Elective work

What we've done so far

- 2 x recovery planning workshops
- Service Directors held (or holding) same workshop/conversations with their direct reports
- Taken feedback to form:
  - Principles for recovery
  - Categories of recovery (and indication of future state phases)
  - Governance & assurance process

Which services, what order, when ….. to do what !

Category 0	Category 1	Category 2	Category 3	Category 4
Maintain Covid structure	No change return to previous model	Some change but no internal consultation or investment required e.g. use AA, change triage approach	Change requiring internal consultation and/or investment e.g. 7 day working	Significant change requiring partner agreement and/or public engagement/consultation e.g. service closure or change of location
Operational recovery (3-6 months)			***Future state (6 months +)***	

Which services, what order, when ..... to do what !

Gloucestershire Health and Care NHS Foundation Trust

Phase 1

Category 0	Category 1	Category 2	Category 3	Category 4
★	★	★	NA	NA

Phase 2

Category 2	Category 3	Category 4
	★ ★	★

Phase 3

Category 3	Category 4
	★

★ Hospitals

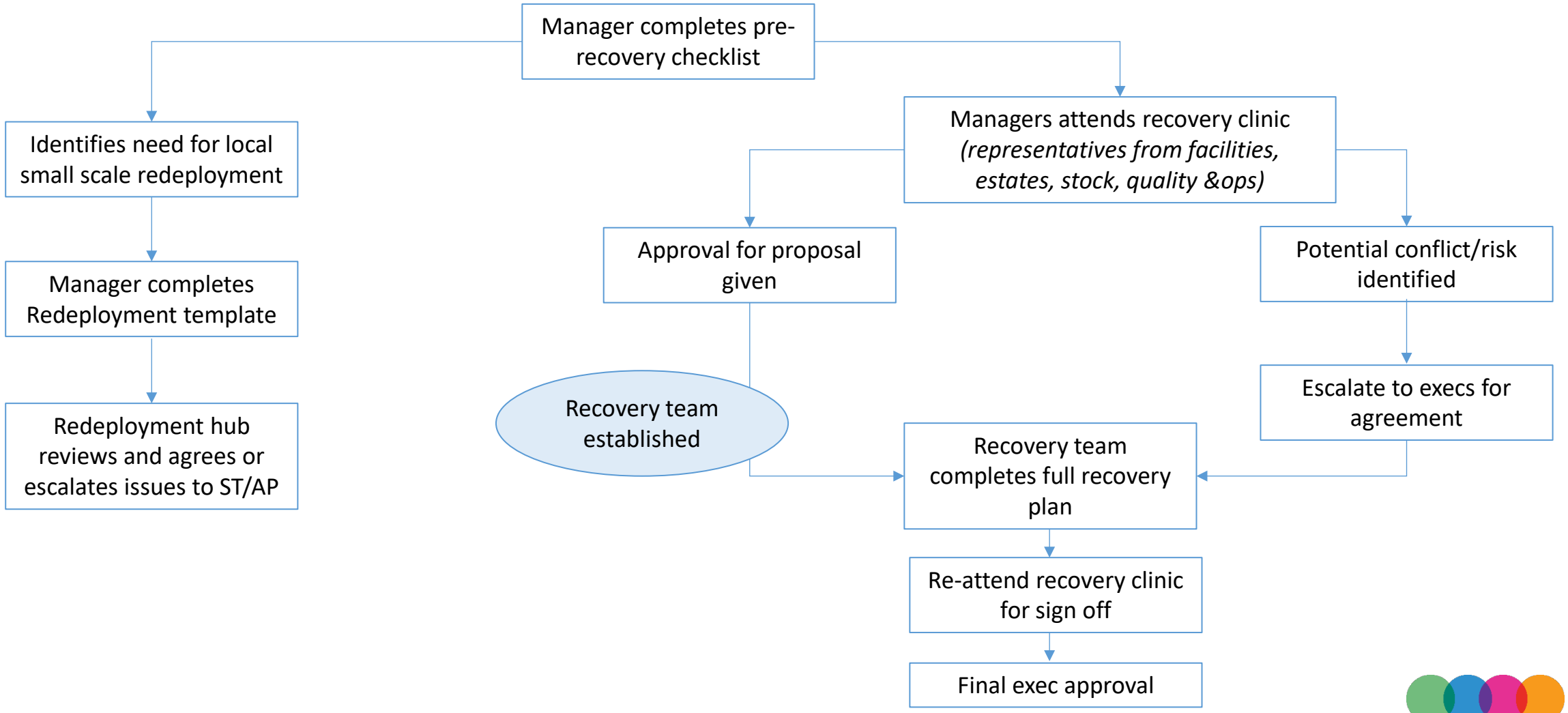
★ MSK

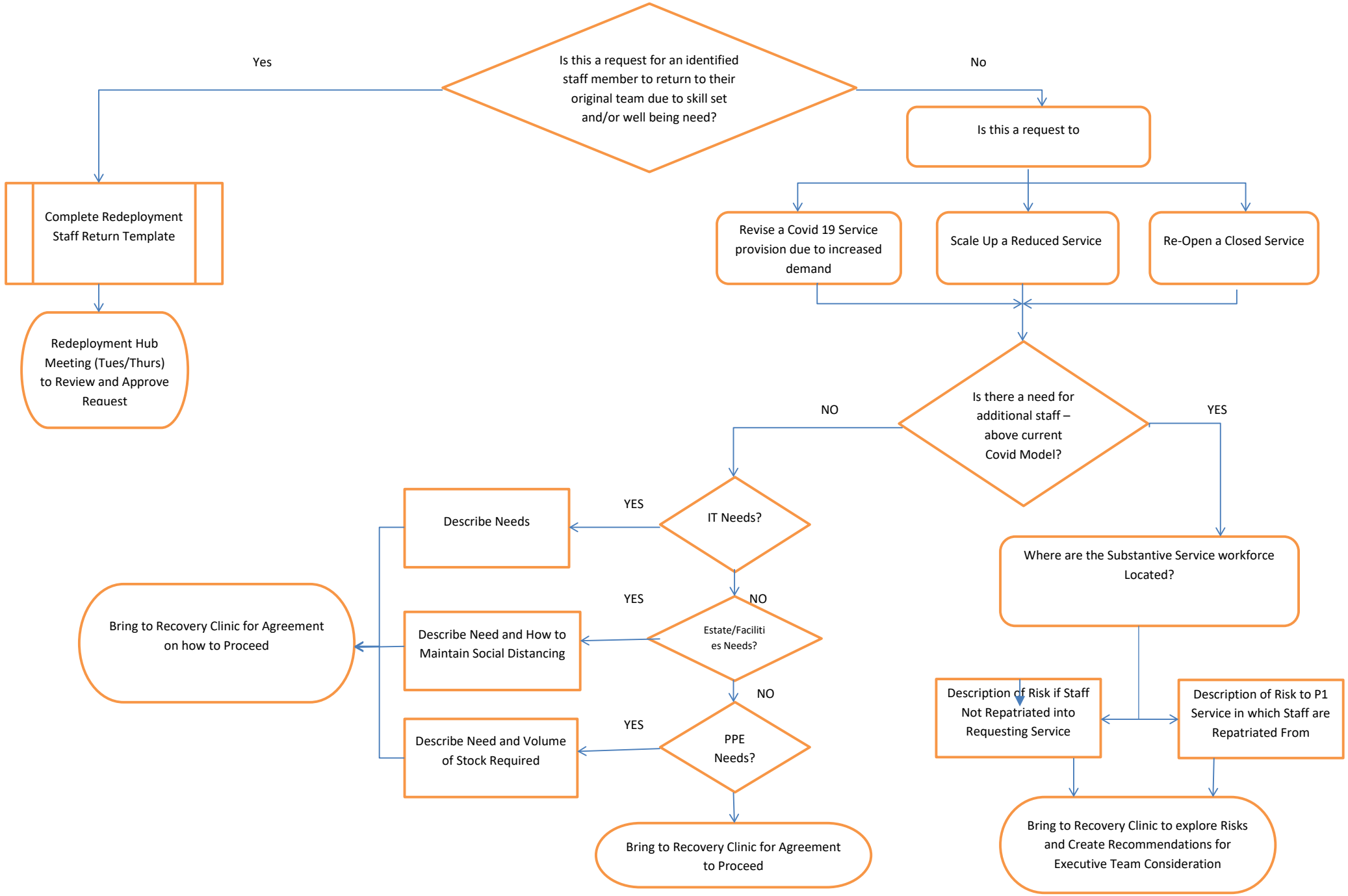
★ CMHT

Principles for Recovery

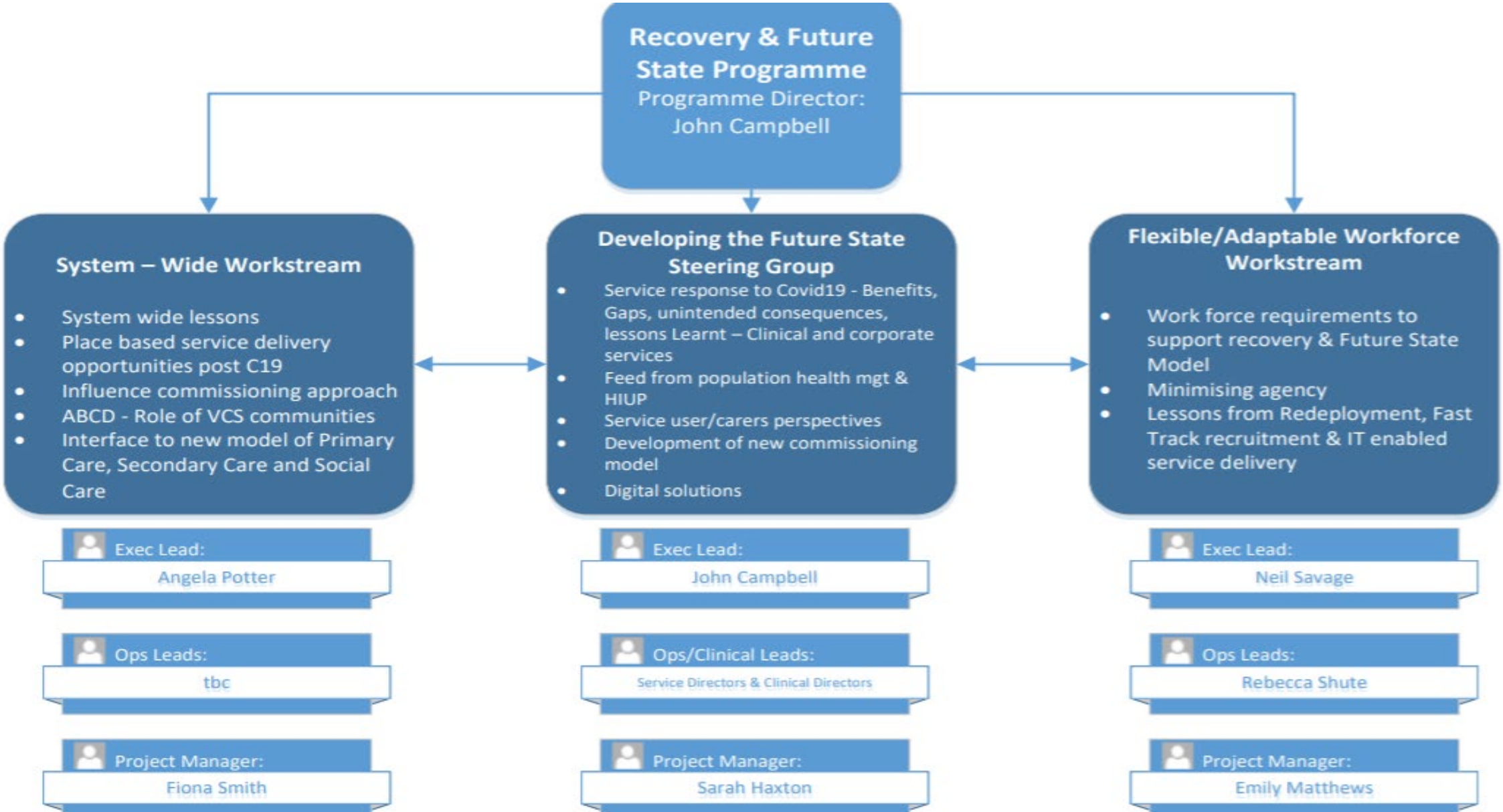
- Focus on Staff Well Being must be part of recovery process
- Internal and external interdependencies need to be identified and considered to understand impact of recovery decisions
- Any staff repatriation plan out of a Priority 1 service must be signed off by the executive team
- Recovery planning must be designed in a way to respond quickly to a 2nd peak
- Recovery plans must recognise and align with the future state programme of work
- Incorporate Learning from Incident into recovery planning
- Considering and seeking service user feedback

Recovery approach

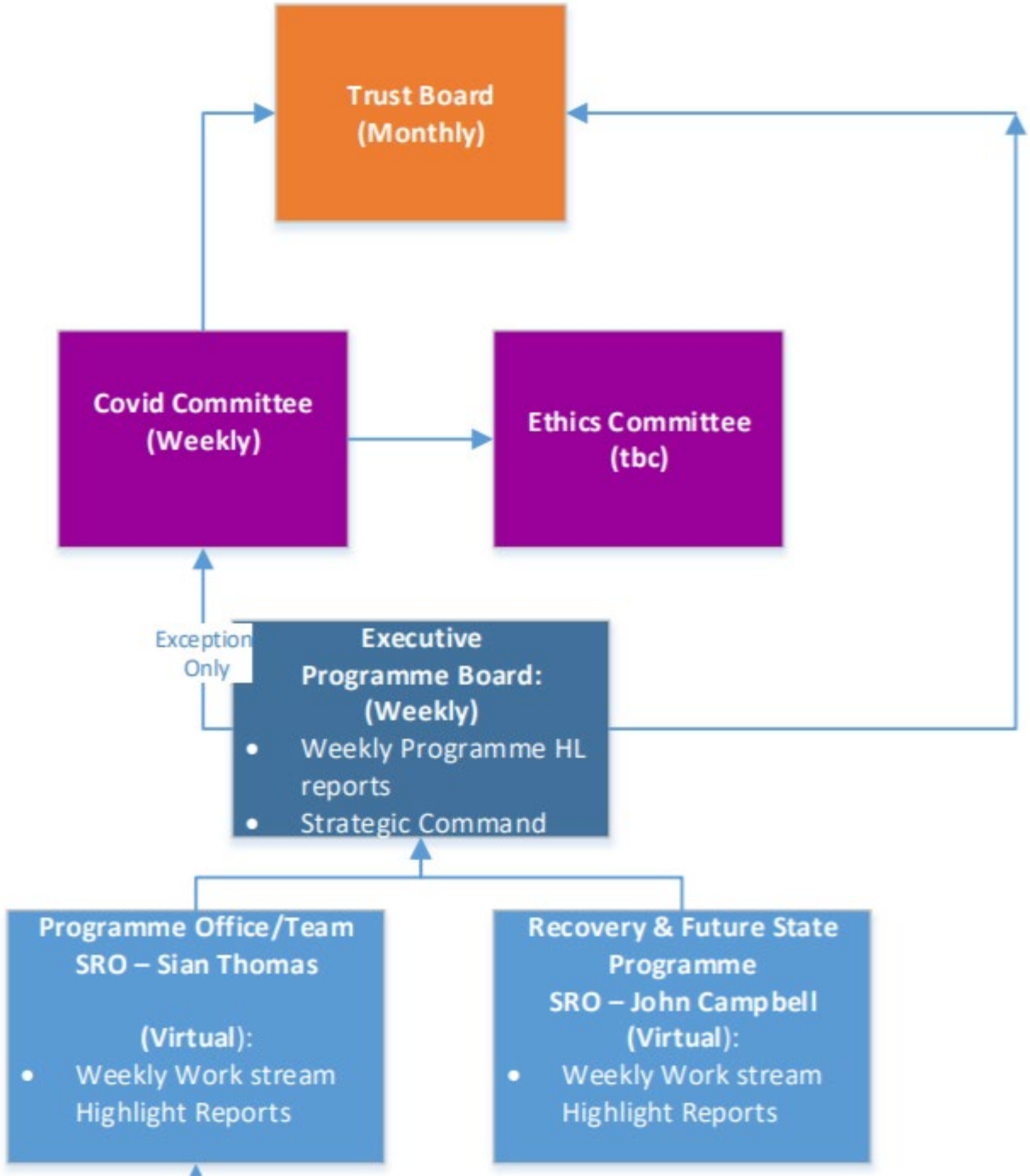



Is this a request for an identified staff member to return to their original team due to skill set and/or well being need?
Yes
No
Complete Redeployment Staff Return Template
Redeployment Hub Meeting (Tues/Thurs) to Review and Approve Request
Is this a request to
Revise a Covid 19 Service provision due to increased demand
Scale Up a Reduced Service
Re-Open a Closed Service
Is there a need for additional staff – above current Covid Model?
NO
YES
IT Needs?
YES
Describe Needs
Estate/Faciliti es Needs?
YES
NO
Describe Need and How to Maintain Social Distancing
PPE Needs?
YES
NO
Describe Need and Volume of Stock Required
Bring to Recovery Clinic for Agreement on how to Proceed
Bring to Recovery Clinic for Agreement to Proceed
Where are the Substantive Service workforce Located?
Description of Risk if Staff Not Repatriated into Requesting Service
Description of Risk to P1 Service in which Staff are Repatriated From
Bring to Recovery Clinic to explore Risks and Create Recommendations for Executive Team Consideration

Future state



Programme Governance



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AGENDA ITEM: 07

REPORT TO: **Trust Board – 20 May 2020**

PRESENTED BY: **Sandra Betney, Director of Finance**

AUTHOR: **Chris Woon, Associate Director of Business Intelligence**

SUBJECT: **Combined Performance Dashboard April 2020 (Month 1)**

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

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

The purpose of this report is to
This *combined* performance dashboard report provides a high level view of key performance indicators (KPIs) in exception across the organisation.

To offer reader clarity, the visualisation is separated into the following reporting sections;

- MH National Requirements (NHS Improvement & DoH)
- MH - Local Contract Gloucestershire (including Social Care)
- Community - National Requirements (Gloucestershire)
- Community - Local Requirements (Gloucestershire)

Performance covers the period to the end of April (month 1 of the 2020/21 contract period). This report aligns to the unprecedented organisational response to Covid-19 and repurposing of services. Unfortunately the scale of this response has impacted our operational colleague's capacity this month for full data validation and their usual ability to provide comprehensive explanatory narrative for all indicators in exception.

Where performance is not compliant, operational service leads are prioritising appropriately to address issues. A Covid-19 Recovery and Future State Programme is currently being drawn up across all services to restore a new-normal. This programme will schedule recovery activity, more fully account for 2020/21 performance indicators in exception and provide legacy Service Recovery Action Plans (SRAP) updates.

Recommendations and decisions required
The Board are asked to:

- Note the aligned Performance Dashboard Report for April 2020/21.
- Note the report as a **significant level of assurance** that our contract and regulatory performance measures are being met or that appropriate service recovery action plans are being developed to address areas requiring

improvement - in line with the C19 Recovery & Future State Programme.

- Note that the Business Intelligence Management Group (BIMG) will uniquely occur later this month (21/05/2020) so this offers the Board an opportunity to ask BIMG to consider any areas for business concern in further detail.

Executive summary

APRIL 2020 PERFORMANCE UPDATE

The Board's attention is requested to review the 11 key **mental health** key performance thresholds listed in the dashboard (with associated narrative) that were not met for April 2020. It is of note that all indicators with the exception of; *3.33: CPI: Assessment to Treatment within 16 weeks* have been in exception previously in the 2019/20 financial year. The CPI service was identified as a priority 2 service for the C19 incident response meaning treatment activity almost completely ceased in the period.

In addition your attention is drawn to the 29 key **physical health** performance thresholds listed in the dashboard (with associated narrative) that were not met for April 2020. It is of note that all indicators have been in exception previously in the 2019/20 financial year.

It is of note that the organisation's response to Covid-19 has adversely contributed to the available *operational* capacity to undertake routine performance monitoring processes for the period**.** Specifically this has had an impact across measures requiring validation or specific narrative feedback. Where possible, it has been highlighted within the indicator narrative where Covid-19 may have specifically contributed to in-period data quality, narrative and/ or performance.

In addition it is of note that all of operational Performance and Finance (P&F) meetings and the monthly Business Intelligence Management Group (BIMG) have been cancelled since March as senior operational management have been managing prioritised service delivery. However these now expect to resume in May 2020.

C19 REPORTING

The comprehensive list of the newly developed corporate and operational C19 reports were provided to the executive in May 2020 and this can be shared at request. From this, the Executive agreed the specification for a weekly C19 monitoring dashboard for the Programme Management Board (see **appendix 1** for specification). This will be separate and *in addition* to the routine monthly corporate performance dashboard. A prototype is currently being drafted and will be published in May 2020.

WIDER BI PROGRESS UPDATE

There have been some unforeseen Covid-19 tasks which now compete with the BI work plan and have meant the redeployment of a number of analysts to alternative duties. However in the main, major *development* items within our BI transition plan are being prioritised and predominantly still on track. Some lower profile items (*particularly reporting related*) are being re-programmed. BI development progress is provided within **appendix 2**.

From this it is of Board note that Covid-19 has impacted the Commissioner's progress of new Key Performance Indicators for 2020/21. Up until March, GHC had fully delivered on their responsibilities and Gloucestershire CCG were due to bring back the negotiated specification outline for endorsement. This has meant that, from a reporting dashboard perspective, 2019/20 KPIs have rolled over and C19 will now likely require parties to revisit our reporting priorities for a future, new-normal state. An internal review of service specifications (including Schedule 6 activity) can still begin in 2020/21 and will be led by the Contracts and Planning team with input from operations, BI and relevant supporting stakeholders.

Risks associated with meeting the Trust's values

Where appropriate and in response to significant and wide reaching performance issues (such as Eating Disorder Services or Wheelchair Services); operational services have Service Recovery Action Plans (SRAP) in place which will additionally outline appropriate risk levels and mitigation steps. A revised template of SRAP was being developed to ensure that they consider the Trust's proposed risk stratification approach and risk appetite domains however Covid-19 has deferred progress. This will be resolved up through BIMG.

Corporate considerations	
Quality Implications	Some indicators include a clinical quality or experience component therefore the information provided in this report can be an indicator into the quality of care patients and service users receive. Where services are not meeting performance thresholds this may also indicate an impact on the quality of the service/ care we provide.
Resource Implications	The Business Intelligence Service provides the support to operational services to ensure the robust review of performance data and co-ordination of the combined performance dashboard and its narrative.
Equality Implications	Equality information is included as part of performance reporting.

Where has this issue been discussed before?
This has only been discussed with the Director of Finance prior to Board.

Appendices:	Appendix 1 - Covid-19 Highlight Dashboard Specification – page 4 Appendix 2 – May BI Update – page 5-6 Performance dashboard (Lite) – page 7 onwards.

Report authorised by: Sandra Betney	**Title: Director of Finance**

Appendix 1

CORONA COVID-19 DASHBOARD SPECIFICATION AGREEMENT

STAFFING

- Daily C19 self-isolation cases & Current (cumulative) C19 isolation today
- Current (cumulative) C19 isolation by role type
- Current other total absences (From Workforce ESR system)
- Current all total absence (Combining the above)
- Predicted 'clinical roles' returning to work within next 7 days (end of isolation)
- *No Staff returning to work post Self-Isolating (late Quality request)*
- Staff wellbeing number of calls to oh
- Number of hits on staff wellbeing intranet

CAPACITY

- Daily physical health bed capacity, C19 & non-C19 occupancy
- Daily mental health bed capacity, C19 & non-C19 occupancy
- Daily total bed capacity. C19 & non-C19 occupancy (Combining the above)
- Current average MH & PH Length of Stay, C19 & non-C19
- *No of Patients discharged from hospital post C-19 (late Quality request)*

TESTING

- Tests undertaken and confirmed C19 *patient* cases to date
- Tests undertaken and confirmed C19 *staff* (Pod) cases to date

QUALITY

- Inpatient Mortality: suspected C19 and confirmed C19 cause of death to date by age group (reported to CPNS)
- C19 Incident Reporting (e.g. PPE related activity monitoring)
- PPE incidents (Adrian Warren collating)

STOCK

- PPE Central stock by type over time
- PPE Locality stock by type over time
- Predicted PPE requirements by type over time

Appendix 2

MAY BUSINESS INTELLIGENCE (BI) UPDATE

The BI service continue to protect key *infrastructure development* tasks to ensure the continuity of business critical reports are maintained during the pandemic and business as usual functions are protected. Unfortunately there have been some inevitable delays to the wider *reporting* development due to unplanned C19 requirements and the redeployment of analytical resources however *development* progress has been positive during the period. This *development* progress includes the preparation of our integrated BI stack by sourcing data extracts from multiple data systems which has giving us the ability to respond to meet developing C19 business needs and early flexibility to consider the fast-tracking of certain items such as mortality data.

The following tasks have been completed since the last update;

- The development of business critical operational performance reports within Tableau and significant progress on many other service level BAU reports which would support the imminent decommissioning of Birtie
- Maintenance of JUYI community health data feed due to the deferment of the Integra Centros project
- Partial introduction where possible but successful maintenance of the newly aligned system hierarchy (ESR, Datix and data warehouse) and initial data loading of Datix, ESR and legacy Integra data.
- Draft budget statement report from legacy Integra system
- New Tableau front page navigation for all BI consumers (including legacy BI tools) although rollout deferred until further notice
- Tableau permission controls for project reporting
- Engagement with Learning & Development Management Tool (Totara) supplier.
- Corona Covid-19 response reporting suite including extractions from GHT pathology and newly developed Isolation/ Working from Home application.

The following tasks continue to be ‘in the development pipeline’;

- Dashboard visualisation capability further developed to include; threshold figures in place of variances, SPC and trend analysis visualisations for all services, benchmarking indicators and data quality flags (delivery extended to June 2020).
- C19 Programme Management Board Dashboard
- Commissioner led local contractual key performance indicator review (Deferred until further notice due to C19).
- Internal service specification review to begin in Summer.
- Server capacity, infrastructure evaluation and development (on track Q3 2019/20).
- Existing data source adjustments (to support data quality monitoring and historic activity) in new environment (Q4 2020).
- Data source replication (prioritisation for ESR, Integra and Datix) (Q4 2020, dependant on GL and ESR progress)
- Key financial reporting to support the new General Ledger (GL) (extended to Sept 2020).
- Final legacy GCS reports migrated to Tableau (Q2 2020)

- Complete data sources replication for complimentary systems (Q3 2020)
- Supplementary system sources brought into BI reporting (Datix, Service Experience, Q4 2020)
- *Integrated* Business Intelligence Performance Dashboard (Q4 2021) for Board/ Resources Committee (incorporating full BI stack).
- Birtie decommissioning (Q4 2021)

PLEASE NOTE THAT THE DELIVERY OF THIS BI DEVELOPMENT TIMETABLE CONTINUES TO BE RESPONSIVE TO THE DEMANDS ON CURRENT CORPORATE/ OPERATIONAL BAU & ADHOC (e.g. C19) REPORTING.

Performance Dashboard Report

Aligned for the period to the end April 2020 (month 1)

The Board is asked to:

- Note the aligned Performance Dashboard Report for the period.

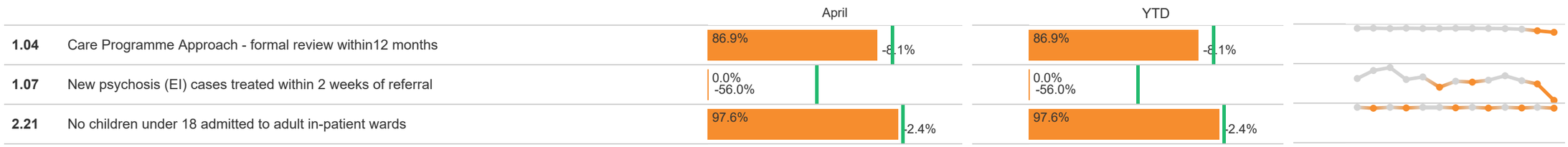
- In its review, recognise the impact of the organisaton's Covid-19 response and the diminished operational capacity at this time to undertake full data validation or provide comprehensive narrative to explain all indicators in exception.

- 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 being developed within the Recovery & Future State Programme to address areas requiring improvement.

Performance Dashboard: *Mental Health - National Requirements (NHS Improvements & DOH)*

KPI Breakdown

Mental Health - National Requirements Gloucestershire



Performance Thresholds not being achieved in Month - Note all indicators have been in exception previously in 2019/20.

1.04: CPA Approach – Formal review within 12 months
Gloucestershire is non-compliant at 86.9% (124 non-compliant records) with the majority of cases within the Recovery Service (70), EI service (15) AOT Service (10) and CPI service (8). Performance has deteriorated since March when it was reported at 88.9. %.

There has been a lack of service response to clarify why this indicator is in exception however it is likely that there may have been reduced data quality checking for this period due to the focus towards **Covid-19 priorities**. The Recovery service has been identified as a priority 2 service and staff were identified for redeployment.

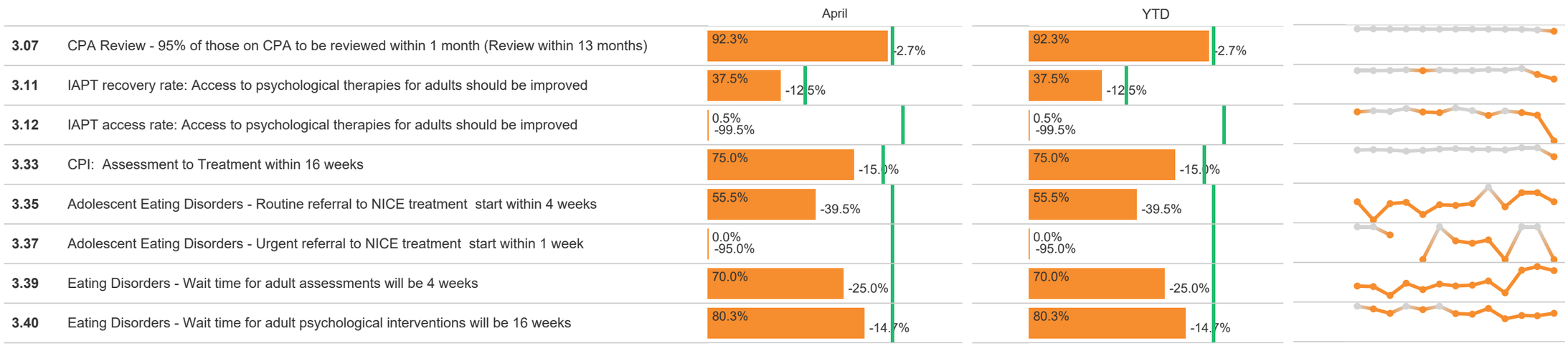
1.07: New Psychosis (EI) cases treated within 2 weeks of referrals
There was 1 person that started treatment in April; unfortunately this was not within the required 2 weeks. The referral was made whilst an inpatient and care-coordination not handed over to the EI team until after discharge which was longer than the required 2 weeks from referral.

2.21: Under 18 Admissions to adult wards
There was 1 admission during April. A 17 year old previously under the care of CYPs and Eating Disorders was brought to the Emergency Department following overdose, self-harm and ligature. The patient required 1:1 care but no beds were available on the paediatric or general ward in Gloucestershire Royal Hospital. The patient consented to same day informal admission to Wotton Lawn whilst awaiting transfer to a Tier 4 bed which became available 4 days later.

Performance Dashboard: *Mental Health - Local Contract (Including Social Care) Gloucestershire*

KPI Breakdown

Mental Health - Local Contract Gloucestershire



Mental Health - Social Care Gloucestershire

There are no Social Care Indicators of concern in exception.

3.07: CPA Review: 95% of those on CPA to be reviewed within 1 month (Review within 13 months)
Performance for April is at 92.3% and is showing a deterioration since last month when it was reported in exception at 94.7% but data correction looks to have returned the indicator to compliant for March (now at 96%). This indicator is a subset of 1.04 (for Gloucestershire patients) and of those non-compliant records above there were 71 where the CPA review is not recorded as having taken place within 13 months. Of those 36 were with the Recovery service, 15 with the EI service, 9 with the AOT service and 5 with the CPI service.

There has been a lack of service response to clarify why this indicator is in exception however it is likely that there may have been reduced data quality checking for this period due to the focus towards **Covid-19 priorities**. The Recovery service has been identified as a priority 2 service and staff identified for redeployment.

3.11: IAPT Recovery rate
Performance for April is again uncharacteristically very low. Clients have been dropping out of therapy midway, as they have other priorities and are also reluctant to transfer to individual treatment from group courses that were part-completed. There are also clients that do not want to move to telephone or video based interventions from face to face or are dropping out as they dislike it. Additionally due to **C19 prioritisation**, the IAPT management team have not yet been able to perform the usual data quality checks for discharges. The disruption that C19 has caused on IAPT delivery has been recognised at a national reporting level and will reduce expectations for Q1 national reporting.

3.12: IAPT Access rate
This indicator is below plan for April, although numbers have begun to increase due to local and public promotion. The **disruption that C19** has caused on IAPT delivery has been recognised at a national reporting level and will reduce expectations for Q1 national reporting.

3.33: CPI: Assessment to Treatment within 16 weeks
Only 4 Clients commenced treatment during April, of these 1 did not start within the required 16 weeks from assessment. Under the **Covid-19 response**, the CPI service has been identified as a priority 2 service and staff identified for redeployment and during "normal service" would start treatment for around 45 clients per month this has significantly reduced. The clients that this service provides treatment for still remain under the care of the Recovery and AOT services.

3.35: Adolescent Eating Disorders: Routine referral to NICE treatment within 4 weeks
There were 4 non-compliant cases in April. Two of these young people had their first appointment within 4 weeks; however CBT, which is not started until the 2nd appointment, was deemed to be the appropriate treatment. In both cases this was within 5 weeks. One client cancelled the appointment offered within 28 days and was seen on day 33. This young person also needed CBT and this began 2 weeks later. The remaining client did start treatment within 4 weeks but no treatment was recorded, the service is arranging for the clinical system to be updated

3.37: Adolescent Eating Disorders: Urgent referral to NICE treatment within 1 week
There were 2 young people with urgent referrals that began treatment in April recorded, both reported at non-compliant. One client did start treatment within the required 7 days but no treatment was recorded, the service is arranging for the clinical system to be updated. The other client was offered an appointment within the required 7 days but the appointment was cancelled by the service. The service has been asked to comment on the reason for cancellation.

The service has recognised that more can be done to improve process and waiting list management tools are being better utilised. Further trajectory modelling will be used to inform new threshold targets for these indicators for 20/21 and to look at reducing CBT waiting times. The Eating Disorders service has been identified as a Priority 1 service and the numbers for adolescents starting treatment from both routine and urgent referrals has not fallen below the expected number.

3.39: Eating Disorders: Wait time for Adult Assessments will be 4 weeks
There were 3 non-compliant cases in April. Two clients were offered appointments within the required 4 weeks but due to DNAs and cancellations were seen within 4 to 6 weeks. The remaining client was also offered an appointment within 4 weeks but the appointment was cancelled by the service. The service has been asked investigate whether this was in fact a patient cancellation. Waiting list management tools are being better utilised and generally any non-compliant cases are due to patient DNAs and cancellations. The Eating Disorders service has been identified as a Priority 1 service; however a drop in the number of referrals **due to Covid-19** is beginning to have an effect on the number of assessments being carried out.

3.40: Eating Disorders: Wait time for Adult psychological interventions will be 16 weeks
There were 10 non-compliant cases in April. The long wait for 4 of these clients was due to not attending appointments or cancellations. The remaining 6 clients were waiting for CBT or IPT treatment which generally has a longer waiting time than for other treatments; these clients were still seen and clinically manged whilst waiting to commence treatment.

The service has recognised that more can be done to improve process and waiting list management tools are being better utilised further trajectory modelling will be used to inform new threshold targets for these indicators for 20/21 and to look at reducing CBT and IPT waiting times.

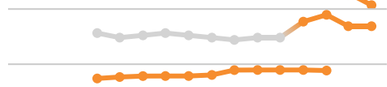
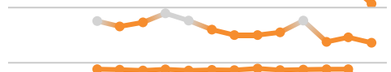
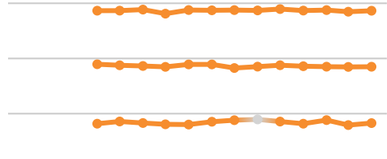
The Eating Disorders service has been identified as a Priority 1 service; however the drop in the number of referrals **due to Covid-19** is starting to have an effect on the number of assessments being carried out in April. The effect of this and any further reductions will not be seen in the number of treatments for several months as there is a 16 week time line.

Performance Dashboard: *Physical Health - National Requirements Gloucestershire*

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Physical Health - National Requirements Gloucestershire

		April	YTD	
31b	HPV Immunisation coverage for girls aged 12/13 years old - Immunisation 1	0.0% -100.0%	0.0% -100.0%	
31c	Percentage of children in Reception Year with height and weight recorded	0.0% -100.0%	0.0% -100.0%	
31d	Percentage of children in Year 6 with height and weight recorded	0.0% -100.0%	0.0% -100.0%	
38	Time to initial assessment for patients arriving by ambulance (95th percentile)	113.3% 13.3%	113.3% 13.3%	
80	SUS+ (Secondary Uses Service) Data Quality Validity (available in arrears)			
82	% of eligible children who receive vision screens at or around school entry.	0.0% -100.0%	0.0% -100.0%	
83	Number of AnteNatal visits carried out	50.0% -50.0%	50.0% -50.0%	
84	% of live births that receive a face to face New Birth Visit within 7- 14 days by a Health Visitor	31.0% -64.0%	31.0% -64.0%	
85	% of children who received a 6-8 weeks review	12.1% -82.9%	12.1% -82.9%	
86	% of children who received a 9-12 month review by the time they turned 12 months	80.3% -14.7%	80.3% -14.7%	
87	% of children who received a 12 month review by the time they turned 15 months	89.3% -5.7%	89.3% -5.7%	
88	% of children who received a 2-2.5 year review by 2.5 years	81.8% -13.2%	81.8% -13.2%	
91	% of infants being totally or partially breastfed at 6-8wks(breastfeeding prevalence)	54.2% -3.8%	54.2% -3.8%	

Performance Thresholds not being achieved in Month - All indicators have been in exception previously in 2019/20.

31b: HPV Immunisation coverage for girls aged 12/13 years old - Immunisation 1
The HPV Immunisation programme has been stopped **due to the COVID-19** outbreak. The cumulative position is now behind the internal trajectory (79.7% compared to trajectory 85%).

31c: Percentage of children in Reception Year with height and weight recorded
The National Childhood Measurement Programme has been stopped **due to the COVID-19** outbreak. The cumulative position is now behind the internal trajectory (66.4% compared to trajectory 70%).

31d: Percentage of children in Year 6 with height and weight recorded
The National Childhood Measurement Programme has been stopped **due to the COVID-19** outbreak. The cumulative position is now behind the internal trajectory (66.1% compared to trajectory 70%).

38: Time to initial assessment for patients arriving by ambulance (95th percentile)
The target of initial assessment within 15 minutes was missed in April 2020 (95th percentile 17 minutes). This is the fourth consecutive month that the target has been missed. There were 14 ambulance arrivals to Minor Injury and Illness Units and three arrivals were recorded as in excess of 15 minutes (Lydney 2, North Cotswolds 1). Validations have not been provided by the service **due to the COV-19** outbreak. This performance is within SPC chart control limits.

80: SUS+ (Secondary Uses Service) Data Quality Validity (available in arrears)
Performance has improved following resubmission of data. Latest report from NHS Digital shows performance of 88.9% compared to target of 96.3%. There are a number of data quality issues within the Emergency Care Data Set data (missing investigation and treatment codes) and Admitted Patient Care Data Set (missing clinical coding diagnoses) which will be reviewed to improve future performance.

82: Proportion of eligible children who receive vision screens at or around school entry
The Vision Screening Programme has been stopped **due to the COVID-19** outbreak. The cumulative position is now behind the internal trajectory (60.4% compared to trajectory 70%).

Additional Commentary for 31b, 31c & 31d & 82
In the absence of an update here is the previous month's commentary for non-compliance: The service have acknowledged that the local threshold plan set for the year to date was much higher than the same period in 2018/19 and with hindsight was too ambitious. The rationale for this was to try and finish the programme earlier to allow more time for data cleansing before submission to NHS Digital. However, this meant completing half of the programme within the first 3 months (November to January) which has not been achieved. 2 Health and Wellbeing Assistants left posts in January and February and there was expected to be a gap between leavers and new starters being trained and competent. Consequently the threshold was expected to be missed in subsequent months however the programme has now been stopped.

83: Number of AnteNatal visits carried out
The target based on 2018/19 outturn (92) was not achieved in April (46). The continued reduction is thought to be as a **result of COVID-19** outbreak with visits cancelled by patients.

84: Percentage of live births that receive a face to face NBV (New Birth Visit) within 7- 14 days by a Health Visitor
The target (95%) was not achieved in April (31.1%). 132 out of 425 visits were completed within the timeframe. The significant reduction in performance is thought to be as a **result of COVID-19** outbreak with visits cancelled by patients. There has also been limited review of exceptions / validations.

85: Percentage of children who received a 6-8 weeks review
The target (95%) was not achieved in April 2020 (12.2%). 54 out of 444 reviews were completed within the timeframe. The significant reduction in performance is thought to be as a **result of COVID-19** outbreak with visits cancelled by patients. There has also been limited review of exceptions / validations.

86: Percentage of children who received a 9-12 month review by the time they turned 12 months.
The target (95%) was missed in April 2020 (80%). 424 out of 528 reviews were completed within the timeframe. The slight reduction in performance may be as a **result of COVID-19** outbreak with visits cancelled by patients.

87: Percentage of children who received a 12 month review by the time they turned 15 months.
The target (95%) was missed in April 2020 (89%). 430 out of 481 reviews were completed within the timeframe and is consistent with previous months.

In the absence of an update here is the previous month's commentary for non-compliance: The parents of all children within the cohort were offered the opportunity to receive a 12 month review, however there are always a number that decline. Some children were not brought to the first booked appointment, therefore the 2nd appointment was out of timeframe because of parental choice. The Community Nursery Nurses forecast the number of clinics that are required to complete developmental reviews in the coming months and add on a 10% margin to allow for DNA's and re-booking. This can be implicated at times if venues are not available.

88: Percentage of children who received a 2-2.5 year review by 2.5 years.
The target (95%) was missed in April 2020 (81.8%). 456 out of 557 reviews were completed within the timeframe and is consistent with previous months.

In the absence of an update here is the previous month's commentary for non-compliance: The parents of all children within the cohort were offered the opportunity to receive a 2-2.5 year review, however there are always a number that decline. Some children were not brought to the first booked appointment, therefore the 2nd appointment was out of timeframe because of parental choice. The Community Nursery Nurses forecast the number of clinics that are required to complete developmental reviews in the coming months and add on a 10% margin to allow for DNA's and re-booking. This can be implicated at times if venues are not available. The Health Visiting Service is currently working with Early Years, in order to promote the importance of the 2 year review with an aim of increasing the number of children that are brought to the appointments and to increase the opportunity for public health and developmental advice to be shared with parents.

91: Percentage of infants being totally or partially breastfed at 6-8 weeks (breastfeeding prevalence)
The target (58%) was missed in April 2020 (54.2%). 253 out of 466 infants were recorded as totally or partially breastfed. This is slightly improved compared to previous months.

In the absence of an update here is the previous month's commentary for non-compliance: Reasons for not meeting the target include parents declining the review, children moved into the county which would have been seen and had their review at the earliest opportunity, DNA appointments and then rebooked out of timeframe, movement out, parental choice to have review out of timeframe.

Additional Commentary for 83, 84, 85, 86, 87, 88, 91
In the absence of an update here is the previous month's commentary for non-compliance: Capacity has been an ongoing issue however the service has now recruited 2.75 WTE Band 6 health visitors. The new starters are in their preceptorship so will be working independently in practice in the coming weeks. The service has an action plan in place to improve reporting covering all key metrics, Public Health Nursing admin are now booking 6-8 week reviews and using text reminders, also promoting the service on social media and on the GHC Health Visiting website page to share the importance of the development reviews.

Performance Dashboard: *Physical Health - Local Requirements Gloucestershire*

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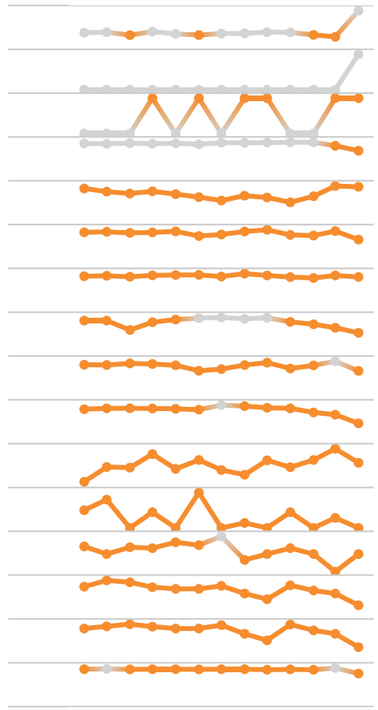
KPI Breakdown

Physical Health Community - Local Requirements Gloucestershire

		April	YTD	
9	Total number of incidents reported	242.9% 142.9%	242.9% 142.9%	
13	% medication errors resulting in moderate, severe harm or death	5.8% 5.8%	5.8% 5.8%	
25	Number of grade 4 Acquired pressure ulcers	100.0% 100.0%	100.0% 100.0%	
28	Bed Occupancy - Community Hospitals	76.1% -15.9%	76.1% -15.9%	
41	Podiatry - % treated within 8 Weeks	92.8% -2.2%	92.8% -2.2%	
44	ICT Physiotherapy - % treated within 8 Weeks	65.0% -30.0%	65.0% -30.0%	
45	ICT Occupational Therapy Services - % treated within 8 Weeks	81.0% -4.0%	81.0% -4.0%	
52	Paediatric Speech and Language Therapy - % treated within 8 Weeks	60.2% -34.8%	60.2% -34.8%	
53	Paediatric Physiotherapy - % treated within 8 Weeks	72.1% -22.9%	72.1% -22.9%	
63	Single Point of Clinical Access (SPCA) Calls Offered (received)	54.4% -45.6%	54.4% -45.6%	
67	Wheelchair Service: Adults: New referrals assessed within 8 weeks	33.3% -56.7%	33.3% -56.7%	
68	Wheelchair Service: Adults: Priority referrals seen within 5 working days	0.0% -95.0%	0.0% -95.0%	
71	Wheelchair Service: Under 18s: Equipment delivered within 18 weeks of referral	50.0% -42.0%	50.0% -42.0%	
93	Chlamydia Screening of Gloucestershire residents aged 15-24 (minimum positivity rate)	28.7% -71.3%	28.7% -71.3%	
94	Chlamydia Screening - Number of Positive Screens	31.3% -68.7%	31.3% -68.7%	
95	Average Number of Community Hospital Beds Open	88.2% -11.8%	88.2% -11.8%	

Performance Thresholds not being achieved in Month - Note all indicators have been in exception previously in 2019/20.

9. Total number of incidents reported
Performance is above SPC chart upper control limit, and above the threshold based on 2018/19 (899 compared to threshold of 370). This is as a result of the implementation of the new DATIX system where it is not currently possible to identify physical health related incidents only and so the reported value is significantly higher than previous and includes mental health. More clarity is being sought from the Quality team for resolution (i.e. increase threshold to accomodate the combined monitoring or exclude the MH activity). Updated analysis suggests excluding MH data should bring activity in line with usual performance around 363.

13: % medication errors resulting in moderate, severe harm or death
Performance is above SPC chart upper control limit, 2 out of 34 medication errors resulted in moderate, severe harm or death. The data is from the new DATIX system and has not been fully validated at this time.

25: Number of grade 4 Acquired pressure ulcers
There were 4 grade 4 acquired pressure ulcers reported in April. This exceeds the SPC chart control upper control limits. This has not been subject to the usual review and validation due to the impact on COVID-19 outbreak whereby every category/grade 4 pressure ulcer is reviewed by the Quality and Safety team who will discuss with the reporter and handler to understand further investigation is needed in the form of a Root Cause Analysis (RCA) investigation and timeline.

28: Bed Occupancy - Community Hospitals
Bed Occupancy in Community Hospitals has shown a continued reduction and is now below SPC chart lower control limit. Performance in April was 76%, below the threshold of 92%. This is as a direct response to the **COVID-19 response** with the opening of additional beds and running at a lower occupancy.

41: Podiatry - % treated within 8 Weeks
Performance continues to be below 95% target, (92.8% April 2020) however the number of patients seen and treated is significantly lower than usual as a direct result of the COVID-19 outbreak. 11 out of 14 patients were seen outside of 8 weeks. Average for 2019/20 per month was 713 patients seen and treated.

In the absence of an update here is the previous month's commentary for non-compliance: the current action plan, has a focus on three main areas:
1. SystmOne process review and redesign to improve data quality and performance reporting.
2. Review and redesign care pathway by speciality level to improve efficiency including;
3. Redesign of workforce model based on demand and capacity modelling.

44: ICT Physiotherapy - % treated within 8 Weeks
In April 65% of patients were seen within 8 weeks compared to target of 95%. 80 out of 229 patients were seen outside of 8 weeks. However the number of patients seen and treated is significantly lower than usual as a direct result of the **COVID-19 outbreak**. In 2019/20 average was 359 per month.

In the absence of an update here is the previous month's commentary for non-compliance: There is an ongoing issue with vacancy recruitment, with overall pressure across all localities. Locum cover now available in some places, new allocations now distributed by management. Locums catch up with patients waiting which in turn affects the longest waiters and Referral to Treatment.

45: ICT Occupational Therapy Services - % treated within 8 Weeks
In April 81% of patients were seen within 8 weeks compared to target of 95%. 35 out of 185 patients were seen outside of 8 weeks. However the number of patients seen and treated is significantly lower than usual as a direct result of the **COVID-19 outbreak**. In 2019/20 average was 436 per month.

In the absence of an update here is the previous month's commentary for non-compliance: Vacancies, particularly in Gloucester locality and in more junior roles (i.e. Band 5) have also impacted on target achievement. The service has secured clinicians via temporary contract and are actively seeking locums, recognising there is a further 2 years in the re-structuring of the service model to align to the revised commissioning intentions and resources available. Recruitment difficulties continue due to the OT review.

52: Paediatric Speech and Language Therapy - % treated within 8 Weeks
The 95% target has been missed in April 2020 (60%). 68 out of 171 patients were seen outside of 8 weeks. Performance has dropped below SPC chart lower control limits.

In the absence of an update here is the previous month's commentary for non-compliance: Capacity is an ongoing issue with 2 members of the team currently on maternity leave, a further 2 posts have been vacant since November. Actions include recruitment with 1 new starter commencing in post in March and 1 in June/July and a plan to increase availability of drop-in sessions if accommodation can be sourced.

53: Paediatric Physiotherapy - % treated within 8 Weeks
The 95% target has been missed in April 2020 (72.1%). 37 out of 133 patients were seen outside of 8 weeks. Performance is within SPC chart lower control limits. However the number of patients seen and treated is significantly lower than usual as a direct result of the **COVID-19 outbreak**. In 2019/20 average was 293 per month.

63: Single Point of Clinical Access - Calls Offered (received)
The threshold (based on 2018/19) of 3,279 calls was missed by 1,492 calls in April 2020. This level of calls is below the SPC chart lower control limit and is likely to be directly impacted by **COVID-19 outbreak** with less calls to the Single Point of Clinical Access.

67: Wheelchair Service: Adults: New referrals assessed within 8 weeks
Target continues to be missed. 1 out of 3 referrals were assessed within the 8 week timeframe.

68: Wheelchair Service: Adults: Priority referrals seen within 5 working days
Target continues to be missed. 2 priority referrals were received in April, none were seen within 5 working days.

71: Wheelchair Service: Under 18s: Equipment delivered within 18 weeks of referral
Target continues to be missed. One of two patients who had equipment delivered in April were provided with this outside of 18 weeks of referral.

Additional Commentary for 67, 68, and 71
The wheelchair service has recognised performance and data quality issues which are being addressed through a service recovery action plan. **Covid-19** has impacted on the service's ability to provide further narrative.

93: Chlamydia Screening of Gloucestershire residents aged 15-24 via the Chlamydia Screening Service (minimum positivity rate)
The minimum positivity rate for Chlamydia Screening of Gloucestershire residents aged 15-24 continues to be below threshold and the rate is now below SPC chart lower control limits. This is likely to be impacted by the **COVID-19 outbreak** with lower number of attendances at Sexual Health clinics.

94: Number of Positive Screens - GCS and Joint responsibility
Number of positive screens continues to be below threshold and is now below SPC chart lower control limits. This is likely to be impacted by the **COVID-19 outbreak** with lower number of attendances at Sexual Health clinics. This metric influences the (reducing) positivity rate (metric 93).

Additional Commentary for 93 & 94
A change in coding was introduced in the Sexual Health clinical system in April 2019. This has reduced the number of positive screens, some of which were incorrectly coded previously. However some online positives are still not being recorded correctly and this will continue to be reviewed with the service to improve the reporting.

95: Average Number of Community Hospital Beds Open
The average number of beds open in Community Hospitals in April 173.3 (compared to usual bed stock of 196 beds) and has dropped below SPC Chart lower control limits. This is directly impacted by the **COVID-19 outbreak**. See also metric 28.

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NHS
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Finance Report
Month 1

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Gloucestershire Health & Care Overview

Gloucestershire Health and Care
NHS Foundation Trust

- The Trust submitted its draft Final Accounts by the revised deadline of the 11th May. External Audit are now reviewing the accounts. Final audited accounts need to be submitted by 25th June.
- The draft year end surplus for GHC was above plan at £2.724m before absorption accounting, and excluding impairments of £3.489m.
- There is a Covid interim financial framework for the NHS in place for April to July possibly extended to October.
- NHSI monitoring of the Trust's performance is measured against income and expenditure run rates for months 8-10 from 19/20 uplifted by 2.8%. These are significantly different to our 20/21 Trusts budgets.
- Block income payments are being made direct to the Trust from main commissioners based on income at month 9 for last year inflated by 2.8% and not reduced by 1.1% efficiency savings.
- All Trusts have to show a break even position at the month end by either accruing for an additional retrospective top up payment if their income is insufficient to cover their expenditure or putting a negative retrospective top up payment if income exceeds expenditure.
- The Trust received a top up payment of £1.005m in April to cover an assumed shortfall in income to cover the expenditure run rate of last year (months 8-10). In order to balance to break even the Trust has removed this top up and assumed it will receive a top up payment of £0.090m.

Gloucestershire Health & Care Overview 2

Gloucestershire Health and Care
NHS Foundation Trust

- The following tables in this report compare month 1 actuals against Trust budgets. No year end forecast has been completed yet.
- The Trust has assumed a £300k reduction in Income from Gloucestershire Hospitals NHSFT as they are not using Theatres, Endoscopy or Outpatients during the pandemic.
- The Trust has seen a c. £150k reduction in NCA income as Trusts have been instructed not to invoice.
- The Trust has removed the impact of the £1.005m top up payment as agreed with NHSI.
- Bank and Agency spend is lower in month 1 than the average spend across last year by £180k.
- Non pay expenditure is £250k over spent. There is a £300k over spend on community care services in the month which is matched by additional income from GCC.
- The Cost Improvement Plan target for the Trust is £7.686m. The CIP removed at budget setting is £3.275m. During the interim Covid financial arrangements the Trust is not expected to deliver the 1.1% efficiency saving.
- Capital plan for 20/21 was set at £9.945m. Spend as at the end of month 1 is £130k. The ICS has a combined capital spend envelope of £31.287m which includes our full £9.945m.
- Cash balance at the end of month 1 is £61.9m due to the Trust receiving both April and May's block contract payments in April.

GHC Income and Expenditure

Gloucestershire Health and Care
NHS Foundation Trust

The performance at Month 1 is above the planned deficit of £0.094m at break even.

	GHC	GHC Month 1			
Statement of comprehensive income £000	**2019/20**		**2020/21**		
	per accounts	**NHS I Interim plan**	**Budget**	**Actual**	**Variance**
Operating income from patient care activities	187,601	19,189	17,422	18,125	703
Other operating income	9,642	825	756	481	(275)
Provider sustainability fund (PSF) income	2,042	1,005	0	0	0
Employee expenses	(142,521)	(15,207)	(13,468)	(13,547)	(79)
Operating expenses excluding employee expenses	(55,456)	(5,467)	(4,470)	(4,729)	(259)
PDC dividends payable/refundable	(2,351)	(350)	(335)	(337)	(2)
Other gains / losses	222	5	1	7	6
Surplus/(deficit) before impairments & transfers	**(821)**	**0**	**(94)**	**0**	**94**
impairments	3,489	0	0	0	0
Remove capital donations/grants I&E impact	56			0	0
Surplus/(deficit)	**2,724**	**0**	**(94)**	**0**	**94**

Note. In the NHS Interim plan no Herefordshire income has been included but £2m of expenditure has.
The variance compares 'Budget' against 'Actual'

GHC Balance Sheet

Gloucestershire Health and Care
NHS Foundation Trust

STATEMENT OF FINANCIAL POSITION (all figures £000)		GHC 2019/20 per accounts	GHC 2020/21 Year to Date Budget	Actual	Variance
Non-current assets	Intangible assets	2,023	2,283	1,194	(1,089)
	Property, plant and equipment: other	115,916	121,551	114,095	(7,456)
	Total non-current assets	**117,939**	**123,834**	**115,289**	**(8,545)**
Current assets	Inventories	288	245	283	38
	NHS receivables	11,017	8,456	13,238	4,782
	Non-NHS receivables	8,973	5,723	6,000	277
	Cash and cash equivalents:	26,619	27,800	61,874	28,192
	Property held for sale	0	500	0	(500)
	Total current assets	**46,897**	**42,724**	**81,395**	**32,789**
Current liabilities	Trade and other payables: capital	(2,143)	(1,784)	(1,332)	452
	Trade and other payables: non-capital	(5,580)	(10,551)	(19,406)	(8,855)
	Borrowings	(76)	(104)	(164)	(60)
	Provisions	(371)	(604)	0	604
	Other liabilities: deferred income including contract liabilities	(16,655)	(820)	(26,818)	(25,998)
	Total current liabilities	**(24,825)**	**(13,863)**	**(47,720)**	**(33,857)**
Non-current liabilities	Borrowings	(1,773)	(8,438)	(1,504)	6,934
	Provisions	(3,491)	(451)	(3,482)	(3,031)
	Total net assets employed	**134,747**	**143,806**	**143,978**	**(5,710)**

Taxpayers Equity	Public dividend capital	127,526	125,181	127,526	570
	Revaluation reserve	6,566	7,098	7,204	106
	Other reserves	(1,241)	(1,241)	(1,241)	0
	Income and expenditure reserve	1,896	12,768	10,489	(1,674)
	Total taxpayers' and others' equity	**134,747**	**143,806**	**143,978**	**(998)**

Note. Property held for Sale budget of £500k should not have been set

Cash Flow Summary

Gloucestershire Health and Care
NHS Foundation Trust

Statement of Cash Flow £000	YEAR END 19/20		ACTUAL YTD 20/21	
Cash and cash equivalents at start of period		**33,553**		**37,720**
Cash flows from operating activities				
Operating surplus/(deficit)	1,308		1,393	
Add back: Depreciation on donated assets	0		4	
Adjusted Operating surplus/(deficit) per I&E	**1,308**		**1,397**	
Add back: Depreciation on owned assets	4,944		779	
Add back: Impairment	3,489		0	
(Increase)/Decrease in inventories	(38)		0	
(Increase)/Decrease in trade & other receivables	(3,516)		1,216	
Increase/(Decrease) in provisions	2,485		15,406	
Increase/(Decrease) in trade and other payables	2,580		5,838	
Increase/(Decrease) in other liabilities	(863)		705	
Net cash generated from / (used in) operations		**10,389**		**25,341**
Cash flows from investing activities				
Interest received	206		1	
Purchase of property, plant and equipment	(4,835)		(1,183)	
Sale of Property	560		0	
Net cash generated used in investing activities		**(4,069)**		**(1,182)**
Cash flows from financing activities				
PDC Dividend Received	570		0	
PDC Dividend (Paid)	(2,565)		0	
Finance Lease Rental Payments	(158)		(4)	
		(2,153)		**(4)**
Cash and cash equivalents at end of period		**37,720**		**61,875**

Gloucestershire Health & Care Covid

Gloucestershire Health and Care
NHS Foundation Trust

- The Trust has established monitoring arrangements for the capture of all Covid related costs. New cost centres and monitoring arrangements for capturing costs have been established.
- We have strengthened financial governance arrangements. SFI's have been reviewed and senior managers have been written to reminding them of their key responsibilities and delegated limits
- A review of the Procurement to Pay process has been undertaken to ensure the systems to ensure payments to suppliers continue. As a consequence the introduction of the new Finance ledger has been deferred until September.
- No Covid related capital costs were identified in 19/20. Covid related capital costs will be incurred in 20/21 and a request to proceed with two schemes has been put forward for national sign-off.
- Covid related revenue costs of £285k were incurred in 19/20 and have been funded.
- Covid related revenue costs of £905k have been identified for April 2020.

For period up to and including 30/04/2020	Pay	Non Pay	
Expanding medical / nursing / other workforce	39,482.30		NHS returners plus fast track students
Sick pay at full pay (all staff types)	419,624.00		Full pay for absence, info from staff hub app
COVID-19 virus testing (NHS laboratories)	8,525.00		Swabbing team
Support stay at home model (highest risk patients)		1,880.67	eg Vulnerable persons hub (no costs yet), Bulk mailing
Plan to release bed capacity (free up Community Hospital and ICT beds)		35,006.60	GIS equipment hire, stores, furniture
Decontamination		37,568.23	Includes portacabin showers, clinell supplies, cleaning etc
Backfill for higher sickness absence	265,134.28		Currently including bank and agency
Remote working for non patient activites		1,452.91	Teamviewer licenses
National procurement areas		86,512.17	PPE (vizors), local accomodation
Other		10,260.72	Printing, estates costs etc
	732,765.58	172,681.30	**905,446.88**

Capital – Five year Plan

Gloucestershire Health and Care
NHS Foundation Trust

Capital 5 year Plan	Plan	Plan	Plan	Plan	Plan	
£000s	**2020/21**	**2021/22**	**2022/23**	**2023/24**	**2024/25**	**Total**
Land and Buildings						
Buildings	4,259	4,000	2,500	2,500	1,000	14,259
Backlog Maintenance	1,393	1,300	1,050	1,050	250	5,043
Urgent Care	475	0				475
IT						
IT Device and software upgrade	600	600	600	600	600	3,000
IT Infrastructure	1,498	1,409	1,400	1,300	1,300	6,907
Medical Equipment	1,220	1,030	1,030	1,030	3,330	7,640
Sub Total	**9,445**	**8,339**	**6,580**	**6,480**	**6,480**	**37,324**
Forest of Dean	500	7,000	3,400			10,900
Total	**9,945**	**15,339**	**9,980**	**6,480**	**6,480**	**48,224**

Risks

Gloucestershire Health and Care
NHS Foundation Trust

Risks to delivery of the 2020/21 position are as set out below:

Gloucestershire Health & Care Risks	20/21 Risks	Made up of: Recurring	Made up of: Non Recurring	Likelihood
			0	
Challenge Scheme CIPs	1,034	1,034	0	Likely
Unidentified Differential CIP schemes	413	413	0	Possible
Delivering non recurring savings	1,224	0	1,224	Possible
		0		
	2,671	**1,447**	**1,224**	

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AGENDA ITEM: 09

Report to:	Gloucester Health & Care NHS FT – Trust Board 20 May 2020
Author:	John Trevains, Director of Nursing, Therapies and Quality
Presented by:	John Trevains, Director of Nursing, Therapies and Quality
SUBJECT:	**Quality Dashboard – April 2020**

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

This report is provided for:

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

PURPOSE OF REPORT

To provide the Gloucestershire Health and Care NHS Foundation Trust Board with a summary assurance update on progress and achievement of quality priorities and indicators in both Physical and Mental Health Services.

Additionally, to provide the Board with the opportunity to review the format of the Quality Dashboard and agree if this provides them with sufficient oversight of key quality related information and if not, consider what additional information they would wish to see included.

RECOMMENDATIONS

The Trust Board is asked to:

- Discuss, Note and Receive the April 2020 Quality Dashboard;
- Agree methodology and principles for the ongoing update of the Quality Dashboard;
- Agree if the format is fit for purpose and whether there is additional information they would like to receive.

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## EXECUTIVE SUMMARY

This report and attached appendix provides an overview of the Trust's quality activities for April 2020 data. This report will be produced monthly for Board, Quality Committee and Operational Governance Forum for information and assurance.

## LOCAL QUALITY PRIORITIES

A series of Quality Priorities were agreed in discussion with our clinicians and commissioners prior to the Covid-19 outbreak. In the current climate, these priorities may no longer meet the needs the population of Gloucestershire which we serve. We will, therefore, be reviewing the clinical and therapeutic needs of our patients, and the configuration of our services to support these needs over the coming months. This will, in turn, inform new quality indicators which will be launched at the appropriate juncture in 2020/21.

## COVID-19 QUALITY IMPACT

The organisation's response to Covid-19 has adversely contributed to available staff capacity to undertake scheduled quality monitoring processes.

In addition it is of note that all scheduled quality governance meetings were paused in March and April 2020 as quality directorate personnel are engaged in supporting prioritised service delivery. A range of Quality Directorate colleagues have been redeployed to prioritised frontline services and other staff in support roles. Patient safety and experience matters have been monitored internally by the quality senior management team. A reduced quality team within the directorate has been established to monitor essential patient safety, incidents, quality and experience functions, these functions are reported in the Dashboard. The Quality Assurance Group will resume virtually in May 2020 as the first step in recovery of business as usual quality governance arrangements. This will be followed by the Board Quality Committee recommencing in June 2020.

## DASHBOARD DEVELOPMENT

Activity regarding Covid-19 reporting, patient experience and patient safety incidents now presents combined physical and mental health services information.

Local quality indicators will be added when these are developed as part of the service recovery plan. In linking these to this recovery, the indicators will better serve the health and social care needs of the local population.

It is proposed that the Quality Dashboard will continue to include progress against the quality indicators for the Trust. It will also provide additional detail and assurance regarding areas identified within the Performance Report as being below target. As a result, the areas of focus may well change month on month. We are keen to present new quality information on service areas that have been less heard historically, for example Sexual Health, Dentistry and community Learning Disability and Autism assessment services. It is proposed that, following scrutiny of the Performance Report, the Board may well request particular areas of focus within the Quality Dashboard and
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the Quality Directorate will be responsive to this. These are reported under the relevant CQC Domains.

**ARE OUR SERVICES CARING?**

Whilst local surveys and the Friends & Family Test (FFT) are suspended during our response to the pandemic, patient experience feedback continues to be gained through complaints, concerns and compliments. The Patient & Care Experience Team remains fully operational and noted a 50% reduction in complaints and a 33% reduction in concerns; compliments received, however, are consistent in volume with historical trends. This is suggestive of how much services are valued and seen as 'Caring'; additionally we estimate that there have been several thousand 'thank you' messages and gifts from local communities, organisations and businesses since the outbreak.

**ARE OUR SERVICES SAFE?**

In terms of incident reporting, 5 SIRIs within mental health services were declared which is not uncommon for the month of April. In light of Covid-19 there is, however, multi-agency 'real time' surveillance of reported suspected suicides and serious self-harm incidents with weekly review by the countywide suicide prevention steering group. General combined physical and mental health service patient safety incident reporting trends are down by 31% from the monthly average, and reported moderate harm incidents now roughly mirror the percentage seen previously by physical health services. Where we are seeing significant variance from target, e.g. acquired pressure ulcers, our response to this is described within the dashboard.

**ARE OUR SERVICES EFFECTIVE?**

With considerable focus on inpatient services currently, bed occupancy in community hospitals and mental health inpatient services has shown a continued reduction and is a direct response to the Covid-19 response with the opening of additional beds and running at a lower occupancy.

Lower occupancy is necessary to maximise patient and staff safety and promote the best possible outcomes for patients. Whilst clearly we have seen mortality rates rise during April, it is heartening to report that 54 patients were discharged from inpatient services having recovered from the virus.

**ARE OUR SERVICES RESPONSIVE?**

The temporary closure of the Vale, Dilke & Tewkesbury MIIUs in response to the Coronavirus outbreak may have impacted upon initial assessment times as activity is now met only in the remaining four MIIUs between 08;00 – 18:00hrs.

Referral to treatment times have all been impacted upon directly by our response to Covid-19 due to suspension, or partial suspension of many community services. As we enter the Recovery phase it is anticipated that these indicators will be revisited. Any changes to trajectories will be confirmed and supported by robust implementation plans. Outcomes will be monitored via this dashboard.
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CPA reviews have been directly impacted due to the need for minimal face to face contacts and social distancing. It is projected that this indicator will continue on a downward trajectory for several months whilst recovery plans are developed..

**ARE OUR SERVICES WELL LED?**

An extensive range of measures have been put in place to support the workforce and promote physical and mental well-being during the pandemic. A wide range of support options are available for colleagues to maintain their mental health, including a counselling service provided by Working Well, 'Wobble Room's and drop-in well-being sessions. The employee assistance programme through Vivup is available 24 hours a day and Let's Talk is offering a priority service for colleagues.

The Trust offers a range of options to help maintain good physical health for colleagues. This includes our fast track MSK physiotherapy support service. Health and Hustle is also a way of keeping fit alongside Trust colleagues and staff from other local organisations. Speaking up is a vitally important for protecting patients and colleagues as well as promoting a culture of transparency and learning from mistakes, and our Freedom to Speak Up Guardians have continued to be available to colleagues throughout this challenging time.

In response to the pandemic, there is now 7 day senior leadership cover each in week to support the wider workforce, in addition to existing on-call arrangements.

The Quality Directorate is delivering a rolling FFP3 mask fit-testing programme. A stratified risk assessment approach is being undertaken. Colleagues who may be exposed to aerosol generating procedures (AGPs) have been prioritised within the phase 1, which is complete apart form a handful of colleagues who have not been available to date (who will not undertake AGPs until they are fit tested). Phase 2 involves extensive roll-out of fit testing to any colleague who may be involved in emergency resuscitation or prolonged restraint. In order to manage the significant increase in those requiring fit-testing, 10 colleagues will be trained to fit-test by the Infection Prevention and Control Team so that they can redeployed as fit-testers. This is in addition to existing fit-testers who are fit-testing within their local clinical area. A comprehensive range of measures are in place to protect colleagues and mitigate risk whilst this programme is underway: respirator hoods on each inpatient ward, emergency FFP3 fit-checking action cards. The organisation is currently exploring making fit-testing for FFP3 masks part of the mandatory training programme for patient-facing colleagues.

Particular quality team focus has been applied to the concerning reports of increased vulnerability of Black and Minority Ethnic (BAME) colleagues to Covid-19. Work has been delivered on improving the occupational health risk assessments, additional advice on PPE and additional Vitamin D supplementation.

Due to the current situation, the delivery of statutory/mandatory training was paused from mid-March, currently until the end of June. Whilst staff are still able to complete on-line training this has inevitably had a negative impact on compliance figures.
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Wards have been provided with backfill from re-deployed and temporary (bank) staff during this period, along with fixed-term agency (12 week contracts) use for continuity of care plus increased external supply as needed, so that they are operating safely with the numbers of staff they require to meet clinical need. Work is ongoing to increase external supply agencies to ensure safe staffing is maintained ahead of the recovery of services and the return of redeployed staff to their substantive roles.

**DECISION**

The Board are asked to review the Quality Dashboard and consider if it provides them with sufficient oversight of key quality issues, and whether there is additional information they would wish to see included.

The Quality Dashboard is a live document which the Board can utilise as a vehicle to gain assurance of recovery plans in areas where targets are not being achieved.

| **Corporate Considerations** | |
|---|---|
| *Quality implications* | By the setting and monitoring of quality targets, the quality of the service we provide will improve |
| *Resource implications*: | Improving and maintaining quality is core trust business. |
| *Equalities implications:* | No issues identified within this report |
| *Risk implications:* | Specific initiatives that are not being achieved are highlighted in the Dashboard |

| **WHICH TRUST VALUES DOES THIS PAPER PROGRESS (P) OR CHALLENGE (C)?** | | | |
|---|---|---|---|
| Working together | P | Always improving | P |
| Respectful and kind | P | Making a difference | P |

| **Report authorised by: John Trevains** | **Date: 17.05.2020** |
|---|---|
| | |

| **Where has this issue been discussed before?** |
|---|
| Not discussed at Quality Committee due to C19 disruption |
| **What wider engagement has there been?** |
| Team discussions |

| **Appendices:** | See full quality report attached |
|---|---|
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Quality Dashboard 2020/21

Physical & Mental Health Services

(Development Version due to C19 disruption)

Data covering April 2020

Produced: 17/05/2020

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

Executive Summary

Gloucestershire Health and Care
NHS Foundation Trust

A series of local Quality Priorities were agreed in discussion with our clinicians and commissioners prior to the Covid-19 outbreak. In the current climate, these priorities may no longer meet the needs the population of Gloucestershire which we serve. We will, therefore, be reviewing the clinical and therapeutic needs of our patients, and the configuration of our services to support these needs over the coming months. This will, in turn, inform new local quality indicators which will be launched at the appropriate juncture in 2020/21. For information, the previously agreed priorities are shown below

	Goal	Target
1	To improve the physical health care for adults (aged18 and over) who are malnourished or at risk of malnutrition in hospital including identifying people at risk of malnutrition and providing nutrition support.	To achieve a target 70% of hospital inpatients having a nutritional screening that meets NICE Quality Standard QS24 with evidence of actions against identified risks. (CQUIN CCG3)
2	To ensure that End of Life care is provided with excellence and compassion	To improve how we identify patients entering the last 6-12 months of life, with the aim of enabling more timely ReSPECT conversations and implementing of advanced care planning
3	Improve transition processes for child and young people who move into adult	To ensure that joint Care Programme Approach (CPA) reviews occur for all service users who make the transition from children's to adult mental health services. If a joint review does not take place, the reason must be recorded. To implement Ready Steady Go for all patients aged over 14 in contact with physical health services who have an Education, and Health Care Plan and two or more specialist services involved.
4	Improving the experience of patients in key areas. This will be measured though defined survey questions for both people in the community and inpatients, and spanning both physical health and mental health services.	Overall, how was your experience with our service and the quality of care you received? > 90%
5		Did you feel you were treated with respect and dignity? > 90%
6		Did you feel the service was delivered safely and protected your welfare? > 90%
7		Were you involved as much as you wanted to be in decisions about your care and treatment? > 90%
8	Minimise the risk of suicide of people who use our services.	To 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. For all our mental health inpatient services to have zero suicides.
9	Promote the delivery of safe physical health care for all people with a learning disability when they need admission to an acute hospital	For all people on the complex heath care pathway under the Community Learning Disability Teams to have a "My Health Passport" ready for use on admission.
10	Embedding Learning from Serious incidents	Focus on further development of quality improvement led approach to robustly embedding lessons learned following incidents.
11	To improve physical health care for hospital inpatients (aged 18 and over) by the improved assessment and documentation of pressure ulcer risks.	To achieve a target of 60% of hospital inpatients (aged 18 and over) having a pressure ulcer risk assessment that meets NICE guidance with evidence of actions against all identified risks. (CQUIN CCG12)

Executive Summary

Gloucestershire Health and Care
NHS Foundation Trust

This Quality Dashboard report shows performance regarding key quality measures and priorities for 2020/21 and reports data and performance by exception. These data include both national and local contractual requirements. With regard to defined contractual or nationally-mandated quality related KPIs, the dashboard is only reporting on indicators not met.

Are Our Services Caring?
Whilst local surveys and the Friends & Family Test (FFT) are suspended during our response to the pandemic, patient and carer experience feedback continues to be gained through complaints, concerns and compliments. The Patient & Carer Experience Team remains fully operational and noted a 50% reduction in complaints and a 33% reduction in concerns; compliments received, however, are consistent in volume with historical trends. This is suggestive of how much services are valued and seen as 'Caring'; additionally we estimate that there have been several thousand 'thank you' messages and gifts from local communities, organisations and businesses since the outbreak.

Are Our Services Safe?
In terms of incident reporting, 5 SIRIs within mental health services were declared which is not uncommon for the month of April. In light of Covid-19 there is, however, multi-agency real time surveillance of reported suspected suicides and serious self-harm incidents with weekly review by the countywide suicide prevention steering group.

General combined physical and mental health service patient safety incident reporting trends are down by 31% from the monthly average and reported moderate harm incidents now roughly mirror the percentage seen previously by physical health services. It is believed that this is due the collapsing of a number of community services, combined with inpatient services focussing on harm related incidents, rather than reporting all no/low harm incidents. This trend will be actively monitored by the Quality Directorate and reviewed monthly.

The reduction in harm from falls is likely to be due to the inpatient population being more physically unwell because of Covid-19 related illness, and as such less mobile.

The number of acquired pressure ulcers reported within the District Nursing Service is above the threshold and it is of concern that 4x Grade 4 Acquired Pressure Ulcers were reported in April. These have not been subject to the usual review and validation due to the impact of Covid-19 on clinical capacity. In response, the Patient Safety Team have developed a pressure ulcer triage matrix for temporary use until the pandemic has settled. These incidents are currently being triaged to determine if they were avoidable. A concise investigation has been completed for one of these which identified that the care was appropriate and this will not be progressed as a SIRI. A further concise investigation is underway for another. The remaining incidents will be further reviewed by the Patient Safety Team with a decision taken regarding whether the threshold for reporting and investigating as serious incidents, either individually or collectively, is met. The patient safety team will be supported by a senior nurse from the NQT during this process in order to identify any wider issues that may be contributing to an increase in reported pressure ulcers- analysis and any improvement work required will be presented to a future quality committee.

Are Our Services Effective?

Bed occupancy in community hospitals and mental health inpatient services has shown a continued reduction and is a direct response to the Covid-19 response with the opening of additional beds and running at a lower occupancy. Lower occupancy is necessary to maximise patient and staff safety and promote the best possible outcomes for patients.

Within mental health services, 2 key quality indicators were not met:

Early Intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral. Compliance was 0% against a 50% target; this was due to 1 person that required treatment in April and unfortunately this was not commenced within the required 2 weeks. The referral was made whilst the person was an inpatient and care-coordination was not handed over to the EIP team until after discharge, which was longer than the required 2 weeks from referral.

Improving access to psychological therapies (IAPT): Proportion of people completing treatment who move to recovery (from IAPT database) Waiting time to begin treatment (from IAPT minimum dataset). Clients have been ceasing therapy mid-way through as they have competing priorities and are also reluctant to transfer to individual treatment from group courses that were part-completed. There are also clients that do not want to move to telephone or video based interventions from face to face or are leaving the course as they dislike it. Covid-19 has disrupted IAPT targets nationally and will reduce expectations for national Q1 reporting.

Executive Summary

Are Our Services Responsive?

The temporary closure of the Vale, Dilke & Tewkesbury MIIUs in response to the Covid-19 outbreak may have impacted upon initial assessment times as activity is now met only in the remaining 4 MIIUs between 08:00 – 18:00hrs. In line with national trends, presentation at MIIUs has been greatly reduced.

Referral to treatment times have all been impacted upon directly by the Covid-19 response due to suspension, or partial suspension of many community services. As we enter the recovery phase it is anticipated that these indicators will be revisited and opportunities will be taken to review pathways. Any changes to trajectories will be confirmed and supported by robust implementation plans. Outcomes will be monitored via this Quality Dashboard.

CPA reviews have been directly impacted due to the need for minimal face to face contact and social distancing. It is projected that this indicator will continue on a downward trajectory for several months whilst recovery plans are worked up.

Are our Services Well Led?

An extensive range of measures have been put in place to support the workforce and promote physical and mental well-being during the pandemic. A wide range of support options are available for colleagues to maintain their mental health, including a counselling service provided by Working Well, 'Wobble Room's and drop-in well-being sessions. The employee assistance programme through Vivup is available 24 hours a day and Let's Talk is offering a priority service for colleagues.

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In response to the pandemic, there is now 7 day senior leadership cover each in week to support the wider workforce, in addition to existing on-call arrangements.

The Quality Directorate is delivering a rolling FFP3 mask fit-testing programme. A stratified risk assessment approach is being undertaken. Colleagues who may be exposed to aerosol generating procedures (AGPs) have been prioritised within the phase 1, which is complete apart form a handful of colleagues who have not been available to date (who will not undertake AGPs until they are fit tested). Phase 2 involves extensive roll-out of fit testing to any colleague who may be involved in emergency resuscitation or prolonged restraint. In order to manage the significant increase in those requiring fit-testing, 10 colleagues will be trained to fit-test by the Infection Prevention and Control Team so that they can redeployed as fit-testers. This is in addition to existing fit-testers who are fit-testing within their local clinical area. A comprehensive range of measures are in place to protect colleagues and mitigate risk whilst this programme is underway: respirator hoods on each inpatient ward, emergency FFP3 fit-checking action cards. The organisation is currently exploring making fit-testing for FFP3 masks part of the mandatory training programme for patient-facing colleagues.

Due to the current situation, the delivery of statutory/mandatory training was paused from mid-March, currently until the end of June. Whilst staff are still able to complete on-line training this has inevitably had a negative impact on compliance figures. Particular quality team focus has been applied to the concerning reports of increased vulnerability of Black and Minority Ethnic (BAME) colleagues to Covid-19. Work has been delivered on improving the occupational health risk assessments, additional advice on PPE and additional Vitamin D supplementation.

Wards have been provided with backfill from re-deployed and temporary (bank) staff during this period, along with fixed-term agency (12 week contracts) use for continuity of care plus increased external supply agencies as needed, so that they are operating safely with the numbers of staff they require to meet clinical need. Work is ongoing to increase external supply to ensure safe staffing is maintained ahead of the recovery of services and the return of redeployed staff to their substantive roles.

Quality Dashboard

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CQC DOMAIN - ARE SERVICES CARING? (Combined physical and mental health services)

No		Reporting Level	Threshold	2019/20 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2020/21 YTD	R / A / G	Exception Report?	DQ Rating	Benchmarking Report
	Friends and Family Test Response Rate	N - T	15%		Suspended																
	% of respondents indicating 'extremely likely' or 'likely' to recommend service	N - R	95%	88%	Suspended																
	Number of Compliments	L - R		2,938	228												228				
	Number of Complaints	N - R		117	5												5				
	Number of Concerns	L - R		620	33												33				

Additional information

Combined figures for both physical and mental health services is shown.

Regarding activity;

- 5 complaints were received which is a 50% (approx.) reduction in volume from the monthly average during 2019/20.
- Numbers of compliments received are consistent with historical data;
- There has also been an approx. 33% reduction in the numbers of concerns raised.

Summary of current Patient & Carer Experience Team (PCET) processes during Covid-19:

- The PCET continue to review all new complaints, concerns and enquiries on a weekly basis during a PECT conference call They also review at what stage in the process we are with ongoing complaints, concerns and enquiries.
- For all new complaints, the complainants receive a Covid-19 Acknowledgement Letter explaining we are expecting significant delays in responding to complaints.
- All new complaints are assessed for the need for an investigation to be initiated and prioritised e.g. if the complaint may have potential issues relating to patient safety or relate to the current Covid-19 pandemic e.g. a patient death.
- If a complaint needs to be investigated immediately, our normal processes with then be followed i.e. agree issues with the complainant, set Terms of Reference, request a colleague is nominated to investigate the complaint.
- For complaints on hold/awaiting investigation these will continue to be monitored in our weekly team conference call.
- The PECT will continue to report this data on a 2/52 basis for the PST and PCET report to the Director of Nursing, Therapies & Quality.
- For formal complaints received prior to 24/3/20, all complainants will receive a Covid-19 Holding Letter. These complaints are recorded as on hold/awaiting investigation, being investigated or Final Response letter (FRL) under way.
- For complaints that have been investigated and the investigation report has been received by the PCET, the normal process for drafting, reviewing and approving FRLs is followed.
- The PCET still provide support and advice to patients, their families and colleagues regarding issues raised and respond to queries as required including the support of resolution at a local level.

- The Friends & Family Test survey is currently suspended as a feedback mechanism. Careful consideration will be given to reinstating this at an appropriate juncture in the future.

Public Feedback

The Trust has received a huge volume of thank you messages and well wishes from local communities, organisations and businesses since the Covid-19 outbreak began.
This includes:

- Donations of items of PPE, such as masks, hand-made scrubs and knitted or sewn ear protectors to help colleagues with wearing face masks
- Toiletries, including hand cream, hand wash and face creams
- Refreshments, including hot meals, soft drinks, Easter eggs and energy bars
- Paintings, drawings and photographs from local children, which have been shared via the Trust's social media channels
- Letters, cards, video messages and social media message of thanks
- Other gifts, such as sculptures and artwork

While we do not have an overall total we estimate that the well-wishers run into several thousand individuals. We are asking staff to record all gifts and hospitality on our Trust Gifts and Hospitality register, via the Trust Secretary.

*In-month threshold (i.e. March)

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

RAG Key: R – Red, A – Amber, G - Green

CQC DOMAIN - ARE SERVICES SAFE? INCIDENTS (Combined physical and mental health services)

		Reporting Level	Threshold	2019/20 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2020/21 YTD	R / A / G	Exception Report?	DQ Rating	Benchmarking Report
	Number of Never Events	N - T	0	1	0																N/A
	Number of Serious Incidents Requiring Investigation (SIRI)	N - R		49	5															G	N/A
	Number of Serious Incidents Requiring Investigation (SIRI) where Medication errors caused serious harm	N - R		0	0															G	N/A
	Number of Serious Incidents Requiring Investigation (SIRI) regarding falls lead to fractures	N - R		6	0																N/A
	Number of Serious Incidents Requiring Investigation (SIRI) regarding pressure ulcers	N - R		5	0																N/A
	Number of Serious Incidents Requiring Investigation (SIRI) regarding suspected suicides	N - R		18	2																N/A
	Number of Serious Incidents Requiring Investigation (SIRI) regarding self harm or attempted suicide	N - R		6	3																N/A
	Number of Serious Incidents Requiring Investigation (SIRI) regarding mental health homicides	N - R		1	0																N/A
	Total number of Patient Safety Incidents reported	L - R		12,109	695															G	N/A
	% incidents resulting in low or no harm	L - R		94.71%	90.50%															G	N/A
	% incidents resulting in moderate harm, severe harm or death	L - R		5.29%	9.50%															G	N/A
	% falls incidents resulting in moderate, severe harm or death	L - R		2.24%	0.96%															G	N/A
	% medication errors resulting in moderate, severe harm or death	L - R		0.61%	6.06%															G	N/A
	Embedding Learning meetings taking place to review the outputs of completed SIRI reports and consider practice implications.	L - R		N/A	0																N/A

*In-month threshold (i.e. March)

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

RAG Key: R – Red, A – Amber, G - Green

Additional information

Combined figures for both physical and mental health services is shown.

All SIRIs reported in April were from within mental health services, it is not uncommon to see relatively high levels of reporting in the month of April within mental health services. It is not known if there was any relationship between these incidents and the impact of Covid-19 although this will be considered as part of the investigative process. All SIRIs have an allocated investigating officer working on production of preliminary investigations. SIRI panel meetings and internal review meetings which have been on hold during the pandemic will resume virtually during May using MS Teams.

No embedding learning meetings, the forum in which individual teams review the output of completed serious incident investigations and consider practice implications, took place in April. This was because no mental health internal reviews or physical health SIRI panel meetings occurred due to the pandemic, and therefore no serious incident final reports were published. It is projected that serious incident final reports will start being finalised and published again in June, after which it is anticipated that embedding learning meetings will commence.

Regarding all patient safety incidents;

- Last financial year 2G had a lower rate of moderate, severe and death patient safety incidents (1.4%) compared with GCS (9.25%) but the whole combined data set for the Trust is now closer to the GCS level in April (9.5%);
- We have seen a clear reduction in the number of patient safety incidents reported in April this year to 695 from the monthly average of 1009 across the two Trusts last year, a drop of 314 from the monthly average;
- There has been a drop of 326 in the number of no/low harm incidents reported and a rise of 13 in moderate+ incidents reported compared to the monthly average;
- Some of the percentage change may, therefore, be accounted for by staff prioritising the reporting of moderate+ incidents and reporting fewer no/low incidents due to COVID pressures; Safer lower priority services may also have been closed, with higher priority services that are still open being those more likely to see moderate+ incidents and this could have affected the data. This trend will be actively monitored by the Quality Team and reviewed monthly;
- The reduction in harm from falls is likely to be due to the inpatient population being more physically unwell because of Covid related illness , and as such, are less mobile; alongside high staff numbers in support.
- The Patient Safety Team review and sign off all incidents graded as moderate and above, taking investigative action where indicated and coordinating Duty of Candour responses in conjunction with the Patient & Carer Experience Team. Currently there is decreased capacity within the team to review all such incidents in detail due to 3 x B7 vacancies 'on hold' during the pandemic, 1 x B7 has been redeployed to the Infection Control Team, and 1 x B8A has been redeployed within mental health inpatient services.

The reported percentage rise in medication errors resulting in moderate or above harm relates to 2 incidents as below:

1. The patient harm was due to dispensing error by a community pharmacy. This has been reported to NHS England who commission community pharmacy services and they are investigating

2. Self-administering insulin under the supervision of the community nursing team after recently being discharged from hospital.

Quality Dashboard

Gloucestershire Health and Care
NHS Foundation Trust

CQC DOMAIN - ARE SERVICES SAFE? Physical Health Services

		Reporting Level	Threshold	2019/20 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2020/21 YTD	RAG	Exception Report?	DQ Rating	Benchmarking Report
	VTE Risk Assessment - % of inpatients with assessment completed	N - T	95%	97.3%	94.6%												94.6%	A		G	
	Safety Thermometer - % Harm Free	N - R L - C	95%	93.2%	N/A												N/A	N/A		A	
	Safety Thermometer - % Harm Free (New Harms only)	L - I	98%	97.8%	N/A												N/A	N/A		A	97.7%
	Total number of Acquired pressure ulcers	L - R	61	784	62												62	R		G	
	Total number of grades 1 & 2 Acquired pressure ulcers	L - R	56	737	54												54	R		G	
	Number of grade 3 Acquired pressure ulcers	L - R	0	46	4												4	R		A	
	Number of grade 4 Acquired pressure ulcers	L - R	0	8	4												4	R		A	

Additional information

Safety Thermometer reporting has currently been suspended due to Covid-19 in agreement with commissioners.

The number of acquired pressure ulcers reported within the District Nursing Service is above the threshold and it is of concern that 4 Grade 4 Acquired Pressure Ulcers were reported in April. These have not been subject to the usual review and validation due to the impact of Covid-19 on clinical capacity. In response, the Patient Safety Team have developed a pressure ulcer triage matrix for temporary use until the pandemic has settled. These incidents are currently being triaged to determine if these were avoidable; a concise investigation has been completed for one of these which identified that the care was appropriate and this will not be progressed as a SIRI, a further concise investigation is underway for another. The remaining incidents will be further reviewed by the Patient Safety Team with a decision taken regarding whether the threshold for reporting and investigating as serious incidents, either individually or collectively, is met. The patient safety team will be supported by a senior nurse from the NQT during this process in order to identify any wider issues that may be contributing to an increase in reported pressure ulcers- analysis and any improvement work required will be presented to a future quality committee. Acquired Pressure Ulcers are a key nursing quality metric within community services and should be examined within the context of caseload complexity, workforce and external challenges in order to draw accurate conclusions and associated learning.

Learning Disability Services

The Operational Policy for community learning disability services has been updated in light of Covid-19. The Community Learning Disability Teams (CLDTs), Learning Disability Intensive Support Service (LDISS) and the Intensive Health Outreach Team (IHOT) have temporarily amalgamated to ensure consistent, responsive and safe service delivery throughout the Covid-19 response. All caseloads have been categorised into 3 priority levels based on their clinical risk and need. Priority 1 (high need) and Priority 2 (moderate need) individuals continue to receive input. Priority 3 service users are not currently actively monitored but they and their support system have been provided with clear details of when and how to escalate any concerns. Our specialist learning disability teams are aware that, due to the unique complexity of their presentation, many people with a learning disability may quickly escalate from P3 to P1 with very little warning. They are also aware that people with a learning disability may present with atypical signs of Covid-19 and may not be able to reliably self-report their symptoms and so they have taken additional steps to identify changes in physical presentation. Guidance has been issued to teams that details atypical clinical presentation including easy read versions to support the service users to report changes.

Within the community, the vast majority of contacts are undertaken via telephone or video consultation. Some clinical interventions require face to face contact and these are completed with appropriate PPE and risk management in place. Reasonable adjustments in relation to the disposal of PPE in line with IPC guidance have been made where there is a risk to the service user disposing of their own waste.

Within Berkeley House, all patients are classed as Priority 1. Detailed planning and training has been undertaken in order to ensure safe staffing levels are maintained within this setting. This has involved redeployment of colleagues from IHOT and LDISS to maintain staffing numbers. Berkeley House has had 2 patients tested for Covid-19 and 1 confirmed case. Excellent work was undertaken to prepare patients to be tested, including social stories and testing by familiar staff (as requested by the patient). Berkeley House colleagues have worked hard to ensure patients are minimally distressed by PPE and unavoidable changes to their usual care and routines.

Subsequent iterations of this dashboard will include annual health check numbers as The Trust has identified this as quality priority in 20/21.

*In-month threshold (i.e. March)

N - T	National measure/standard with target	L – I	Locally agreed measure for the Trust (internal target)
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RAG Key: R – Red, A – Amber, G - Green

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

CQC DOMAIN - ARE SERVICES EFFECTIVE?

		Reporting Level	Threshold	2019/20 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2020/21 YTD	RAG	Exception Report?	DQ Rating	Benchmarking Report
Community Hospitals																					
	Bed Occupancy - Community Hospitals	L - C	92%	94.4%	76.1%												76.1%	A		A	90.4%
Mental Health Services																					
	Early Intervention in psychosis EIP: people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral	N - T	50%	69%	0%																
	Ensure that cardio-metabolic assessment & treatment for people with psychosis is delivered routinely in the following service areas:																				
	Inpatient Wards	N - T	90%	80%																	
	GRiP	N - T	90%	85%																	
	Community	N - T	75%	78%																	
	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	N - T	50%	50.1%	37.5%																
	Admissions to adult facilities of patients under 16 years old.	N - R		2	0																
	Inappropriate out-of area placements for adult mental health services	N - R	average bed days	19	30																
Childrens Services - Immunisations				2019/20 Academic Year	Academic Year 2019/20					Academic Year 2020/21											
	HPV Immunisation coverage for girls aged 12/13 years old (1st Immunisation)	N - T	85%*	89.5%	79.7%					Programme commences January 2021							79.7%	R		G	
Childrens Services - National Childhod Measurement Programme				2019/20 Academic Year	Academic Year 2019/20					Academic Year 2020/21											
	Percentage of children in Reception Year with height and weight recorded	N - T	70%*	97.7%	66.4%					Programme commences in November 2019							66.4%	R		G	
	Percentage of children in Year 6 with height and weight recorded	N - T	70%*	97.2%	66.1%					Programme commences in November 2019							66.1%	R		G	

Additional Information

Bed Occupancy
Bed Occupancy in Community Hospitals has shown a continued reduction and is a direct response to the Covid-19 response with the opening of additional beds and running at a lower occupancy. Lower occupancy is necessary to maximise patient and staff safety and promote the best possible outcomes for patients.

Mental Health
Early Intervention - There was 1 person that started treatment in April; unfortunately this was not within the required 2 weeks. The referral was made whilst an inpatient and care-coordination not handed over to the EI team until after discharge which was longer than the required 2 weeks from referral.
IAPT - Clients have been dropping out of therapy midway, as they have other priorities and are also reluctant to transfer to individual treatment from group courses that were part-completed. There are also clients that do not want to move to telephone or video based interventions from face to face or are dropping out as they dislike it. Covid-19 has disrupted IAPT targets nationally and will reduce expectations for national Q1 reporting.

Children's Services
These reported programmes have been stopped due to the Covid-19 outbreak.

As we enter the Recovery phase it is anticipated that these indicators will be revisited. Any changes to trajectories will be confirmed and supported by robust implementation plans. Outcomes will be monitored via this dashboard.

CQC DOMAIN - ARE SERVICES RESPONSIVE?

Physical Health Services

Minor Injury and Illness Units

		Reporting Level	Threshold	2019/20 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2020/21 YTD	RAG	Exception Report?	DQ Rating	Benchmarking Report Feb Figure
	Time to initial assessment for patients arriving by ambulance (95th percentile)	N - T	<15 m	00:14	00:17												00:17	R		A	
Referral to Treatment																					
	Podiatry - % treated within 8 Weeks	L - C	95%	73.6%	92.9%												92.9%	A		A	
	ICT Physiotherapy - % treated within 8 Weeks	L - C	95%	79.8%	65.1%												65.1%	R		A	
	ICT Occupational Therapy Services - % treated within 8 Weeks	L - C	95%	83.5%	79.4%												79.4%	R		A	
	Paediatric Speech and Language Therapy - % treated within 8 Weeks	L - C	95%	88.5%	60.2%												60.2%	R		G	
	Paediatric Physiotherapy - % treated within 8 Weeks	L - C	95%	84.5%	72.2%												72.2%	R		G	
	Paediatric Occupational Therapy - % treated within 8 Weeks	L - C	95%	95.4%	92.9%												92.9%	A		G	
	Single Point of Clinical Access (SPCA) Calls Offered (received)	L - R	3,279	35939	1787												1787	R		G	
Mental Health Services																					
	CPA Review within 12 Months	N - T	95%	96.9%	86.9%												86.9%	R		A	

Additional information

The temporary closure of the Vale, Dilke & Tewkesbury MIIUs in response to the Covid-19 outbreak may have impacted upon initial assessment times as activity is now met only n the remaining four MIIUs between 08;00 – 18:00hrs

Referral to treatment times have all been impacted upon directly by our response to Covid-19. As we enter the Recovery phase it is anticipated that these indicators will be revisited. Any changes to trajectories will be confirmed and supported by robust implementation plans. Outcomes will be monitored via this dashboard.

Again, CPA reviews have been directly impacted due to the need for minimal face to face contacts and social distancing. It is projected that this indicator will continue on a downward trajectory for several months whilst recovery plans are developed.

Termination of Pregnancy Services

GHC responded swiftly to the Department of Health and Social Care emergency amendment to the Abortion Act (1967) (2), which allows the patient's home to be a suitable place to take both parts of the medical abortion treatment during the Covid-19 pandemic. This means that in women who are assessed to be clinically suitable, all of their consultation can be done remotely. Medicines can then either be picked up from Hope House, or posted out. All women will be assessed for their suitability for the abortion method in terms of safety (medical reasons and safe home environment). A robust risk assessment is in place and effective communication across all stakeholders has been issued. For those women who are not assessed as suitable for this procedure GHC continues to offer alternative options.

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Quality Dashboard

Gloucestershire Health and Care
NHS Foundation Trust

Additional KPIs Physical Health

		Reporting Level	Threshold	2019/20 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2020/21 YTD	RAG	Exception Report?	DQ Rating	Benchmarking Report Feb Figure
	Proportion of eligible children who receive vision screens at or around school entry.		70%*	N/A	60.4%												60.4%	R		A	
	Number of AnteNatal visits carried out		92	944	46												46	R		G	
	Percentage of live births that receive a face to face NBV (New Birth Visit) within 7- 14 days by a Health Visitor		95%	91.5%	31.1%												31.1%	R		A	
	Percentage of children who received a 6-8 weeks review.		95%	94.1%	12.2%												12.2%	R		A	
	Percentage of children who received a 9-12 month review by the time they turned 12 months.		95%	84.8%	80.3%												80.3%	A		A	
	Percentage of children who received a 12 month review by the time they turned 15 months.		95%	90.2%	89.4%												89.4%	A		A	
	Percentage of children who received a 2-2.5 year review by 2.5 years.		95%	83.5%	81.9%												81.9%	A		A	
	Percentage of infants being totally or partially breastfed at 6-8wks(breastfeeding prevalence).		58%	54.9%	56.7%												56.7%	A		A	
	Chlamydia Screening of Gloucestershire residents aged 15-24 via the Chlamydia Screening Service (minimum positivity rate)		3108	1929	895												895	R		A	
	Number of Positive Screens		169	1329	53												53	R		A	
	Average Number of Community Hospital Beds Open		196	195.4	173.3												173.3	R		G	
	Average Number of Community Hospital Beds Closed		0	1.1	19.2												19.2	R		G	

Additional Information

Each of the above indicators have seen further reduction in performance due to the impact of Covid-19 and there is a partial suspension of Health Visiting services.

All mandated contacts/referrals are triaged through a decision making framework to enable prioritisation and selection of the most appropriate delivery method- telephone/video call/face to face. Colleagues utilise the Trust's screening tool to ensure the appropriate PPE is used when delivering face to face care.

The service will continue to utilise the Family Health Needs assessment to determine the family offer, this will be in partnership with parent/carer and liaison with other professionals as appropriate, ensuring those with vulnerability have their needs met.

Chlamydia screening is likely to have been impacted due to a lower number of reported attendees at sexual health clinics.

Community hospital bed base has been reduced to reflect service provision in response to Covid-19. Lower occupancy is necessary to maximise patient and staff safety and promote the best possible outcomes for patients.

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Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

CQC DOMAIN - ARE SERVICES WELL LED?

		Reporting Level	Threshold	2019/20 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2020/21 YTD	RAG	Exception Report?	DQ Rating	Benchmarking Report
	Staff Friends and Family Test - Percentage of staff who would recommend the Trust as a place of work	N - R L - T	61%																		
	Staff Friends and Family Test - Percentage of staff who would recommend the Trust as a place to receive treatment	N - R L - T	67%																		
	Mandatory Training	L - I	90%		85%																
	% of Staff with completed Personal Development Reviews (Appraisal)	L - I	90%	80%	74%																
	Sickness absence average % rolling rate - 12 months	L - I	<4%	4.72%	4.9%																
	SUS+ (Secondary Uses Service) Data Quality Validity - Available in arrears	N-R	96.30%																		

Additional information

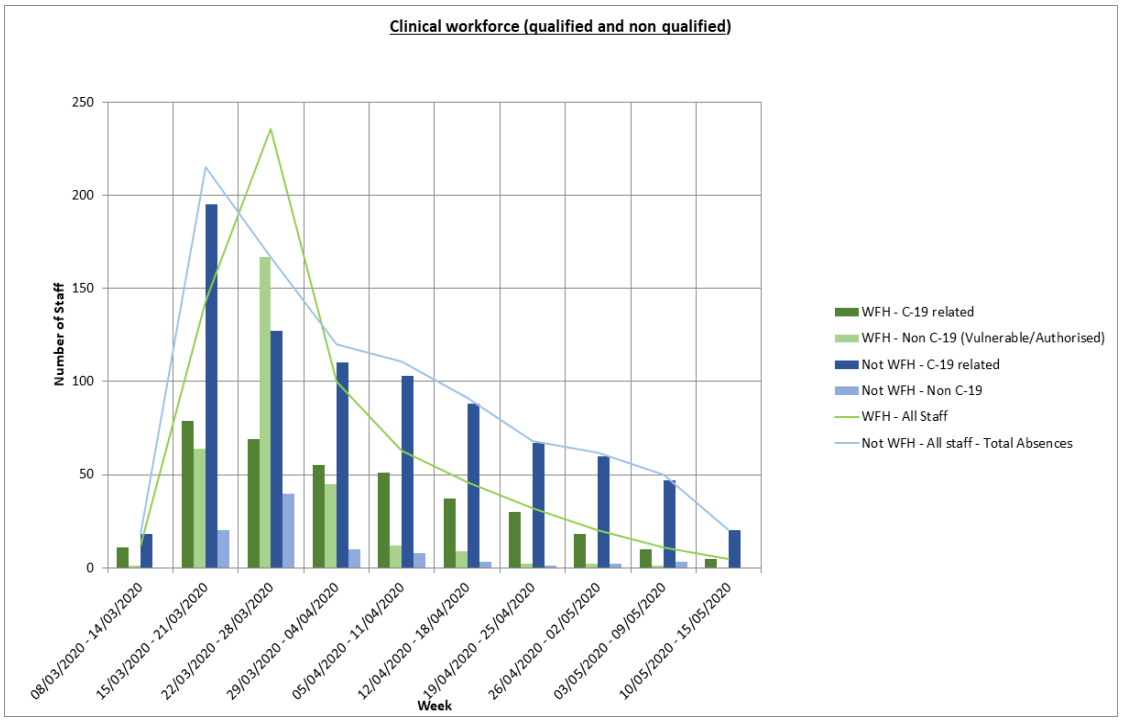
Combined figures for both physical and mental health services is shown.

- Due to the current situation, the delivery of statutory/mandatory training was paused from mid-March, currently until the end of June. Whilst staff are still able to complete on-line training this has inevitably had a negative impact on compliance figures. Once training recommences staff will be able to access training that is out of date. However it's likely that full recovery will take a little time due to the backlog of staff needing training and limits on services areas to release staff along with capacity of training places.
- Appraisal compliance has dropped by 6%, a direct result of the current situation including the redeployment of staff. As with training, recovery back up to trajectory will take some time.
- Sickness/absence as routinely report rose to 4.9% compared to the 2019/20 out turn. Data to the right is in addition to this and relates to nursing (registered and non registered) and AHPs that have been affected by Covid.

An extensive range of measures have been put in place to support the workforce and promote physical and mental well-being during the pandemic. A wide range of support options are available for colleagues to maintain their mental health, including a counselling service provided by Working Well, 'Wobble Room's and drop-in well-being sessions. The employee assistance programme through Vivup is available 24 hours a day and Let's Talk is offering a priority service for colleagues.

The Trust offers a range of options to help maintain good physical health for colleagues. This includes our fast track MSK physiotherapy support service. Health and Hustle is also a way of keeping fit alongside Trust colleagues and staff from other local organisations. Speaking up is a vitally important for protecting patients and colleagues as well as promoting a culture of transparency and learning from mistakes, and our Freedom to Speak Up Guardians have continued to be available to colleagues throughout this challenging time.

In response to the pandemic, there is now 7 day senior leadership cover each in week to support the wider workforce, in addition to existing on-call arrangements.



CQC DOMAIN - ARE SERVICES WELL LED?

Safe Staffing Levels

			Day		Night		Day		Day	Day		Day		Night		Night		Day		Day		Day	
			Registered nurses	Care Staff	Registered nurses	Care Staff	Registered Therapists	Unregistered Therapists	Registered Nursing Associates	Registered nurses		Care staff		Registered nurses		Care staff		Registered Therapists		Unregistered Therapists		Registered Nursing Associates	
		Current established beds	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	Average fill rate - registered therapists (%)	Average fill rate - unregistered therapists (%)	Average fill rate - Registered nursing associates (%)	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours
Community Hospitals																							
	Average	18	92.1%	89.7%	90.5%	90.2%	89.3%	76.6%	108.5%	1267.5	1167.5	1875.8	1682.5	510.0	461.7	545.0	491.7	442.8	395.6	236.7	181.3	39.17	42.50
	Cirencester - Coln Ward	22.3	101.9%	83.0%	88.5%	94.4%	92.1%	100.0%	100.0%	1575.0	1605.0	2070.0	1717.5	585.0	517.5	675.0	637.5	478.8	441.0	150.1	150.1	172.50	172.50
	Cirencester - Windrush Ward	15.8	84.8%	91.3%	100.0%	83.3%	92.1%	100.0%	0.0%	1035.0	877.5	1800.0	1642.5	450.0	450.0	450.0	375.0	261.2	240.6	81.9	81.9	0.00	0.00
	Dilke - Forest Ward	19.5	93.0%	90.6%	76.9%	96.7%	73.7%	62.0%	0.0%	1605.0	1492.5	2070.0	1875.0	585.0	450.0	675.0	652.5	427.5	315.0	349.0	216.5	0.00	0.00
	Lydney	19.5	100.0%	97.9%	100.0%	96.7%	81.3%	79.0%	0.0%	1102.5	1102.5	1777.5	1740.0	450.0	450.0	450.0	435.0	350.0	284.5	245.0	193.5	0.00	0.00
	North Cots - Cotswold View Ward	22	100.0%	100.0%	101.7%	96.7%	97.3%	69.5%	0.0%	900.0	900.0	1575.0	1575.0	450.0	457.5	450.0	435.0	413.5	402.3	196.9	136.9	0.00	0.00
	Stroud - Cashes Green Ward	16.5	83.2%	84.8%	90.0%	75.0%	88.4%	86.5%	116.7%	1252.5	1042.5	1875.0	1590.0	450.0	405.0	450.0	337.5	210.9	186.4	130.4	112.8	180.00	210.00
	Stroud - Jubilee Ward	15.7	95.5%	96.3%	101.7%	96.2%	88.4%	86.5%	0.0%	1170.0	1117.5	1620.0	1560.0	450.0	457.5	585.0	562.5	237.8	210.1	147.1	127.2	0.00	0.00
	Tewkesbury - Abbey View Ward	17.2	106.7%	85.6%	88.5%	89.7%	95.5%	99.8%	0.0%	1335.0	1425.0	1980.0	1695.0	585.0	517.5	585.0	525.0	932.3	890.5	290.0	289.5	0.00	0.00
	Vale	16.8	66.0%	82.6%	76.9%	79.5%	87.6%	59.9%	0.0%	1432.5	945.0	2115.0	1747.5	585.0	450.0	585.0	465.0	673.0	589.8	540.0	323.5	0.00	0.00

Additional information

Community Hospitals

Vacancies continue to be high across most inpatient wards, however wards were able to backfill with re-deployed and temporary (bank) staff during this period, along with fixed-term agency use for continuity of care, so that they are operating safely with the numbers of staff they require. As part of our Covid-19 response, the Trust has signed up to an NHS Providers Bank contract as an additional source of staffing for the community hospitals. Wards have been provided with backfill from re-deployed and temporary (bank) staff during this period, along with fixed-term agency (12 week contracts) use for continuity of care plus increased external supply as needed, so that they are operating safely with the numbers of staff they require to meet clinical need. Senior NTQ visits to all community Hospitals continue to be undertaken to support Matrons and staff to regularly review staffing levels and potential associated impact in light of Covid-19.

Work is ongoing to increase external supply agencies to ensure safe staffing is maintained ahead of the recovery of services and the return of redeployed staff to their substantive roles.

It has been necessary to augment the safe staffing numbers to reflect the increased demands of donning and doffing PPE .

Presentation of Data

Safe staffing data for community hospitals and mental health inpatients is recorded and presented differently. The Quality Team will review presentation of the data over coming months to harmonise the reporting approach.

PPE (all relevant physical and mental health sites)

The Quality Directorate is delivering a rolling FFP3 mask fit-testing programme. A stratified risk assessment approach is being undertaken. Colleagues who may be exposed to aerosol generating procedures (AGPs) have been prioritised within the phase 1, which is complete apart form a handful of colleagues who have not been available to date (who will not undertake AGPs until they are fit tested). Phase 2 involves extensive roll-out of fit testing to any colleague who may be involved in emergency resuscitation or prolonged restraint. In order to manage the significant increase in those requiring fit-testing, 10 colleagues will be trained to fit-test by the Infection Prevention and Control Team so that they can redeployed as fit-testers. This is in addition to existing fit-testers who are fit-testing within their local clinical area. A comprehensive range of measures are in place to protect colleagues and mitigate risk whilst this programme is underway: respirator hoods on each inpatient ward, emergency FFP3 fit-checking action cards. The organisation is currently exploring making fit-testing for FFP3 masks part of the mandatory training programme for patient-facing colleagues.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

CQC DOMAIN - ARE SERVICES WELL LED?

Safe Staffing Levels - Month

			Day		Night							
			Registered nurses	Care Staff	Registered nurses	Care Staff						
		Current established beds	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)		Available Bed Days	Occupied Bed Days Exc, Leave	& Occupancy	Occupied Bed Days inc, Leave	& Occupancy
Mental Health & LD Inpatient												
	Average											
	Abbey Ward WLH	18	90%	150%	130%	120%		481	342	71.1%	363	75.5%
	Dean Ward WLH	15	105%	140%	100%	150%		449	395	88.0%	445	99.1%
	Kingsholm Ward WLH	15	125%	175%	130%	160%		361	154	42.7%	154	42.7%
	Priory Ward WLH	18	115%	100%	110%	80%		533	371	69.6%	386	72.4%
	Montpellier WLH LSU	12	110%	105%	110%	100%		360	270	75.0%	270	75.0%
	Greyfriars WLH PICU	10	100%	105%	100%	150%		272	217	79.8%	217	79.8%
	Chestnut Ward CLC	14	98%	110%	100%	130%		390	203	52.1%	213	54.6%
	Mulberry Ward CLC	18	125%	125%	175%	130%		468	295	63.0%	315	67.3%
	Maple Ward CLC	8	0	0	0							
	Willow Ward CLC	16	105%	100%	100	150%		432	402	93.1%	402	93.1%
	Laurel House	13	140%	110%	100%	100%		330	215	65.2%	215	65.2%
	Honeybourne	10	110%	110%	100%	100%		390	272	69.7%	325	83.3%
	Berkeley House	7	90%	120%	105%	100%		4676	3346	**71.6%**	3515	75.2%

	Code 1		Code 2		Code 3		Code 4		Code 5	
Ward Name	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions
Dean	35	4	7.5	1	0	0	0	0	0	0
Abbey	250	31	15	1	0	0	0	0	0	0
Priory	225	29	0	0	0	0	0	0	0	0
Kingsholm	25	3	0	0	0	0	0	0	0	0
Montpellier	55	7	32.5	4	0	0	0	0	0	0
Greyfriars	355	41	0	0	0	0	0	0	0	0
Willow	120	14	7.5	1	7.5	1	0	0	0	0
Chestnut	122.5	15	0	0	0	0	0	0	0	0
Mulberry	37.5	5	22.5	2	0	0	0	0	0	0
Laurel	7.5	1	0	0	0	0	0	0	0	0
Honeybourne	15	2	0	0	0	0	0	0	0	0
Berkeley House	30	3	0	0	0	0	0	0	0	0
Total In Hours/Exceptions	1277.5	155	85	9	7.5	1	0	0	0	0

Definitions of Exceptions;

Code 1 =	Min staff numbers met – skill mix non-compliant but met needs of patients
Code 2 =	Min staff numbers not complaint but met needs of patients e.g. low bed occupancy , patients on leave
Code 3 =	Min staff numbers met – skill mix non-compliant and did not meet needs of patients
Code 4 =	Min staff numbers not compliant did not meet needs of patients
Code 5=	Other

Additional information

Mental Health & LD Inpatient

Whilst acknowledged there were RMN exceptions for Abbey Ward and Berkeley House (day shifts), the HCA fill rates in these environments exceeded the minimum required and therefore provides assurance that safe staffing establishments were achieved. Furthermore it can be accepted that management would have been available during these periods and not captured within the roster reports. Wards have been provided with backfill from re-deployed and temporary (bank) staff during this period, along with fixed-term agency (12 week contracts) use for continuity of care plus increased external supply as needed, so that they are operating safely with the numbers of staff they require to meet clinical need. Work is ongoing to increase external supply agencies to ensure safe staffing is maintained ahead of the recovery of services and the return of redeployed staff to their substantive roles.

The data indicates a high volume of Health Care staff availability and a likely consequence of redeployment of AHPs during Covid-19. It is also recognised that high levels of RMN and HCA availability on Kingsholm and Mulberry Ward has supported the identified Covid-19 Red environments.

Willow ward 1 x red code 3 due to sickness and unable to cover..

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 10

REPORT TO: **Trust Board – 20 May 2020**

PRESENTED BY: **Sonia Pearcey**

AUTHOR: **Sonia Pearcey**

SUBJECT: **Freedom to Speak Up (FTSU) Guardian Update**

If this report cannot be discussed at a public Board meeting, please explain why.	Colleague confidentiality is respected.

This report is provided for:

Decision **X** Endorsement ☐ Assurance **X** Information ☐

The purpose of this report is to

Provide assurance to the Trust Board that speaking up routes remain open for colleagues to speak up in these unprecedented times of Covid-19.

Recommendations and decisions required

- The Board is asked to note that FTSU processes are in place and continuing to be utilised by colleagues at these unprecedented times
- Future papers will be presented 6 monthly and in a structured format to ensure compliance with the *"Guidance for Boards on Freedom to Speak Up in NHS trusts and NHS foundation trusts"* updated published guidance July 2019 here

Executive summary

All organisations which regulate or provide NHS healthcare should implement the principles and actions set out in the report Freedom to Speak Up: An independent review into creating an open and honest reporting culture in the NHS.

This paper provides an update regarding FTSU activity at GHC to provide assurance to the Trust Board that speaking up routes remain open for colleagues to speak up in these unprecedented times of COVID-19.

18 concerns were raised in Quarter 4 2019-20 and this data is used as a comparison to concerns raised from the beginning of Quarter 1 2020-21 from the period of Covid-19. As of 13 May 2020 12 colleagues have spoken up, 1 from another NHS Trust, to the Freedom to Speak Up Guardian in Quarter 1.

Of the 11 concerns raised from colleagues within GHC, 8 were specifically related to COVID-19.

The FTSU Guardian has been supporting the Trust's incident response team as a COVID relationship lead, to support colleagues who may need specific advice relating to COVID-19. This has enhanced the role of the FTSU Guardian in enabling a further strategic outlook on the organisation and liaising with new colleagues.

Risks associated with meeting the Trust's values

All risks are clearly identified within the paper.

Corporate considerations	
Quality Implications	A positive speaking up culture within our workforce will ensure that patient safety matters are heard and that colleagues are supported
Resource Implications	Specifics that are not being achieved are highlighted in the report
Equality Implications	Nil

Where has this issue been discussed before?

Due to these unprecedented times of COVID-19 this report has not been discussed at a previous committee.

Appendices:	N/A

Report authorised by: Sonia Pearcey	**Title: Ambassador for Cultural Change / Freedom to Speak Up Guardian**

1. INTRODUCTION

1.1 On the 25 March 2020, Dr Henrietta Hughes OBE FRCGP, National Guardian for the NHS wrote to NHS Trust Chairs and CEOs to thank Guardians for continuing to support colleagues and for Trust's to consider how routes remain open for workers to speak up if the Guardian is being re-deployed.

1.2 There was also a follow up letter on the 23 April from the National Guardian and the Care Quality Commission, highlighting now more than ever that safety remains a priority for the whole system. All leaders of health and care services can support this by encouraging a supportive culture where people are able to speak up about risks and adverse outcomes, without fear of blame or repercussions. A psychologically safe culture provides a compassionate, inclusive, and trusting environment – one that shares safety insights and empowers people who use services and staff with the skills, confidence, and mechanisms to improve safety.

Speaking up is an essential element of a safe culture and should be 'business as usual' for everyone working in care, regardless of their role.

2. ASSESSMENT OF FTSU CASES

2.1 All concerns raised through the FTSU route are detailed in Table 1 for the two recent quarters.

Table 1

Quarter	Number of concerns raised	Number of cases raised anonymously	Detriment	Speak Up again
Q4: 2019-20	18	0	1	Yes - 7
Q1: 2020-21 (present)	12	0	0	Yes - 6

As of the 13 May 2020 the FTSU Guardian is supporting 11 cases of speaking up.

One colleague reported suffering determent from speaking up and the FTSU Guardian is working with the Director of Nursing, Therapies and Quality to support this individual further.

Reporting is quarterly to the National Guardian Office and there has been a delay on submission of Quarter 4 results and consolidation of the data for the year 2019-20 by the National Guardian Office die to the pandemic.

2.2 Themes

The "Guidance for Boards on Freedom to Speak Up in NHS trusts and NHS foundation trusts" updated published guidance July 2019, specifies that themes should be published within Board updates. Trends within areas (maintaining confidentiality) will be included within the 6 monthly reports moving forwards.

Tables 2 & 3 below are the mandated data that is submitted to the National Guardian Office, Covid-19 related data not reportable.

Table 2

Quarter	Number with an element of patient safety/ quality	Number with an element of bullying or harassment	Number with an element of other behaviours	Number with an element of systems and/or processes
Q4: 2019-20	3	7	8	5
Q1: 2020-21 (present)	3	6	0	6

Table 3 The professional background of those colleagues speaking up

Professional Group	Q4: 2019-20	Q1: 2020-21 (present)
Doctors		
Nurses	9	5
Health Care Assistants	1	
Midwives		1
Dentists		
Allied Health Care Professionals	4	3
Administrative staff	1	2
Facilities	2	
Corporate	1	1
Board Members		
Other		

When the 'other category' is considered, anonymous 'speak ups' fall into this category.

COVID-19 related

Quarter	Number with an element of patient safety/ quality	Number with an element of bullying or harassment	Number with an element of other behaviours	Number with an element of systems and/or processes
Q4: 2019-20	0	0	0	0
Q1: 2020-21 (present)	3	1	0	4

COVID-19 related themes raised include;

- Lack of social distancing
- Inappropriate use of PPE
- Home working discouraged
- Payment of a member of bank staff
- Redeployment
- Feeling bullied when did speak up to a manager

The National Guardian's Office has undertaken two Pulse surveys with Guardians to measure the impact which COVID-19 is having on Freedom to Speak Up.

A higher proportion (87%) of respondents to the second Pulse survey reported that speaking up was increasing compared to last month's survey, which is consistent with GHC. Colleague safety and wellbeing continues to be the main issue (83%) which workers are speaking up nationally about (up from 76% last month). This includes issues like PPE, social distancing, risk assessments and the impact of COVID-19 on BAME colleagues, which are reflective at GHC. The two survey results can be found here.

3. PATIENT SAFETY AND/OR WORKER EXPERIENCE FEEDBACK

Feedback is requested from colleagues when a case is closed, even when the person speaking up may be unhappy with the outcome of their case.

Some feedback from colleagues is below.

- Your Independent role gave me confidential a safe space and the confidence to speak up

- Given my experiences, yes I would speak up again. I have found the process to be efficient and non-threatening. However, I'm still not clear on the evidence behind PHE decisions. You and Ingrid in particular have been very supportive, so thank you for that as it was a big deal putting together the initial letter and worry about repercussions or getting a bad name etc. Thank you for your support over this - you've been fab!

- Absolutely I would speak up again. It was incredibly helpful to be heard and to feel that I was doing something proactive to have a voice, where I had been feeling that I had no voice and no power /influence. I am very grateful for the prompt help that was offered

4. ACTIONS TAKEN TO IMPROVE THE SPEAKING UP CULTURE

To create a positive speaking up culture, colleagues need to know how to speak up and to whom. Work continues to further improve the speaking up culture especially during these times where speaking up is more important than ever. The following builds upon previous significant work.

Continued and targeted communications - Regular messaging through the communications to reinforce the message that speaking up is welcomed and colleagues will always have access to the support needed.

Staff Health and Wellbeing portal – A portal for all of our staff health and wellbeing advice. Speaking Up includes narrative and contacts for the FTSU Guardian, Paul's Open Door and Work in Confidence.

Work in Confidence - We want all colleagues to feel confident that they can share their views or concerns, with a senior colleagues, without the need to share their identity. All colleagues can access Speak in Confidence; a safe, independent, anonymous and confidential web-hosted system on our intranet page. The FTSU Guardian has primary administrator access to this system to oversee the governance and promotion of this route to speaking up.

Speaking Up at Work policy - The Trust's policy has been updated in line with best practice and has been reviewed by HR and Staff Side colleagues here

Social media - Promoting speaking up through social media platforms and as a peer supporter on the new Trust Facebook group

New branding as GHC – Business cards and a banner have be produced with refreshed branding for GHC as a new merged organisation. The FTSU Guardian has considered with colleagues ways in which more inaccessible colleagues can be

reached and how the messaging can be tailored to, and reach vulnerable colleagues and those who may face particular barriers to speaking up.

Renaming and merger of the FTSU Advocate role and Dignity at Work Officer role – This role is progressing to offer further support to colleagues who are harder to reach and offers support to sign post them on to speak up to a relevant colleague. The decision to integrate these roles was from colleague feedback on a consistent approach to speaking up as a 'Speak Up Champion'. This is also in response to the most recent FTSU case review here conducted by the National Guardian Office, which recommends the term 'ambassador' or 'champion' be used instead of the word advocate, as advocate has associated legal implications. Specific training has been provided previously and that will be refreshed to meet the needs moving forwards.

5. LEARNING AND IMPROVEMENT

As of the 13 May 2020 the Freedom to Speak Up Guardian is supporting 11 cases of speaking up and all others have been closed. Below is a list concerning high level detail of learning points related to the current and previous quarter concerns raised.

- The development of a new service was reviewed and positive actions to improve the support to staff and their ability to fulfil the role and outcomes
- Resolution for pay related to colleagues who work on the Bank during COVID_19
- Further training to support the appropriate use of Personal Protective Equipment
- Review of social distancing within clinical sites and at multi-disciplinary team meetings
- A number of teams have reviewed local induction processes to support colleagues to 'speak up' through line managers and locally based 'Speak Up Champions'
- Further promotion of the Trust Values and role modelling by leaders

.6. Recommendations

Within this paper details have been provided for assurance in terms of approaches, developments, concerns raised and current speaking up arrangements.

Within the next 6 months, dependant on the current health landscape, recommendations are made that the following work will be conducted to ensure speaking up approaches at GHC:-

- Future papers will be presented 6 monthly and in a structured format to ensure compliance with the "Guidance for Boards on Freedom to Speak Up in NHS trusts and NHS foundation trusts" updated published guidance July 2019

- Focused exploration of professional groups who report using the speaking up route via the FTSU Guardian, specifically medical colleagues. This will include meetings with the Medical Director and attending the Medical Staff Committee and Junior Doctor's Forum

- Explore the triangulation of FTSU data with patient safety, safeguarding and employee relations

- Support and have a regular presence at the planned development of staff diversity networks, and continue to reach out to colleagues that are more hard to reach

- Further enhance speaking up as integral to the health and wellbeing of colleagues

- Scope and progress the development of the Board Self Review Tool and an implementation plan of the Freedom to Speak Up (FTSU) strategy in line with the strategic aims of the Trust.
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